# ABSENTEEISM IN DISTRICT RURAL HOSPITALS IN THE EASTERN CAPE: THE EXPERIENCES OF NURSES

By

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## DECLARATION

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## ABSTRACT

Absenteeism is a global concern that has a negative impact on employees, patients and the organization. Whilst absenteeism is exacerbated by working conditions such as resources (human, equipment), rural communities have a higher prevalence of chronic conditions than their urban counterparts which increases the workload.

The aim of the study was to explore the experiences of nurses in district rural hospitals in the Eastern Cape. The objectives of the study were to:

- Gain understanding of nurses' experience of absenteeism at the workplace.
- Explore the influence of intrinsic factors on absenteeism as experienced by nurses.
- Explore the influence if extrinsic factors on absenteeism as experienced by nurses.

A descriptive qualitative design was applied. A sample size of 12 was drawn from a total population of 183 at three participating hospitals, using purposive sampling. A pilot interview was conducted using a semi-structured interview guide based on the study's objectives. Credibility, confirmability, transferability and dependability was assured by using Lincoln and Cuba's criteria of trustworthiness. All ethical principles were met.

Seven themes emerged from data analysis, i.e., managing human resources, work planning and scheduling, job dissatisfaction and workload, diminished patient care, staff well-being, relationship building amid absenteeism and strategies for managing absenteeism. The findings support Hertzberg's theory on motivation factors regarding what motivates workers to perform well and not be absent from work. Hygiene factors such as heavy workload, lack of equipment, benefits and support staff, poor co-worker relationships as well as inconsistent implementation of policies all contributed to job dissatisfaction and ultimately absenteeism. As a result, human resource policies and practices should be revised and implemented to provide a more supportive work environment to reduce absenteeism.

**Keywords:** absenteeism, absenteeism and the nurse, absenteeism and the patient, absenteeism and the organization, job satisfaction, job dissatisfaction.

## OPSOMMING

Afwesigheid is ‘n wêreldwye kommerwekkende kwessie wat ‘n negatiewe impak op werkers, pasiënte en die organisasie het. Afwesigheid word verskerp deur werksomstandighede soos personeeltekorte en hulpbronne (mense, toerusting) asook plattelandse gemeenskappe met ‘n hoër voorkoms van kroniese siektetoestande as hulle stedelike eweknieë wat die werklading laat toeneem.

Die doel van die studie is om die ervaringe van die verpleegsters in plattelandse distrikshospitale in die Oos-Kaap te ondersoek.
Die doelwitte van die studie is om die:

- Begrip van verpleegsters se ervaring oor afwesigheid by die werkplek te bepaal
- Invloed van intrinsieke faktore oor afwesigheid soos ervaar deur verpleegsters te ondersoek
- Invloed van die ekstrinsieke faktore oor afwesigheid soos ervaar deur verpleegsters te ondersoek.

‘n Beskrywende kwalitatiewe ontwerp is toegepas. ‘n Steekproefgrootte van 12 (is geneem vanuit ‘n totale bevolking van 183 aan drie deelnemende hospitale, deur gebruik te maak van ‘n doelgerigte steekproefneming. ‘n Loodsondersoek is uitgevoer deur gebruik te maak van ‘n semi-gestruktureerde onderhoudsgids, gebaseer op die doelwitte van die studie. Kredietwaardigheid, bevestigbaarheid, oordraagbaarheid en afhanklikheid is verseker deur Lincoln en Guba se kriteria oor betroubaarheid. Alle etiese beginsels is nagekom.

Sewe temas is vanuit die data-analise geïdentifiseer, naamlik die bestuur van menslike hulpbronne, beplanning en skedulering van werk, werkersontevredenheid en werklading, afname in die versorging van pasiënte, personeelwelstand, verhoudingsopbouing te midde van afwesigheid en bestuurstrategieë vir afwesigheid. Dié bevindinge ondersteun Herzberg se teorie oor die motiveringsfaktore, ten opsigte van wat die werkers motiveer om goed te presteer en om nie afwesig te wees van die werk nie. Gesondheidsorg faktore soos ‘n swaar werklas, ‘n gebrek aan toerusting, voordele vir en ondersteuning van personeel, swak medewerkersverhoudinge, asook

inkonsekwente implementering van beleidstrategieë het bygedra tot werkersontevredenheid en gevolglik afwesigheid.

Hiervolgens moet die beleid vir menslike hulpbronne en praktyke hersien en geïmplementeer word, om ‘n verbeterde ondersteunende werkomgewing te verskaf en sodoende afwesigheid te verminder.

**Sleutelwoorde:** afwesigheid, afwesigheid en die verpleegster, afwesigheid en die pasiënt, afwesigheid en die organisasie, werkersbevrediging, werkersontevredenheid.

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## ABBREVIATIONS

| | |
|---|---|
| ENA | Enrolled Nursing Assistant |
| RN | Registered Nurse |
| CEO | Chief Executive Officer |
| CPD | Continuous Professional Development |
| COVID-19 | Coronavirus disease of 2019 |
| ECDOH | Eastern Cape Department of Health |
| EN | Enrolled Nurse |
| HIV | Human immunodeficiency |
| ILO | International Labour Organisation |
| IPC | Infection Prevention and Control |
| OSD | Occupation Specific Dispensation |
| OPD | Outpatients department |
| OM | Operational Manager |
| QAM | Quality Assurance Manager |
| SANC | South African Nursing Council |
| TB | Tuberculosis |
| WHO | World Health Organisation |

# CHAPTER 1

# FOUNDATION OF THE STUDY

## 1.1 INTRODUCTION

Absenteeism is defined as employee absence from scheduled work time (Alreshidi, Alaseeri & Garcia, 2019:1). This problem persists globally with approximately 7% of healthcare workers that are absent once weekly (Kisakye, Twehheyo, Ssengooba, Pariyo, Rutebemberwa & Kiwanuka, 2016:81). Absenteeism was evident in low to middle income countries with rates ranging from 25% in Kenya, 35% in Bangladesh, 37% in Uganda and up to 40% in India and Peru (Kisakye *et al.,* 2016: 82). South Africa is no exception, particularly in nursing (Mbombi, Mothiba, Malema & Malatji, 2018:3). In comparison to other healthcare providers, nurses' absenteeism rates are the highest (Baydoun, Dumit & Daouk-Oyry, 2016:97). Although the Basic Conditions of Employee Act 75 of 1997 (Republic of South Africa, 1997) grants employees with annual, sick, maternity and family responsibility leave, nurses still absent themselves from work. As a result, it placed a significant burden on the healthcare setting (Baydoun *et al.,* 2016:97).

Absenteeism is an exorbitant and multifaceted managerial problem for institutions that contributes to loss of productivity and quality of work. Organisations are in financial dismay to ensure continuity of patient care due to absenteeism (Baydoun *et al.,* 2016:97). Moreover, absenteeism is the result of an increased workload that impacts on nurses' physical and mental health (Tichwara, Cope & Murray, 2018:1). Owing to an increased risk of occupational exposure, absenteeism is evident during pandemic threats (Kisakye *et al.,* 2016:81). Absenteeism is unfavourable for employees resulting in low staff morale and contributing factors to dissatisfaction and an undesirable work environment (Alreshidi *et al.,* 2019:1). Eskandari and Gorji (2018:4) postulate that an increase in work stress predicts a decrease in job commitment and job dissatisfaction. In addition, Tichwara *et al.,* (2018:109) suggest low work satisfaction occur with high absenteeism rates as opposed to job satisfaction with low absenteeism.

The researcher, an operational manager of a 25-bed rural hospital in the Eastern Cape for the past year has observed patterns and trends of absenteeism among nurses, which affect the daily management of human resources by assigning more duties to staff or staff are required to work extra shifts. Exploring how nurses experience absenteeism provided insight and understanding of the conditions under which nurses must work in district rural hospitals.

## 1.2 RATIONALE

It is evident in literature that numerous studies were conducted on absenteeism about factors leading to, and predictors of absenteeism. According to Alreshidi *et al.,* (2019:1) factors such as employee illness, discontent with institutional conditions and inadequate interpersonal relationships contribute to absenteeism. Incoherent decision making of supervisors, biased promotions of staff, selection process of nurses for training and lack of reward systems also contributed to absenteeism (Mudaly & Nkosi, 2015:631). Labrague, Nwafor and Tsaras (2020:1110) found that toxic leadership behaviours result in low job contentment and frequent absenteeism. This has led to the intention of nurses to leave the organisation or the nursing profession (Labrague *et al.,* 2020:1110).

Nurses constitute the largest workforce in hospitals and the cohesiveness of the entire healthcare team are disrupted when nurses are absent (Vadgaonkar & Velhal, 2018:29412). Such disruption leads to inadequate skill-mix and distribution of nurses especially in district rural hospitals (Kisakye *et al.,* 2016:8). Furthermore, absenteeism influences health care service delivery, especially given the already limited numbers of healthcare workers. Mbombi *et al.,* (2018:1) postulate that absenteeism results in poor quality patient care and an increased risk of medical errors. Although hospitals have contingency plans in place to ensure continuous efficient service delivery in the event of staff shortages due to absenteeism, these plans are not implemented, leaving nurses dissatisfied. Absenteeism is still widespread in healthcare, and strategies are needed to reduce absenteeism among nurses (Kisakye *et al.,* 2016:8). No studies could be found on how nurses experience absenteeism in rural hospital settings in the Eastern Cape in South Africa.

## 1.3 PROBLEM STATEMENT

Literature reveals that absenteeism of nurses is a significant phenomenon which imposes an immense burden on healthcare organisations (Vadgaonakar & Velhal, 2018:29412; Tichwara *et al.*, 2018:109; Mbombi *et al.,* 2018:2). When nurses are absent, the nurses who are on duty perform more duties than was allocated. Nurses who cover for the nurse shortage have to postpone their leaves at times and changes in scheduling of shifts have to be done. Absenteeism of nurses also have financial implications on the organisation as overtime needs to be paid to staff who cover for colleagues who are absent. The reasons for absenteeism need to be identified in district rural hospitals particularly in Eastern Cape so that employee attendance polices can be reviewed, required changes made and attendance polices should be consistently reinforced. Furthermore, factors leading to staff being dissatisfied with working conditions and ultimately absent themselves from work need to be explored as well as how nurses experience absenteeism. Given that nurses are the largest workforce in hospitals, the cohesiveness of the entire healthcare team is disrupted when nurses are absent (Vadgaonkar & Velhal, 2018:29412). It is therefore against this background that the researcher endeavours to explore the experiences of all nursing categories regarding absenteeism at the workplace.

## 1.4 RESEARCH QUESTION

What are the experiences of nurses regarding absenteeism working in district rural hospitals in the Eastern Cape?

## 1.5 RESEARCH AIM

The aim of the study was to explore the experiences of nurses regarding absenteeism in district rural hospitals in the Eastern Cape.

## 1.6 RESEARCH OBJECTIVES

The objectives of the study were to:

- Gain understanding of nurses' experience of absenteeism at the workplace.
- Explore the influence of intrinsic factors on absenteeism as experienced by nurses.

- Explore the influence if extrinsic factors on absenteeism are experienced by nurses.

## 1.7 CONCEPTUAL FRAMEWORK

The study was underpinned by Herzberg's two-factor theory of motivator and hygiene factors. The theory implies that certain factors can either lead to a positive or negative attitude towards work. Therefore, being satisfied or dissatisfied leads to employees being present or absent from work. In the Herzberg theory, the motivating (intrinsic) factors that lead to satisfaction are achievement, recognition, the work itself, responsibility, growth and advancement whereas hygiene (extrinsic) factors like policies, supervision, interpersonal relationships, working conditions and benefits result in dissatisfaction. Critical integration of these factors on how nurses experience absenteeism displayed the narrative and the reason why this theory was the most suitable for this study.

## 1.8 RESEARCH METHODOLOGY

A qualitative research methodology was applied in this study. A detailed description will be provided in chapter 3.

### 1.8.1 Research Design

A descriptive qualitative research design was applied to determine the experiences of nurses regarding absenteeism in district rural hospitals in the Eastern Cape.

### 1.8.2 Study Setting

The study was conducted at three district rural hospitals in the Eastern Cape.

### 1.8.3 Population and Sampling

Participants were purposively selected to provide in-depth information. For the purpose of the study, nurses of each nursing category were selected at each of the participating hospitals. Twelve participants were interviewed.

### 1.8.4 Inclusion and Exclusion Criteria

All registered and enrolled nurses as well as enrolled nursing assistants who were permanently employed for at least two years at the participated hospitals were included except nurses who were on annual, sick, maternity or study leave.

### 1.8.5 Data Collection Tool

Data were collected through individual in-depth interviews, using a semi-structured interview guide.

### 1.8.6 Pilot Interview

A pilot interview was conducted with one participant who met the inclusion criteria. The pilot interview was included in the main study for data analysis**.**

### 1.8.7 Trustworthiness

Trustworthiness determines the rigidity, quality, the extent of the dependability, conformity, credibility, and transferability of a qualitative study (Lincoln & Cuba, 1985). The latter principles were applied to ensure accurate findings of the participants' experiences regarding absenteeism. An in-depth discussion of these principles will be included in chapter 3.

### 1.8.8 Data Collection

The researcher personally conducted all the interviews for the study. Data collection took place from September 2021 to April 2022.

## 1.9 DATA ANALYSIS

To gain better understanding of qualitative data means to organise the data and breaking it down into steps (Grove, Gay & Burns, 2015:502). Data was analysed according to the steps as outlined by Terre Blanche, Durrheim and Painter (2006:322).

## 1.10 ETHICAL CONSIDERATIONS

Approval was obtained from the Health Research Ethics Committee (HREC Reference Number: S21/04/070) of Stellenbosch University (Appendix 1), the Eastern Cape Department of Health (Reference: EC_202106_011) (Appendix 2) and management of participating hospitals (Appendix 3).

Respect for persons, beneficence and justice are the three ethical principles that guide ethical research (Grove & Gray, 2019:95). Based on the human rights that need to be protected, these principles are based on the right to self-determination, privacy, anonymity, confidentiality, fair treatment and being protected from discomfort and pain (Brink *et al.,* 2013:43). These principles will be discussed in detail in chapter 3.

## 1.11 DEFINITIONS

**Absenteeism:** employee non-attendance from schedule time in the workplace (Alreshhidi *et al.,* 2019:1). 'Absenteeism' relates to nurses not being present for scheduled work time in the study.

**Nurse:** A person registered in a category under section 31(1) to practise nursing or midwifery in terms of the Nursing Act, No 33 of 2005. In this study, 'nurse' is used as a general term, including registered, enrolled and enrolled auxiliary nurses.

**Experiences:** plural for experience; knowledge or skill obtained from job or activity in various situations (Collins, 2020:n.p). In this study 'experiences' refer to the encounters nurses have regarding absenteeism.

**Rural hopsitals:** Rural hospitals are characterised by geographical remoteness and long distances between levels of care, typographical features that hinder access to healthcare like poor road conditions, low population and masses, high cost of service delivery due to lower economies and expensis of travel to facilities, difficult to recruit and retain healthcare workers due to distance from amenities and compounded by intra-district variation inacess to care (Rural Health Advocacy Project, 2020:1). In this study 'rural hospitals' relates to small remote hospitals exeperiencing healthcare service deprivation, poor infrastucture and understaffing.

## 1.12 DURATION OF THE STUDY

**Table 1.1 Study Duration**

| Year | Month | Activity |
|---|---|---|
| 2021 | April | Submission of proposal to Ethics Committee |
| 2021 | May | Provincial /Institutional permission |
| 2021 | August | Pilot test |
| 2021/2022 | September-April | Data collection |
| 2022 | June | Data analysis |
| 2022 | July | Writing of thesis with continuous review by supervisor |
| 2022 | August | Technical and grammar editing |
| 2022 | September | Submission of thesis |

## 1.13 CHAPTER OUTLINE

**Chapter 1: Foundation of the study**

The researcher provided an overview of the study including the research aims, objectives, methodology, definitions of terms and the significance of the study.

**Chapter 2: Literature review**

Chapter 2 provides an in-depth review of the literature regarding absenteeism in the rural healthcare setting.

**Chapter 3: Research methodology**

Chapter 3 describes the research design and methodology used in this study.

**Chapter 4: Findings of the study**

The findings of the study are discussed in Chapter 4 using themes and sub-themes.

**Chapter 5: Recommendations and conclusion**

This chapter focusses on synthesized findings based on the objectives of the study. The researcher drew conclusions and made recommendations based on the evidence.

## 1.14 SIGNIFICANCE OF THE STUDY

Knowledge on the reality of how nurses experience absenteeism in rural hospitals will contribute to the composition, management and practice of strategies to curb absenteeism. The study provides a deeper understanding on how nurses experience absenteeism in rural hospitals. Consequently, protocols and policies pertaining to absenteeism could be reviewed which will be beneficial for the nurse, the patient and the healthcare institution. Robust policies and standard operating plans will provide staff with the knowledge about what is expected of them, provide rules, regulations and consistency and a clear response in dealing with situations. It provides a clear framework for delegation and decision making as well as means of communication and methods of dealing with complaints to avoid claims of bias and favouritism. Also, the experiences of nurses will aid in decision making regarding human resources which is critical in providing quality care. Furthermore, effective human resource management strategies are required to achieve better health outcomes. Similarly, workforce planning is imperative to ensure adequate skill mix, staff not being overworked leading to burnout and absenteeism. Healthcare facilities can therefore implement acceptable, uniformed standards for absenteeism.

## 1.15 SUMMARY

The aim of the study was to explore the experiences of nurses regarding absenteeism in district rural hospitals in the Eastern Cape. In chapter one, the study context, the

rationale and research problem were discussed. An overview of the research methodology was depicted. Data collection methods applicable to the study were concisely discussed. Furthermore, ethical principles, operational definitions, the duration and layout of the study were also discussed. In chapter two, the literature that supports the topic will be discussed to gain an in-depth perspective regarding absenteeism among nurses.

## 1.17 CONCLUSION

The global phenomenon of absenteeism particularly in nursing requires essential attention as it remains a major problem in healthcare facilities. It is evident in the literature that it can have serious repercussions for the patient, nurse and the organisations which are interrelated. The current literature reviewed mostly focus on urban areas, which is rightly so due to facilities having multiple statuses including training, research and providing care. However, rural areas also provide care and literature regarding absenteeism in rural areas are lacking. Understanding the experiences of nurses regarding absenteeism could provide greater insight into interventions required to address the related issues.

# CHAPTER 2

# LITERATURE REVIEW

## 2.1 INTRODUCTION

A literature review is a systematic process of collecting and critically appraising literature which is known to the topic and synthesising of the results (Grove & Gray, 2019:150). Employee absenteeism has been vastly emphasised as a problematic phenomenon in the health sector (Baydoun *et al.,* 2016:97).

The literature review was done to identify what is known and not known about how nurses experience absenteeism based on Herzberg's two factor theory of motivator and hygiene factors. In addition, the literature review provided information with recent knowledge on the topic and in succession contributes to the recognition of the deficit in that knowledge (Grove, Gray & Burns 2015:164). In this Chapter, the literature review focused on the impact nurses' absenteeism has on the patient, the nurse and the organisation integrating hygiene and motivator factors

## 2.2 SELECTING AND REVIEWING THE LITERATURE

The literature review was conducted over a period of approximately 13 months through electronic databases such as PubMed, Sabinet, CINAHL, EBSCHOST, Scopus Pro Quest Dissertations and Theses, Ovid literature Lippincott, Williams and Wilkins and Wiley online library. Keywords utilised were nurse absenteeism, patient care, effects on nurses, organisation (institution), motivator factors and hygiene factors.

Boolean operators like AND, OR AND NOT were used to define the relationships between words and groups in the study and to expand the search. Literature was citied from studies not more than 10 years old, except for some earlier seminal studies, using empirical and theoretical sources found in articles, theses and dissertations. Grey literature from Government legislation were also used.

## 2.3 FINDINGS OF THE LITERATURE REVIEW

The findings of the literature are presented under the following headings.

- Healthcare in South Africa

- Absenteeism and the patient
- Absenteeism and the nurse
- Absenteeism and the organisation
- Herzberg theory
- Extrinsic factors influencing absenteeism
- Intrinsic factors influencing absenteeism

## 2.4 HEALTHCARE IN SOUTH AFRICA

During the apartheid era subordination in nursing was pivotal as opposed to insubordination that was not tolerated (Lees, 2015:17). Nurses feared being disciplined and the latter resulted in decreased absenteeism. Post-apartheid, laws were set out to govern labour in South Africa and the rights of employees were established. In South Africa, the Basic Condition of Employment Act (Act no. 75 of 1997) provides for leave. Bourgeault, Atanackovic, McMillan, Akuamoah-Boateng and Simkin (2022:199) posit that healthcare professionals have a higher likelihood to be absent from work due to leave provisions.

### 2.4.1 Healthcare Prior to 1994 (Pre-Apartheid Era)

Globally, policymakers have worked not only to improve overall population health but also health disparities based on socio-economic status, race, gender, ethnicity and geography (Omotso & Koch, 2018:1). Despite the latter, socio-economic differences exist particularly in developing African countries (Omotso & Koch, 2018:1). According to Katuu (2017:136) rather than improving health, South African healthcare focussed essentially on supporting the apartheid state resulting in inequity, fragmentation, and bias towards healthcare services. The apartheid system based on race was the official system of segregation disempowering the black majority by the white minority (Katuu, 2017:136). The racial divide saw white minority benefit from abundant resources as opposed to the under-resourced black majority (Omotso & Koch, 2018:1). Ngobeni, Breintenbach and Aye (2020:2) postulate that the unjust policies of apartheid caused disparities in access to healthcare between the rich white minority and the poor black majority. Less money was spent on black people’s health than on whites. The unequal spending on health services during the apartheid era is evident in the table below, which shows health spending by race for each person in 1985 and 1987.

**Table 2.1 Health spending per person in 1985 and 1987**

| Year | 1985 | 1987 |
|---|---|---|
| **Whites** | R451 | R597 |
| **Indians** | R249 | R356 |
| **Coloureds** | R245 | R340 |
| **Africans** | R115 | R137 |

Due to overcrowded living conditions during the apartheid era, social conditions also led to epidemics such as Tuberculosis (Ngwena, 2014:889). In 1971 deaths were 100 times more common in black than in white children due to diarrhoea and in 1978, 48 times higher due to typhoid fever (Ngwena, 2014:889). The African and coloured populations carried the heaviest disease burden, reflecting racial and socio-economic inequalities (Department of Health, 2021). Disparities prior 1994 were also evident in life expectancies at birth, maternal and infant mortality (Department of Health, 2021). Table 2.2 depicts health indicators in South Africa during the pre-apartheid era.

**Table 2.2 Health indicators pre-1994 in South Africa**

| Population group | Life expectancy at birth | Maternal mortality rate per 100 000 (1990) | Infant mortality rate per 1 000 per live births (1990) |
|---|---|---|---|
| **White** | Males: 69<br>Females: 76 | 3 | 7,4 |
| **Indians** | Males: 69<br>Females: 70 | 15 | 15,9 |
| **Coloureds** | Males: 59<br>Females: 70 | 30 | 28,6 |
| **African** | Males: 60<br>Females: 67 | 23 | 48,3 |

### 2.4.2 Current Healthcare (Post-Apartheid Era)

The country reformed to democracy in 1994, and the National health plan was developed which paved the way for a more reasonable health system (Omotso & Koch, 2018:2). South Africa's health system provides healthcare to an estimated 58

million people consisting of private and public sectors (Omotso & Koch, 2018:2). In 2019/20 the National Department of Health spent 206 billion rand which were allocated to the nine provinces (Statistics South Africa, 2022). Hospital services cost R125,6 billion, accounting for 61% of the total healthcare expenditure. In second was public health services with R69,1 billion (33%), followed by paramedical services with R8,6 billion (4%) and R3,3 billion (2%) for other small items (Statistics South Africa, 2022). All aspects of private and public healthcare delivery are coordinated locally, at district level, provincially and nationally by the National Department of Health (Katuu, 2017:136).

The right to healthcare (public and private hospitals) enshrined in the South Africa constitution is a constitutional requirement (Walls, Veary, Smith & Hanefeld, 2016:14).

#### *2.4.2.1 Public versus private healthcare*

Equitable access to healthcare is rooted in South Africa's constitution (Omotso & Koch, 2017:2). Nevertheless, private hospitals are only accessible to those who can afford health insurance or pay out of their pockets which accounts for 16% of South Africans, with the remaining 84% relying on public healthcare services (Dell, Khan & Klopper, 2018:16). Young (2016:9) confirmed that the majority of South Africans cannot afford the exorbitant costs of private healthcare. In addition, 50.3% of hospitals are in the private sector and 49, 7% in public sector, clearly indicating inequality between private and public healthcare sectors (Ngobeni *et al.,* 2020:2).

As previously mentioned, South Africa's healthcare were vertically and horizontally fragmented under the apartheid system leading to social and economic disempowerment (Katuu, 2017:136). In South Africa, there is a socio-economic division in the utilisation of healthcare (Gordon, Booysen & Mboningaba, 2020:1). Although policies and reforms were implemented to reverse the discriminatory practices before 1994 (Omotso & Koch, 2018:2) current inequalities stem from the inability to pay for healthcare where the socio-economically disadvantaged are discriminated against, across the continuum of access to care (Gordon *et al.,* 2020:1). Young (2016:1) reveals that the gap between private and public healthcare are evident, with the private sector having short waiting times, appointments that are not rushed, better facilities and proper disease control and prevention practices. A study

by Dunga in 2019 revealed that 21.5% (12 642 000) of South African households have health insurance and can demand private healthcare services (Dunga, 2019:68). A year later in 2020 a decline in private healthcare was evident with 83% (forty-nine million) of South Africa's population dependent on public healthcare (Ngobeni *et al.,* 2020:1).

According to the National Health Act of 2003, public hospitals are classified as district, regional, provincial tertiary, national central and specialised (Dell, Khan &Klopper, 2018:16). However, the Primary Healthcare system, which consists primarily of clinics and community healthcare centres, is the first line of access to healthcare (World Health Organisation, 2017). Private healthcare consists of private hospitals and highly specialised healthcare services (WHO, 2017).

Delivering quality healthcare services are obligatory in South Africa (Maphumlo & Bhengu, 2019:1). Nevertheless, healthcare quality has been negatively compromised by challenges, particularly the shortage of human resources (Maphumlo and Bhengu, 2019:2). Rispel (2015:1) confirms that South Africa is in a "nursing crises" due to nurse shortages. According to Khunou and Davhana-Maselesele (2016:2) nurses work overseas and envisage emigrating which can account for the nursing crises the county experiences. Rispel and Bruce (2015:117) described the peril of the country because of poor leadership and governance of nursing in South Africa. Furthermore, the practise environment is influenced by split loyalties and accountability leading to erosion of professionalism caused by nurses who moonlights and work for agencies and nurse educator quality, educational resources and governance of educational resources which are looming crises South Africa is facing (Rispel & Bruce, 2015:117).

South Africa has a high communicable disease burden and a struggling healthcare system (Walls *et al.,* 2016:14). Human immunodeficiency (HIV), tuberculosis (TB), maternal and child health, injury and violence and non-communicable diseases all pose a quadruple burden of disease in South Africa (Moosa & Wearne, 2018:84). More than half of human and financial resources are allocated to the private sector which has compromised the ability to deliver essential key programmes like HIV/TB, child and maternal health.

#### *2.4.2.2 Rural healthcare*

Compared to their urban counterparts, populations in rural areas experience poorer health status and lower life expectancy (Strasser, Kam & Regalado, 2016:395). Rural communities face major challenges in service delivery, like governance, financing, transportation, communication and human resources (Strasser *et al.,* 2016:395). In 2008 the World Health Primary Report called for universal health coverage and service delivery reforms (WHO, 2008). Challenges such as poor infrastructure, poor roads and limited transportation make it difficult for individuals to reach health services, resulting in a delay in their access to care (Strasser *et al.,* 2016:398). Unsafe working conditions, inadequate resources, lack of career development, lack of management and supervision, work overload and burnout contribute to a shortage of human resources for healthcare in rural areas (Mburu & George, 2017:1). According to Ngobeni *et al.,* (2020:2) nurses are pivotal in rural healthcare where physicians are reluctant to practice. Reluctance stem from inadequate public infrastructure and although South Africa invests in medical doctor education, 30% of South African doctors have emigrated (Ngobeni *et al.,* 2020:2). Therefore, key delivery programmers, like HIV, TB, child, mental and maternal health are key programmers that are delivered by nurses in rural areas (Ngobeni *et al.,* 2020:2)

Although rural areas have greater health needs, fewer healthcare professionals work in rural than in urban areas (Haskins, Phakati & Grant, 2017:174). Rose and Janse van Rensburg-Bonthuyzen (2015:1) indicates that attracting and retaining health professionals remain a challenge. Baron and Padarath (2017:3) noted disparate distribution of healthcare professionals in South Africa between public and private sectors. Ngobeni *et al.,* (2020:2) noticed a considerable difference in human resource availability between the private and public sectors. In South Africa, the public sector employed 31.3 medical practitioners, 11.4 medical specialists, 9.7 pharmacists, 6.10 radiographers, 2.60 psychologists, and occupational therapists and 146.8 professional nurses per 100 000 in 2013, (Vawda, 2019:105). The private sector had an employment of 37% general healthcare practitioners, 59% of medical specialists, 38% of nurses (Vawda, 2019:105). The author also noted a disparity in the distribution of nurses across provinces. Table 2.1 illustrates the provincial distribution of nurses versus the South African population (SANC, 2021).

**Table 2.3 Provincial distribution of nurses versus the South African population**

| Provinces in South Africa | Population per Registered Nurse | Population per Enrolled nurse | Population per Enrolled Nursing Assistant |
|---|---|---|---|
| Eastern Cape | 404:1 | 1178:1 | 229:1 |
| Free State | 349:1 | 1334:1 | 951:1 |
| Gauteng | 381:1 | 922:1 | 874:1 |
| KwaZulu Natal | 318:1 | 507:1 | 878:1 |
| Limpopo | 452:1 | 1083:1 | 599:1 |
| Mpumalanga | 537:1 | 1681:1 | 1230:1 |
| Northwest | 385:1 | 1273:1 | 894:1 |
| Northern Cape | 519:1 | 3192:1 | 1284:1 |
| Western Cape | 376:1 | 1097:1 | 884:1 |

Haskins et al., (2017:173) found disparities between rural and urban South Africa where only 19% of all healthcare professionals work in rural areas even though 46% of South Africans stay in rural areas. Owing to this, rural communities are deprived of health benefits as opposed to their urban counterparts, due to inadequate healthcare professionals (Haskins *et al.,* 2017:173). Ronnie (2016:31) states that a third of South African healthcare positions in the public sector are unfilled with almost 40 000 vacancies. According to statistics from the South African Nursing Council as of May 2020, South Africa has more than 400 000 registered nurses (Msomi, 2020:1). Only 20% of nurses work in rural areas (Mburu & George, 2017:2). According to the International Labour Organisation (ILO), South Africa has less than one doctor and nurse per 1000 citizens (Du Plessis, Tawana, Barkhuizen, 2019:1). The distribution of healthcare workers between rural and urban areas are notably uneven, with 12% of doctors and 19% of nurses serving rural areas (Mburu & George, 2017:2). Table 2.3 illustrates registered nurses per population ratio in urban and rural healthcare strings in South Africa.

**Table 2.4: Registered Nurses per population ratio**

| Rural healthcare setting | Density ratios | Urban healthcare setting | Density ratios |
|---|---|---|---|
| Mpumalanga | 156:10 000 | Gauteng | 270:10 000 |
| Northern Cape | 192:10 000 | Western Cape | 270:10 000 |
| Limpopo | 195:10 000 | | |

Rural provinces like Mpumalanga, Northern Cape and Limpopo had density ratios of 165, 192 and 195 per 100 00 respectively in comparison to Gauteng and the Western Cape who had density ratios of 270 per 10 000 as their urban counterparts (Mburu & George, 2017:2). In rural areas, it is crucial to find a fit for purpose and fit for practice to maintain health coverage and primary health access (Strasser *et al.,* 2016:401). Health workforce maldistribution is exacerbated by skill-mix imbalances (Strasser et al., 2016:401). This is evident with rural provinces having the lowest number of specialists per 100 000 ranging from 1.8 - 3.1 in contrast to their urban counterparts with numbers ranging from 20.3 - 31.3 (Mburu & George, 2017:2).

According to Gumede, Taylor and Kvalsig, (2021:2) attracting nurses to work in rural healthcare is challenging which lead to staff shortages. Strasser *et al.,* (2016:395) confirmed that the shortage of health professionals is more prominent in rural areas. Ultimately shortage of staff leads to nurses being overworked and they absent themselves from work (Mbombi *et al.,* 2018:3).

## 2.5 ABSENTEEISM AND THE PATIENT

Globally, healthcare providers have been committed to improving healthcare (Tumlinson, Gichane, Curtis & Le Masters, 2019:1). Therefore, human resources are critical to health systems development and patient health outcomes (Rispel, 2015:1). In 2015 the world transitioned from millennium development goals to sustainable development goals for 2016-2030, with a focus on improving healthcare particularly in developing countries (Kalipeni, Iwelunmor & Grisby-Toussaint, 2017:1). However, the aforementioned can be a challenge due to inability of retaining healthcare professionals in rural areas such as lack of good schools and social amenities areas (Gumede *et al.,* 2021:2). In rural areas, access to healthcare is a challenge due to poor conditions of the roads and the unreliability and expensiveness of transportation

(Gumede *et al.,* 2021:2). The authors noted that 20% of South Africans live more than an hour away from the nearest hospital, and 15% of rural households live more than an hour away from the nearest clinic (Gumede *et al.,* 2021:2).

In South Africa there are differences in healthcare needs, urban areas face challenges like non- communicable diseases and obesity whereas rural areas face infectious diseases and malnutrition (Ewing, Reid & Morris-Paxton, 2020:2). According to the WHO (2018) non-communicable diseases include hypertension, diabetes, cardiovascular diseases, cancer, psychiatric illness, cancer, lung diseases like asthma and trauma. The WHO also identified communicable diseases such as HIV/AIDS and TB (tuberculosis). Waterborne diseases are also prevalent particularly in rural areas which are gastroenteritis, cholera, viral hepatitis, typhoid fever, bilharziasis, dysentery and malaria. The main cause of death in South Africa is TB at 8.8%, followed by influenza and pneumonia (5.2%), HIV (5.1%), cerebrovascular disease (4.9%), diabetes mellitus (4.8%), heart diseases (4.6%) and 3.7% hypertensive diseases (WHO, 2018). Absenteeism can affect health outcomes of patients (Zhang, Fink & Cohen, 2021:2). According to Pedder, Jones and Rejon (2020:2) higher death rates are associated with absenteeism.

According to Tumlinson *et al.,* (2019:1) maternal and child health are embedded in the millennium goals and globally maternal and children under five mortalities has decreased by 44 and 56% respectively since 1990, respectively. In contrast, maternal and child mortality remains high in sub-Saharan countries. Sixty-six percent of maternal deaths and one in thirteen children die before the age of five (Tumlinson *et al.,* 2019:1). Maternal and child healthcare are negatively affected by absenteeism which consequently leads to low service demand and reliability, preventing mothers and children from seeking needed care (Tumlinson *et al.,* 2019:3). Furthermore, absenteeism also contributes to less women that are likely to learn about their HIV status (Tumlinson *et al.,* 2019:3). According to Zhang, Fink and Cohen (2021:2) absenteeism could adversely impact patients seeking healthcare as well as health outcomes. The study revealed that foregoing or the delay in seeking treatment may be caused by health worker absenteeism. In addition, the study suggests that absenteeism may lead to a decline in diagnostic testing and higher rates of patients utilising over the counter medication.

According to Di Giorgio, Evans, Lindelow and Nguyen (2020:3) an essential step towards providing quality care is the presence of healthcare providers. In addition, service delivery is compromised with the absence of healthcare providers (Tumlinson *et al.,* 2019:1). Bolan, Cowgill, Walker and Kak (2021:160) posit the imperativeness of addressing the critical shortage of healthcare workers to attain the 2025 health targets as part of the sustainable development goals. According to Al-Sharif, Kassem and Shorky (2017:63) there is a reduction in quality of patient care when nurses are absent. Sfantou, Laliotis, Patelrou and Sifaki-Pistolla, (2017:02) defined quality of care as achieving predicted health outcomes with professional competence within the health service. Aron (2015:09) suggests that quality of care is increased with professional knowledge which increase the likelihood of desired health outcomes. Safe, effective, efficient, reliable, patient-centred, and equitable patient care are considered high quality patient care (Sfantou *et al.,* 2017:02).

Absenteeism reduces effectiveness and compromises the provision of quality healthcare services to patients (Kisakye *et al.,* 2016:81). Furthermore, patients receive substandard care by nurses who remain on duty, resulting in the risk of medical errors (Mbombi *et al.,* 2018:3). Substandard care, synonymous with poor patient care, is a critical issue that is arising in nursing (O'Donnell, Markey & O'Brein, 2020:1). Jones, Johnstone and Duke (2016:2126) posit that substandard care is the partial or complete omission of patient care, delays in providing care, the failure to do things correctly, cutting corners in patient assessment and essential nursing care. Mbombi *et al.,* (2018:3) reported that 59% of nurses made medical errors because of the increased pressure to complete their tasks due to absent staff. Zhan *et al.,* (2021:2) agreed that the quality of patient care would be significantly reduced when nurses are absent.

Leitao, de Sousa and Santiago (2017:120) suggest that absenteeism is used to monitor quality as it can interfere with quality patient care. In a quality improvement project where strategies were developed by nurse leaders to improve patient care and reduce burnout, absenteeism was decreased by 27.5% in a general surgery ward in South-eastern community hospital in Australia (King, Contarz, & Wei, 2020:1). In contrast, findings from a recent South African study, indicate that quality improvement programmes did not meet the desired standards which mean fewer errors in patient

care, reduced delay in care delivery and improvement in efficiency (Maphumlo & Bengu, 2019:1). Absenteeism of nurses cause an increase in workload that affects the quality of patient care as well as an increase in morbidity and mortality rates (Brborovic, Brborovic & Mustajbegovic, 2016:2; Mbombi *et al.,* 2018:3). Absenteeism of nurses are also associated with missed nursing care (Brborovic *et al.,* 2016:2). Missed care is defined as omitted or delayed required patient care due to numerous demands or insufficient resources (Lake, de Cordova, Barton & Singh, 2016:378). The authors state that inadequate staffing is a strong predictor of missed care and that missed nursing care contribute to poor patient outcomes, adverse events, readmission and patient dissatisfaction.

Patient satisfaction is a crucial concern of healthcare delivery and probable outcome of medical care (Pan, Liu & Ali, 2015:145). The authors postulate patient satisfaction is a key indicator in assessing the quality of care (Pan *et al.,* 2015:146). In a study exploring the impact staff absenteeism has on patient satisfaction, patient satisfaction was found to be significantly and negatively correlated with nurse absenteeism, indicating that patient satisfaction is linked to staff absenteeism (Duclay, Hardouin, Sebille, Anthoine, 2015:833). Kieft, de Brouwer and Delnoij (2014:2) posit that adequate staffing is pivotal in positive patient experiences.

Mbombi *et al.,* (2018:2) posit that absenteeism has an impact on nurse- patient ratio which is a source of concern. Absenteeism leads to increased patient-staff ratio resulting in decreased patient care. Although negatively associated with increased cost, increased nurse-to patient ratios are associated with improved patient care (Maass, Liu, Daskin, & DuckScharpio, 2017:1).

### 2.6 ABSENTEEISM AND THE NURSE

Globally there are approximately 29 million nurses which contribute to the largest segment of the healthcare profession (Haddad, Annumaraju, & Toney-Butler, 2020:1). Globally the nursing workforce is 27.9 million and a global nursing shortfall of 5,9 million nurses with 89% of these shortages occurring in low -and lower-middle countries, including African countries (World Health Organisation, 2020). South Africa has a nursing shortage of over 44 700 and nursing of all categories has declined by 40% since 2013 (Welthagen, 2019:1). Limpopo, Mpumalanga, Northern Cape and

Eastern Cape are the provinces with the largest nursing shortages (Statistics South Africa, 2020). Mbombi *et al.,* (2018:1) states that absenteeism contributes to nurse shortages, and it is essential to understand the dynamics and the impact of absenteeism on nurses.

## 2.7 EFFECTS OF ABSENTEEISM

### 2.7.1 Physical Effects of Absenteeism on the Nurse

According to Furlan, Stancato, Campos and Silva (2018:4) nurses need to be in good physical condition to be able to carry out their tasks. However, with the increased demands in the health sector, the health of nurses is a challenge (Gohar, Lariviere, Lightfoot and Lariviere, 2021:536). Job demands include excessive workload, poor working environment, lack of administrative support and poor doctor-nurse relationships (Dybre, Shanafelt, Johnson & Johnson, 2019:2). Gohar *et al.,* (2021:536) posit that physical injury at work can lead to future sick leave (absenteeism). Kanwal, Riaz, Riaz & Safdar (2017:110) agreed that absenteeism is a growing concern which can contribute to sickness absence. The authors found that nurses absent themselves due to ailments such as headache and back pain where 42% agreed and 17.5% strongly agreed that sickness causes absenteeism. Ergonomic factors such as prolonged standing, lifting and moving heavy patients as well as increased work are related to high absenteeism rates (Ramsamy, Ditlopo & Rispel 2021:13). The aforementioned are related to musculoskeletal disorder which were the second leading reason (12%) for sickness absence (Ramsamy *et al.,* 2021:13). A study by Gohar *et al.,* (2021:536) revealed that sickness absence is likely to increase with the presence of musculoskeletal pain and further increase if it is back pain.

Dybre *et al.,* (2019:1) found a relationship between burnout and nurses who are absent. Burnout is a syndrome characterised by cynicism related to one's job and feelings of exhaustion. The study revealed that burnout due to exhaustion was associated with self-reported absenteeism. King *et al.,* (2020:359) also confirmed that burnout is related to absenteeism. As a result, the authors suggested improvement projects to reduce burnout. Absenteeism recorded for pre-quality intervention was 51 (out of 76% of unit employees) and post- intervention absenteeism was 37%, showing a decrease in absenteeism by 27.5%. A systems dynamic model by Farid, Purdy and Neumann, (2020:952) revealed that longer working hours, double nurse fatigue and

increase burnout and absenteeism by five to six times respectively. Similarly, Dubale, Friedman, Chemali and Denniger (2019:1) posit that due to the nature of their work nurses may experience exhaustion due to work demands. According to Nkosi (2015:623) increased workloads result in burnout and absenteeism in working environments already suffering from staff shortages (Mudaly & Nkosi, 2015:623). The author also suggests that burnout promotes absenteeism and ultimately leads to poor service delivery. Burnout affects interpersonal skills, career satisfaction, mental health and job performance (Dubale *et al.,* 2019:1).

High workload can also lead to sleeping disorders like insomnia (Sadeghniiat-Haghighi, Najafi, Eftekhari & Tarkhan, 2021:308). The study revealed that absenteeism among nurses is strongly associated with insomnia; 57,2% suffered from sub threshold insomnia, 21,4% from moderate insomnia and 1,3% from severe insomnia amounting to 79,9% of the study population. Furthermore, insomnia was significantly high in nurses who were absent due to illness (Saseghniiat-Haghundi *et al.,* 2021:307). Shift workers have an increased risk of suffering from insomnia (Hajo, Reed, Hans & Tulloch, 2020:2). According to the authors, shift work can also be linked to absenteeism. Moreover, a combination of sleep, physical activity and sedentary time are associated with better overall health. However, nurses do not meet the last-mentioned criteria because they spend half of their day sedentary and do not get enough sleep (Hajo *et al.,* 2020:1).

### 2.7.2 Psychological Effects of Absenteeism on the Nurse

Psychological health of nurses is affected by absenteeism (Mbombi *et al.,* 2018:1:2). Absenteeism can be used to measure psychological wellbeing of healthcare workers (Mat Suran, Mohd Yusoff, Mohd Fauizi & Wan Puteh, 2020:2). In a recent study on the fear of COVID-19, psychological distress, work satisfaction and turnover intention among frontline nurses, an increased level of fear was associated with decreased job satisfaction (Labruge & de Los Santos, 2021:395). The study suggested proper training, accurate and regular COVID-19 updates as well as social, mental and psychological support services to alleviate fear in nurses and to improve a sense of safety leading to improved psychological wellbeing, resilience and to cope with stress (Labruge & de Los Santos, 2021:395). Increased levels of stress are caused by nurses that do not get a chance to rest due to staff absenteeism (Gohar, Larivière, Lightfoot,

Wenghofer, Larivière & Nowrouzi-Kia, 2020:755). Brborvic *et al.,* (2016:1) support the latter by stating that nurses who absent themselves, have higher levels of stress, compared to those without absenteeism.

Increased workloads and additional tasks to finish could increase psychological stress (Mbombi *et al.,* 2018:2). In addition, the burden of work, lack of support and inadequate environmental management support is caused by a stressful work environment (Shazad *et al.,* 2019:87). Mat Suran *et al.,* (2020:12) agree that high job demand is among the job stressors that relate to increased absence due to illness. The study revealed that unplanned absenteeism can be indirectly due to stressors. Stress can be caused by unpreparedness and mental readiness in treating patients, making them vulnerable to make mistakes and leaving them no choice but to absent themselves (Mat Suran *et al.,* 2020:12). More stress is also caused by technological advances which require nurses to develop higher skill levels (Mat Suran *et al.,* 2020:12). However, knowledgeable and prepared nurses can prevent withdrawal behaviour. Withdrawal behaviour is a deterioration in job performance of employees due to a set of behaviours and attitudes (Aggarwal, Chand Jhamb & Mittal, 2020:2). The authors stated that employees with withdrawal behaviour experience low morale, realise work pressure negatively and feel stressed. Furthermore, employees can experience psychological withdrawal behaviours which can be ascribed to wilful lateness, intent to leave and absenteeism. Negative behaviours are displayed with psychological withdrawal behaviour like turnover intentions and intentional absenteeism (Aggarwal *et al.,* 2020:4). The authors also found that psychological empowerment has a positive effect on employees by enhancing work engagement, commitment, job satisfaction and reduce absenteeism. Therefore, psychological empowerment leads to low psychological withdrawal behaviour (Aggarwal *et al*., 2020:4).

In a study by Ramsamy *et al.*, (2021:13), mental disorders were the leading medical reason for absenteeism (incapacity leave). The authors revealed that mental disorder was higher in younger healthcare professionals which suggest that younger employees may not have the necessary skills to cope with stressful situations and high workloads in comparison to their senior counterparts. According to Iqbal and Cheema (2018:254) nurses work in an environment which is unhealthy materially and psychologically which can increase the possibility of absenteeism. The study revealed

that 85% of nurses are absent from work due to increased stress caused by excessive workloads, long duration of work hours and no tea breaks to relax. Therefore, nurses need to be trained on coping strategies to guard them against personal stress, prevention against burnout and poor health outcomes (Khamisa, Peltzer, Ilic & Oldenburg, 2017:257). Furthermore, addressing staff issues could alleviate work stress and evaluating of the latter will aid to ascertain the effectiveness of the strategies (Khamisa *et al.,* 2017:257).

Increases in absenteeism is linked to depression (Branford & Reed, 2016:488). Nurses experience depression at a higher rate than individuals at any other profession due to high job demand and nursing being stressful (Branford & Reed, 2016:288). Depression is associated with persistent sadness, being anxious, feeling empty, feelings of hopelessness or pessimism, feelings of guilt, worthlessness, or helplessness, loss of interest in activities or hobbies and irritability (Branford & Reed, 2016:488). In a study on the prevalence and risk factors of depression, depressive symptoms were prevalent in over 30% of nurses (Maharaj, Lees & Lal, 2019:6). The authors suggest that ignoring depressive signs may not only result in low quality patient care and high workloads, but in increased individual emotional stress. The study also revealed that nurses who suffer from mental illness are more likely to stay out of work, approximately 5 working days and 11 days of reduced annual productivity; amounting to billions of dollars lost due to absenteeism. Therefore, nurses working in a stress-free environment are less absent and more productive (Mbombi *et al.,* 2018:2).

### 2.7.3 The Effects of Absenteeism and Nurse Productivity

Absenteeism has a negative effect on productivity (Mbombi *et al.,* 2018:2). According to the authors sickness presenteeism refers to being at work despite feeling sick. Sickness presenteeism reduces productivity due to feeling ill (Brborovic *et al.,* 2016:2). In addition, employees generally feel tired, have a low opinion of their work resulting in poor work quality and low work productivity. Sickness presenteeism may also increases the risk of error due to decreased attention (Brborovic *et al.,* 2016:3). Fifty-nine percent (59%) of nurses in a study by Mbombi *et al.,* (2018:3) agreed that medical errors occur due to an increase in workload because of their colleagues being absent.

In a study that explored the relationship between burnout, job performance and absenteeism, nurses who experienced burnout were more likely to be absent and displayed poor work performance (Dybre *et al.,* 2019:1). Noben, Evers, Nieuwenhuijsen, Ketelaar, 2015:891) state that nurses may become less productive because of burnout. An increase in workload affects nurses' physical and psychological wellbeing negatively by leading to burnout, increased tension and emotional exhaustion, stress and depression (Mbombi *et al.,* 2018:3). In a study on determinants of absenteeism, 70,29% of nurses were absent due to workload by pressure put on them as a result to a colleague being absent (Iqbal & Cheema, 2018:257). Owing to staff shortages caused by absenteeism, nurses are given secondary roles and incident reports are more prevalent on days those nurses are absent (Mbombi *et al.,* 2018:3). The latter is a result of nurses being burdened with additional work which they may not be qualified for (Tumlinson *et al.*, 2019:1).

According to AShazhad *et al.,* (2019:87) nurses need to do more work at times which lead to job frustration. This is due to the burden of the workload which the authors postulate has a relation with absenteeism. Among other factors, absenteeism is a side effect of nurses being overworked (Mat Suran *et al.,* 2020:2). Additional responsibilities and overloading of professional boundaries lead to occupational stress among nurses. Swiger, Vance and Patrician (2016:245) state that nurses find it difficult to cope due to lack of capabilities, resources and the availability of time due to nurses performing a variety of roles like attending to patients and administration. Work strains are related to absenteeism (Kottwitz, Schade, Burger and Ralinger, 2018:110). The authors found that absenteeism was predictive of stress processes related to sickness absence.

Studies have shown that most nurses are dissatisfied with their workplace (Khunou & Davhana-Maselesele, 2016:7; Khamisa, Peltzer, Illic & Oldenburg, 2017:255; Payne, Koen, Niehaus & Smit, 2020:1). The aforesaid is particularly evident in South Africa who transitioned from hospital-based services to primary and community-based services in both private and public sectors where nurses are responsible for larger populations (Khamisa *et al.,* 2017:253). Dlamini and Visser (2017:3) posit that nurses' stress may be due to insufficient resources like the unavailability of oxygen, medication and food in the work environment.

According to Mayfield Mayfield and Ma (2020:715) there is a definitive correlation between the absence of a creative environment which leads to job dissatisfaction and consequently absenteeism. Akinwale and George (2020:73) describe a creative environment as creating task activities like training and giving nurses autonomy and a sense of accomplishment when work has been done. Furthermore, the environment has to ensure the employees' safety, security, recognition for good performance as well as involving staff in decision making by management (Akinwale & George, 2020:73). High absenteeism may also be a symptom of other problems such as job dissatisfaction, tension at work and low morale (Jooste, Bezuidenhout & Muller, 2020:1). Absenteeism is a determinant of the level of job satisfaction (Haywood, 2020:26). Nurses are in constant interaction with patients and must do more work to attend to ill patients, which causes dissatisfaction with their jobs (Kanwal *et al.,* 2019:110).

Job dissatisfaction is a global concern with a high number of nurses being dissatisfied in their jobs which has a major influence on job related absenteeism (Molefe & Sehularo, 2015:474). The authors maintained that job dissatisfaction can also be due to excessive workload (Molefe & Sehularo, 2015:473). Kanwal *et al.,* (2017:110) postulate that heavy workload is a cause of absenteeism. The authors defined a heavy workload as exceeding one's duties as expected. A heavy workload is also the cause of long duty hours due to absenteeism. Dlamini and Visser (2017:3) suggest nurses are not given sufficient time to rest due to rejected leave request because of a staff shortage. In addition, nurses have performed duties beyond their professional boundaries such as assuming the role of a teacher, guardian, counsellor, technician, and coordinator exerting personal strain on nurses.

High absenteeism was identified as the leading cause of job dissatisfaction in a study based on nurses' perceptions on job dissatisfaction (Molefe & Sehularo, 2015:473). The authors claim that nurse shortages are due to dissatisfied nurses which adversely may affect nurses' performance and lead to low morale. A study on nurses who remained on duty whilst their colleagues were absent found that the nurses who stayed on duty had a low morale (Mbombi *et al.,* 2018:3). Baydoun *et al.,* (2016:98) suggest that employee motivation is an important variable in the decision of an

employee to be present at work. According to Hassan, Azmat, Sarwar and Adil (2020:78) increasing motivation, increases employee morale which increases job performance and ultimately job satisfaction.

Job satisfaction has been identified as a result of supervisory roles and support of effective managers and leaders (Sojane, Klopper and Coetzee, 2016:4). Therefore, factors that influence job satisfaction are of paramount importance to nurse managers to consider human resource planning in the case of absenteeism (Okitizulvia, Dachriyanus & Vionalisa, 2017:1). Nurse managers are often conflicted between rendering quality healthcare and overworked staff, staff shortages and absenteeism (Koesnell, Bester & Niesing, 2019:6). According to Dlamini and Visser (2017:4) nurses feel unappreciated and unmotivated to come to work. A reduction in absenteeism among employees results from job satisfaction and increased levels of motivation (Haywood, 2020:28). Consequently, nurse managers should boost employees' self-esteem and encourage employees to improve supervisor-nurse relationships (Dlamini & Visser, 2017:5). In addition to increased job satisfaction, supervisors should instil motivation to decrease absenteeism (Haywood, 2020:17).

## 2.8 ABSENTEEISM AND THE ORGANISATION

### 2.8.1 Organisational Culture

Serpa (2016:51) conceptualised organisational culture as the perceptual expectations of individuals who share a way of thinking and acting mutually and in coordination. Odor (2018:23) posits that the values and beliefs in the way an organisation operates is its organisational culture. The author states that organisational culture determines the performance of the individuals working for the organisation. Organisational performance is reduced by absenteeism which adversely affects workforce effectiveness (Peretz, Levi & Fried, 2015:882). There is a reduction in efficacy when workers are absent, compromising quality of healthcare (Kisakye *et al.,* 2016:8). The authors also found with regulatory absenteeism strategies where organisation culture have been modified, resulted in decreased absenteeism. Strategies in modifying organisational culture included defining disciplinary procedures, documenting the process, monitoring, auditing, disciplining or even dismissal when employees were absent (Kisakye *et al.,* 2018:8).

Healthcare organisations strive to develop employees' full potential through long term goals when personalised relationships and a climate of trust between employee and employer have been established (Jourdain & Chênevert, 2015:187). The authors found that when the organisation (the employer) is more flexible with its employees, a more social relationship is developed. In addition, when concern for employees' well-being from supervisors is evident, absenteeism is more likely. The aforesaid is contrary to a study done by Tumlinson *et al.,* (2019:4) which found that a lack of, and infrequent supervision leads to absenteeism. Tweheyo, Reed, Campbell and Davies (2019:6) support the findings by stating that unsupervised patient care which portray informal delegation leads to nurses feeling ill-equipped to perform tasks which stem from absenteeism. Jourdain & Chênevert (2015:187) see employees as part of the organisational culture.

Organisational culture can increase group performance among staff and reduce absenteeism (Kisakye *et al.,* 2016:87). In a study done on what nurse managers say about absenteeism, the absence of culture and policy in the organisation is easing the absence decision (Baydoun *et al.,* 2016:100).

Negative organisational culture may also lead to workplace incivility (Cash, White-Mills, Crowe & Rivard, 2018:2). The presence of incivilities can negatively impact the organisations culture by undermining the organisation's mission itself (Campbell, Lafreniere, Almekdash & Perlmutter, 2021:8). Incivility has negative outcomes for healthcare like negative interpersonal relationships which may infringe workplace norms (Cash *et al.,* 2018:1). Incivility is defined as the violation of norms and standards ranging from a breach of etiquette to rudeness and harassment (Cash *et al.,* 2018:2). The authors found that employees were absent at least once a week when exposed to incivility. Zia-au-Din, Arif and Shabir (2017:217) support the findings by revealing the positive significance between incivility and absenteeism. The study results also revealed that workplace incivility affects quality of work and causes absenteeism.

Absenteeism is also caused by uncivil encounters (Campbell *et al.,* 2021:2). Miller (2015:1) posits that absenteeism is the cause of uncivil behaviour detrimental to organisational goals. Moreover, professional relationships are also jeopardised by absenteeism related issues caused by incivility (Zia-au-Din *et al.,* 2018:217). Due to

disruptive behaviours, organisations have reported 70-80% medication errors, 77% physicians abuse of nurses, 65% of nurses reported abuse from other nurses and 31% of nurses resign due to workplace incivility (Clark, 2019:45). Nagy (2018:159) recommends that building positive relationships are fundamental in workplace civility. Civility is defined as working together by understanding each other's behaviours and the roles everyone plays leading to mutual respect in the workplace. Furthermore, civility is not the total opposite of incivility; civility has a positive outcome like lower absenteeism rates (Nagy, 2018:159).

### 2.8.2 Socio-economic Effects

The workforce is the most important resource of any healthcare organisation, particularly nurses and their absence affect the expenditure of healthcare institutions (Mbombi *et al.,* 2018:1). Expenditure is negatively affected due to employee absenteeism (Kandemir & Sahin, 2017:4). The impact of absenteeism leads to financial losses to organisations (Raja & Gupta, 2019:585). Globally, governments suffer financial losses and 5% of healthcare workers are employed permanently each year as a result of absenteeism (Tweheyo *et al.,* 2019:2). In a study in Turkey, financial losses due to absenteeism accounted for 2372.46 TRY (Turkish New Lira), billions of dollars in Canada and $661 (US Dollars) in the United States (Kandemir & Sahin, 2017:16). In Portuguese hospitals 189,679.87 EUR was spent due to sickness absence, estimated at 10% of hospital costs (Kandemir & Sahin, 2017:16). In Britain, 8.4 to 12 billion pounds (GBP) were spent on sickness absence constituting 40% of total work loss (Kandemir & Sahin, 2017:16).

In low-income countries the economic losses are 10-fold higher than in high income countries with health workforce absenteeism ranging between 17 and 48% (Tweheyo *et al.,* 2018:2). Although causing frustration that led to absenteeism, Uganda's public service financial policy states that workers will lose their salary if it was not paid the previous year (Tweheyo *et al.,* 2019:5). The study revealed that salary inadequacy led to employees feeling entitled to take leave. Moreover, this was prevalent among physicians and managers and not in nurses who regarded absenteeism as unprincipled and immoral (Thweheyo *et al.,* 2019:5). Financial losses are due to continued payment of salaries of absent workers (Karimbril, 2019:1). In addition, the author states that absenteeism negatively influences organisational finances due to

administration cost of tracking hours which increases with more employees that are absent and getting paid.

Organisations are in financial dismay to ensure continuity of patient care due to absenteeism (Baydoun *et al.,* 2016:97). According to Mbombi *et al.,* (2018:4) a financial implication that institutions must deal with is hiring of replacement nurses when nurses are absent. Hiring nurses, also known as relief or replacement staff, are nurses employed by a commercial nursing agency to provide temporary coverage in hospitals and are registered with the South African Nursing Council (Ripsel & Moolman, 2015:3). In a provincial survey on nursing agency utilisation, R1.4 billion was spent on nursing agencies with agency expenditure ranging from R36.45 million in Mpumalanga Province to R356.43 in the Eastern Cape (Rispel, 2015:2). The author postulates that agency nurses who assist hospitals when nurses are absent are unreliable, lack commitment and provide sub-optimal nursing care. Craft, Christensen, Wirihana and Bakon (2017:37) confirmed that there is a reduction in the quality of service, a reduction in continuity of care and a high number of agency nurses are linked to patient complaints which may lead to low morale. The latter can be attributed to unfamiliarity with hospital policies and procedures. A study on transforming nursing policy, practice and management in two South African hospitals revealed that in one week the indirect cost of both hospitals exceeded the direct cost of nursing agencies (Rispel, 2015:2). However, if nurses who are absent are not replaced with agency staff, patients are not admitted for treatment (Wang *et al.,* 2020:20). Rispel and Moolman (2015:2) stated that the hiring of replacement nurses is an essential strategy to deal with staff shortages and absenteeism. The study also revealed that replacement nurses allow nurses with children to work more flexible hours.

Indirect cost institutions encounter is the orientation, supervision and mentoring of agency nurses as well as the amount of time senior nursing staff spend on arranging temporary cover (agency nurses) when nurses are absent. The disruption in the continuity of patient care is one of the consequences of indirect cost (Tweheyo *et al.,* 2019:2). Karimbil (2019:1) states that an indirect cost due to absenteeism is poor quality service. Tumlinson *et al*., (2019:7) postulate that employees that provide quality service may receive a financial incentive. The authors recommend that employee absenteeism may be discouraged by incentives because high rates of absenteeism

reduce the number of patients seen and the amount of funding available to the organisation for employees. Absenteeism is also caused by overtime payments not made (Alharbi *et al.,* 2018:1787). Therefore, nurses should be rewarded for low absenteeism with bonuses and other incentives. The lack of the aforesaid influence job satisfaction negatively (Holmberg, Garo & Sobis, 2018:581).

## 2.9 STRATEGIES TO MANAGE ABSENTEEISM

Damart and Kletz (2016:4) postulate that strategies must be implemented to reduce absenteeism by self- legitimising, the more the strategies are used, the more they are regarded as useful and normal.

### 2.9.1 Organizational policies

Managers are accountable to their institutions by streamlining the policies and procedures for controlling absenteeism (Ndhlovu, 2015:27). Owing to this, managements spend considerable time on reassigning duties of staff that are absent (Ndhlovu, 2015:25). Organizational absenteeism policies should therefore include an attendance policy, absence disciplinary procedures, documentation and monitoring of the absence review, auditing of discipline and even dismissal (Kisakye *et al.,* 2016:85). Silva and Merino (2017:551) recommended policies that would assist and recognise nurses who are constantly absent to address absenteeism. Multimodal strategies should be implemented that focus on creating a conducive, effective work environment with positive practices that encourage staff rather than policies such as disciplinary actions for absenteeism (Craft *et al.,* 2017:41).

### 2.9.2 Better working conditions

Nurses require a healthy work environment with sufficient staff and equipment to perform their duties effectively (Furlan *et al.,* 2018:4). The primary cause of work-related stress is a heavy workload (Allah, Elshrief & Ageiz, 2017:183). The study revealed an imbalance between resources, tasks and expectations. As a result, it was recommended that resource allocation needs attention, education of healthcare workers and the prioritization of employee job description. Staffing issues also include recruitment and retention of staff (Khamisa *et al.,* 2017:257).

A conducive working environment includes appropriate nurse-patient ratios (1:4) and workforce planners must be cognizant of nurses' scope of practice (Malatji, Ally & Makhene, 2017:325). According to the South African Nursing Council (2020), there was one nurse for every 213 people in South Africa both in private and public sector in comparison to Australia which has one nurse for every four patients per shift. Consequently, policies should clearly define staffing patterns pertaining to nursing shifts and nursing skills mix (Malatji *et al.,* 2017:331). Long term implementation of an open policy regarding nursing agencies to ensure needs of the South Africa system are met (Olojede & Rispel, 2015:82).

### 2.9.3 Motivational activities and incentives

Allah *et al.,* (2020:186) recommended that to encourage staff retention, salaries and allowances must be line with qualifications and experience. Staff motivational activities include reviewing and improving nursing services with clear career advancements, support and recognition for nurses by creating training opportunities like workshops and seminars, and award recognition to employees who develop their skills (Allah *et al.,* 2020:186). A lack of appropriate reward for efficient service of nurses may lead to absenteeism (Kanwall *et al.,* 2017:112). Annual awards ceremonies could be implemented to motivate dedicated staff and consequently reduce absenteeism and to reduce strain on already overworked nurses, all vacant posts should be filled (Kanwall *et al.,* 2017:114).

### 2.9.4 Leadership/management support

According to Bargau (2015:182) management and leadership are frequently used interchangeably and that both are essential in the workplace. Although there is an overlap in the requirements, leadership and management roles differ (Kniffin, Detert & Leroy, 2020:544). Leaders are patience orientated and staff satisfaction is essential to them (Harris & Mayo, 2018:1), whereas nurse managers plan, organise, support nurses for optimal results for the organisation (Kniffen *et al.,* 2020:544). The absence of communication channels between nurses and management may lead to absenteeism (Baydoun *et al.,* 2016:100). A study by Fero *et al.,* (2018:405) revealed that the absence of effective communication can lead to absenteeism. The authors highlighted the imperativeness of supervision of communication to ensure

effectiveness to avoid nurses' dissatisfaction and absenteeism. Baydoun *et al.,* (2016:10) assert that in order to reduce absenteeism, communication is key.

Mudalay and Nkosi (2015:628) postulate that organisational factors like poor management and incoherent decision making may cause absenteeism. Owing to absenteeism, managements spend considerable time on reassigning duties of staff that are absent (Ndhlovu, 2015:25). Furthermore, nurse managers have an important role in reducing absenteeism by addressing employees' concern which can lead to increased productivity, increased staff morale and satisfied patients.

According to Buzeti (2021:3) leaders' action affect people as they are seen as change agents and they have an impact on how subordinates experience their job. Subsequently, supportive roles by leaders are associated with a reduction in absenteeism (Erskine & Georgiou, 2017:30). The authors added that reduction of absenteeism is not only in providing support, but also in the quality of support provided. This includes solving conflict effectively, provision of developmental opportunities, creating a culture of recognition and rewards which harvest respect associated with employees being present (Erskine & Georgiou, 2017:30). Løkke (2022:1) found that leadership styles affect employee absence. Similarly, Buzeti (2021:4) confirmed that leadership styles are a determinant of employee absence. Nurse leaderships are complex and nurse leaders need to adopt various types of leadership roles (Hughes, 2018:7).

A study on the influence of toxic and transformational leadership practices associated toxic leadership with lower job satisfaction, higher stress levels and frequent absenteeism (Labrague *et al.,* 2020:1). The inability to influence nurses adequately coupled with autocratic leadership are factors that influence absenteeism (Erskine & Georgiou, 2017:28). However, transformational leadership displayed a consistent advantage in reducing absenteeism as opposed to poorer outcomes demonstrated for autocratic, laissez-faire and transactional leadership (Erskine & Georgiou, 2017:28). The latter is considered negative leadership style which contributes to undesirable working conditions (Molino & Gortese, 2019:1).

## 2.10 HERZBERG'S TWO FACTOR THEORY

In 1959, Frederick Herzberg, a psychologist developed a theory based on employee job satisfaction and dissatisfaction at the workplace (Reukauf, 2018:12). The theory resulted from research based on employee attitudes. Herzberg hypothesised that unsatisfied factors lead to dissatisfaction and demotivation of employees and that motivation factors result in job satisfaction (Herzberg, 1966). The absence of motivation and hygiene factors contribute to decreased employee engagement or absenteeism (Herzberg, 1966). A link between the prevalence of the criteria from the motivation-hygiene theory and improved attendance was confirmed by Horton and Willis (2018:1). Herzberg's two factor theory of motivators consist of achievement, recognition, the work itself, responsibility, advancement and growth; whereas hygiene factors include policies, supervision, relationships, working conditions and benefits.

The following figure illustrates the various elements contained in the conceptual framework.

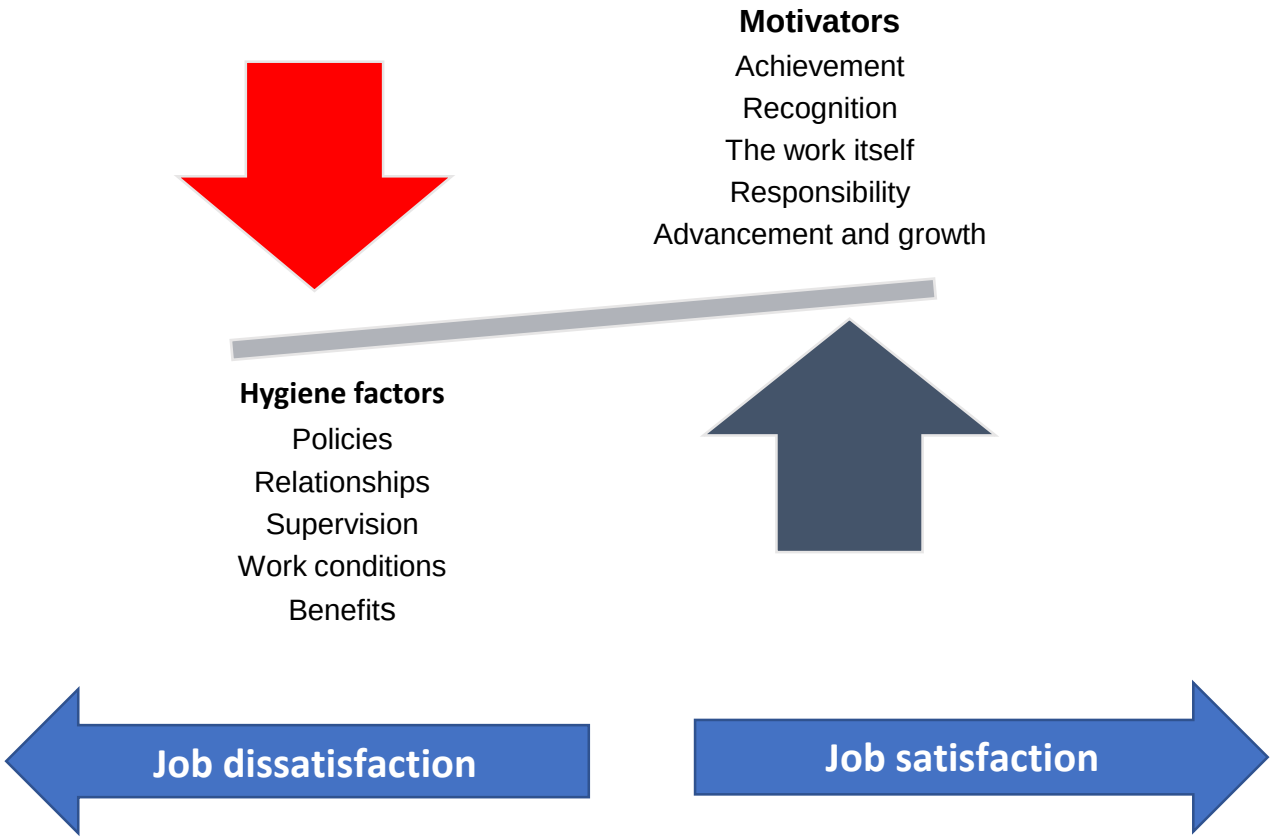


**Figure 2.1: Herzberg two factor theory**

### 2.10.1 Extrinsic Factors Influencing Absenteeism

#### *2.10.1.1 Policies*

A policy provides uniformity in the interpretation and implementation of expected actions pertaining to a specific matter (Booyens, Jooste & Sibiya, 2015:59). According to the authors policies foster a productive working environment particularly to health services. Various types of policies exist, and work-family policies are among the main causes of absenteeism (Medina-Garrido, Biedma-Ferrer & Shanchez-Oritz, 2020:1). Policy makers should therefore establish a balance between nurses' family life and nurses' work life such as providing fringe benefits (AlAzzam, AbuAlRub & Nazzal, 2017:278).

Policies such as recruiting, providing incentives for nurse graduates, full-time government employment, and rural allowance have been implemented to combat nursing shortages leading to absenteeism (Park & Yu, 2019:298). Poor policies can impact the employee negatively, leading to job dissatisfaction (Alshmemri *et al.,* 2017:14). According to Kisakye *et al.,* (2016:85) poor polices include not outlining the disciplinary procedures for absence, not documenting the process of absence review and failing to inform staff of changes in attendance register policies. Reformed national health policies result in downsizing of nurses which had a ripple effect on nurses and patient care like decreased staffing, increased workload, decreased job satisfaction, and decreased quantity and quality of patient care (Shariff, 2014:1).

According to Al-Sharif *et al.,* (2017:1) policies influence the rate of employee absenteeism. Mbombi *et al.,* (2018:4) recommend the introduction of workplace polices addressing absenteeism in the workplace and how nurses who remain on duty could be assisted with the workload of colleagues who continuously absent themselves. However, in a study on the causes of absenteeism rate among nurses, understanding and policy implementation were found to be the least common cause of absenteeism (Alharbi, Almuzini, Aljohani, Albowini, Aljohani & Althubyni, 2018:1786). Strategies to mitigate the effects of absenteeism should be applied frequently until they are considered normal and useful (Damart & Letz, 2016:1).

Scott and Scott (2021:1) claim that the quality of healthcare will be influenced effectively when nurses engage with policy makers. The authors also state that

engaging nurses with policymakers is critical to get nursing care issues on the policy agenda. Arabi, Raffi, Cheraghi and Ghiyasvandian (2014:315) agree that nurses' influence on health policy protects the quality of care. In addition, nurses' influence on health policy allows them to influence collaboration with other members of the health team and establish effective relationships (Arabi *et al.,* 2014:315).

#### *2.10.1.2 Relationships*

Workplace relationships is the exchanging of information between individuals and groups who want to achieve their goals (Tran, Nguyen, Dang & Ton, 2018:2). A positive workplace relationship creates an understanding among nurses and increased perception of the social impact whereas high quality workplace relationships are negatively and significantly related to job stress (Tran *et al.,* 2018:11). Unfavourable working conditions like task stressors and time pressures that force staff to achieve work related goals lead to low job satisfaction, low commitment, negative relationships and ultimately absenteeism (Kottwitz *et al.,* 2017:109). Negative relationships are recognised globally for negatively affecting the professional and private lives of nurses (Bambi, Foà, De Felippis, Lucchini, Guazzini & Rasero, 2018:51). The study also revealed that the prevalence of bullying ranged between 2.4 and 81%.

Workplace incivility, also known as bullying, is a problem in many healthcare facilities (Warner, Sommers & Zappa, 2016:22). According to Magee, Gordon, Robinson, Caputi and Oades (2017:319), workplace bullying is related to absenteeism. Nurse absenteeism was found to be positively significant with incivility in the workplace (Zia-au-Din *et al.,* 2017:216). Bambi *et al.,* (2018:51) confirmed that nurses who were victims of bullying recorded 1.5 times more absenteeism than those of their non-victimised peers. Workplace incivility contributes to low morale and a negative work environment (Kisner, 2018:29). In contrast, if nurses are encouraged to resolve issues, workplace relationships and the environment can be enhanced (Kisner, 2018:29).

Alshmemri *et al.,* (2017:14) postulate that a harmonious working environment is a regulatory mechanism to control absenteeism, which include positive relationships between the employee and his or her superiors, subordinates, and peers with job-related and social discussions in the work environment. Effective communication, collaboration and decision making among nurses improve workplace relationships

(Tran *et al.,* 2018:11). In contrast absenteeism is caused by inadequate interpersonal relationships by a lack of nurses' involvement in developing strategies in achieving organisational goals (Alshmemri *et al.,* 2017:7). The authors postulate that for stronger effective relationships between nurses, fairness, equality and constructive feedback from mangers should be provided.

#### *2.10.1.3 Supervision*

Supervision is guiding someone to carry out a task by directing and influencing (Booyens *et al.,* 2015:268). In health systems management, supervision is one of the most relevant tasks Mwenda, Eilish, Ogena and Honorato, 2017:1). According to Tumlinson *et al.,* (2019:6) limited, infrequent and inadequate supervision contribute to absenteeism particularly in rural areas where it is most prevalent. Absenteeism can be the result of a combination of limited consequences and a lack of supervision (Tumlinson *et al.,* 2019:5). Managing inadequate staff was identified as a main barrier to supervision (Hughes, 2018:11).

Inadequacy of staff was one of the determining factors influencing absenteeism among healthcare staff (Batool & Afzal, 2019:6781). According to Mwenda *et al.,* (2017:2) high levels of absenteeism are aggravated by inadequate staffing and reduces access to service. Therefore, to reduce and mitigate absenteeism, adequate supervision is required by applying health worker management strategies through integrated on the job training and supportive supervision. Supportive supervisor is a supervisory approach emphasising mentoring, two-way communication between the supervisor and the supervisee and joint problem solving (Mwenda *et al.,* 2017:2). The study suggested that through supportive supervision, communication between healthcare workers could improve and possibly lead to fewer unexplained absences.

Absenteeism can be linked to roles of leaders associated with competence or incompetence, fairness or unfairness and the supervisor's responsibility to teach or willingness to delegate (Alreshidi *et al.,* 2019:1). Inadequate delegation can result in insufficient supervision of delegated tasks (Johnson, Magnussson, Allan, Evens, Ball, Horton, Curtis & Westwood, 2015:29). Addressing inadequate delegation requires the acquisition of adaptive leadership skills, as leadership styles have been identified as one of the factors associated with absenteeism (McCay *et al.,* 2018:361).

In a study on health workers' responses and institutional adaptations to absenteeism, unsupervised task shifting from clinicians (doctors) to nurses because of altering weekly schedules, differing patient appointments and offering unnecessary patient referrals resulted in retaliatory absence of nurses (Tweheyo *et al.,* 2018:8). In addition, absenteeism resulted in unsupervised, patient-led patient care, and informal task delegation of clinical roles where nurses felt incapable of performing. Therefore, formal or informal delegation to junior staff, left unsupervised due to absenteeism was reported high.

Bekru, Cheri and Anjulo (2017:14) postulate that supportive supervision enhances employee efficiency. According to Mwenda *et al.,* 2017:1) supportive supervision are essential to the performance of healthcare workers. In addition, supportive supervision is the key determinant in quality service particularly in low resource settings (Mwenda *et al.,* 2017:1). In study on staff absenteeism in public health facilities in Uganda, 91.2% of the respondents, replied that absenteeism is a result of inadequate supervision (Nyamweya, Yekka, Mubutu & Kasozi, 2017:1126). The authors revealed that increased administrative duties led to inconsistent support supervision. According to Musaka, Sensoy Bahar, Ssewamala and KirkBride (2019:8) Sub-Saharan Africa has a significant shortage of healthcare workers, and there is minimal supervision in government facilities which has been associated with high absenteeism rates in south-western Uganda. Employees also tend to be absent when supervisors are absent (Muska *et al.,* 2019:8). The authors also reveal that no disciplinary actions were implemented against employees for absenteeism due to the lack of supervision. A South African study conducted on the challenges that professional nurses face during supervision revealed that supervisees were demotivated and experienced burnout as a result of absenteeism, which occur when employees take frequent sick leave that contributes to staff shortages (Raliphaswa, Luhalima & Netshandama, 2021:18631).

#### *2.10.1.4 Working conditions*

A good work environment satisfies employees (Alshmemri *et al.,* 2017:14) whereas budgetary constraints, poor infrastructure, shift work, staff shortage, increased workload and long working hours affect working conditions negatively (Manyisa & van Aswegen, 2017:29). Consequently, excessive job demands have an impact on nurses' physical and mental health which contributes to absenteeism (Tichwara *et al.,* 2019:111). Kottwitz *et al.,* (2017:109) agree that higher rates of sick absenteeism are

prevalent with unfavourable working conditions. Job demands are linked to burnout and burnout is associated with absenteeism (Magnano, Santisi and Platania, (2017:305). Factors resulting from burnout are, sub optimal patient care, mistakes in treatment, shouting at patients and not performing diagnostic tests due to a desire to finish hastily (Kim, Mazenga & Yu, 2018:1). Burnout also contributes to patient morbidity and mortality (Kim *et al.,* 2018:1). In addition, staff absenteeism generates discontinuity in patient care (Baydoun *et al.,* 2016:97). To ensure continuity of care, the same healthcare practitioners must be available to patients for the duration of their illness (Jowsey, Dennis, Yen, Islam, Parkinson & Dawda, 2016:855).

Mortality and morbidity rates may be increased particularly with the minimum nursing care provided because of nurses being absent (Mbombi *et al.,* 2018:3). The authors also postulate that nurses who remain on duty due to colleagues being absent result in substandard care and patients being in jeopardy of medical errors. Feldhaus, Souza, Fernandes, Carvalho, Bordin and de Olivera (2018:6) confirm that nurse absenteeism favours the occurrence of adverse events. Mbombi *et al.,* (2018:4) postulate that individualised nursing care is lacking due to nurse absenteeism finding it difficult to meet patients' needs and ultimately a reduction in quality patient care. Similarly, Al-Sharif *et al.,* (2017:64) found that absenteeism has a negative impact on organisational commitment from nurses and raises a concern in hospitals as it decreases quality patient care. Quality nursing care are more likely to be reported by resilient nurses even though resilience was not predictive of absenteeism (Williams, Hadjistarvropoulos, Ghandehari, Malloy, 2016:1). Working conditions that do not consider different patient needs, level of education and experience of nursing staff lead to dissatisfaction (van den Oetelaar, van Stel & van Rhenan & Stellato, 2016:1). The authors postulate that there should be a good balance between nurses and their level of experience to ensure a proper fit that is applicable to different hospital wards and to ensure patient needs are attended to.

#### *2.10.1.5 Benefits*

Benefits consist of all forms of compensation and hospital policies should be transparent (Alshmemri *et al.,* 2017:14). Nurses are dissatisfied with working conditions, particularly with their salaries (Abeer & Nahed, 2018:4290). The authors found that absenteeism was due to nurses' dissatisfaction with fringe benefits.

According to Alharbi *et al.,* (2018:1787), overtime payments significantly affect rates of absenteeism. The authors also postulate that considering overtimes per shift are important motivators that could decrease the rates of absenteeism. However, working overtime can have a negative effect on working environments, the health of staff, patient outcomes and increase healthcare cost (Jeffs, Grinspun, Closson & Mainville, 2015:23). The authors also suggest that the nursing workforce should be maximised, and overtime minimised to ensure efficient, effective and quality healthcare.

Salary issues can affect the quality of care provided and lead to absenteeism (Ferro, Zacharias, Fabriz, Scholholzer, Valnete, Barbosa, Viola & Pinto, 2018:399). Nurses are generating additional personal income to compensate for salary inconsistencies and ultimately leading to absenteeism (Agwu, Ogbozor, Odii, Orjiakor & Onwujekwe, 2020:1019). The authors postulate that justifiable gaps should be closed by strengthening health systems particularly in low- and middle-income countries (Agwu *et al.,* 2021:1019). The latter could be applied in the public sector, especially health system factors like delayed or omitted salaries (Tweheyo *et al.,* 2017:1). In America, male nurse practitioners earn 12 859 dollars more than their female counterparts, the study concluded that salary equity assessments should be done to identify and ameliorate pay inequities (Greene *et al.,* 2017:669). In Uganda, East Africa, nurses felt entitled to absent themselves due to salary inadequacy (Tweheyo *et al*., 20217:70). In a South African study on the level of job satisfaction, 87.8% were dissatisfied with their salaries (Khunou & Davhana-Maselele, 2016:1). In contrast Valiani (2019:76) postulates the significance that remuneration is not among the top concerns among nurses which can be attribute to the implementation of the occupation-specific dispensation (OSD) reform of 2007.

Due to a shortage of nurses, the South African health department has implemented the Occupation Specific Dispensation (OSD) as a financial strategy to retain health professionals, especially nurses in the public sector (Khunou & Davhana-Maselelesele, 2016:2). The OSD defines the remuneration structure, frequency of pay and grade progression, career path, recognition of prior experience and required levels of performance. According to Valiani (2019:27) all categories of nurses in recognition for their pivotal role in public healthcare delivery were prioritised with the implementation of the OSD. According to studies conducted in the Northwest province

and the Free State, there were numerous gaps in the implementation of the OSD policy, including inadequate attention to time and resources, tasks specifications, communication and coordination (Khunou & Davhana-Maselesele, 2016:2). In contrast, a study conducted in KwaZulu Natal found that OSD was effective in improving nurse salaries. Although OSD has been implemented, nurses' remuneration is still not aligned with other healthcare professionals (Khunou & Davhana-Maselesele, 2016:9). The authors elucidate that even after the implementation of the OSD, the level of job satisfaction of nurses remained low. In a study on absenteeism and intent to leave, a definite relationship between job dissatisfaction and absenteeism were evident where absenteeism rates were reported higher in nurses who were less satisfied at work with 82 % of the sample being absent the previous year of the study (Burmeister, Kalisch, Xie, Doumit, 2019:143).

Despite job dissatisfaction, performance-based remuneration systems should be executed to motivate and appraise nurses for their performance (Alhassan, Spieker, Ostenberg, Ogink, Nketiah-Amponsah & de Wit, 2013:9). According to Kocakulah, Kelly, Mitchell and Ruggieri (2016:93) incentives can be used to reduce absenteeism. Kisakye *et al.,* (2016:87) agreed and recommended the provision of incentives to lower absenteeism. The authors conducted a study on regulatory mechanisms for absenteeism in the health sector and found financial rewards for good attendance were implemented among all nurses in the United States and the United Kingdom. Absenteeism was also reduced by 36% in nurses who got bonus checks for outstanding attendance (Kisakye *et al.,* 2016:87). In Peru lower absenteeism rates was evident with permanent salary-based employment which increased job security and therefore motivation for attendance. The aforementioned is supported by Baydoun *et al.,* (2016:101) who found lower absenteeism in permanent employees with a higher level of job security. In contrast, it was found that in terms of job security in Costa Rica changing from contract to permanent employment resulted in increased absenteeism (Kisakye *et al.,* 2016:87). According to Aninanya, Howard, Williams and Apam (2016:1) both financial and non-financial incentives should be used interchangeably depending on the nurses' performance which increase motivation as opposed to low health worker motivation characterised by absenteeism.

## 2.11 INTRINSIC FACTORS CONTRIBUTING ABSENTEEISM

### 2.11.1 Achievement

Wigfield, Rosenzweig and Eccles (2017:1) refer to achievement as learning to use self-regulatory tools to fulfil the desire for competence towards a specific goal. Al-Sharif *et al.,* (2017:64) postulate that in achieving competence, an employee must be committed. Furthermore, being committed reflects the extent to which nurses want to achieve results in their work.

Seeing positive results in one's work is a positive achievement (Alshmemri *et al.,* 2017:14). In contrast, a lack of progress at work or poor decision-making may lead to negative achievement. Absenteeism is a major problem in gaining skills to achieve professional goals (Nawaz, Hussain & Sarwar, 2018:212). According to Dula, Abara and Reddy (2019:21), training and development were significantly negatively correlated with absenteeism. Mudaly and Nkosi (2015:628) revealed that unfair selection of nurses for training leads to absenteeism which hinders professional and personal advancement. Achievement motivation is of paramount importance as equips nurses with sufficient power to successfully complete their tasks, achieve their goals or reach a certain level of competency to attain the necessary success (Omidi *et al.,* 2018:112). Moreover, absenteeism was reduced through job support and motivation (Aronsson, Hagberg, Björklund & Aboagye et al., 2020:415).

Public service motivation also contributes to lower levels of absenteeism (Mastekaasa, 2020:61). The authors defined public service motivation as a general, altruistic motivation to serve patients. Therefore, nurses with public service motivation are less likely to be absent because being absent means missed opportunities to perform at work and helping their patients.

### 2.11.2 Responsibility

According to Alshmemri *et al.,* (2017:13) responsibility as authority are synonymous in relation to duties. Given the responsibility and freedom to make decisions relate to gaining satisfaction. In contrast, job dissatisfaction can result from a lack between responsibility and authority leading to employee dissatisfaction which is a causative factor of absenteeism (Mbombi *et al.,* 2018:1). According to Kanwal *et al.,* (2017:110) absenteeism can be caused by habitual non-attendance from duty or responsibility.

For nurses to be satisfied or content, autonomy, nurse responsibility and co-operative relationships with colleagues should be encouraged (Sheenan, Tham, Holland & Cooper, 2019:2). Among other factors, the lack of nurse responsibility was identified as a communication barrier between the nurse and quality patient care (Andriyato, 2019:105). Taking responsibility for providing good patient care was attributed to good nursing practice (Gabrielsson, Sävenstedt & Olsson, 2016:434). A deficit in providing care and taking responsibility led to feelings of frustration and distress (Gabrielson *et al.,* 2016:434). Brborvic *et al.,* (2016:1) assert that job stress is related to absenteeism.

### 2.11.3 The work itself

According to Tichwara *et al.,* (2018:114), absenteeism may be the result of the nature of the work and the workload. Feldhaus *et al.,* (2019:3) elucidate the importance of recognising workloads in nursing as it can lead to absenteeism. The authors state that absenteeism is most dominant in the team with the highest workload. Rosiani and Lubis (2020:2) recommend that an equitable workload distribution should be considered to reduce absenteeism by preventing fatigue and illness caused by overwork. The authors also suggest work-life balance programs like leaves (annual, maternity/paternity, sick, special leaves), employee team building (skills development activities) should be implemented to reduce the level of absenteeism. Absenteeism levels are reduced with high performance work systems which include motivation, opportunity and attaining and enhancement of skills (De Reuver, Van de Voorde & Kilroy, 2021:2889).

According to Wang, Johnson, Nguyen, Goodwin and Groth (2020:30) attaining and application of new skills are considered favourable. The authors also indicate that the utilisation of skills exhibit a non-linear relationship with job satisfaction and absenteeism. Bravetti, Cocchieri & Vellone (2016:1) postulate that the complexity of nursing care is fundamental to evaluate the demand for nursing care. Complexities of nursing care include nursing duties, workload, patient acuity and severity of illness (Bravetti *et al.,* 2016:1). Subsequently, absenteeism is minimised where work demands are inclined to be low (Tichwara *et al.,* 2018:114). Nevertheless, job demands can accumulate and can have an exacerbating effect on absenteeism (Van Woerkom, Bakker & Nishii, 2016:141). Baydoun *et al.,* (2018:2) considered working conditions as indicator of patient care. A good balance of nursing staff and patients

will also ensure a proper fit between patients, the workload, adequate staff, an appropriate skill mix and equally distributed workload for all nursing staff (van den Oetelaar *et al.,* 2016:1). Barnes, Barnes and Welsh (2021:210) posit that nurse-patient relationships are developed on their moments together and by displaying compassion and skill nurses should be recognised which reinforces a sense of value and fuelling resilience.

### 2.11.4 Recognition

Nxumalo, Goudge, Gilson and Eyles (2018:1) indicate that globally health systems are under pressure in proving value for money and people working within the system determine the quality of care provided. Therefore, a performance assessment is imperative in improving the performance of nurses (Nxumalo *et al*., 2018:1). Burke, Jablonski and Cunningham (2020:225) support this by stating that recognising the opportunity for professional development creates structures that give nurses a stronger voice. Owing to task complexities and variations, recognition of human activity is challenging (Haque, Mahbub, Tarek, Lota & Ali, 2019:719).

Khaya and Oral (2018:113) underline the challenge as a struggle in being objective and fair in work evaluations as confusion exists in how to distinguish performance from competence. The authors elucidate that performance measure achievement of competency. Moreover, these competencies are used in the evaluation system to justify rewards, bonuses and promotion (Khaya & Oral, 2018:113). Kisakye *et al.,* (2016:87) indicated that financial incentives like bonuses reduced absenteeism by 36%. In contrast, Alfitian, Sliwka & Vogelsang (2021:2) revealed that presenting employees with a bonus had an opposite intended effect and led to substantial increase in employee absenteeism due to employees' perception of intrinsic cost of absenteeism and less significant feelings of guilt of being absent (Alfitian *et al.,* 2021:2). Consequently, empowering nurses, creating a positive environment and giving meaningful recognition are strategies in dealing with nurse related problems that can lead to absenteeism (Allah *et al.,* 2020:186)

Positive recognition occurs when employees receive praise for reaching a specific goal whereas negative recognition includes criticism and blame for a job not done (Alshmemri *et al.,* 2017:13). According to Baydoun *et al.,* (2016:101) not

acknowledging nurses may have a negative effect on work performance. Factors like experiencing constructive results from one's work, resolving problems and accomplishment of a difficult task contribute to one achieving specific success (Alshmemri *et al.,* 2014:14). Similarly, fairness and consistency should be applied when dealing with nurses and whenever possible give credit and recognition (Allah *et al.,* 2020:186). The nurse should be praised and recognised individually or as a team for achievement and contribution towards the organisation as well as award of recognition to those who developed their skills. In addition, performance level and job enrichment in terms of training would produce motivated and high-performing nurses because of career development (Allah *et al.,* 2020:186).

### 2.11.5 Advancement and growth

Career advancement specifies promotions, organisational important responsibilities, coveted recognitions, autonomy for decision making and job opportunities (Malhorta & Singh, 2016:212). Sheikhi, Fallahi Khoshnab, Mohammadi and Oskouie (2015:74) agree that performance improvement is dependent on career advancement programs which are invaluable in achieving quality patient care, clinical skills and professional growth. Negative advancement involves poor decision making and failure to make work progress because of job dissatisfaction whereas completing a task, solving a job-related problem, and achieving success result in job satisfaction (Alshmemri *et al.,* 2017:13-14). Clear arrangements should therefore be made for career advancement, creation for more training opportunities such as seminars and updated workshops (Allah *et al.,* 2020:186). Budiyanto (2020:276) postulates that if the organisation's organisational climate is such that nurses strive to build team spirit and motivate colleagues' productivity, then a conducive climate will be created to support nurses' performance.

The need for individual growth and self-actualisation is driven by motivation and job satisfaction tends to be low with absenteeism (Monis, 2017:66). According to King *et al.,* (2020:4) stress is low and growth and productivity is high when the nurse reaches self-actualisation. Nurse managers should however initiate interventions to promote self-actualisation through staff participation and focusing on personal strengths, mindfulness, and acts of kindness (King, 2021:17). Furthermore, the study findings

revealed that absenteeism was reduced by 39%. Consequently, promoting well-being of nurses, leads to decrease in absenteeism.

## 2.12 SUMMARY

This chapter provided a review of the literature pertaining to relevant information of the topic researched. The key factors involved in absenteeism were discussed based on the current literature affecting the nurse, patient and the organisation. The conceptual framework, i.e., the Herzberg's motivator-hygiene factors provided explains how both internal and external factors contribute to absenteeism.

## 2.13 CONCLUSION

Absenteeism remains a challenge as it affects the nurse, patient and the organisation. A linear link has been established between absenteeism and satisfaction of nurses, patients and the organisation. Therefore, understanding how nurses experience absenteeism is important to enable essential changes towards better policy implementation and considering policy reviews. The next chapter provides a comprehensive description of the research methodology applied for the purpose of the study.

# CHAPTER 3

# RESEARCH METHODOLOGY

## 3.1 INTRODUCTION

This chapter provides a comprehensive explanation of the research methodology as applied in the study in the exploration of how nurses experience absenteeism in district rural hospitals in the Eastern Cape. The focus of the chapter is to describe the research study setting, research design, population and sampling, the data collection procedure, data analysis and measures to provide trustworthiness. According to Mohajan (2017:59) the essential elements in research methodology is reliability and validity. Subsequently, the latter can be evaluated by reading the methodology section.

## 3.2 RESEARCH AIM

The aim of the study is to explore how nurses experience absenteeism in district rural hospitals in the Eastern Cape.

## 3.3 OBJECTIVES

The objectives were to:

- Gain understanding of nurses' experience of absenteeism at the workplace.
- Explore the influence of intrinsic factors on absenteeism as experienced by nurses.
- Explore the influence if extrinsic factors on absenteeism as experienced by nurses.

See Figure 3.1 below for an overview of the study methodology.

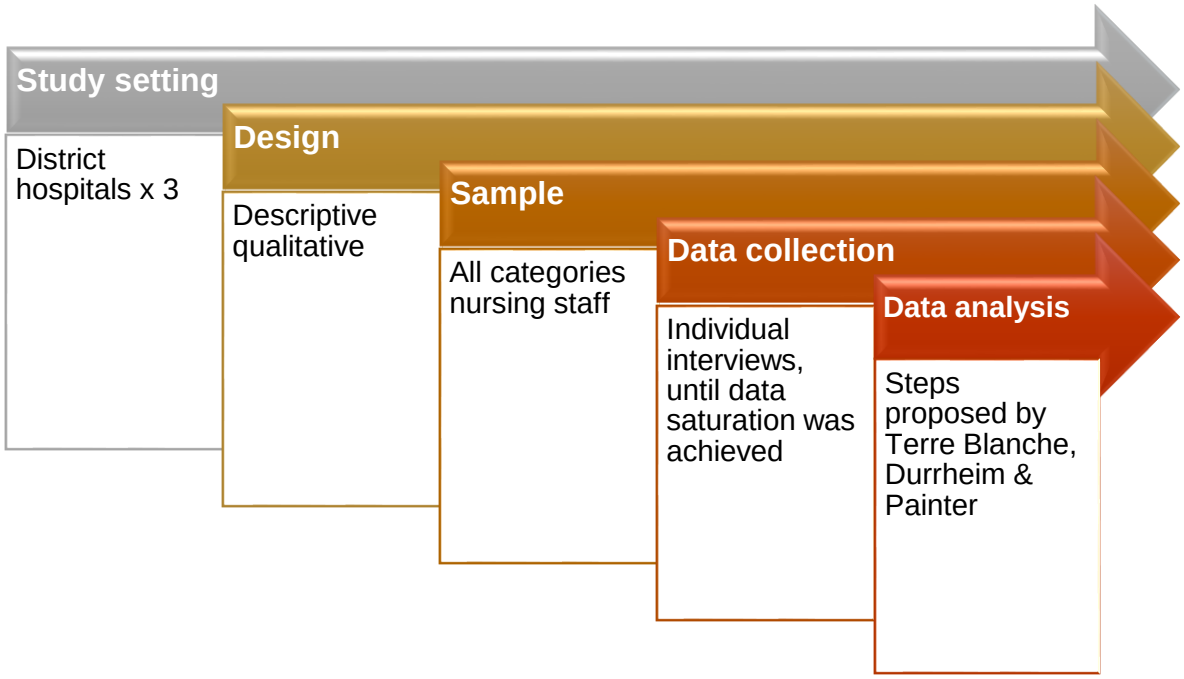


**FIGURE 3.1: Methodology as applied in the study**

### 3.4 STUDY SETTING

The study setting refers to where participants are recruited and data is collected (Lobiondo-Wood & Haber, 2018:93). The Eastern Cape is divided into the Nelson Mandela Bay and the Buffalo City metropoles. There are six municipal health districts, namely, Alfred Nzo, Chris Hani, Amathole, O.R. Thambo, Joe Gqabi and Sarah Baartman. The Sarah Baartman district is situated in the western part of the Eastern Cape and is approximately a third of its geographical area, making it the biggest health district in the Eastern Cape. The Sarah Baartman health district is divided into seven sub districts namely, the Blue Crane Route, Makana, Ndlambe, Sundays River Valley, Koukamma, Kouga and Dr Beyers Naude. The study was conducted in a natural setting, in three district rural hospitals in Dr Beyers Naude sub district in the Baartman health district, located at the western end of the Eastern Cape.

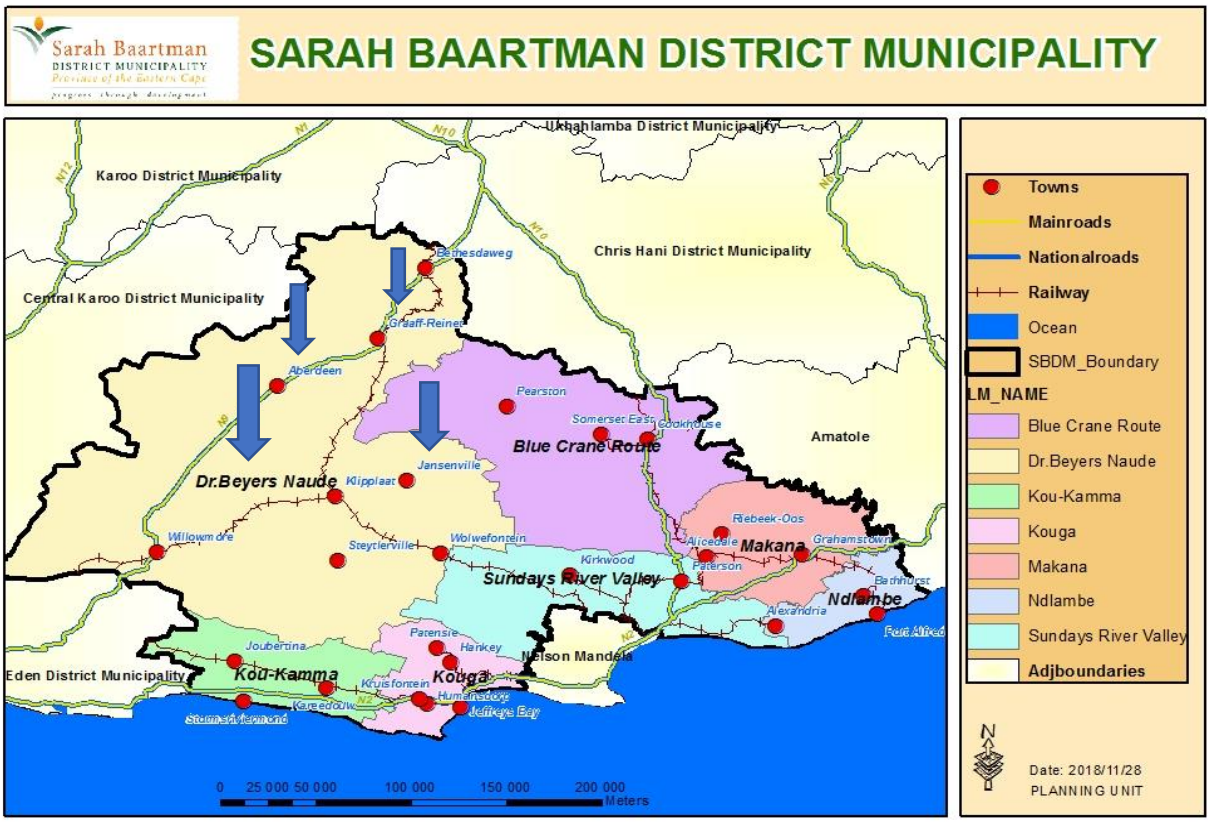


**FIGURE 3.2: Map of the local municipalities in the Sarah Baartman health district**

Governmental district hospitals are classified as level one in South Africa. District hospitals are two dimensional: they support primary health care on one hand and serve as a gateway to more specialist care on the other. Level one services are provided to in-patients and outpatients, has a 24-hour emergency service and an operating theatre. However, two of the hospitals where the study was conducted have no operating theatre. Nurses in two of the three district hospitals, are not allocated to a specific ward and must cover outpatient department (OPD)/emergency department maternity, paediatric and general wards.

### 3.5 RESEARCH DESIGN

The blueprint for conducting a study is known as the research design (Grove & Gray, 2019:191). The research design is a plan to aid in answering the question posed by collecting and analysing evidence utilising appropriate methods and resources (Jaakkola, 2020:18). According to Johnson, Adkins and Chauvin (2020:138) the

research question must be explicit and direct, supported by a robust conceptual framework contributing to the enhancement of trustworthiness and minimisation of bias. The research design must also contain a strategy for collecting and interpreting analysed data to provide sufficient findings to make recommendations based on the study (Asenahabi, 2019:77). The researcher employed a descriptive qualitative research design for the study.

### 3.5.1 Qualitative research

Qualitative research uses a systematic approach from the perspectives of persons to describe experiences and situations (Grove & Gray, 2019:59). The researcher promotes a deeper understanding of the experience of the participants by finding meaning in the words and providing a description of their experience (Grove & Gray, 2019:59). Consequently, the purpose of the study was to describe absenteeism as experienced by nurses in district rural hospitals in the Eastern Cape, to gain more in-depth understanding of the participants' experiences.

### 3.5.2 Qualitative descriptive research

Qualitative description is used to describe qualitative studies of healthcare and nursing related phenomena (Kim, Sefcik & Bradway, 2017:1). This methodology focuses more on the "what" then the "why" of the phenomenon. The why question can only be answered by experimental research to determine cause and effect, whereas the "what" can be answered through descriptive research (McCombes, 2019:1) Descriptive studies recognise the circumstances under which participants are working and how they feel about the situation. A descriptive research design also provides candid descriptions of the participants' experiences which will be presented in a manner that closely resembles the terminology used in the initial research question (Doyle, McCabe, Keogh & Brady, 2020:443). Owing to this, it enables the researcher to describe how nurses experience absenteeism while working in district rural hospitals in the Eastern Cape while also providing meaningful answers to the research question.

## 3.6 POPULATION AND SAMPLING

The population refers to elements or individuals who meet the sampling criteria whilst a sample is a portion or a group of the population selected for the study (Grove & Gray,

2019:229). Population may comprise of events, items, animals, or persons (Lobiondo-Wood & Harber, 2018:212).

The population included all nurses in a managerial position, registered nurses, enrolled nurses and enrolled nursing assistants working in the three district rural hospitals. Latham, (2018:1) postulates that a sample size of 11 is adequate in qualitative research. A total of 12 nurses were purposefully selected to participate in the study. The target population of the district hospitals are depicted in Table 3.1.

**Table 3.1 Population and Sample**

| Name of hospital | Total population (N) | Sample (n) |
|---|---|---|
| 1. Hospital A | 22 | 4 |
| 2. Hospital B | 29 | 4 |
| 3. Hospital C | 87 | 4 |
| **Total** | **138** | **12** |

Lobiondo-Wood and Harber (2018:213) state that sampling refers to selecting of participants from a population. A subset of the members of the population selected is referred to as the sample (Grove & Gray, 2019:43). Purposive sampling is based on the participant's ability to provide comprehensive, relevant information (Grove & Gray, 2019:482). As a result, participants who met the inclusion of being permanently employed and working at the participating hospitals for at least two years were included. Furthermore, the method of purposive sampling is used to enable participants who can provide appropriate insight into the in-depth understanding of their experiences (Grove *et al.,* 2015:270). A total number of 11 participants were purposefully selected who participated in the study. In qualitative studies the sample size depends on data saturation, meaning that no new information is provided with the addition of participants. (Grove & Gray, 2019:63). Data saturation on how nurses experienced absenteeism in district rural hospitals in the Eastern Cape was reached by the 12$^{th}$ interview.

### 3.6.1 Inclusion criteria

All nurses who are permanently employed for at least two years at the participating hospitals were included in the study.

### 3.6.2 Exclusion criteria

All permanently employed nurses at participating hospitals that were on annual, sick, maternity or study leave at the time of the study were excluded.

## 3.7 INTERVIEW GUIDE

Interviews in qualitative research range from unstructured to semi-structured interviews using fixed set of questions with no fixed responses and open-ended questions with probes (Grove & Gray, 2019:77). According to Doyle *et al.,* (2020:447) the most common data collection approach in qualitative descriptive studies are individual, face-to face interviews. To reach the objectives of the study, the researcher used a semi-structured interview guide to conduct individual interviews. The semi-structured interview guide was based on the objectives of the study and validated by the supervisor of the study. Owing to this, it enabled the researcher to obtain in-depth information regarding the topic under study and comprehensive understanding of answers (Grove & Gray, 2019:78).

The interview guide was divided in two sections (see Appendix A). Section A included demographic information such as gender, age, the shift the participant was working (day or night), nursing qualification, years in service as a nurse at the current hospital. To ensure inclusion of all potential participants, they had the option for interviews to be conducted in their language of choice (Afrikaans, English or Xhosa). Section B consisted of five open ended questions with probes related to Herzberg's two-factor theory to obtain information about how nurses experience absenteeism at the workplace. Questions related to Herzberg's two-factor theory to determine job satisfaction among nurses working in district rural hospitals included how supervisory support, recognition and achievement in the workplace affect absenteeism. Working conditions and relationships among colleagues were explored and whether incentives influence employees absenting themselves.

## 3.8 PILOT INTERVIEW

A pilot interview is an attempt to determine if the phenomena being investigated is appropriate in relation to the proposed interview procedure and schedule of questions (Harvey, 2022:n.p). The pilot interview for this study was conducted to assess the appropriateness of the interview guide and the feasibility of the approach (Malmqvist,

Hellberg, Mollas & Rose, 2019:1). No adjustments were made to the interview guide as no pitfalls were encountered during the pilot interview. The pilot interview was conducted with one participant (operational manager) who met the inclusion criteria for the main study. Prior to the interview written informed consent was obtained. Data collected from the pilot interview were included in the findings of the main study as the study was conducted in an analogous manner reflecting all similarities of the main study and validated the feasibility of the study (Burns, Grove & Gray 2015:45). In addition, the pilot interview assisted the researcher in establishing that sufficient proof was found to serve as a basis for a larger research study (Lobiondo-Wood & Haber, 2018:225).

## 3.9 TRUSTWORTHINESS

Trustworthiness confirms the meticulousness, rigour and standard of a qualitative study and the extent to which the study is credible, dependable, transferable and confirmable (Grove & Gray, 2019:361). These four principles determine the extent of trustworthiness as discussed below.

### 3.9.1 Credibility

Credibility refers to whether the data collected is accurate, plausible, unbiased and trustworthy and whether correct interpretations were drawn from the participants' original views (Shufutinsky, 2020:51). Interviews were transcribed verbatim to ensure accuracy and credibility of the study findings. This not only attempts to capture the meaning and perceptions or record the interview, but also records the context in which these were formed. Member checking was done to confirm accuracy of participants' views in how they experienced absenteeism. Subsequently, the researcher returned to the participants and asked them to clarify interpretations, query and confirm accuracy of views stated and to delete or add information to ensure that data collected accurately reflected their experiences (Lobiondo-Wood & Haber, 2018:6). Peer debriefing was done by the supervisor who reviewed transcripts for appropriateness of themes to ascertain whether the researcher reflected the realities of the participants and determined sufficiency and adequacy of interpretations for the study (Grove *et al.,* 2015:89).

### 9.2 Dependability

Dependability refers to the constancy of data and steps and decisions made over time during the collection and analysis of data (Grove & Gray, 2019:362). Participants were interviewed using the same semi-structured interview guide and questions. All activities and steps were documented by the researcher to check for obvious mistakes during the transcription. Transcripts abstracted from audiotapes were verified by the researcher and the supervisor.

### 3.9.3 Transferability

Transferability is the measurement of effectiveness of study findings when applied in other contexts, settings or to other participants (Munthe-Kaas, Nockleby, Lewin & Clenton, 2020:2). The researcher facilitates the transferability judgement for potential users by providing a thick description of the participants and research process. The selection of the participants, the collection, analysis and the interpretation of data was described in full detail by the researcher. This was done by describing not only the experiences of participants but also their context, in order for the experience to be meaningful to an outsider. Thick descriptions were used to describe the experiences of the study participants by collecting data until no new data emerged, i.e., data saturation was achieved. The researcher also spent substantial time reflecting on and reading data to yield applicative results. Thick descriptions were provided to boost transferability regarding the experiences of the participants and the report was written so that readers can assess the applicability of data with similar participants in other settings (Nowell, Norris, White & Moules, 2017:3).

### 3.9.4 Confirmability

Confirmability refers to the potential for congruency of data in terms of accuracy, relevance or meaning by demonstrating that the results are linked to the conclusions in a way that can be followed (Moon, Brewer, Januchoeski, Hartley & Adams, 2016:2). Confirmability is established when all other three of the characteristics of trustworthiness are achieved. To ensure that the data reflected the voice of the participants, audit trails were kept by the researcher. The study was conducted in such a way to ensure that the conclusions and recommendations are supported by the data (based solely on the participants' responses) and that there is a consensus between the researcher's interpretation and the actual evidence.

## 3.10 DATA COLLECTION

Data collection is the process of gathering and measuring information on variables of interest, in a recognized methodical manner that allows one to answer stated research questions, test hypotheses, and appraise outcomes (Kabir, 2016:202).

### 3.10.1 Recruitment of participants

Upon permission from the nursing service manager of the selected hospitals, eligible candidates were approached directly to recruit them for the study. Face to face recruitment was done which involved walking from ward to ward recruiting all nursing staff categories adhering to COVID-19 protocols i.e., wearing a mask, keeping social distancing and sanitising before and after recruitment of each potential participant. The background of the study, the aims and the objectives were explained, and each individual candidate was given an information leaflet. During the recruitment the interview procedure was explained to participants. Explanation was further provided to participants that their participation is voluntary, and they should not feel coerced into participating. All questions were answered, and concerns clarified particularly pertaining to confidentiality and further explanation was given to participants that informed consent was to be signed upon acceptance to partake in the study.

The total population at the three participating hospitals were 138. Six (6) participants were approached at hospital A with a population of 22, of which two (2) declined and two (2) did not meet the inclusion criteria, and four (4) were interviewed, including the pilot interview. At hospital B with a population of 29, five (5) participants were approached from which one (1) did not meet the inclusion criteria and four (4) participants were interviewed. In hospital C with a population of 87, 10 participants were approached, six (6) declined and four (4) were interviewed. As a result, a total of 12 participants were interviewed. See Table 3.2 below.

**Table 3.2 Population and Sample**

| | Hospital A | Hospital B | Hospital C | Total |
|---|---|---|---|---|
| Population | 22 | 29 | 87 | 138 |
| Participants approached | 6 | 5 | 10 | 21 |
| Participants declined or not meeting the inclusion criteria | 2 | 1 | 6 | 9 |
| Participants interviewed | 4 (including the pilot) | 4 | 4 | 12 |

### 3.10.2 Interview setting

The interviews were conducted in the operational manager's office at each of the participating hospitals. Two of the participating hospitals had no board or a seminar room and at the third hospital the boardroom was unavailable at the time. Interviews were conducted over lunch times as not to interfere with ward operations. The office where the interviews were conducted were quiet and participants' and the researcher's phones were on silent to prevent disturbance. Telephones could not be taken off the hook because it was the only telephone available in the ward; however, during one interview, the office's landline telephone rang causing disruption. Eleven of the participants were interviewed at work setting, while one participant chose to be interviewed at home. The chairs in the office were comfortable and the room was well ventilated.

### 3.10.3 Interview procedure

The interviews were conducted over a period of seven (7) months. Data collection was delayed due to difficulties obtaining institutional permission from one participating hospital and reluctance of nurses to participate in the study. The purpose of the study was explained to the participants again prior to the interview to ensure that they understood the study and to provide an opportunity for participants to raise concerns that were satisfactorily addressed by the researcher, resulting in informed consent being signed. The participants were informed about second tape recorder in case of technical difficulties. Refreshments were offered and when participants were comfortable the interviews commenced.

Eleven interviews were conducted at the participants' place of employment and one at the participant's house as per the participant's preference. Participants sanitised their hands before and after the interviews in accordance with COVID-19 protocols. During all interviews, participants wore masks and maintained social distancing, making it difficult to hear what they were saying at times. Siedlecki (2022:78) recommend building rapport with participants in order for them to provide a rich and detailed account of their experiences with the topic under study. The author also suggests the use of non-threatening open-ended questions. Participants were made to feel at ease and the interviews commenced with a question such as "Tell me about yourself." The responses to this type of question provided demographic data, i.e., age, gender and number of years worked at the current hospital. Once the participants were at ease, open-ended questions were posed. Although participants had the choice to conduct interviews in preferred language of choice, all participants chose English to conduct the interviews. The interviews were commenced with a non-intimidating question which was "Can you tell me about your experiences of absenteeism in the workplace?"

Probing words used during the interviews were based on the hygienic (intrinsic) and motivator (extrinsic) factors (see Figure 2.1 under section 2.7), however both factors result in job satisfaction or job dissatisfaction. Questions posed were: "Could you please tell me what motivates you not be absent?" "In your view, what are the reasons for long absences?" "Is there anything more you would like to add?" was used as a final question. These probing questions yielded information such as satisfaction obtained from the job itself, and what positive and negative aspects are contained in this type of work. After each question answered, responses or answers were summarised, and researcher reflected on what was said to ensure detailed answering of the questions to support objectives to answer the research question. The duration of the interviews was between 30 to 60 minutes. Bracketing was applied to mitigate potentially deleterious effects of preconceptions that could taint the research process. Data saturation was reached at the 12$^{th}$ interview.

Throughout the interviews, the researcher observed participants for any discomfort in case they needed to be referred to the hospitals' employee wellness program. None

of the participants required referral. Post all interviews, the participants were presented with a R50 voucher as a token of appreciation for participating in the study.

### 3.11 ETHICAL CONSIDERATIONS

Upon ethical clearance from the Health Research Ethics Committee of Stellenbosch University (HREC Reference: S21/04/070), the researcher requested permission to conduct the study at the Eastern Cape Department of Health (ECDOH). Following permission from ECDOH (Reference: EC_202106_011), institutional permission was requested and granted from the Chief Executive Officers (CEOs) of two of the three participating hospitals and the Nursing Service Manager of one of the participating hospitals as the CEO of the hospital was assisting in the Sarah Baartman district office. Ethical considerations like the principle of respect for persons, beneficence and confidentiality and anonymity were adhered to.

#### 3.11.1 The principle of respect for persons

All the participants' right to autonomy was respected. Autonomy refers to individual liberty and the right to self-determination (Grove et al., 2015:500). Participants were not coerced to partake in the study and were informed that they have a right to refuse and withdraw from the study at any time without repercussions. Informed consent is providing information to a potential participant regarding the study (Grove & Gray, 2019:104). Participants displayed understanding and comprehension of provided information as well as competence in making a voluntary decision in participating in the study. All willing participants provided written consent as well as permission for interviews to be recorded.

#### 3.11.2 The principle of beneficence

Beneficence is to promote wellbeing and protection from harm (Bester, 2020:53). The purpose and the procedure were explained to all potential participants. The participants were protected by carefully monitoring the participants for any signs of emotional distress. No participants displayed emotional distress. However, provision was made to refer participants for counselling at the participating hospitals' wellness program for emotional and psychological support. Participants were offered tea or coffee and scones during the interview as well as awarded a gift voucher of R50 as reimbursement for time.

### 3.11.3 Confidentiality and anonymity

Participant's rights to privacy and confidentiality were maintained throughout the study. Transcripts and audio recordings were labelled anonymously. Pseudonyms were used for participants' names; hospital names any other identification were not mentioned. Electronic files were generated of the data collected. The files are kept on the researcher's personal computer which is password secured and only known by the researcher. Furthermore, the data was stored on a hard drive as well as in cloud for backup. All hard copies of consent forms and interview questionnaires are being kept in locked cabinet with only the researcher having a key to access it. The transcriber signed a confidentiality agreement not to divulge information.

## 3.12 DATA ANALYSIS

Data analysis entails rigidity (Grove & Gray, 2019:84). Furthermore, the process requires discipline which is consistent with the methods of study (Grove & Gray, 2019:85). Data will be analysed according to the steps as outlined by Terre Blanche, Durrheim and Painter (2006:322).

### 3.12.1 Familiarisation and interpretation

This stage comprised the development of ideas and arrangement concerning the interviews of how nurses experience absenteeism in rural hospitals. Familiarisation with the data was facilitated by repeated listening to audio tapes. Transcripts were read repeatedly and compared with recorded responses from participants to become familiar with the data. The entire transcript was read, then sections of it to see how they fit into the overall picture. Contradictions, vivid expressions, figures of speech and metaphors that emerged were identified. Repetitions and gaps were identified. The construction of sentences was observed such as whether the sentences were passive or active. Consequently, the researcher was able to immerse herself in the data and get a better understanding of the topic under study.

### 3.12.2 Inducing themes

In step two, there was induction, which refers to drawing conclusions from specific instances and determining the organizing principles that naturally underpin the data. The researcher grouped codes together and consistent patterns were identified.

Transcripts were used to formulate meaningful statements or themes to explain the essence of the phenomenon using the hermeneutic circle. Consequently, moving back and forth between statements and key words related to motivator and hygiene factors associated with absenteeism were identified. If too many themes were identified, themes were rearranged by adding subthemes. To develop the right anticipations, inducing themes was a continuous process of trial and error in identifying and formulating statements.

### 3.12.3 Coding

Coding is breaking the texts into subparts and giving a label to that part of the text (Grove & Gray, 2019:85). Coding was done while developing themes. All relevant data pertaining to the research aim was coded. Transcripts were analysed to identify emerging themes. Segments related to absenteeism was named and labelled, focusing on wording, phrasing, context, and consistency. The labels were colour coded and allowed the researcher to identify patterns in the data and texts that were coded in the same way which can be compared for similarities and differences (Grove & Gray, 2019:85). Motivator and hygiene factors associated with absenteeism were coded into subparts, for example experiences related to supervision and policies may have similarities as hygiene factors and experiences related to advancement and growth may have similarities as motivator factors. Numerical codes such as P1 or P2 were used to ensure and maintain privacy of the participants.

### 3.12.4 Elaboration

Elaboration explores themes or codes more closely. Therefore, texts were compared, and coding continued until it appeared to be similar. Themes of motivator and hygiene factors regarding absenteeism were compared until all data on these factors showed no significance, and all irrelevant data was excluded. Codes were evaluated for relevance and related codes were listed in categories based on the research aim.

### 3.12.5 Interpretation and checking

Interpretation and checking involve a written account of data, themes and subthemes. Nurses' experience on absenteeism were contextualised and areas of biases and prejudice were identified where the researcher might have over interpreted nurses' experiences regarding absenteeism. Inductive and deductive reasoning was applied

by identifying a relationship in meaning between all nursing categories on how they experience absenteeism working in district rural hospitals. Irrelevant data were deducted as a whole, meanings that were missing were identified, data that were no longer important or necessary were moved to the background, alternative explanations were looked at and data were analysed to assess whether the research aim were addressed by all nursing categories (Park, Bahrudin & Han, 2020:7). The supervisor further verified the researcher's interpretations before reaching a conclusion. A comprehensive and detailed description was provided on the experiences of the participants regarding absenteeism, including all clustered themes. Owing to this, clarity and understanding of the participants' experiences were ensured. Finally, the researcher compiled a report based on the interpretations that emerged from the data analysis.

## 3.13 SUMMARY

This chapter provided an in-depth discussion on the research methodology and its application to the research topic. The research design, study setting, population and sampling, inclusion and exclusion criteria, the pilot interview, data collection, trustworthiness and data analysis were all discussed. Therefore, in describing the experiences of nurses in district rural hospitals a qualitative descriptive design was chosen, purposive sampling was used to sample participants who met the inclusion criteria, a pilot interview was conducted which was included in the main study, data was collected adhering to ethical principles and trustworthiness which determined the rigidity and standards of the study.

## 3.14 CONCLUSION

Research methodology clarified the research inquiry and its importance whereas the methodology described the foundation for the research methods chosen. The next chapter comprises the study findings.

# CHAPTER 4
# FINDINGS

## 4.1 INTRODUCTION

This chapter involves the findings of the research which are presented and discussed according to the themes and sub-themes identified through the analysis of the data collected to describe the experiences of nurses regarding absenteeism in district rural hospitals in the Eastern Cape. Raw data was transcribed verbatim with quotes of the participants used throughout this chapter to corroborate the researcher's analysis. Also, data was analysed using the 5-steps proposed by Terre Blanche, Durrheim and Painters (2006:322). This approached was discussed in chapter 3, section 3.12.

Data will be presented in two sections. Whilst section A outlines the demographic data section B describes the themes and sub-themes that emerged from the interviews.

## 4.2 SECTION A: BIOGRAPHICAL DATA

The demographic data consisted of interview preference, gender, age, working day or night shift, nursing qualification, years in service as a nurse and years in service at the current hospital.

### 4.2.1 Language preference

All the interviews were conducted in English, in accordance with participants' preferences.

### 4.2.2 Gender

Eleven of the nurses were female and one was male. This could be ascribed to the female dominated workforce of the nursing profession. According to the SANC (2018) there were 9.6% males, compared to 91.4% females registered as nurses in South Africa.

### 4.2.3 Age

The ages of the participants ranged between 28 and 62 years. Two of the participants were in their twenties, two in their thirties, four in their forties, one in the fifties and three in their sixties. Most of the participants were older nurses who are described as

nurses 45 years and older. The WHO (2020) describes nurses who are 55 years and older as approaching retirement (MacLeod, Zimmer, Kosteniuk & Penz, 2021:2). According to the authors the prevalence of older nurses is evident in rural areas which already have staff shortages due to high turnover and misdistribution of staff geographically.

### 4.2.4 Working Day or Night shift

All the participants worked both day and night shifts but during the interviews 10 were on day shift and two were on night shift.

### 4.2.5 Nursing Qualification

Six participants were registered nurses of which three were operational managers. All three (3) registered nurses did the diploma course as well as two (2) of the operational managers and one (1) operational manager did the degree. The remaining six participants were enrolled nurses (3) and enrolled nursing assistants (3).

In South Africa, the Nursing Act, 2005 (Act No. 33 of 2005) regulates all the aspects of the nursing profession and establishes the scope of practice for all nursing categories. The South African Nursing Council (SANC) regulates the different professional categories (registered, enrolled and enrolled nursing assistants) who work under supervision in the subsequent hierarchy. The operational manager (OM) is a registered nurse in charge of a ward and all nursing categories work under the supervision of the OM.

### 4.2.6 Years in service as nurse

The participants' work experience ranged from two to 43 years. Seven of the participants had worked for their healthcare provider for more than 15 years, while five had worked for less than 10 years.

### 4.2.7 Years in service at the current hospital

Nine of the participants worked for their institution of employment for less than 15 years, while three of the participants worked for more than 15 years. According to Mburu and George (2017:1) nurses do not stay in rural areas for long periods due to migration of nurses from rural to urban areas and the inability to attract and retain

nurses caused by challenges such as poor working conditions, lack of management and supervision, work overload and burnout.

## 4.3 SECTION B: THEMES AND SUB-THEMES THAT EMERGED

Seven main themes and 19 subthemes that emerged from the data are represented in table 4.1 below. The participants' verbatim statements are in italics.

**Table 4.1 Themes and subthemes that emerged**

| THEMES | SUB-THEMES |
|---|---|
| **4.3.1 Managing human resources** | Availability of resources |
| | Management support |
| | Incentives |
| | Staff development |
| **4.3.2 Work planning and scheduling** | Staff shortages |
| | Work allocation |
| | Ancillary staff |
| **4.3.3 Job dissatisfaction and workload** | Workload |
| **4.3.4 Diminished patient care** | Quality of patient care |
| | Delayed patient care |
| | Holistic patient care |
| **4.3.5 Staff well-being** | Physical health |
| | Psychological health |
| **4.3.6 Relationship building amid absenteeism** | Staff-staff relationships |
| | Staff-patient relationships |
| **4.3.7 Strategies for managing absenteeism** | Disciplinary action |
| | Motivation |
| | Policies |

### 4.3.1 Managing human resources

Operational managers work 8-hour straight shifts (Monday to Friday) and nurses work 12-hour rotational shifts. One of the hospitals has staff allocated to various wards and in two of the hospitals, nurses work in all wards (OPD/casualty, maternity, general and paediatric wards). Participants pointed out that absenteeism coupled with the working

conditions caused frustration which stem from the availability of resources, lack of management support and incentives.

**Availability of resources -** Participants revealed that the equipment is insufficient to correspond with the number of units in the hospital. This negatively influenced the physical well-being of nurses having to work with limited resources. One participant stated that there were not enough ECG machines (i.e., one available for the whole hospital) this means borrowing from another unit which is tiring.

> *"…We had a scenario some time back where we only had one ECG machine for the whole hospital, so you can imagine if you need to do an ECG in your unit, now you need to run to another unit to get it. Really, it is tiring."* (Participant 7, (EN) Enrolled Nurse).

Furthermore, participants stated that the unavailability of stock causes frustration and can be detrimental to patients.

> *"…if you are busy with a resuscitation, okay, you need an oral airway. You don't have a one. In that time, the doctor is also frustrated, because you are busy here. So, the patient can die."* (Participant 8, (RN) Registered Nurse).

Similar views were shared by participants with regard to the inability to perform tasks without the necessary stock which leads to frustration and demotivation.

> *"… I refer back to your stock because if you don't have stock to work with how can you do the work so that is very frustrating. It is very demotivating."* (Participant 1, (OM) Operational Manager).

Another participant expressed similar feelings of demotivation but added that they were borrowing from other wards due to a lack of or substandard equipment.

> *"You forever have to go and borrow in other wards. So that is also a thing that demotivates one."* (Participant 12, (ENA) Enrolled Nursing Assistant).

Irrespective of the shortage of equipment and stock, participants made the best of the situation by providing patient care as reflected below.

> *"… a lot of things that we don't have and we very good as nurses to make the best of the situation. So, when we don't have things working like the BP machines or the HGT*

*machines or whatever, it is frustrating and then we cannot do our work hundred percent."* (Participant 11, OM).

Substandard or the unavailability of resources (surgical/medical stock or equipment) caused frustration and demotivation of staff. The aforementioned caused staff to feel unable to perform their duties and ultimately absent themselves from work due to job dissatisfaction.

**Management support -** This subtheme comprises the negative experiences nurses had with hospital management. The three salient aspects were support or lack thereof and leadership styles. There were mixed feelings regarding management support.

Participants stated that in identifying trends and patterns of absenteeism, management should get to the root of the problem.

*"…the management what I think is to try and get the core, the reason why this person is always absenting himself."* (Participant 2, RN).

Participants in managerial positions (OMs) revealed that they provide the necessary support, and that staff should stop denying being supported by management.

*"One thing is I put myself available to be able to help where I see there is a shortage and not being scared to get my hands dirty or wet so just to show the staff there is support from management and they must stop playing the blame game."* (Participant 1, OM).

Some participants (RNs, ENs and ENAs) disagreed and reported a lack of support from management. This lack of support is especially prevalent when staff is absent resulting in favouritism and ultimately affecting staff morale.

*"Certain people get reprimanded, but others don't get it. So, there is favouritism in the workplace. There is not enough support from our managers from our side, because when you are absent from work, you always get labelled. Never mind what your problem is." (*Participant 8, RN).

One participant disclosed that the unit manager favoured some staff members while showing no respect to others.

> *"…whether the managers or your superiors are actively involved in the unit, it is still the favouritism. Some of the managers seem to form like certain friendship bonds with some staff members… And the others, there is like no respect…managers is there, but you do not, it is like you do not care."* (Participant 7, EN).

Another participant stated that management support should be provided on an individual basis because everyone has different perspectives and personalities.

> *"…you cannot come with a blanket approach when it comes to individuals. Each person has a different personality and different views and things so when you deal with people one on one you will realise which style actually to use with them…"* (Participant 11, OM).

Supporting staff in various ways are important to reduce absenteeism. Similar opinions were expressed about how to treat support staff. For example, managers should not assume reasons for absenteeism without first speaking to staff as mentioned by this participant.

> *"…talk to you and ask you don't just assume that this is that and this talk to you and ask you what the problem might be. Why didn't you pitch up for work or what so what so...*" (Participant 4, ENA).

Managers must support staff in all spheres and exhibit managerial characteristics such as fairness, objectivity, lack of bias and no favouritism. A rapport between staff and management can be established by being proactive and hands on.

**Incentives -** Many participants shared similar views regarding their love for nursing and those incentives are simply additional benefits that have no effect on their absenteeism. However, some participants argued that benefits will act as a motivator to be present at work.

Participants expressed affection for the nursing profession and those incentives are inconsequential.

> *"…if you love your work and you love what you are doing, benefits to me doesn't matter that much because you need to love what you do. So no benefits doesn't really."* (Participant 12, ENA).

Participants indicated that no allowances were ever requested and that the primary concern was patient care.

> *"…the day I started nursing, I promised that I will look after my patient. There was no night duty allowance. There was no overtimes. And we worked. We never ever once said, "We want money for this." It was part of our work."* (Participant 10, ENA).

Furthermore, participants stated their sense of responsibility towards their patients despite receiving benefits.

> *"Benefits won't do anything because I feel responsible. I feel I have got a duty towards my patient..."* (Participant 1, OM).

Participants revealed that they will not absent themselves due to a lack of or no benefits due to the longevity of nursing as opposed to the current implementation of benefits and incentives.

> *"No, I will not, because these benefits comes now. It did not come from that time. So, the work, it comes from a long time. So, the benefits come now. So, whether there are benefits or not I will come to work."* (Participant 4, ENA).

Some participants disagreed and stated that incentives could aid in decreasing absenteeism.

> *"You know, it is those benefits and your PMDS, your appraisals, they also, yes, work well to motivate people to come on duty."* (Participant 9, OM).

Another participant argued that incentives may be equivocal to employees. Incentives could either cause employees to be absent from or present at work.

> *"…but it could work for certain other people. I am now talking about myself. Benefits might be a great deal."* (Participant 8, RN).

Participants' responses were ambiguous with some indicating that incentives play no role in their absence, while others felt the opposite. Nevertheless, managers must ensure the payment of incentives that are due employees.

**Staff development -** The imperativeness of staff development was emphasised by participants and how it aids with staff's advancement and growth within the nursing

profession. Several participants believed that in-service training, attending short courses and workshops allow them to develop in a positive way.

Participants outlined how staff development training can instil a sense of achievement.

> *"…it works positively because achievement in a sense if you…the training was open for everyone to attend to become a vaccinator and all that. I think that positively influence because now the ones that did the training and all that is very keen to go and work even the outreaches."* (Participant 11, OM).

Another participant agreed and stated the diversity of nursing and how training can assist with nursing patients with various illnesses.

> *"Going for short courses will help. It did help. We had in-house training. You nurse a lot of different types of sicknesses and that makes you want to learn more about that specific illness."* (Participant 10, ENA).

Participants indicated that being present at work enhances your development as opposed to being absent.

> *"…but when you were supposed to come on duty, and there was a training or something that you missed, because whoever is telling you, is not going to tell you like the way that one who came here first was teaching other people."* (Participant 6, EN).

Similarly, one participant expressed that a lack of achievement will lead to absenteeism.

> *"The thing that is making her or him to absent herself at work is because she is not achieving as she would like to achieve. And that means, your short courses, your, what do you call it, your in-service trainings, yes, they will play a role there."* (Participant 9, OM).

Another participant agreed as explained below.

> *"It will help the, and even the absenteeism rate, it will help. Because then you have something that you really can say I have worked for this" (Participant 8, RN).*

The same participant felt discouraged due to a lack of achievement.

*"For six years, in that six years that I have been working at the place that I am currently working, I can say I have not achieved anything."* (Participant 8, RN).

Being goal driven is an element which aids with staff development. Participants revealed their desires for further studies.

*"…because going to do the bridging course is one of my goals, and I feel like that will, that motivates you." (Participant 7, EN).*

Participants displayed their enthusiasm pertaining to staff development. Nursing is dynamic and staff must be up to date with new developments concerning their profession. Therefore, partaking in courses to broaden knowledge is essential.

### 4.3.2 Work planning and scheduling

Staffing forms an integral part of nursing in healthcare institutions particularly in district rural hospitals. Participants voiced their dissatisfaction with staff shortages which in turn has a negative effect on work allocation, the shifts of staff and how ancillary staff can aid in relieving the staff deficit.

**Staff shortages -** Participants expressed their frustration regarding staff shortages predominantly due to absenteeism.

*"I experienced a lot of them, when someone is off absent. It is very stressful."* (Participant 4, ENA).

Another participant shared the same feelings of frustration and added that staff members lack responsibility and accountability.

*"…to me it is a big problem because I feel the people don't take responsibility. They don't own up; they feel like they've been owed… and it's very frustrating, especially because of it causes short staff shortages."* (Participant 1, OM).

Participants voiced that absenteeism are experienced frequently which leads to staff shortages (e.g., five nurses per shift).

*"We are usually experiencing absenteeism, and there is a lot of shortages with nurses. At times we would find that in our shift we are five, but if one is absent, then there will be lacking."* (Participant 5, EN).

Participants also revealed that nursing staff employed in district rural hospitals are not residents of the town in which they work. Consequently, they must travel long distances, take extra time off despite being officially off for seven days and are mostly absent causing a shortage of staff.

> *"Because we had a lot of people at first from other places. So, we used to work like sevens and sevens off…and then they take another seven days. And then the impact that it on the staff that stays behind, was quite…exhausting."* (Participant 3, RN).

Contrary to the latter one participant stated that absenteeism is minimal with her team due to a conducive work environment, the team she is working with is community goal driven as they reside locally.

> *"My own team, they don't absent themselves so frequently. So, with us here, because we are working in a very conducive atmosphere né because the people. We are working with people, mostly some of them are from the same place, so those that are from the same place they also want to help their community meaning they are always on duty."* (Participant 2, RN).

Evidently, absenteeism causes staff shortages which lead to frustration among employees. As a result, managers should ensure an adequate number of staff to deal with frustration and employ local nurses to minimise absenteeism.

**Work allocation -** Managers find it difficult to allocate staff when their fellow colleagues are absent and working in district rural areas with short staff as it is, additional pressure are exerted to perform duties.

Participants mentioned that when the dynamics of the ward or the institution change such as taking on extra patients during the COVID-19 pandemic, but the staff compliment remain the same, it is challenging allocating staff.

> *"…when your conditions in the ward change where the dynamics or the patient allocation or patients that's moved. When you are forced to now take on a load of patients from another ward because another ward is being allocated for COVID."* (Participant 11, OM).

One participant shared her frustration when a nurse is absent in her category, and she had to fend for herself without any assistance from nurses of other categories

> *"You get frustrated. Because you cannot get always help from the other category. From the staff nurse or the sister. You know, she will say straight, "Oh, no. I have got my work to do." How must I change a patient that is heavy? I cannot change a patient on my own."* (Participant 10, ENA).

Another participant expressed her wishes of having sufficient staff on duty such as two of each category of nurses (ENs and ENAs) on each shift in case of staff being sick or on leave. This will enable them to provide continuous nursing care while professional nurses (also known as RNs) perform their duties.

> *"I wish at least in each team we could have at least two of the enrolled nurses and two of the ENAs, people get sick, people go on leave and when I know that the ENA is not at work…who is going to do the observations, who is going to do the dressings, because those professional nurses are busy with their stuff."* (Participant 6, EN).

Participants revealed that absenteeism can also be ascribed to staff preference on who they want to work with.

> *"…when you are doing the off duties it is better to put people on the same shift that works well together, who doesn't have a lot of differences to like kind of curb that absenteeism or to help bring the absenteeism level down."* (Participant 2, RN).

One participant indicated that staff allocation is not adhered to when staff members are absent.

> *"...seeing that you are allocated for a specific task, then you can't get to that your task because you need to do somebody else's task as well, and that's a hell of a lot of job."* (Participant 7, EN).

Some participants thought it was difficult to allocate staff because they took turns to staying out of work which caused conflict and felt like they were "paying back each other".

> *"Another thing that they do lately. If you did not come on duty today, "I am going to watch you. Next week it is my turn. I am going to be out of work. You are going to be alone. I am going to get you back." That is how they get each other. It is a tit-for-tat thing."* (Participant 10, ENA).

Participants explained that working in rural hospitals, one is responsible for more than one department. This situation combined with absenteeism leads to frustration and challenges to allocate staff. Managers must ensure that shifts are covered and proper allocation of staff is done to ensure safe and quality patient care.

**Ancillary staff -** numerous participants highlighted relief ancillary staff would contribute to fill the gap when staff members are absent. They also alluded to the fact that government should consider agency nurses in rural areas.

One participant stated that due to budgetary constraints, rural hospitals are unable to afford agency nurses (nurses that work on a temporary (or 'locum') basis through a nursing agency rather than the hospital). Since agency nurses work for private contractors, their services are too expensive for hospitals to use.

> *"…there is no qualified staff readily available, we don't have a nursing agency so and the costs that a nursing agency will ask would be too much. That is going against your budget in the first place."* (Participant 1, OM).

Participants revealed that they have accepted that agency nurses are out of their reach although the assistance of the aforementioned would help substantially.

> *"…it would help a lot. The more hands, the better. But unfortunately, we do not have things like that."* (Participant 8, RN).

Participants revealed that employing agency nurses would relieve the strain exerted on nurses remaining on duty when their colleagues are absent. This also leads to staff being asked to come to work during their time off.

> *"… agents, if they can be available in the district hospitals, it will also relieve the strain to those that are coming on duty actually. Because we actually need those extra pair of hands, which we do not have. Sometimes we have to call someone from home who is actually day off."* (Participant 9, OM).

Participants revealed that only registered nurses, i.e., higher category nursing staff are being replaced when absent.

> *"…extra staff that just come and help? Like in overtime for the day, they do not do that. They do not. If a person is absent on your shift, you guys continue like that. The only one that they might replace is a sister…"* (Participant 3, RN).

One participant suggested the employment of ancillary staff (ward assistants and porters) to assist nurses with additional duties delegated to them as a result of absenteeism.

> *"They must add more staff. Ward assistants, if possible, porters who can do the job of transferring patients from OPD to casualty. Ward assistants to assist patients with feeding and changing of beds."* (Participant 5, EN).

Similarly, another participant agreed that ancillary staff will assist in nurses practising within their scope of practice.

> *"…Then everyone is set to do what they must do. Me doing that, the other one is doing that… and there is enough staff to just stay at the wards doing what they should do…"* (Participant 4, ENA).

Employing ancillary staff will be beneficial for both the nursing staff and healthcare institutions by preventing staff form being overworked and burnout and by providing quality patient care.

### 4.3.3 Job satisfaction and workload

Job dissatisfaction was apparent in most of the participants which stem mainly form the additional workload when staff members are absent. As a result, staff are not properly developed. Participants indicated that there is a lack of staff development which can be a contributing factor to absenteeism

**Workload-** Several participants felt that their workload is increasing when staff are absent. They expressed their unhappiness when having to assume dual or even triple roles at times to see that work are being done.

> *"I have to do a job of two people when the one is absent, especially the ENA. I have to start from the observations and then do my job like to give medication, do dressings, things like that. So even when professional nurse is not available, then I have to help there to aid professional nurses."* (Participant 6, EN).

Participants emphasised the disruptive effect the extra workload has on staff due to the absence of the same category of staff.

> *"It is disruptive. I am a nursing assistant. If my fellow nursing assistant colleague does not come to work, it means I am doing my work, where we were two, I would be doing it alone, and that is not nice." (Participant 10, ENA).*

Another participant agreed that due to the workload and the inability to fulfil duties lead to disappointment and dissatisfaction.

> *"The mere fact that you experience the double workload, the dissatisfaction that things doesn't get done the way you would love it to be done. That is one of my main reasons why I do not want to burden other personnel now by being absent myself for no good reason."* (Participant 12, ENA).

One participant stated that vacant posts that are not being filled also exert additional workload on staff.

> *"…it can also be the workload, seeing that we are understaffed, yes, because now with this Corona, a lot of our staff members have passed away and their positions haven't been filled yet. So, that put a lot of extra strain on us as nurses."* (Participant 7, ENA).

Participants felt that with absenteeism, increased workload can also be time consuming and exhausting.

> *"…it is exhausting. I think with the whole shift, it is...because you need a partner to do, I mean, to complete the work. So sometimes you had to do turnings, you cannot do it alone. If you do it alone, it takes more time. So instead of being a helping hand someone else, to do it, you know, faster and quicker." (Participant 3, RN).*

Participants expressed their frustration, dissatisfaction and unhappiness with the excessive workload in the case of absenteeism. If managers are unable to find replacement for absent nurses, they must step up and assist where they can.

### 4.3.4 Diminished patient care

Absenteeism has a negative impact on patient care, especially if it is unplanned, unexpected or prolonged. These absences affect the quality of patient care, delay patient care and lead to the lack of holistic patient care.

**Quality of care** - Participants felt it was difficult to provide quality care in the absence of staff. One stated that mistakes occur which have a negative impact on patient care and ultimately a decrease in quality patient care.

> *"There is a shortage of staff, so sometimes mistakes can happen, which maybe not be on purpose, but it happens because there is not enough hands, and which in turns where the patient will suffer. So, the quality care of your, care to the patient is really becoming a big problem."* (Participant 8, RN).

Participants stated that nurse-patient ratios are affected and expressed their unhappiness working in a non-conducive environment. For example, the nurse patient ratios should be 1:4 but due to absenteeism the nurse patient ratios are 1:10 resulting in poor nursing care.

> *"…you overburdened with patients because we are supposed to be one nurse for every four patients. In the end the staff ends up being one nurse for every ten patients and then you basically just kill the fires. So to me it is a definite negative affect on patient care."* (Participant 1, OM).

One participant indicated that quality care is lacking due to the omission of treatment when staff are absent.

> *"It lacks, because some of the things, maybe they can be omitted mainly because we are short-staffed."* (Participant 5, EN).

Participants acknowledged that quality of care is inadequate and that they feel like failures for failing to report abnormalities such as pyrexia due to other obligations.

> *"…this patient has got a high temperature and you missed reporting it because you're still got to get to the dressings…a patient could have gotten the necessary treatment for having a high temperature, you failed to report it unto your manager in the ward."* (Participant 12, ENA).

Quality of care is negatively influenced when staff members are absent. Similarly, participants felt that patients cannot be provided with optimal care as a result of the aforementioned.

**Delayed patient care -** Participants affirmed that due to the excessive workload when their colleagues are absent patient care schedules are not adhered to which result in

delayed care and increase length of hospitalization. Participants all agreed that absenteeism has a negative impact on patient care and expressed their frustration at not being able to adhere to timelines, i.e., medication not administered timeously, dressings done late and delayed nursing care.

> *"Absenteeism has a total negative affect on that because your timeline gets distorted. If you suppose to give meds at 08:00 and you only get it 09:00 then your follow up of your next medications, your treatment, your care, your dressings, everything gets all scrunched up…"* (Participant 1, OM).

Some participants felt that delegating tasks instead of doing such tasks themselves can also lead to delayed patient care, patient neglect and ultimately longer hospitalisation.

> *"…the sister is delegating it to me or to somebody else, and the one would just feel like why telling me and not the other one. The patient is being neglected. Because bloods that should have been taken today are not being taken, so they stay longer in hospital."* (Participant 7, EN).

In addition, participants revealed that delayed nursing care can lead to complaints from both the patients and the operational manager.

> *"Patients will complain. Even your operational manager will also complain, saying your notes, you have not done much. You did not do your nursing cares, your nursing progress or whatever."* (Participant 5, EN).

Participants were disgruntled as work allocation had to be re arranged when staff members were absent which result in patient care being delayed.

> *"…you do the allocation in the morning and you allocate people to certain tasks then you need to have to have an equal spread of nurses that can do it. It does definitely…the patient doesn't get their things on time whether it is breakfast or whatever and their tablets and even their treatment or whatever."* (Participant 11, OM).

Participants revealed that delayed nursing care can lead to prolonged hospitalisation and can even be detrimental to patients. Nursing managers must ensure that sufficient staff are available on each shift.

**Holistic patient care -** Participants felt that nursing care are not provided holistically when the units are understaffed and coupled with absenteeism, proper care cannot be rendered.

> *"Proper care is when you give unto your patients the necessary attention, the necessary nursing care. Sometimes s people get sick due to stresses of what's going on in their lives and stuff and then sometimes it is just necessary to also be there for that patient in a spiritual way."* (Participant 12, ENA).

One participant expressed dissatisfaction with the fact that even when employees are present, duties are performed haphazardly which are exacerbated when an employee is absent.

> *"You find people are on duty, but they do not do anything. So you yourself, you become dissatisfied, you know? So patient care lacks a bit…then we do the basics and we let the people through. So sometimes you might miss something."* (Participant 3, RN).

Participants expressed their frustration at not being able to meet the patient's needs particularly in the absence a staff member.

> *"…run to that patient, because that patient needs me also. So, while I can spend ten minutes here with one patient."* (Participant 4, ENA).

Similarly, another participant felt that holistic patient care is of paramount importance even how minuscule as it can be detrimental to patients.

> *"…in terms of hospitalisation, all those things play a role. Whatever, if it's a small thing, it is the main priority as a nurse. You must always make sure that you do everything correctly… in nursing, one small thing can cause a patient's death."* (Participant 8, RN).

Holistic patient care becomes unattainable when staff-patient ratios are distorted. Participants were frustrated and dissatisfied with their inability to provide holistic care to patients. Management's responsibility to ensure adequate staff cannot be reiterated enough.

### 4.3.5 Staff well-being

Absenteeism has a direct impact on the physical and psychological well-being of nursing staff.

**Physical health -** Owing to an increased workload, a shortage of staff and absenteeism participants are frequently required to work in stressful conditions that can result in fatigue and physical illness. Numerous participants expressed how exhausted they are from filling the gap when their colleagues are absent.

> *"They are so fatigued and, you know, they try to reach each and every patient's needs, but it is not going to be possible to do that all the time when you are always short-staffed because of the absenteeism*." (Participant 9, OM).

Some indicated that they work non-stop which affects their physical health. One participant stated that she will be absent from work due to her being in physical pain.

> *"…was too busy yesterday. My back is sore today. I am not coming in. I am going to doctor."* (Participant 10, ENA).

Participants revealed suffering from various illnesses such as headaches and hypertension due to stress and being overworked.

> *"…physically your body is drained and so on. You feel sick, sometimes, the day after that, because you were stressing the day before so much. You have got headaches... The blood pressure goes up…"* (Participant 4, ENA).

Another participant admitted to being tired and deliberately was absent from work to rest.

> *"It will lead them to be absent because you are tired. You are a human being. It is normal to feel that way. So, you will take that time off just for a day or two, and then you will just stay out of work."* (Participant 8, RN).

Participants emphasise the unfairness of working a 12-hour shift and having to work the same hours with double the work due to absenteeism.

> *"…I am working my 12 hours knowing that I am going to do what am I allocated for and my scope of practise. But now, if I am going work the whole 12 hours for the jobs, for the job of two people, you see, it is straining."* (Participant 6, EN).

Participants were clearly dissatisfied with the consequences that absenteeism has on their physical health. Managers must ensure that shifts are fully covered enabling nurses to look after patients.

**Psychological health -** equally important to physical health, is psychological health which can be jeopardised leading to depression in an unconducive working environment. Participants revealed that nurses remaining on duty are emotional, moody and suffers from depression when fellow staff members are absent.

> *"…emotionally it is stressful. Sometimes some of us are suffering from depression. So, you can say it depresses you a lot, or you sometimes feel moody."* (Participant 5, EN).

Participants also expressed their disappointment upon arriving on duty to find insufficient staff, which has an impact on nurses' emotional well-being.

> *"…worked on you emotionally, you know, because, when you come on duty, you expect the full team. Now you're come, someone is not there."* (Participant 3, RN).

One participant revealed that employees suffer from emotional trauma because of being unable to take or control a situation that could lead to a patient's death.

> *"There is also emotional baggage then that comes with it because now you have to deal with did you do your best for the day because remember when you do a death audit you also ask questions as to how could you have prevented it."* (Participant 11, OM).

To cope and avoid stress, participants indicated they did not want to come to work. This also affected their emotions as shown below.

> *"There is a lot of tension. They do not feel like coming to work…which is not really ideal. It makes you feel unhappy. It makes you feel angry. It makes you feel irritated, agitated, everything. It is a lot of emotions. It affects your physiological from stress to everything."* (Participant 8, RN).

Participants argued that despite the high workload and minimum provision of patient care, managers are not supporting nurses remaining on duty, instead they are punished for those being absent.

*"It is like they are trying to punish you as well for the other people that is not coming on duty."* (Participant 7, EN).

One participant felt that absenteeism adds to an already pressurized working environment and less focus on patient care.

*"All the pressures from above, from the district, from province then you can focus your attention better on other things as well but at the moment, because of the absenteeism everything it is just a vicious cycle."* (Participant 1, OM).

Managers are responsible to create an environment where staff members feel safe and comfortable. Early signs of psychological health deviations must be detected by managers so that employees can be adequately referred.

### 4.3.6 Relationship building amid absenteeism

Absenteeism can influence both relationships among staff members as well as patient-staff relationships. Staff members are unable to establish rapport among each other and with patients due to a heavy workload caused by absenteeism.

**Staff-staff relationships -** in order for staff to work well together teamwork and a sense of belonging must be instilled. Consequently, staff will display responsibility before absenting themselves inconsequentially. One participant stated that a positive attitude can assist in establishing rapport.

*"I am always going to refer to my team. The people I am working with, they don't want to be separated from me because of my attitude I think because even when I am asking someone to do something, I ask, I don't tell."* (Participant 2, RN).

Participants expressed that negative behaviour at work can jeopardise staff relations.

*"…they take it out on their fellow staff members or they influence them into such a degree that the people just start getting negative because you can only take so much negativity and then you start to go down as well."* (Participant 1, OM).

Numerous participants revealed that absenteeism causes conflict among staff due to increased responsibilities.

*"It definitely does have an effect, the relationships for now you going to feel offended with the person that stayed out of work simply because now all the responsibilities are*

*now on you and so it does affect the relationship on you and the one that is absent."* (Participant 12, ENA).

Participants felt that management did not appreciate all of their hard work and that some staff members can do whatever they want to.

*"…staff members being overworked and managers that don't appreciate staff…Certain staff members can do as they please."* (Participant 7, EN).

One participant mentioned that the managers lack empathy as they are more focused on the work itself and having sufficient staff on duty.

*"…without asking you how are you, what is the problem, how can we help you. For them it is about work. It is not about you as the person. As long as the unit is full of staff. Everyone is on duty."* (Participant 8, RN).

Positive staff relationships foster a positive organisational climate and boost positive staff morale. Participants felt that absenteeism influence staff relationships negatively. Managers must provide constructive criticism when addressing staff.

**Staff-patient relationships -** absenteeism has had a significant impact on the staff-patient relationships, especially in district rural hospitals where the same staff must cover all wards. Participants felt when the community shows appreciation a definite relationship has been established.

*"…because the community appreciates me for being here. Thank you so much sister. If it wasn't for you, I couldn't have dealt with it. If it wasn't you not you on the team today, I wouldn't have come. All such things you understand."* (Participant 2, RN).

Similarly, several participants expressed satisfaction when patients are grateful for the service provided.

*"It is just that thank you that most of the patients give you…"* (Participant 7, EN).

According to one participant, the patients are treated like family.

*"…the patients are, it is like a part of our family."* (Participant 6, EN).

Furthermore, the patient's progress can be monitored which strengthens the staff-patient relationship.

> *"I am always looking forward to see how the progress or the condition of the patient is the following day. So, I really come to work just to get to see the results…"* (Participant 6, EN).

Participants were satisfied with their ability to help patients adopt a positive attitude despite being hospitalised.

> *"So, just to cheer them up. Making them laugh and do not think about their problems or why they come in."* (Participant 4, ENA).

Participants were adamant that patient attitudes cause a vast amount of tension due to patients being impatient. Nurses are also expected to always be professional, or risk being labelled as rude.

> *"…you are busy with the patient, and then just that moment, the nurse can maybe just say something out of the ordinary and then, in the workplace, you have to be professional at times, so then that already sets a bad vibe, because it says that nurses are rude, which isn't so."* (Participant 8, RN).

Participants revealed that being able to establish relationships with patients provides them with satisfaction, which motivates them to come to work. Managers must ensure that staff are familiar with Batho Pele and patient rights as to strengthen staff-patient relationships.

### 4.3.7 Strategies for managing absenteeism

Strategies to limit absenteeism requires uniformity from managers. Strategies should be developed not just to attempt to reduce absenteeism but also to have coping mechanisms or contingency plans in place in case of long absences.

**Disciplinary action -** disciplinary action should be progressive (starting from counselling, verbal warning, written warning, final written warning and dismissal) and it should be emphasised that disciplinary actions are not punitive but rather corrective. Participants felt if disciplinary procedures were followed correctly, absenteeism would decrease significantly.

> *"…you are not being punished in that correct manner as they should be punished. So, I think if people or staff members will be disciplined in the correct manner absenteeism should drop."* (Participant 7, EN).

One participant had reservations regarding disciplinary actions and expressed that staff manipulate disciplinary procedures. For example, staff members are aware that they will be called in for corrective counselling regarding absenteeism before money is deducted from their salary. Owing to this staff occasionally change their behaviour as high absenteeism means loss of pay.

> *"They know it is a period before you will get money deducted off your salary, because you first got to be called in. There are steps to take before, and then just before they say we are going to, then they are good again. So, they sort of manipulating the situation."* (Participant 10, ENA).

The same participant felt that staff members are nonchalant about disciplinary actions as staff cannot be dismissed for minor incidents.

> *"Disciplinary. It does not bother them, because at the back of their minds they say… "They cannot fire me just for anything."* (Participant 10, ENA).

Participants were adamant that managers should first engage with staff before resorting to disciplinary action.

> "*They must first sit down with that particular person who's constantly absent at work to find out what is really the problem. Maybe they don't know what the underlying cause for the person to be absent all the rime at work."* (Participant 5, EN).

Furthermore, one participant advocated for two-way communication as a staff retention strategy as opposed to disciplinary action while at the same time discussing the impact of absenteeism on the remaining staff.

> *"I think, you know, if you discipline people, they tend to be more upset at times. You know…it is a two-sided- Get their view, your view, and maybe. But then try to listen, but also make that person aware that you absent and the impact to the others..."* (Participant 3, RN).

One participant emphasized the importance of remaining objective and that managers must ensure that staff are aware of the reasons for and consequences of breaking the rules when disciplinary action is taken against them.

> *"Don't take out grudges and definitely not alienate people but please we should explain the procedure and the reasons and people should know why they are disciplined."* (Participant 11, OM).

The same participant expressed that staff must be held accountable and face the consequences of excessive absences. Moreover, consistently enforcing the attendance policy will ensure that it is taken seriously.

> *"Although we don't want it to be punitive, we also want to send a message out that it is not acceptable. And once you've done wrong you should bear the consequences of your wrongdoing."* (Participant 11, OM).

Participants highlighted disciplinary procedures as a pivotal element in healthcare. They further alluded that those disciplinary procedures should be handled according to merit. Nurse managers must be fair and show no favouritism when implementing disciplinary procedures.

**Motivation -** motivation was viewed as a significant factor in reducing absenteeism. Participants stated that being recognised was a major factor in their ability to be present at work. It is evident that management lack displaying appreciation towards participants as shown below.

> *"It makes you feel unappreciated as well seeing that Management is not… They don't give you their recognition that you should get."* (Participant 7, EN).

One participant stated despite feeling discouraged, he comes to work because that is what he loves doing.

> "*Most of the times it feels like the managers do not see that you go the extra mile, and then you feel discouraged. But you still get up in the morning and go and do what you love doing, but mostly I feel like the managers is sometimes not appreciative of what you do."* (Participant 7, EN).

Another participant indicated being dependable and feeling proud comes with being appreciated and thus being present at work.

> "*So, I will feel proud and uplift my spirit to just the next day, stand up and to … Because someone thanked me for that."* (Participant 4, ENA).

Participants were of the opinion that if managers provide guidance and encouragement to nursing staff, they will feel appreciated and will be less likely to miss work.

> "*Supervision by praising your nurses. Encouraging to do what's right. Those type of things will encourage people not to stay out of work."* (Participant 12, ENA).

Several participants stated that recognition and having a positive attitude toward your work will serve as motivation to be present at work.

> *"…by giving them recognition for what they are doing is very, very important to keep a positive attitude."* (Participant 1, OM).

One participant revealed that for continuity of patient care they sometimes do not take breaks, which are not recognised by management. This can be demotivating and result in absenteeism.

> *"…because sometimes you do not even take your teatime, or your lunchtime, because you want to get the flow out of the hospital, and you can continue with the general job."* (Participant 5, EN).

In addition to not taking or going late for breaks, the same participant voiced her frustration as managers supervise autocratically, i.e., dictating orders and control all nursing activities.

> *"…they would supervise you in a way that you feel like you are in a prison cell. Where one would look at it, yes, you know you have to be out by half-past nine for teatime, and you are back by 10:00, but there are times when you have to do some of the things."* (Participant 5, EN).

Participants felt that a sense of appreciation is necessary, especially if they are acknowledged by patients.

> *"That thank you from that patient is more than a certificate. Thank you, nurse. I appreciate. That is what we appreciate. The patient appreciates us." (Participant 10, ENA).*

Another participant indicated that awarding staff with titles such as nurse of the year would motivate staff to refrain from absenting themselves.

> "*At the previous hospital that I was working in, there would be a nurse of the year. You know, that thing is motivating people*. You can never be the nurse of the year if you absent yourself.*" (*Participant 9, OM).

One participant stated that applying what you acquired (in terms of training) in practice is a strong motivator to stay at work.

> *"…implementation is the biggest part. You can do all the things in the world but implementing it will be that satisfaction that to get out of that achievement that you've done. That will prevent me from staying from work."* (Participant 11 OM).

Participants state that what will motivate them is when management take responsibility and lead by example. Therefore, despite being in a managerial position, managers should assist with nursing activities (offer bedpans and do dressings) if there is a shortage of staff in the ward.

> *"Being a sister with epaulettes on your shoulders does not mean, "Oh, I only do this and that and do not do this." You can also still carry a bedpan. And if the staff nurse is not there…take a dressing trolley. You do the dressing."* (Participant 10, ENA).

Participants revealed that a sense of commitment or lack thereof will motivate staff to be either present or absent from work.

> *"…if you find that everybody in every category helps out, then you have got that nice commitment to each other. Then you feel, even if I do not give my 100% tomorrow, at least I know the Operational Manager will also help." (Participant 10, ENA).*

One participant suggested teambuilding as a motivator to decrease absenteeism.

> *"One last thing which I feel very strongly is the team buildings and it is nice to sometimes go outside of work. I like to propose any manager, the best results that you can get is take your staff on a weekend trip…it definitely lessen the absenteeism"* (Participant 11, OM).

It was evident that participants felt that managers must lead by example and that recognition and achievement are seen as strategies to curb absenteeism. Therefore, managers are responsible and accountable for behaviour towards staff and ensure that staff are continuously motivated.

**Policies -** policies are laws regulated by the government to ensure goals and objectives are met. Participants stated that policies are essential in healthcare facilities to clearly communicate the expectations for work behaviour and disciplinary action to all staff members. Participants indicated that policies provide organisation and order at the workplace when dealing with absenteeism.

> *"Otherwise, each and every place will be chaotic, if there are no policies."* (Participant 6, EN).

Participants stated that policies are pivotal in providing guidance such as how to report absences, follow-up on unsanctioned absences and the consequences for excessive absenteeism, as well as outlining management and or staff expectations.

> *"…from my point of view, some people try and take advantage of their situations. That is why policies are of paramount importance to guide you…so that they don't overstep their boundaries and that they will be corrected…if there is no boundaries then everything is going to go haywire."* (Participant 1, OM).

One participant reiterated the importance of adhering to policies.

> *"You've got to obey; you can't be stubborn on policies. Policies is something that needs to be obeyed by you as an employee of the place."* (Participant 2, RN).

The same participant felt the absence of policies will lead to an increase in absenteeism.

> "*Yes, they will help because if without policies everybody will be absent anytime."* (Participant 2, RN).

Another participant shared the same sentiment and echoed the detrimental effects of the absence of policies.

> *"… if you don't have policies and guidelines, you've got nothing to stand on and then they can do with you just what they want, when they want and how they want."* (Participant 1, OM).

Another participant stated that staff do not take the time to internalise policies and views them as threats.

> *"As much as the policies and stuff are read to them, are given to them so that they know there are consequences for their actions, but if it is never done, they always take the policies as threats."* (Participant 9, OM).

One participant explained the importance of introducing new policies to all staff members to prevent retaliation. This means that the manager must ensure that all staff members are made aware of the absenteeism policy.

> "*We are human beings and if something don't sit well with us or suit us we tend to retaliate but also it is important to explain policies and then when a policy comes to in affect you should be very careful that people are aware.*

Furthermore, because policies relate to legislation at the national level, they cannot be changed at the local level to suit their peculiar situation. Working in district rural hospitals however, Standard Operating Plans (SOPs) can be developed to meet the needs of the hospital and its staff.

> *"When it is national policies we can't change it but when it is SOP's we can always look at it to suit. We have different settings and each ward actually is different and when you draw up a SOP for a ward, it will specific to that ward but people should be also involved in SOP's specifically."* (Participant 11, OM).

Participants expressed their unhappiness with management not being transparent regarding policies.

> *"…feel policy has also got a big role to play. If our management also will be more open and more see-through about these policies and see to it that the wards get these policies*. (Participant 10, ENA).

Participants also expressed their discontent at the inconsistent implementation of policies, e.g., certain staff members are reprimanded while others are not.

> *"There are the policies and procedures followed for absenteeism. They do not do it. Certain people get reprimanded, but others don't get it."* (Participant 8, RN).

Several participants were of the opinion that staff members are abusing leave policies such as being absent without proof of a sick note, being booked off sick by a doctor

when they are not sick. Policies should be more stringent to ultimately reduce absenteeism.

> *"…we tend to abuse our, let us say, your sick leaves, because there is this one, the leave, the sick without, with no sick note, it is the one that people mainly abuse. And also, this one where you can go to a doctor, and the doctor will book you off sick. The policies must be more strict here about that."* (Participant 5, EN).

In contrast, participants also felt that leave polices can have a positive effect on staff pertaining to employee wellness. They mentioned that staff may go through difficult times in their lives such as substance abuse and with management support deal with personal issues that may be affecting their attendance.

> *"…policies in absenteeism especially when you have a staff member that's been addicted to substance abuse, is definitely a necessary thing for then it can be arranged for the staff member to be seen to an institution to be able to help them with their substance abuse."* (Participant 12, ENA).

Availability of policies is imperative. Participants were unwavering in their belief that managers are not transparent when it comes to policies, particularly new policies. Participants also experienced inconsistencies in policy implementation. The onus rest on the managers to ensure that policies are implemented consistently.

### 4.4 SUMMARY

In this chapter, the study's findings of nurses' experiences of absenteeism in district rural hospitals in the Eastern Cape were presented. Data were analysed where themes and subthemes emerged. Rural healthcare environment staffing, job dissatisfaction, patient care, occupational health, occupational relationships and reducing absenteeism strategies were the themes that emerged. The next chapter will provide a discussion of the findings in relation to literature, the limitation and the final conclusion.

# CHAPTER 5
# DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

## 5.1 INTRODUCTION

The previous chapters provided the foundation of the study, a literature review, the research methodology with a qualitative design into the objectives and the aim of the study as well as the study findings that emerged from data collected regarding the experiences of nurses on absenteeism working in district rural hospitals in the Eastern Cape. This chapter consists of recommendations on the study findings.

## 5.2 DISCUSSION

The aim of the study was to explore the experiences of nurses regarding absenteeism in district rural hospitals in the Eastern Cape. The study's findings in relation to each of the objectives are discussed below:

### 5.2.1 Objective 1: Gain understanding of nurses' experience of absenteeism at the workplace

Herzberg (1966) implied that certain factors are consistently associated with employee job satisfaction (hygiene) whereas others can cause job dissatisfaction (motivational) (see Chapter 2, conceptual framework). The proper management of hygiene factors can prevent job dissatisfaction; therefore, managers should focus on motivating factors, or satisfiers to increase employee satisfaction. Job satisfaction is also an important factor for staff retention in the workplace.

The nurses' perspectives on absenteeism are related to the extrinsic and intrinsic factors that influence their job satisfaction. Consequently, some of the views presented here may overlap with the facts discussed in the other two objectives. Negative opinions about absenteeism of nurses at the workplace were revealed.

Rural healthcare environment presents with numerous challenges leading to frustration and dissatisfaction. Whereas South African hospitals are experiencing a shortage of medical equipment (McQuoid-Masson, 2016:681), rural hospitals in particular experience a higher shortage of equipment than their urban counterparts coupled with poor maintenance and repair of broken equipment, making the availability of efficient and well-functioning equipment difficult (Moyimane *et al.,* 2017:5). Fejar,

Guo, Kelly and James (2021:1) found that inadequate resources lead to a reduction in healthcare provider satisfaction. The authors also state how working in rural areas precipitate feelings of dissatisfaction. Participants in the current study unanimously indicated that limited and at times unavailability of resources lead to frustration, demotivation and ultimately absenting themselves from work (see Chapter 4, section 4.3.1). With urban areas providing specialty care and rural areas providing basic care, the lack of resources, adds to the frustration. Participants felt that without the necessary equipment, they are unable to perform their duties (see Chapter 4, section 4.3.1). This is consistent with the South African six ministerial priority areas where the availability of equipment and supplies are required to provide quality care. According to McKay, Smith, Kyle and Beatie (2020:21) the sustainability of rural healthcare is jeopardised with resources unavailability. Participants indicated that the lack of equipment can also be detrimental to patients (see Chapter 4, section 4.3.1). Similarly, Mokoena (2017:53) found that medical equipment scarcities negatively impact life expectancy of patients.

Dissatisfaction in terms of quality patient care (hygiene factor) was also raised. Although the availability of medical equipment is important in providing nursing care, quality care cannot be provided even if equipment is available and there is no staff to operate it. The inability to render quality patient care was emphasised by participants in the absence of their colleagues. Quality of patient care can be affected by the workload having to perform multiple duties (see Chapter 4, section, 4.3.2). This is supported by Mbombi *et al.,* (2018:3) who found that nurses who remain on duty when their colleagues are absent suffer the effect of increased workload and consequently a reduction in quality of patient care. Similarly, Batool and Afzal (2019:6780) found that 70,29% were in consensus that they absent themselves due to an increase in workload in the absence of their colleagues. Moreover, Baydoun *et al.,* (2015:101) found it perturbing that nurses voluntarily absent themselves due to the workload. Participants ascribe it to a lack of responsibility (see Chapter 4, section 4.3.2). Gabrielsson *et al.,* (2016:434) suggested that a crucial part in quality nursing care is taking personal responsibility.

Although there are no nursing agencies that provide ancillary staff in the rural areas where the study was conducted, participants welcomed the idea. Participants

indicated that the government should consider the establishment of nursing agencies in rural areas (see Chapter 4, section 4.3.2). Reich, Ruggiero and Triantos (2018:224) confirmed that the utilisation of nursing ancillary staff to provide basic nursing care activities (personal hygiene care, bathroom and ambulation assistance) contributes to quality patient care. The authors also postulate that developing a nursing ancillary shared governance association is pivotal in achieving quality healthcare outcomes. In contrast, community healthcare workers are ancillary staff in rural South Africa who (improve access to care, provide continuity of care and act as a link between communities and hospitals) are primary healthcare based (Wilford, Phatakti, Haskins & Jama, 2018:1).

Participants acknowledged the need to provide holistic and quality patient care. Moreover, to render quality patient care, nursing care must be holistic, i.e., addressing the patient's physical, emotional, social and spiritual needs (Ventegodt, Kandel, Ervin & Merrick, 2016:1935). With rural hospitals being short staffed, participants indicated that absenteeism makes holistic care impossible (see Chapter 4, section 4.3.4). According to Kinchen (2015:238) holistic nursing care requires a holistic approach which is relationship-based**.**

Patient care was found to be delayed due to an increased workload caused by absenteeism. Consequently, this prolongs hospital stay and affect staff-patient relationships (see Chapter 4, sections 4.3.4; 4.3.6). Patient-staff relationships are essential in patients' progress and participants found it motivating and satisfying to see patients progressing (see Chapter 4, section 4.3.6). The aforesaid can be hampered when staff are absent**.** O'Conner and Clover (2017:483) state that positive staff-patient relationships can contribute to patient recovery and interaction is also beneficial in improving patient experiences of care. Healthcare seeking behaviour can be influenced by absenteeism of healthcare workers although patients are very reliant on public healthcare, particularly in rural areas (Zhang *et al.,* 2021:1). The study results revealed that health worker absenteeism reduces the probabilities of patients seeking care at public facilities and increases the likelihood of paying cash for treatment.

Motivators such as management support elicited mixed responses. Participants indicated that the lack of management support for assisting in the case of an absent

colleague is dissatisfying (see Chapter 4, section 4.3.1). Perceptions of non-support are consistent with the findings of Ferro *et al.,* (2018:399) who indicated that management support plays a critical role in strengthening commitment to quality patient care and reducing absenteeism. Furthermore, managers displayed favouritism by being biased, unfair to staff members and branded them for being absent. (see Chapter 4, section 4.3.6). Nesengani, Downing, Poggenpoel and Stein (2019:1) found that staff dissatisfaction was due to perceived employee favouritism. In contrast, Grigore (2020:401) found that absenteeism was not influenced by management support as management provided support to employees. Participants in managerial positions in this study also emphasised statements of supporting staff, which contradicted what other staff members said (see Chapter 4, section 4.3.1). Similarly, Aitama, Leino-Kilpi, IIltanen and Suhonen (2016:9) found that there is no clear definition of management support and that nurse managers and nurses' views on what constitutes justice in terms of working conditions differ.

Staff allocation due to absenteeism is challenging particularly if the absentee staff are not replaced and those present must assume multiple roles (see Chapter 4, section 4.3.2). Iqbal and Cheema (2018:257) found that nurses complete all work allocated to them in the absence of -their colleagues but absent themselves. SzwArc, BocEwicz, Banaszak and Wikarek (2019:1) are of the opinion that scheduling strategies need to be implemented to deal with unexpected absenteeism. Absenteeism is linked to higher nurse-patient ratios, and South Africa has one of the lowest with one nurse for every 213 patients (SANC, 2020). Optimal nurse-patient ratios benefit both the nurse and the patient by enhancing patient satisfaction through clinical improvements in patient care and reducing staff fatigue and burnout (Sharma & Rani, 2020:2631). Smith, Plover, McChesney and Lake (2019;469) confirm that nurse-patient ratios were higher in rural areas and lead to poor quality patient care. Similarly, Quereshi, Purdy, Mohani and Neumann (2019:971) found that quality care deteriorated with missed nursing care at 120%. Participants felt that having sufficient staff, omissions of care can be prevented (see Chapter 4, section 4.3.4). In a study on omissions of nursing care in hospital units, 84, 4% of missed nursing care was due to inadequate number of staff (Lima, Silva & Caliri, 2020:1).

Participants reiterated that they had to work the same number of hours with double the workload when colleagues are absent. Owing to this, nurses' physical and psychological health are affected (see Chapter 4, section 4.3.5). Tichwara *et al.,* (2018:109) found that absenteeism was ascribed to a heavy workload, which negatively impacted nurses' physical and psychological health. Musculoskeletal disorders are mainly associated with high physical demands of nurses, which result in absenteeism. A study on work related musculoskeletal disorders of nurses (51, 4%) were strongly linked to long standing work and absenteeism (Ribeiro, Serranheira & Loureiro, 2017:72). This is congruent with the findings of a study by de Silva and Merino (2017:546) who found that musculoskeletal disorders are one of the main reasons for absenteeism. The authors also found that psychological disorders contribute to absenteeism and suggested a more holistic approach when assessing nurses' health. Furthermore, Demou, Smith, Bhaskar and MacKay (2018:1) found that mental health disorders, particularly depression accounted for the majority of days absent.

In conclusion, it was evident that nurses were dissatisfied with the current working conditions (extrinsic factors) in the ward such as the unavailability of resources, the high workload and lack of support from management. Nurses also expressed dissatisfaction with being expected to work the same number of hours with double the workload while performing multiple roles, endangering their physical and psychological health. Moreover, the increased workload due to absenteeism results in decreased quality patient care.

### 5.2.2 Objective 2: Explore the influence of intrinsic factors on absenteeism as experienced by nurses

Intrinsic factors like recognition, achievement, advancement and growth and responsibility motivate staff to enhance work performance. Consequently, the findings are presented pertaining to Herzberg's Theory of Motivation (see Chapter 2, section 2.7) on the conceptual framework. Participants indicated that being motivated would contribute to the tendency to report for work, thereby reducing absenteeism. However, managers did not express this sentiment (see Chapter 4, section 4.3.7). Recognition and appreciation towards employees for their hard work are key elements for a productive working environment (Eddy, Kivick & Caboral, 2021:14). The lack of the

aforesaid is evident where low motivation leads to absenteeism (Negussie & Oliksa, 2020:3). The study findings revealed that nurses who were shown respect were 52,8 % more likely to be motivated.

Participants viewed the ability to advance, grow and achieve as a motivator not to absent themselves. Owing to absenteeism participants felt demotivated as none of the aforesaid occurred and management used various management styles, including autocratic and laissez-faire at times (see Chapter 4, section 4.3.6). Labrague *et al.,* (2020:1104) postulate that working with toxic management leads to absenteeism.

Managers who create a conducive work environment that empowers nursing staff will enhance employee engagement, participation and satisfaction while significantly reducing absenteeism. Participants expressed a desire to engage in educational activities to advance their careers (see Chapter 4, section, 4.3.1). Ferro *et al.,* (2018:403) confirmed that the absence of a career plan leads to absenteeism as education plays a leading role in healthcare management to provide quality nursing care. In a study where nurses felt responsible for their task of taking care of the patients due to motivation from management, absenteeism were lowered (Ibrahim, 2019:70).

Participants stated that strategies involving intrinsic factors (recognition, achievement, advancement, and growth) could be implemented to reduce absenteeism (see Chapter 4, section 4.3.7). Organisational factors like professional development and recognition rewards were identified as strategies to reduce absenteeism, with nurses feeling appreciated by participating in activities such as best teamwork, best unit and employee of the month (Baydoun *et al.,* 2016:101). Employees should also be encouraged to gain new knowledge by attending conferences. Joseph (2015:105) agreed that management should take a proactive approach to motivating employees to boost morale and productivity while decreasing absenteeism.

Finally, it can be deduced that nurses were dissatisfied with the current management support provided in the wards. In this study, absenteeism was exacerbated by a lack of motivation, achievement, advancement, and growth. In addition, some participants were also dissatisfied with the leadership style of the unit manager.

### 5.2.3 Objective 3: Explore the influence of extrinsic factors on absenteeism as experienced by nurses.

Extrinsic factors such as relationships, policies, supervision and benefits were factors that cause dissatisfaction among staff. These factors were consistent with Herzberg's theory presented under the conceptual framework (see Chapter 2, section 2.7). Participants stated that relationships between staff and relationships amongst patients influence whether employees are absent (see Chapter 4, section 4.3.6). Participants indicated that the necessity to establish rapport with patients in a small community is not feasible due to the increased workload on staff associated with the absenteeism of their colleagues. Duclay *et al.,* (2016:833) found that when staff are absent patients are dissatisfied. In addition, Robbins & Davidhizar (2020:11) suggest a rise in patient satisfaction when nurses are content and satisfied at work. As a result, even brief staff-patient encounters can contribute to positive patient outcomes (Gittel, Logan, Gronenwett & Foster, 2020:12).

Communication among staff members is critical for teamwork and patient care (Lim, Kanfer & Stroebel, 2019:54). Participants indicated that absenteeism from colleagues create animosity within the team (see Chapter 4, section 4.3.6). They were of the opinion that there is a lack of communication from supervisors, as well as lack of supervision in general. This situation is confirmed by Tumlinson *et al.,* (2019:1) that infrequent supervision can lead to absenteeism. Clinical supervision is an essential element for good professional practice and promote professional development by nurturing a supportive working relationship (Saab, Kilty, Meehan & Goodwin, 2020:360). According to Davey Jackson & Henshall (2020:992) mentoring increases confidence and competence in problem solving. Participants also revealed a lack of support from their supervisors particularly pertaining to patient care (see Chapter 4, section, 4.3.6). Ylänne, Aldridge-Waddon, Spiliioti & Bartlett (2019:51) recommend a cooperative approach for effective communication between staff and supervisors and enhance motivation for teamwork. Also, tasks do not have to be structured all the time. The authors opted for making handover a more spontaneous activity that can result in team cohesion and staff well- being.

Participants felt that policies are imperative in healthcare institutions as they regulate order related to absenteeism (see Chapter 4, section 4.3.7). In contrast, ignorance of hospital rules and policies was found to be the least common cause of absenteeism (46.4%) (Alharbi *et al.,* 2018:1787). According to Gunn, Muntaner, Ng and Villeneuve (2019:1) policies are poorly understood by nurses. Participants in this study concurred with the aforesaid, stating that there is no transparency in policies. They felt that policies, particularly those pertaining to absenteeism should be applied consistently (see Chapter 4, section 4.3.7). In contrast, Alharbi *et al.,* (2018:1787) found that 77,1% of absenteeism were due to no action taken for repeated absence. Therefore, participants felt that disciplinary action taken could reduce absenteeism (see Chapter 4, section 4.3.7). According to Darkwa, Newman, Kwakab and Chowdhury, 2015:7) managers have limited power to impose disciplinary action against employees who remain absent in rural areas in Bangladesh. A South African study (Kisakye *et al.,* 2016:93) found that a regulatory mechanism to regulate absenteeism was the use of organisational policies. The authors stated that the importance of policy implementation have to be outlined.

Participants had mixed feelings on how incentives or benefits influence absenteeism (see Chapter 4, section 4.3.1). Firstly, participants felt that benefits do not influence their presence or absence from work because nursing is what they enjoy doing. Butler and Johnson (2020:10) support this by revealing that salaries and benefits are less important in influencing absenteeism than other factors like burnout, family related issues and stress. In contrast, some participants felt that incentives could motivate staff against absenting themselves (see Chapter 4, section, 4.3.1). Tichwara *et al.,* (2019:109) found that where financial incentives are granted absenteeism was lower. This was corroborated by the findings that nurses felt deserving of incentives like danger allowances when working with psychiatric patients and OSD (Moshidi, Malema, Muthelo & Mothibi, 2021:8). Absenteeism leads to low morale of staff and a lack of rewards, and a low salary can ultimately lead to staff terminating services (Nesengani *et al.,* (2019 :7).

It is evident that extrinsic factors like relationships, supervision, incentives and policies can cause absenteeism. Relationships are negatively affected amid absenteeism. Relationships among staff members lead to conflict due to increased workload and

responsibility when their colleagues are absent. Absenteeism impedes the ability of staff to establish rapport with patients, particularly hospitalised patients. A lack of supervision, motivation and incentives lead to absenteeism although some participants felt that incentives are not a major contributor for absenteeism because nursing is what they love. Policies have to be implemented fairly and consistently as strategy to manage absenteeism.

## 5.3 LIMITATIONS OF THE STUDY

The study was conducted in the public healthcare institutions of the Eastern Cape and excluded the population of private healthcare institutions. Data were collected from three district rural hospitals in the public sector. Public sector hospitals represent the majority of healthcare instututions in the Eastern Cape, particulary the Sarah Baartman district with no private healthcare hospitals in the Beyers Naude health municipality where the study was conducted. Moreover, nurses working in the private sector may have different views on the topic under study.

## 5.4 RECOMMENDATIONS

This section provides recommendations based on the objectives, information and evidence that stemmed from the study which will aid in improving working conditions of nurses in district rural hospitals.

### 5.4.1 Healthy work environment

According to the American Nurses Association (ANA) (2022) nurses have the right to work in an environment which supports their optimal health and safety and to fulfill their obligation to their patients. Salehi, Barzegar, Yekanini and Ranjibar (2020:828) found a significant relationship between a healthy work enviroment and job satisfaction. Participants in the the study felt that when they are satisfied in their work, absenteeim would be reduced. Participants stated that their physical end psychological health are negatively affected as a result of absenteesim, hence employee wellness programs must be available on a daily basis to assist with employees' holistic wellbeing. Managers should also encourage nurses to take planned vacations to recharge in order to manage absenteeism (Tichwara *et al.,* 2018:109). Staff tend to thrive and have lower absenteeism, higher customer ratings

and higher problem-solving skills when all five aspects of well-being (purpose, social, financial, community and physical) are met (O'Boyle & Harter, 2014:2).

Nurses have the right to work in an environment that is safe and risk free from hazards such as faulty equipment and infection (Munro & Hope, 2020:4). Hansen, Zimmerman and van de Moretel (2018:212) found that Infection, Prevention and Control (IPC) measures in place may reduce absenteeim. As a result, managers must ensure that IPC measures are in place (Dekker, Jongerden, de Bruijne & Jelsma, 2022:3). According to the WHO (2022) IPC is a practical, evidence-based approach that protects patients and healthcare workers from avoidable infection and antimicrobial resistance and can reduce sickness absenteeism.

#### *5.4.1.1 Equipment*

Equipment are an essential part of healthcare facilities and planning is imperative to meet the needs of a particular institution. The intended equipment for healthcare service delivery should be divided into life support, diagnostic, therapeutic and analytical functions (Zamzam, Wahab, Aizan and Satapathy (2021:6). Nurse managers must consider the aforementioned paricularty in rural healthcare facilities where equipment shortages contribute to absenteeism.

**Procurement of resources -** The results of the study revealed the frustration of nurses towards resource unavailability with the onus on management to ensure the latter are available. In South Africa, the Public Finance Management (PFMA) Act (Act 1 of 1999) establishes mechanisms for collecting, allocating and accounting for public resources. As a result, nurse managers have to budget annually to buy new equipment and ensure that resources are procured timeously adhering to PFMA regulations. Resources should be allocated fairly in all healthcare settings to prevent compromising healthcare provision. The provision of substandard medical care to patients is referred to as compromised healthcare (Goswami, 2022). The principle of justice and equity should be applied irrespective of rural or urban healthcare, as the primary concern is duty to the patients. Nurse managers have to consolidate with unit or operational managers to assess what the needs are and plan accordingly to ensure that resources like equipment, medical surgical supplies as well as medictaion are procured to enure

quality and continuity of patient care. Insufficient or unavailability of resources are related to absenteeism (Mtyalela & Mbatha, 2015:1).

**Maintenance of equipment -** According to Moyimane, Matlala and Kekana (2017:2) the WHO estimated that 50-80% of medical equipment in developing countries are not working which impede the prevention, treatment and rehabilitation of patients. This is particulary alarming in rural healthcare hospitals where emergency patients must be stabilised prior transfer to regional or tertiary hospitals. Medical equipment that is nonfunctional or malfunctioning can have a negative impact on patients. Owing to this, patients who are hospitalised may be admitted for an extended period of time and may be misdiagnosed (Moyimane *et al.,* 2017:4) As a result, the procurement of equipment (and other resources) as well as the maintenance thereof are imperative.

Nurse managers have to ensure that all epuiment are serviced at prescribed times and that maintenance plans are drawn up annually. Instruction manuals have to be readilly available on the use of equipment particullary new equipment (Aitken, Marshall & Chaboyer, 2019). In addition, in–service training should be provided on the use of new equipment to ensure equipment are properly used. Managers must ensure that all staff are trained on new equipment and familiarise themselves with Standard Operating procedures (SOPs) regarding the use and maintenance of equipment (Corciovă, Andriţoi, & Luca, 2020:235). For example, SOPs must specify that equipment such as refrigerators containing medications be checked twice daily and that any abnormalities or deviations to be reported immediately. The aforementioned can prevent adverse events involving medical equipment like incorrect or delayed diagnosis and treatment of patients.

#### *5.4.1.2 Incentives*

**Non-financial incentives:** The study revealed that participants felt that non-financial incentives from managers such as motivation and recognition will reduce absenteeism. As a result, managers can motivate staff by giving recognition for good work and attendance by award ceremonies. The implemetation of a Performance Development System (PMDS) motivates staff to perform at their optimal level (Mello & Thabayapelo, 2021:59).

**Financial incentives:** Due to employees working more hours than scheduled in the case of an absent employee, overtime payment have to be made timeously (Akinwale & George, 2020:87). Furthermore, other allowances like night duty allowance, public holiday payments, grading and performance bonuses are motivators that aid in reducing absenteeism (Kisakye *et al.,* 2016:87).

#### *5.4.1.3 Leadership and support*

Particapants felt that their individual needs have to be attended to particluarly when adressing asbenteeism. As a result, leaders must be alert to employee concerns, recognise employee diversity and respond to individual needs. Roberson and Perry (2022:755) found that inclusive leadership entails valuing differences and encouraging collaboration. Hence, nurse managers have to adopt a transformational leadership style in rural hopsitals which will result in job satisfcation. Also, transformational leadership will inspire employees, give them self confidence over spesific jobs and improve subordinate task performance, particulary during originisational change (Farahnak, Ehrhart, Torres & Aarons, 2020:99).

### 5.4.2 Policies

The Department of Health (DOH) (2021) issued a directive on the determination on leave of absence in the public service which outline the determination and directive on leave absence. Managers must ensure directives are availabe to all staff (hard and soft copies) so staff are familiar with and internalise the types of leave that are available. The manager should also discuss the policy with all staff and have them sign it to show their understanding. Leave management policies and procedures which provide a regulatory framework for the efficient management of leave must be implemented vigorously to ensure uniformity, particularly in the case of absenteesim.

In addition, staff members must understand their rights and responsibilities under the Labour Relations Act (Act 66 of 1995) and the Public Service Act (Act 103 of 1994), as well as the consequences of violating the latter. If necessary, the manager should outline the steps they will take if absenteeism persists such as disciplinary action and dismissal for habitual offenders. Consequently, it is pivotal that staff are trained on disciplinary policies and procedures and that policies are accessable to all staff.

Also, managers must asses trends and patterns of absenteeim through regular monitoring and adress it appropriately. Policies on referral pathways must indicate employee assited programs or employee wellness programs to assist with counselling regarding leave patterns and assisting with personal problems i.e., substance abuse which must be dealt with on an individual basis. Follow-ups should be scheduled and, disciplinary action should be taken if problem persist and no progress is noted on the absence record.

Policy implemetation should be done fairly and consistenly by nurse managers in all situations. Nurse managers must also develop skills to aid in their participation in health policymaking, hence improving policy implementation, effectiveness and efficieny in the health system (Hajizadeh, Zamanzadeh & Khodayari-Zarnaq, 2021:1).

### 5.4.3 Staff development

Training and devopment is an essential element in nursing due to its dynamic nature. Nurses have to be abreast with changes in nursing and therefore training and development are imperative. In addition, nurse managers play an integral part in the continuous development of nurses. Training can be done in the form of formal training, workshops, seminars, in-service trainings and during orientation (Chaghari, Saffari, Ebadi & Ameryoun, 2017:30). The goal of training should be to improve patient outcomes and provide quality patient care. Hakami, Almutairi, Otaibi and Otaibi (2020:2) postulate that patient outcomes are related to nurse satisfaction, and satisfied nurses are more committed to their jobs, perform better and are less absent. Consequently, establishing good relationships among managers and staff can enhance a dymanic process of learning (Södersved Källestedt, Asp, Letterstål & Widarsson, 2020:4790). The PMDS also recognise training and development needs and promote continuous monitoring to improve quality of service delivery (Khubeka & Tshiyoyo, 2018:174). During this process of continuous monitoring a staff-manager rapport is established, resulting in good communication which is essential for a therapeutic working environment.

In 2013 the SANC established and commenced a Continuous Professional Development (CDP) System for all health practitioners registered with the council. The CPD system will be implemented in phases with a wide range of formal and informal

learning activites that will generate CPD points and practitioners must accumulate 15 points annually. The purpose of the CPD system is to maintain professional standards and excellence, promote life-long learnning, and strenghthen accountability of healthcare practitioners (SANC, 2022). Nurse managers must ensure that nurses are aware of the CPD system and that nurses participate in a variety of learning activities to improve knowledge and skills to stay current with new developments in the healthcare sector. This will also enable nurses to provide quality healthcare to rural healthcare communities in an efficient and competent manner.

### 5.4.4 Quality assurance

Managers must ensure that quality principles are in place to prevent patient safety incidents and adverse events like patients falling out of bed, medication errors and referral of patients from rural hopsitals to tertiary hospitals. Standard Operating Procedures must be developed for standardised care. Moreover, care plans must be drawn up and patient-specific care plans must be developed to meet the needs of indivual patient needs based on their health status.

Rural hospitals, like urban hospitals, should appoint quality assurance managers to asses if healthcare sevices are up to standard. The quality assuarance mangers (QAMs) would audit files regulary, identify gaps and draw up quality improvement plans that outline what needs to be done, who needs to do it and when it needs to be done. Managers shold hold regular quality circle meetings with QAM and staff to discuss staff improvements, recognise efforts and encourage collaboration with quality improvement projects like staff giving input in the developing of SOPs. Staff engagememt, mutual communication and providing a supportive staff enviroment aid in rendering quality patient care and ensure the process of quality assurance is followed.

The study clearly showed that patient care is being neglected due to absenteeism (Chapter 4, section 4.3.4). Furthermore, quality leadership entails achieving the organisations's missions and goals regarding better patient and staff outcomes. This is consistent with magnet hospitals characteristics, which are a globally recognised accreditation programme that aligns nursing goals to improve patient care (Friese, Xia, Ghaferi, Birkmeyer & Banerjee, 2015:986). The authors state that magnet accredited

hospitals can also attract and retain nurses who provide excellent nursing care. McCaughey, McGhan, Rathert and Williams (2020:21) found that nurses are more satisfied and committed in hospitals that have magnet accreditation. Similary, in South Africa an Ideal Hospital Framework was developed to address deficiencies in hospitals, provide a framework for public hospitals, create a national paramater as a quality benchmark to standardise service levels (Department of Health, 2018). Consequently, nurse managers have to ensure nurses are familiar with the Ideal Hospital manual and the elements it contains to strive for quality service delivery.

## 5.5 FUTURE RESEARCH

A quantitative study is recommended to provide more information and to determine the level of job satisfaction for nurses in district rural hospitals regarding absenteeism. Moreover, a quantitative study will provide accurate data and will enable researchers to make generalised statements regarding absenteeism of nurses in the workplace in the Eastern Cape.

## 5.6 DISSEMINATION

The study will be available at the Stellenbosch University's website. The study will also be distributed to the Easten Cape Department of Health as well as the management the participated hopsitals, upon request. Articles derived from this study will be published in peer reviewed journals.

## 5.7 SUMMARY

In the final chapter of this study, the three objectives were achieved and the results confirmed that job satisfcation leads to absenteeism. Motivator and hygiene factors according to Hertzberg's theory can lead to staff either being absent or present at work. The objective in terms of how nurses experience absenteeism while working in district rural hospitals in the Eastern Cape was extensively discussed with participants expressing their frustation when their colleagues are absent, as well as how hygiene factors play a role in their absence. Furtherrmore, how motivator factors can aid in managing absenteeism was discussed. The study's objectives provided answers on how absenteeim affects the nurse, the patient and the orginisation. The research question on what the experiences of nurses in district rural hopsitals in the Eastern Cape was answered in the study.

## 5.8 CONCLUSIONS

The study revealed that job dissatisfaction led to absenteeism. A lack of support, motivation, recognition, excessive workload in the absence of staff, having to fulfil multiple roles lead to frustration and demotivation. Absenteeism was common and staff were not replaced but were forced to work under conditions in which managers adopted autocratic leadership styles. Participants expressed how absenteeism has a negative impact on patient care, with patient care being missed, delayed, or omitted at times. They also revealed the inconsistencies in the application of policies by managers. Finally, participants alluded that they enjoy their jobs but managers must create and provide a more therapeutic work environment through support, by having the necessary equipment and resources to provide optimal patient care.

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# APPENDICES

## APPENDIX A: SEMI-STRUCTURED INTERVIEW GUIDE

Title: Absenteeism In district rural hospitals in the Eastern Cape: the experiences of nurses.

**Section A: Instrument for demographic data collection**

**Upon completion of demographic data, please:**

- A1-2= circle
- A3= insert age
- A4= circle where appropriate
- A51-4=please tick
- A5.5-5.6= insert totals

| **Demographic Data** | | | |
|---|---|---|---|
| Male | Female | Age | Day/Night Shift (circle) |

| Nursing qualifications (please tick) | | Interview Preference (please tick) | |
|---|---|---|---|
| Management position (OM/CEO) | | English | |
| Professional nurse | | Afrikaans | |
| Enrolled nurse | | IsiXhosa | |
| Enrolled nursing assistant | | | |
| | | | |
| Years in service as a nurse: (insert) | | | |
| Years in service as a nurse at current hospital: (insert) | | | |

**Section B: Semi-structured interview guide**

1. Could u please tell me about your experiences of absenteeism at the workplace?
**Probing words:** job satisfaction, job dissatisfaction

2. Could you please tell me what motivates you not to absent yourself from work?
**Probing words**: achievement, recognition, responsibilities, work itself, benefits, advancement and growth

3. In your view, what are the reasons for long absence?
**Probing words:** policies, supervision, work conditions, relationships

4. Can you tell me how absenteeism influences patient care? Give your views.
**Probing words:** good, negative, consequences

5. Can you tell me about the current coping strategies to prevent absenteeism in the ward? How can management assist to address absenteeism?
**Probing words:** workload, support, ancillary staff, disciplinary action

## APPENDIX B: PARTICIPANT INFORMATION AND CONSENT FORM

**PARTICIPANT INFORMATION LEAFLET AND CONSENT FORM**

| **TITLE OF RESEARCH PROJECT:** | |
|---|---|
| **Absenteeism in district rural hospitals in the Eastern Cape: the experiences of nurses.** | |
| **DETAILS OF PRINCIPAL INVESTIGATOR (PI):** | |
| **Title, first name, surname: Miss Lindill Jonas** | **Ethics reference number:** |
| **Full postal address:** [redacted] | **PI Contact number:** [redacted] |

We would like to invite you to take part in a research project. Please take some time to read the information presented here, which will explain the details of this project. Please ask the study staff or doctor any questions about any part of this project that you do not fully understand. It is very important that you are completely satisfied that you clearly understand what this research entails and how you could be involved. Also, your participation is **entirely voluntary** and you are free to decline to participate. In other words, you may choose to take part, or you may choose not to take part. Nothing bad will come of it if you say no: it will not affect you negatively in any way whatsoever. Refusal to participate will involve no penalty or loss of benefits or reduction in the level of care to which you are otherwise entitled. You are also free to withdraw from the study at any point, even if you do agree to take part initially.

The Health Research Ethics Committee at Stellenbosch University has approved this study. The study will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki, the South African Guidelines for Good Clinical Practice (2006), the Medical Research Council (MRC) Ethical Guidelines for

Research (2002), and the Department of Health Ethics in Health Research: Principles, Processes and Studies (2015).

**What is this research study all about?**

- *The study seeks to explore the experiences of nurses regarding absenteeism in district rural hospitals and will be conducted at three district hospitals in the [redacted] health district. Participants will be recruited from the participating hospitals. At your hospital four participants will be recruited, one of each nursing category (ENA, EN, PN) and a nurse in a managerial position. Twelve participants will be interviewed altogether. However, if data saturation is not met (meaning that with every interview new information is provided), more interviews will be required.*
- *The study aims to explore how nurses experience absenteeism particularly working in district rural hospitals in [redacted] health district in the Eastern Cape. In exploring these experiences of absenteeism insight and understanding may be gained of the conditions under which nurses must work.*
- *Participants will be recruited virtually or face-to face. Virtual recruitment will include email announcements and advertising on social media groups. Face to face recruitment will involve the researcher walking from ward to ward recruiting participants adhering to COVID-19 guidelines of wearing a mask, keeping social distance, and sanitising before and after each participant recruitment. Written consent will be obtained from the participant (you). In cases of virtual interview an e signature will be required. A time and place convenient for the participant (you) will be used adhering to COVID-19 regulations. The interviews will be recorder and a second tape will be used in case of equipment failure. The audiotapes will be transcribed (put into writing) and analysed. The interview will be conducted in the language of your choice. The researcher is fluent in both English and Afrikaans. If the participant (you) prefers to conduct the interview in isi-Xhosa, a translator will be used who went for similar training as the researcher in interview techniques. The interview will consist of open-ended questions which the participant (you) is requested to answer freely. In cases of feelings of discomfort, the participant (you) will be referred to your institution's employee wellness program. To ensure confidentiality, a pseudonym (false name) will be used.*

Why do we invite you to participate?

- *You were invited to participate since you are a permanently employed nurse of no less than two years' experience at your institution.*

**What will your responsibilities be?**

- *A convenient date, time and venue will be arranged with you in advance, convenient to the ward.*
- *You are requested to answer all questions openly, honestly and freely.*
- *You can ask questions at any time and if you feel uncomfortable, indicate that.*

**Will you benefit from taking part in this research?**

- *There will be no personal benefits from the research study, but the investigator hope that the results of the research may assist in future to improve nurses' knowledge of what is expected from them, provide rules and regulations and consistency and a clear response in dealing with absenteeism in district rural hospitals in the Eastern Cape.*

**Are there any risks involved in your taking part in this research?**

- *The investigator does not foresee any risks and discomforts. However, if the participant (you) feels uncomfortable or distressed, you will be referred to your institution's wellness program.*

**If you do not agree to take part, what alternatives do you have?**

- *There will be no consequences should you decide not to participate.*

**Will you be paid to take part in this study and are there any costs involved?**

- *You will not be compensated to take part in the study and you will not have to pay for anything if you do take part.*
- *Tea/coffee and scones will be provided during the time of the interview and a R50 gift voucher as token of appreciation.*

**Is there anything else that you should know or do?**

- *You can phone Miss Lindill Jonas at* [redacted] *if you have any further queries.*
- *You can phone the Health Research Ethics Committee at* [redacted] *if there still is something that the researcher (Miss Lindill Jonas) has not explained to you, or if you have a complaint.*
- *You will receive a copy of this information and consent form for you to keep safe.*

**Declaration by participant**

By signing below, I …… agree to take part in a research study entitled (Experiences of nurses in district rural hospitals in the Eastern Cape: the experiences of nurses).

I declare that:

- I have read this information and consent form, or it was read to me, and it is written in a language in which I am fluent and with which I am comfortable.
- I have had a chance to ask questions and I am satisfied that all my questions have been answered.
- I understand that taking part in this study is **voluntary,** and I have not been pressurised to take part.
- I may choose to leave the study at any time and nothing bad will come of it – I will not be penalised or prejudiced in any way.
- I may be asked to leave the study before it has finished, if the study doctor or researcher feels it is in my best interests, or if I do not follow the study plan that we have agreed on.

Signed at (*place*) …… on (*date*) …… 2019.

…… ……

**Signature of participant** **Signature of witness**

**Declaration by investigator**

I *(name)* …… declare that:

- I explained the information in this document in a simple and clear manner to ……
- I encouraged him/her to ask questions and took enough time to answer them.
- I am satisfied that he/she completely understands all aspects of the research, as discussed above.
- I did/did not use an interpreter. (*If an interpreter is used then the interpreter must sign the declaration below.)*

Signed at (*place*) ..... on (*date*) ..... 2019.

..... .....

**Signature of investigator** **Signature of witness**

**Permission to have all anonymous data shared with journals:**

*Please carefully read the statements below (or have them read to you) and think about your choice. No matter what you decide, it will not affect whether you can be in the research study, or your routine health care*

When this study is finished, we would like to publish results of the study in journals. Most journals require us to share your anonymous data with them before they publish the results. Therefore, we would like to obtain your permission to have your anonymous data shared with journals.

**Permission for sharing samples and/or information with other investigators:**

*Please carefully read the statements below (or have them read to you) and think about your choice. No matter what you decide, it will not affect whether you can be in the research study, or your routine health care.*

In order to do the research, we have discussed, we must collect and store [*describe the samples that are going to be collected e.g. blood/tissue/urine etc. and volume of blood/tissue/urine etc.*] and health information from people like you with [*disease X*]. We will do some of the tests right away. Other tests may be done in the future. Once we have done the research that we are planning for this research project, we would like to store your sample and/or information. Other investigators from all over the world can ask to use these samples in future research [*please indicate if the samples will be shipped from South Africa, where the samples will be stored and who will have access to these samples].* To protect your privacy, we will replace your name with a unique study number. We will only use this code for your sample and information about you. We will do our best to keep the code private. It is however always possible that someone could find out about your name but this is very unlikely to happen. Therefore, we would like to ask for your permission to share your samples and information with other investigators.

**Tick the Option you choose for anonymous data sharing with journals:**

I agree to have my anonymous data shared with journals during publication of results of this study

☐ Signature_____

OR

I do not agree to have my anonymous data shared with journals during publication of results of this study

☐ Signature_____

**Tick the Option you choose for sharing samples and/or information with other investigators:**

I do not want my sample and/or information to be shared with other investigators

☐ Signature_____

OR

My sample and/or information may be shared with other investigators for further analysis and future research in a field related to … [*describe the field of your study, e.g. diabetes research*]

☐ Signature_____

# APPENDIX C: ETHICAL APPROVAL FROM STELLENBOSCH ETHICAL COMMITTEE

UNIVERSITEIT STELLENBOSCH UNIVERSITY

**Approval Notice**

**New Application**

08/06/2021
**Project ID:** 22118

HREC Reference No: S21/04/070
**Project Title:** Absenteeism in district rural hospitals in the Eastern Cape: the experiences of nurses

Dear Miss Lindili Jonas

The **New Application** received on 21/04/2021 11:33 was reviewed by members of **Health Research Ethics Committee** via **expedited** review procedures on 08/06/2021 and was approved.

Please note the following information about your approved research protocol:

**Protocol Approval Date: 08 June 2021**

**Protocol Expiry Date: 07 June 2022**
Please remember to use your Project ID 22118 and Ethics Reference Number S21/04/070 on any documents or correspondence with the HREC concerning your research protocol.

Please note that the HREC has the prerogative and authority to ask further questions, seek additional information, require further modifications, or monitor the conduct of your research and the consent process. **After Ethical Review**

Translation of the informed consent document(s) to the language(s) applicable to your study participants should now be submitted to the HREC.

Please note you can submit your progress report through the online ethics application process, available at: Links Application Form Direct Link and the application should be submitted to the HREC before the year has expired. Please see *Forms and Instructions* on our HREC website (www.sun.ac.za/healthresearchethics) for guidance on how to submit a progress report.

The HREC will then consider the continuation of the project for a further year (if necessary). Annually a number of projects may be selected randomly for an external audit.

Please note that for studies involving the use of questionnaires, the final copy should be uploaded on Infonetica.

**Provincial and City of Cape Town Approval**
Please note that for research at a primary or secondary healthcare facility, permission must still be obtained from the relevant authorities (Western Cape Department of Health and/or City Health) to conduct the research as stated in the protocol. Please consult the Western Cape Government website for access to the online Health Research Approval Process, see: https://www.westerncape.gov.za/general-publication/health-research-approval-process. Research that will be conducted at any tertiary academic institution requires approval from the relevant hospital manager. Ethics approval is required BEFORE approval can be obtained from these health authorities.

We wish you the best as you conduct your research.For standard HREC forms and instructions, please visit: Forms and Instructions on our HREC website https://applyethics.sun.ac.za/Project/View/Index/22118

If you have any questions or need further assistance, please contact the HREC office at [redacted]

Yours sincerely,
Mrs. [redacted] Coordinator
*National Health Research Ethics Council (NHREC) Registration Number:REC-130408-012 (HREC1) ·REC-230208-010 (HREC2)*
*Federal Wide Assurance Number: 00001372*
*Office of Human Research Protections (OHRP) Institutional Review Board*
*(IRB) Number: IRB0006240 (HREC1) ·IRB0006239 (HREC2)*

*The Health Research Ethics Committee (HREC) complies with the SA National Health Act No. 61 of 2003 as it pertains to health research. The HREC abides by the ethical norms and principles for research, established by the World Medical Association (2013), Declaration of Helsinki: Ethical Principles for Medical Research Involving Human Subjects;the South African Department of Health (2006), Guidelines for Good Practice in the Conduct of Clinical Trials with Human Participants in South Africa (2nd edition); as well as the Department of Health (2015). Ethics in Health Research: Principles, Processes andStructures (2nd edition).*

*The Health Research Ethics Committee reviews research involving human subjects conducted or supported by the Department of Health and Human Services, or other federal departments or agencies that apply the Federal Policy for the Protection of Human Subjects to such research (United States Code of Federal Regulations Title 45 Part 46) ; and/or clinical investigations regulated by the Food and Drug Administration (FDA) of the Department of Health and Human Services.*

## APPENDIX D: PERMISSION LETTER FROM THE EASTERN CAPE DEPARTMENT OF HEALTH

**Province of the EASTERN CAPE**

**HEALTH**

**Enquiries:** [redacted]

**Tel no: 079 074 0859**

**Email:** [redacted]@gmail.com

**Date: 17 June 2021**

**RE: Absenteeism in district rural hospitals in the Eastern Cape: the experience of nurses (EC_202106_011)**

**Dear Miss Lindill Jonas**

**The department would like to inform you that your application for the abovementioned research topic has been approved based on the following conditions:**

1. **During your study you will follow the submitted protocol with ethical approval and can only deviate from it after having a written approval from the Department of Health in writing.**

2. **You are advised to ensure, observe and respect the rights and culture of your research participants and maintain confidentiality of their identities and shall remove or not collect any information which can be used to link the participants.**

3. **The Department of Health expects you to provide a progress update on your study every 3 months (from date you received this letter) in writing.**

4. **At the end of your study, you will be expected to send a full written report with your findings and implementable recommendations to the Eastern Cape Health Research Committee secretariat. You may also be invited to the department to come and present your research findings with your implementable recommendations.**

5. **Your results on the Eastern Cape will not be presented anywhere unless you have shared them with the Department of Health as indicated above.**

**Your compliance in this regard will be highly appreciated.**

**SECRETARIAT: EASTERN CAPE HEALTH RESEARCH COMMITTEE**

**TOGETHER, MOVING THE HEALTH SYSTEM FORWARD**

## APPENDIX E: APPLICATION LETTER FOR HOSPITAL A

Stellenbosch
UNIVERSITY
IYUNIVESITHI
UNIVERSITEIT

The CEO

[redacted] Hospital

[redacted]

[redacted]

Research Title: Absenteeism in district rural hospitals in the Eastern Cape: the experiences of nurses

Health Research Ethics Commitee Reference No: S21/04/070

Eastern Cape Department of Health Appoval: EC202106_011

Date: 01 June 2021

Dear Dr [redacted]

Application to conduct research at your facility

My name is Lindill Jonas and I am a Masters student at the University of Stellenbosch. The research I whish to conduct Masters thesis involves the experinces of nurses regarding absenteeism. This project will be conducted under the supervision of [redacted] (Stellenbosch University).

I am hereby seeking your consent to interview nurses who meets the inclusion criteria of the project.

I have provided you with a synopsis of my research proposal, letter of ethical approval from the HREC of Stellenbosch University, as well as a provincial appoval letter from the Eastern Cape Department of Health.

Upon completion of the sudy, I undertake to provide the Department of Health with a bound copy of the full research report. If you require any futher information, do not hesirate to contact me on [redacted] or at [redacted]@email.com. Thank you for your time and consideration in this matter.

[redacted]

Regards

[redacted] (Miss)

Stellenbosch University

## APPENDIX F: APPROVAL LETTER FROM HOSPITAL A

Province of [redacted]
HEALTH

[redacted] Provincial Hospital, P O Box [redacted], Republic Of South Africa

Tel: +[redacted]

Website: www[redacted].gov.za email: [redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted] September 2021

RE: Ms Lindill Jonas's application to conduct research at [redacted] Hospital

I have pleasure to inform you that your application to conduct research at [redacted] Hospital has been approved. Please bring your acceptance letter from Department of Health and your Identity document to the Sister in charge on arrival.

[redacted]

10 September 2021

Ms C[redacted]

Date

Assistant Manager Nursing

[redacted]Hospital

Together, moving the health system forward

Fraud prevention line: [redacted] hour

Call Centre: [redacted]

Website: www[redacted].gov.za

## APPENDIX G: APPLICATION LETTER FOR HOSPITAL B


The CEO

[redacted] Hospital

[redacted]

[redacted]

Research Title: Absenteeism in district rural hospitals in the Eastern Cape: the experiences of nurses

Health Research Ethics Committee Reference No: S21/04/070

Eastern Cape Department of Health Approval: ECDOH 306 0311

Date:

Dear Mrs January

Application to conduct research at your facility

My name is Lindill Jonas and I am a Masters student at the University of Stellenbosch. The research I whish to conduct Masters thesis involves the experinces of nurses regarding absenteeism. This project will be conducted under the supervision of [redacted] (Stellenbosch University).

I am hereby seeking seeking your consent to interview nurses who meets the inclusion criteria of the project.

I have provided you with a synopsis of my research proposal, letter of ethical approval from the HREC of Stellenbosvh Unoversity, as well as a provincial appoval letter from the Eastern Cape Deapermnet of Health.

Upn completion of the sudy, I undertake to provide the Department of Health with a bound copy of the full research report. If you require any futher information, do not hesirate to contact me [redacted] or at [redacted]mail.com. Thank yoy for your time and consideration in this matter.

Regards

[redacted] (Miss)

([redacted]

St[redacted]iversity

## APPENDIX H: PERMISSION LETTER FROM PARTICIPATING HOSPITAL B

Province of the [redacted]

HEALTH

[redacted] ) Hospital - [redacted] —Eastern Cape, P.O Box [redacted] -REPUBLIC OF [redacted]

[redacted] GOV.ZA/[redacted]@gmail.com

[redacted]

[redacted]

[redacted]

Email: [redacted].gov.za

Date: 27 September 2021

Subject: Approval to conduct a qualitative research study at [redacted] Hospital in [redacted]

Your application to conduct a qualitative research study by means of interview with the nursing employees is approved. The approval is granted as per the Eastern Cape Health Research Committee's conditions. Your cooperation in this regard is profoundly valued

[redacted]

Mrs. [redacted]

CEO: [redacted] Hospital

Date: 27/09/2021

Together, moving the health system forward

Fraud prevention line [redacted]

24 hour Call Centre: [redacted]

Website: www.[redacted].gov

## APPENDIX I: APPLICATION LETTER FROM HOSPITAL C

Stellenbosch
UNIVERSITY
IYUNIVESITHI
UNIVERSITEIT

CEO

[redacted] Hospital

[redacted]

[redacted]

Research Title: Absenteeism in district rural hospitals in the Eastern Cape: the experiences of nurses

Health Research Ethics Committee Reference No: S21/04/070

Eastern Cape Department of Health Approval: ECDOH 106 011

Date:

Dear Mr [redacted]

Application to conduct research at your facility

My name is Lindill Jonas and I am a Masters student at the University of Stellenbosch. The research I whish to conduct my Masters thesis in, involves the experinces of nurses regarding absenteeism. This project will be conducted under the supervision of [redacted] (Stellenbosch University).

I am hereby seeking your consent to interview nurses who meets the inclusion criteria of the project.

I have provided you with a synopsis of my research proposal, letter of ethical approval from the HREC of Stellenbosvh University, as well as a provincial appoval letter from the Eastern Cape Deapermnet of Health.

Upon completion of the sudy, I undertake to provide the Department of Health with a bound copy of the full research report. If you require any futher information, do not hesirate to contact me on [redacted] or at [redacted]gmail.com. Thank you for your time and consideration in this matter.

Regards

[redacted] (Miss)

[redacted]

Stellenbosch University

## APPENDIX J: APPROVAL LETTER FROM HOSPITAL C

Province of the
EASTERN CAPE
HEALTH

[redacted] HOSPITAL, Tel [redacted] Fax: [redacted] Cell: [redacted]
Private Bag [redacted], E-mail: [redacted].gov.za

**Me L** [redacted]

**Subject: Approval to conduct a qualitative research study at** [redacted] **Hospital in** [redacted]

**Dear Me** [redacted]

I have pleasure to inform you that your application to conduct a qualitative research study by means of interviewing the nursing employees is approved. The approval is granted as per the Eastern Cape Health Research Committee's conditions. Please bring your acceptance letter and ID with. Please report to Mrs [redacted] DMN.

**Kind Regards**

[redacted] **Date: 6 April 2022**

United in achieving quality health care for all

24 hour call centre: [redacted] Website: www.[redacted]h.gov.za

**APPENDIX K: CERTIFICATE OF ABSTRACT TRANSLATION TO AFRIKAANS**

Lona's Language Services

English/Afrikaans
Afrikaans/English

3 Beroma Crescent Beroma Bellville

Cell 0782648484
Email illona@toptutoring.co.za

* Translations * Editing * Proofreading
* Transcription of Historical Docs
* Transcription of Qualitative Research
* Preparation of Website Articles

***TO WHOM IT MAY CONCERN***

This letter serves to confirm that the undersigned

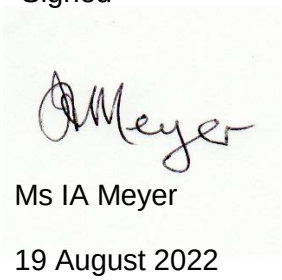
**ILLONA ALTHAEA MEYER**

has translated the **ABSTRACT** into **Afrikaans** as the

**OPSOMMING** for the thesis of **Lindill Jonas**

**TITLE OF THESIS: ABSENTEEISM IN DISTRICT RURAL HOSPITALS IN THE EASTERN CAPE: THE EXPERIENCES OF NURSES**

Signed



Ms IA Meyer

19 August 2022

## APPENDIX L: CERTIFICATE OF LANGUAGE EDITING


30 August 2022

To Whom It May Concern

**LANGUAGE EDITING CONFIRMATION LETTER**

This is to confirm that the thesis of Lindill Jonas titled, ***ABSENTEEISM IN DISTRICT RURAL HOSPITALS IN THE EASTERN CAPE: THE EXPERIENCES OF NURSES,*** was edited by me. It is the product of research towards the candidate's degree of Master of Nursing Science in the Faculty of Medicine and Health Sciences, Stellenbosch University.

The work of editing mainly involved ensuring that the usage of the English language is in accordance with the required standards.

Sincerely,

.....

David Kwao-Sarbah
Mobile: +233504228334
Email: dksarb@gmail.com

Registered Name of Business: Bud Prime Solutions (Pty) Ltd t/a Nursing Solutions • Reg. No.: 2016/525234/07
Directors: Dr B. Swartz, Mr D Kwao-Sarbah, Mr M. Swartz

## APPENDIX M: CERTIFICATE OF TECHNICAL EDITING

4 Nerina Avenue,
Brantwood,
Kuilsriver.
7580
☎ +27 71 768 4141
rukshana@sun.ac.za

RUKSHANA ADAMS
COPYWRITING AND EDITING SERVICES

### CERTIFICATE OF TECHNICAL FORMATTING AND EDITING

This is to certify that the thesis titled

**"ABSENTEEISM IN DISTRICT RURAL HOSPITALS IN THE EASTERN CAPE: THE EXPERIENCES OF NURSES"**

written by

**LINDILL JONAS**

Was Reviewed for Technical Formatting and Editing by **RUKSHANA ADAMS**

Date: 31 AUGUST 2022
Signature: R. Adams