1. PART – I: INTERNSHIP REPORT

1.1 JAYPEE GROUP

1.1.1 About Jaypee Group:

The Jaypee Group is a 15,000 crore well diversified infrastructural industrial conglomerate in India with over 50,000 employees. Over the decades it has maintained its salience with leadership in its chosen line of businesses:

- Engineering and Construction
- **Cement**
- **Power**
- **Hospitality**
- **Real Estate**
- **Expressways and Highways**

Shri. Jaiprakash Gaur, Founder Chairman of Jaiprakash Associates Limited after acquiring a Diploma in Civil Engineering in 1950 from the University of Roorkee (now Indian Institute of Technology Roorkee), had a stint with Govt. of U.P. and branched off on his own, to start as a civil contractor in 1958, group is the 3rd largest cement producer in the country.

Jaypee Group is five decade old conglomerate based in Noida, India, involved in various industries that include Engineering, construction , Cement, Power, Hospitality, Real Estate, Expressways, Highways, Education and Social Commitment. The groups cement facilities are located today all over India in 10 states, with 18 plants having an aggregate cement production capacity of 24 Million Tonnes and same is poised to become 36 Million Tonnes before October 2011.

1.1.2 Spread of the company:

Cement:

Jaypee Group is the 3rd largest cement producer in the country. The group produces special blend of Portland Pozzolana Cement (PPC) under the brand name ‘Jaypee Cement’.

Engineering & construction:

It has the unique distinction of having simultaneously executed 13 Hydropower projects spread across 6 states and the neighboring country Bhutan for generating 10,290 MW power

Sports:

The Group finished the construction and execution of India's first ever F1 Grand Prix on 30th October, 2011. In addition to F1, the track will also host other top-level international motorsports events from 2012 onwards.

Hospitality:

The Group's hospitality business owns and operates 6 properties spread across New Delhi, Uttar Pradesh and Uttarakhand.

Education:

"People of resources must contribute towards making a better tomorrow for all". Shri Jaiprakash Gaur, Founder Chairman of the Group firmly believes that quality education on an affordable basis is the biggest service which, as a corporate citizen, we can provide.

Real estate and expressways:

Stretching over 452 acres, it also includes residences, commercial spaces, corporate park, entertainment and nature in abundance. Jaypee Greens also launched its second project in Noida in November 2007. India's First Wish Town, is an Integrated Township spread over 1162 acres of land comprising one 18 hole and two 9 hole golf facility & world class residences.

Social commitments:

The Group has always believed in "growth with a human face" and to fulfill its obligations it has set up Jaiprakash Sewa Sansthan (JSS), a 'not-for-profit trust' which primarily serves the objectives of socio – economic development, reducing the pain and distress in society. For over 4 decades now, Jaypee Group has supported the socio-economic development of the local environment in which it operates and ensured that the economically and educationally challenged strata around the work surroundings are also

benefited from the Group's growth by providing education, medical and other facilities for local development.

Some of the commitments of the Jaypee Group include:

Jaiprakash Sewa Sansthan (JSS)

Comprehensive Rural Development Programme (CRDP)

The activities are carried out on a regular and continual basis and thus far the following initiatives have been undertaken:

- **Drinking water/Water Supply in selected areas**
- **Self Employment**
    - Tailoring courses for women
- **Village Roads**
- Literacy campaign
    - **Balwadi**

      Till date 166 Balwadi organized & 6300 children admitted & all 26 are villages covered.
    - **Young Girl Project**

      Special attention is given to young girls [8 – 14 years] who have never attended school. A pilot project with 42 girls is progressing, which would enable these girls to become literate. First batch of 6 students have appeared in Class-V examination.
    - **Adult Education**

      Conduct adult education campaign.
- Renovation of School Buildings and Development of Village Infrastructure.
- **Jal Sangrahan Yojana**

  Three Water Reservoirs have been developed in the Mines area. With these, not only the depleting water level in the surrounding villages has been arrested, but in fact the ground water level has increased by over 1 meter in last five years.
- **Health Care and Medical Facilities:**

The free medical facilities given at these hospitals and dispensaries include the following

- Free Consultancy
- Free Medicine
- BQ Camp
- ECG
- X-Ray
- Lab Facilities

➢ **Medical Camps:**

The group on a year round basis conducts year round medical camps. Some of which are:

- **Pulse Polio camps**
- **Jachaa Bachaa camps**
- **Health Checkup of Village Children**
- **Health & Hygiene Awareness Camps**

Information technology:

The Group's InfoTech arm JIL Information Technology Limited (JILIT) specializes in providing services in the area of:

- IT Infrastructure Management
- Preparing HMIS for hospitals
- Software Development & Consultancy
- Multimedia Services
- Content Management, Security & Delivery
- Multimedia based Educational Content Development
- Agricultural Content Development
- Learning Solution

1.1.3 Leadership team:

Fig: 1. The leadership team

1.1.4 JAYPEE MEDICAL CENTRE:

Jaypee Medical Centre hospital is a flagship project of the Jaypee Group coming up in Noida (NCR), UP. The Medical Centre is planning to establish 8-10 hospitals across India by 2015 with combined bed strength of 5000 and will be one of the fastest growing chains of super-specialty hospitals in India. It plans to position itself as ethical, customer friendly and quality driven organization that will bring innovation and good clinical practices of international standards to the country. The first phase of the project will have 500 beds at Noida centre.

Fig: 2. A prototype of Jaypee Medical Center (JMC)

Overview of Jaypee medical center:

- Flagship Hospital of the Jaypee Group
- Spread over 110000 Square Meters of campus
- Total Beds: 1000 beds. (505 Beds in Phase 1)
- Proposed Nursing college on campus
- Would be a LEED Certified building
- Would target for Joint Commission International accreditation in first year.

The logo of Jaypee medical center:

Fig: 3. The JMC logo.

About the logo:

- **The leaf** represents that we are environment friendly and follow medication safety. The sharp edges and corners represent the modern side (cutting edge technology and world class infrastructure) and the rounded corners represent the patient-care side of Jaypee Medical Center.
- **The Blue** in Jaypee is identified with Confidence, Credibility and Competence, represents Jaypee Medical Centre's multi-disciplinary capability, cutting edge technology and service foundation built on world-class infrastructure and processes.
- **The Orange** represents the vibrancy, high energy and 'lets make it happen' attitude of our people.
- **The Orange** in leaf and Medical Center represents that we are a New Life in the group which is supported by Blue Leafs and J of Jaypee Group as pillar of strength.

Vision / mission - Jaypee medical center:

Promoting healthcare to the common masses with the growing needs of society by providing quality and affordable medical care with commitment."

-Founder Chairman's Vision on Healthcare

Mission:

"The Jaypee Group is committed to meet the healthcare needs of the population in Noida and the surrounding regions through building Jaypee Medical Center as a super specialty hospital with advanced healthcare facilities, the latest diagnostic services, and state-of-the-art technology focused on medical specialties that meet the needs of the population. The Jaypee Medical Center will be the ultimate choice for medical care."

Jaypee group –healthcare philosophy:

Three Secondary care medical facilities currently operational at –Bhutan, Rewa (M.P) & Baspa (H.P) providing care to approximately One million lives treated annually.

Other Healthcare Initiatives - Medical Camps, Pulse Polio Camps, Maternity camps, Health Checkup of Village Children, Health & Hygiene Awareness Camps

Mobile Medical Van (with Lab and other diagnostic facilities) Diagnosis and medicine distribution free of cost (about 100 patients per day).

Pillars of Jaypee medical centre:-

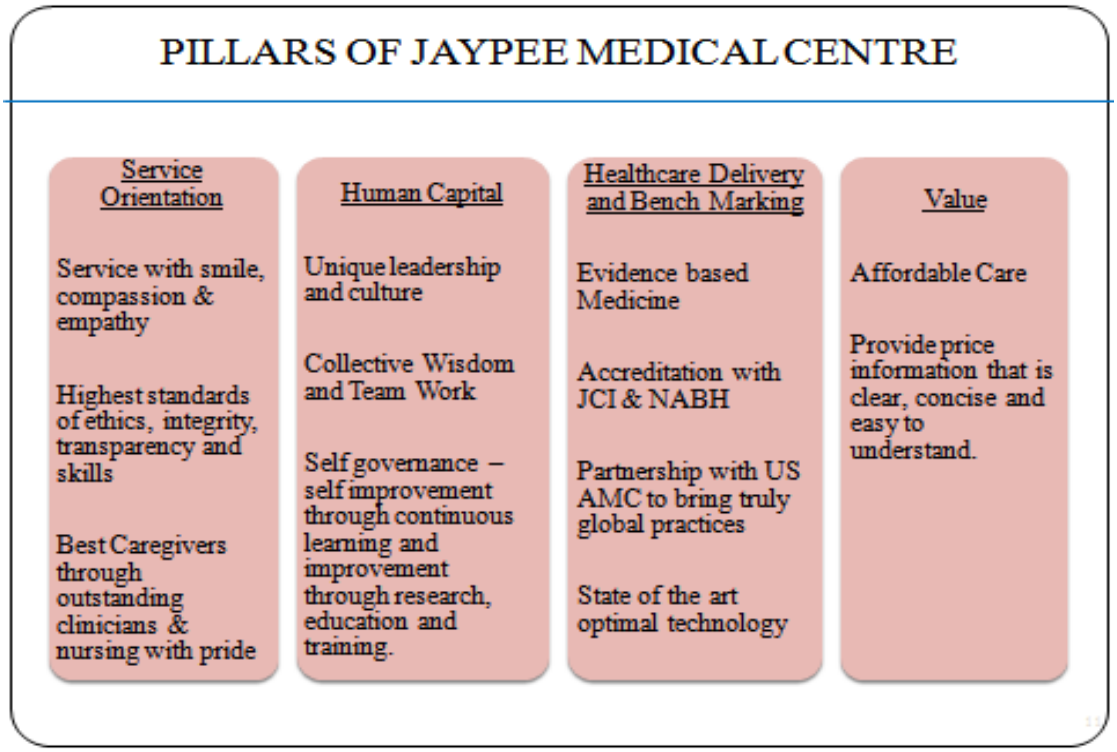


Fig: 4. Pillars of Jaypee medical centre

Services to be offered:

Fig: 5. Services to be offered

Floor wise departmental planning:

Table: 1. Floor wise departmental planning

Sl. No.	FLOOR	DEPARTMENTS
1	Seventh	wards
2	Sixth	wards
3	Fifth	wards
4	Service	IT Server, AHU, PTS station and MEP
5	Fourth	OT Complex, ICCU, Cath lab.
6	Third	Economy Bed, IVF, MICU, SICU, NICU, LDR.
7	Second	Chemotherapy, Cosmetology, Endoscopy, Physiotherapy, Paediatric, Office.

Sl. No.	FLOOR	DEPARTMENTS
8	First	Behavioural science, Ortho. Neuro. Gen. Surgery/MAS, Pulmonology, Opthal. Dantal, ENT, Diabetes Cardiac.
9	Ground	Executive Health Check up, Dialysis, Radiology, Day care, Emergency and Trauma, Pharmacy.
10	Upper basement	Blood Bank, Pathology Laboratory, Nuclear medicine, Kitchen, Administration.
11	Lower basement	Bio-medical Eng., Radiation Oncology, Laundry, Mortuary, CSSD.

1.2.Managerial task performed during the internship period:

1.2.1 Market survey and product landscaping of biomedical equipments:

Along with the project I was assigned for the market survey and product landscaping of various high-end bio-medical equipments of the six major departments viz:

- Radiology
- Radiation oncology
- Nuclear medicine
- Cath-lab
- Critical care units
- Operation theatre

The responsibilities in this segment of work include the following:

- An extensive online search of the various market players of biomedical equipments in the above mentioned segments/departments.
- Preparation of a tool for data collection regarding the survey.
- The tool included the make, model and specifications of the various high-end equipments of the above mentioned six departments.
- The data was collected from around 20 corporate hospitals regarding the make, model and specifications of the same.
- The analysis was conducted through a team approach.

The outcome of the project:

Through this segment of work I have got practical exposure to utilize my knowledge and skills of the marketing module: product, market analysis, market share, market segmentation, etc.

1.2.2. Planning of endoscopy department:

In this activity, I have got ample opportunity to utilize my knowledge and skills derived through the operations and quality module.

The planning of the department is done on the basis of 3 components that were being taught in the above modules i.e. structure, process and outcome under the guidance of Mr. Piyush Kumar, asst. manager, operations. The following are the activities done while planning the endoscopy department:

- An extensive study of the layout and the interior design laid down by Raglan squire and partners (RSP-company outsourced for architectural layouts and designs) and Design Worldwide Partnership (DWP- company outsourced for interior) followed by visit of the project site of the concerned department.
- Planning of entry and exit routes for patients, staffs and utilities.
- Formulated the organogram, activity flow and manpower requirements for the department.
- Drafted the list of registers to be maintained.
- Drafted the requirements of equipments, materials, consumables and furniture.
- An extensive study of the environmental requirements for the endoscopy department.
- Quality indicators for the concerned department.
- An extensive study on the service mix available at other corporate hospitals.

Along with these, I was also involved in other areas like:

- Preparation of manual and SOPs of various other departments like pathology laboratory and nursing.
- Preparing a database for the normal values of the laboratory investigations necessary for the development of HMIS.

- Formulation and drafting of form for various departments like ICU, wards, laboratory, endoscopy, etc

1.3 Reflective learning:

During the course of internship I got ample opportunity to utilise my theoretical knowledge of the hospital quality module during my exposure to my assignment on planning of endoscopy department.

The quality module has 3 basic components:

- Structure,
- Process, and
- Outcome.

Structure: This segment comprises of the design and layout of the department and as well as the infrastructural requirement necessary for the setting up of the department. Through this component I learnt to study the layout of the department, planning the entry and exit route plans for patients, staffs as well as materials. Followed by this the structural planning was continued with the environmental requirements for the setting up of the particular department maintaining the quality and standards. The other segments under this were to formulate the organogram, manpower requirements, equipment and furniture requirement, service mix, etc.

Process: Through this I learnt to design the process flow for the department and the other records and work instructions necessary to be maintained in the particular unit. The learning through this component will continue as I will be formulating the SOPs and Manuals for the Department under the guidance of senior staffs.

Outcome: Under this segment I learnt to formulate various quality indicators in order to measure the compliance as well as the performance standards of the department. The bench marks and the formulas for calculating the indicators will be developed in the forthcoming days.

Part II: INTRODUCTION TO THE TOPIC AND LITERATURE REVIEW

Causes of Attrition amongst the Nursing fraternity in Private Healthcare Facilities across the Delhi/NCR Region: A cross-sectional study.

2. Chapter – I: Introduction

"Not enough here…… Too many there……."

-Unknown

2.1 Background of the study:

2.1.1 Health workforce in India:

A critical ingredient for building an effective and responsive health system is the health workforce which includes physicians, nurses, public health workers, policy makers, administrators, educators, clerical staff, scientists, pharmacists and health managers amongst others (http://whoindia.org/en/Section2/Section404.htm). Human resources in health care are central to its functioning. They play a crucial role in determining the health status of the population as they contribute different skills and undertake various tasks in the health system. Today, we are witnessing a growing challenge to maintain the needed numbers, quality, mix and distribution of personnel to meet the healthcare needs of the population. This scarcity of health care workers negatively affects the quality and efficiency of services provided by a country's health system.

While India is being propelled to a position of international eminence, it faces three main groups of challenges: first, dealing effectively with unfinished agendas of communicable diseases, maternal and child health, and health systems strengthening; second, dealing with new emerging challenges such as premature burden of non-communicable diseases; and third, dealing with globalization related issues while contributing to the management and shaping of the global policy environment. In addressing these challenges, the health workforce is confronted by shortages, migration, issues of quality, accountability, public-private coordination, and the complexity of service provision to large and diverse populations.

The perception of human resources in India depends on the eye of the beholder: it can appear as a half empty glass or just as equally it can appear half full. Leveraging the country's existing human resources and planning for tomorrow is an ongoing challenge. Nonetheless, it is important to approach the underlying issues with a forward-looking perspective that brings together the pragmatism of resource planning with the strength of evidence.

2.1.2 The definition of employee turnover:

Organizational turnover has sometimes been defined as ''the ratio of the number of organizational members who have left during the period being considered divided by the average number of people in that organization during the period'' (Price, 1977) and it is often detrimental to the effective functioning of an organization.

On the other side, Adams and Beehr (1998) provided a definition of organizational turnover ''turnover involves 'leaving any job of any duration' (Feldman, 1994) and is usually thought of as being followed by continued regular employment''.

Similarly, managers analyse the employee turnover as the entire process associated with filling a vacancy. Each time position is vacated, either voluntarily or involuntarily, a new employee must be hired and trained. This replacement cycle is known as turnover (Woods, 1995). This term, employee turnover, is also often utilized in efforts to measuring relations of employees in an organization as they leave, regardless of reason (Gustafson, 2002).

2.1.3 Employee turnover in India:

Employee turnover has always been one of the challenges to the human resource managers and the respective employers in any fast growing economies including the country like India. Most of the employers in the country are not aware of why employees choose to leave their organizations and why they stay. Employees who leave on the organization's request as well as those who leave on their own initiative can cause disruptions in operations, work team dynamics and unit performance. Both types of the turnover create costs for the organization.

However, retaining their best employees; managers must make sure their organizations clearly communicate expectations about rewards, working environment and productivity standards and then deliver on the promise. Having said that employee turnover being such a serious problem in organizations, there is limited research investigating it, especially studies on causes are scanty. This paper examines the causes of employee turnover, and suggests some strategies on how to reduce employee turnover of India's heath care system.

2.2 Problem statement:

A cross-sectional study to identify the causes of attrition among the nurses of private and corporate hospitals in Delhi, NCR.

The attrition rate in Max Healthcare is 34-36 per cent. I would not call it critical but definitely important enough to be addressed," shares Surajit Banerjee, Director HR, Max Healthcare, Delhi (*http://www.expresshealthcare.in/201005/healthcarelife01.shtml*).

To find a substitute is always a key challenge in this case. He adds that recruiting and training programmes for employees is an expensive affair. The company has to invest a lot while recruiting an employee. But the situation gets worse when attrition happens at a key skill position, as there is already a scarcity of such resources in the market.

Attrition amongst Nurses

Recruiting and retaining nurses is fast becoming a point of concern for Indian hospitals. According to HR experts, attrition rate among nurses is the highest, varying from 28 per cent and 35 per cent as compared to the average 10.1 per cent healthcare sector attrition rate for 2005.

According to industry estimates, the current day requirement is for about 10.3 lakh nurses. At present, there are roughly nine lakh nurses registered with various nursing councils in India. Thousands have already migrated to greener pastures overseas. There are thousands more waiting in the pipeline, signed up with commercial chains that facilitate migration of nurses. In fact, there is a boom in the number of agencies helping nurses find jobs overseas.

2.3 Review of literature:

Nurses, along with other health care professionals, are involved in the direct delivery of health care to the population and therefore form an essential part of the health system. To overcome these shortages, the developed countries are undertaking active recruitment of foreign nurses. Most of the nurses migrating to the high income countries come from the developing countries (Buchan & Scholaski 2004). India is one of the major source countries providing nurses to the developed nations. The source country's health systems, especially the developing ones, face a severe loss of trained staff as the nurses migrate from both the public and private sector. A country with an already dismal health system suffers more when nurses migrate to other countries.

2.3.1 History of nursing in India:

Historically, nursing in India had evolved under British rule. The British Medical Services, later known as the Indian Medical Services, were the first to develop nursing as a profession in India. Between the periods of 1920 to 1939, many nursing schools were set up in different parts of India with the objective of standardizing nursing training (Gulani 2001). Nursing service has been considered an integral part of both the 'preventive and curative' aspects of the country's health system. The Indian Nursing Council, which was set up in 1950, provides nursing estimates of the country since its inception (Mathur & Manocha 1988).

The nursing programmes offered at present are basic and post-basic B.Sc degree (nursing), General Nursing & Midwife (GNM) diploma, Auxiliary Nursing & Midwifery (ANM) diploma, M.Sc (Nursing), M.Phil (Nursing) and Phd (Nursing) (Kumar 2005).

2.3.2 Nurses in India:

Nurses and midwifery personnel comprise of around 70% of all the health personnel of health care system. Their responsibilities include health promotion, disease prevention, care and rehabilitation of patients both in hospitals and in the community. The practice of nursing, at present and in the past has encountered quite similar recurring problems. Shortages of nursing personnel occur continually. The shortage also occurred in the private sector due to a high turn-over rate when compared to the government sector as they are highly paid now.

Employee turnover is expensive for organisations since they incur significant costs, both direct (for example, costs of recruitment and selection, training and development, etc), and indirect (for example, employee commitment, service/product quality, productivity and profit) (Griffeth et al., 2000; Kinicki et al., 2002; Price, 2001; Mobley, 1982). With respect to the causes and correlations of employee turnover, studies have been conducted from numerous perspectives. Cotton and Tuttle (1986) identified three categories of causes of employee turnover:

- Work-related factors (for example, job satisfaction, pay, performance, organizational commitment);
- Individual factors (for example, age, education, sex, job tenure); and
- External factors (for example, unemployment rates, employment perceptions, Union presence).

The most studied work/job-related antecedent of turnover has been job satisfaction, which has typically been treated as an intervening variable. Most researchers agree that job satisfaction refers to the feelings one has about one's job (Locke, 1976; Robbins and Coulter, 1996). Furthermore, numerous western studies have generally supported a negative relationship between job satisfaction and employee turnover (Griffeth et al., 2000; Kinicki et al., 2002; Price, 1977, 2001), although in some cases it is not strongly related (Mobley et al., 1979; Wong et al., 2001).

2.3.3 Shortage of Nurses in the country and its causes:

Evidence from the turnover literature suggests that nurse turnover rates are not only high, but high relative to other female dominated occupations (Aiken 1983, Stamps and piedmonte 1986). A synthesis of the literature suggests that personal and professional dimensions constitute the two overarching categories of factors influencing nurse turnover.

A comparison of health indicators of India with other developing countries shows that the mortality levels experienced in India remain quite high. In India, the IMR in 2004 was 62 per 1000 live births, and MMR in 2000 was 540 per 100000 live births. Sri Lanka, another developing country from the South-East Asian region, had an IMR of 12 per 1000

live births in 2004 and MMR of 92 per 100000 live births (WHO 2006 a). India's population constitutes 17 per cent of the world population, whereas it accounts for 20 per cent of global disease burden (GOI 2007).

The disparities in health status in India can be observed across the rural-urban regions and amongst the states. The differences in health status of the population of India reflect in part the disparities in terms of the availability and accessibility of health services. Nurses represent the largest share, i.e. 38 percent, of the total health workforce of India (Rao, Bhatnagar, Berman, Saran, & Raha 2008). The nurse to population ratio found in the country is suggestive of the shortage of nursing personnel existing in the country. The nurse to population ratio found in India stood at 0.80 nurse per 1000 population in 2004, which brings out the fact that not even one nurse is available to a population of 1000 in the country (WHO 2006 a).

The distribution of nurses in India presents a picture of imbalance across states. The state with low mortality rates reported higher availability of nurses as compared to the states experiencing low health status. The rural-urban distribution of nurses showed that more nurses preferred working in the urban areas. However, the need for nursing services is more in the rural than the urban areas because of lower health status and higher mortality rates experienced by rural population. The nurses working in urban areas were nearly three times more in number than the nurses employed in the rural areas (Rao, Bhatnagar, Berman, Saran, & Raha 2008).

The nursing profession in India lacks high professional status, has low and unattractive salaries, gets inadequate recognition from the community for the services provided by them and has little incentives for quality performance (Gill 2009). The institutions responsible for nursing training lack the required physical and human resources. Most of these training institutes work as appendages to hospitals (Kumar 2005).

Professional, social and economic reasons can be considered behind the nursing shortage in India. The rural job preference amongst nurses is shaped by factors such as living conditions, chances of sexual harassment at the workplace, personal and professional

growth opportunities, intellectual stimulation, transportation, availability of jobs for the spouse and educational facilities for their children (Harnar & Lehman 1987).

The nursing profession continues to be neglected in India. Some of the causes behind this neglect are more emphasis on medical education, political influence by the medical community and less allocation of financial resources on health by the Indian government (Rao, Rao, Kumar, Chatterjee, & Sundararaman 2011).

The nursing profession is given low social status because of the prevalent religious and societal traditions. Nursing work involves rendering services on a personal level to the patient and has chances of being exposed to bodily fluids and contaminations. The work undertaken by nurses still has social stigma attached to it (Nandi 1977). This can be cited as one of the main reasons behind the low perception held by the Indian society towards the nursing profession. The nurses are considered to be secondary in position as compared to other health professionals in India. There is a vast difference in the prestige and recognition accorded to doctors as compared to nurses (Gill 2009).

The professional and financial incentives to retain qualified nurses in the country are found to be inadequate. The attrition rate of nurses is highest among health personnel in the health care industry of India (Business Line 2004, The Economic Times 2008, Business World 2008). The scarcity of nurses in the country is leading the private health sector to fill its demand by employing untrained nurses or undertaking nurse poaching from other health institutions. The public health institutions are facing the dual challenge of dealing with the existing shortage of nurses and the loss of trained nursing personnel to private health organizations and other countries.

2.3.4 International migration of nurses from India:

Earlier, a few Indian nurses used to migrate because earning prospects were high. This helped them to send remittances back home, which were used for various purposes, e.g. building a new house, financing children's education and for a small business that the husband might start. But, in the post-1980's there was a shift to mass migration of nurses from India, most of them belonging to the state of Kerala (Nair & Percot 2007). India has been discovered as a new source country for recruiting well trained, English speaking

nurses by the high-income countries to overcome shortage of nurses faced by them. The migration of nurses from India can be traced from the decade of 1970's (Meija, Pizurki, & Royston 1979).

The majority of the nursing workforce in the country is represented by Keralite Christians, who comprise a large section of the nurses migrating from India (Nair & Percot 2007). Nursing is taken up by women as part of their family strategy in which their education and migration constitute a vital part of the entire process. The majority of nurses in India come from lower-middle class families (Percot & Rajan 2007).

Migration is an on-going process with few chances of the nurses coming back to India. The government of India sees a positive factor in the increase of foreign opportunities for Indian nurse. The National Commission on Macroeconomics and Health mentions "in fact, with the large number of opportunities opening up for employment in foreign countries, particularly for nurses, it would be to India's advantage to focus on expanding the number of colleges and nursing schools alongside efforts to ensure good quality to make them employable" (GOI 2005, p. 63).

2.3.5 Consequences of migration of healthcare personnel:

The migration of health workers from India leads to the non-availability of standard quality health services to the poor section of the population as most of them depend on the public health care system, particularly in the states which provide low incentives to health workers. The biggest challenge faced by the public health care system is the shortage of skilled health human power in the country. There is an acute scarcity of nurses in the country. Most of nurses who migrate abroad are highly experienced. Thus, loss of qualified staff can severely impact the functioning of health systems in the country. Migration of skilled health personnel from developing countries, especially in Sub-Saharan Africa has led to virtual collapse of health systems in the region. Consequences of international migration in extreme cases have been measured in lives lost (WHO 2006 b).

Thus, the health professionals migrating may not constitute a high proportion of the health workforce for the destination country, but loss of the health workers can represent

a significant proportion of HRH (Human Resource of Health) of the source countries. Nursing migration can further augment the existing nursing shortage in the country.

2.4 Objectives:

The general objective of this study is to identify the causes of attrition among nurses in various departments in Delhi, NCR region.

The specific objectives are:

- To know the prevalent causes of attrition amongst nurses across functions.
- To understand the nursing staff behavioral intent to leaving job in various situations.
- To find out the retention factors for retaining nurses.

3. CHAPTER – II: METHODOLOGY

3.1 Search Strategy:

The aim of this study was to explore the prevalent causes of attrition among nurses in various departments in Delhi, NCR region. In order to extract relevant research from the published literature to achieve this aim the electronic databases from proquest and other online news and journals were searched. Keywords were 'nurses', 'retention' and 'job satisfaction' with synonyms and phrases being used as appropriate (for example, the term retention was used and combined with attrition, intent to leave, intent to quit, propensity to leave, intent to stay and turnover). The years 2002 - 2012 were chosen as a limit option in order to select only recent published work. That may hold more relevance for the nursing profession today due to the rapidly changing nature of nursing over recent years. Where possible, the search was globally limited to research and manually where electronic search limits were not possible. Specific criteria for inclusion and exclusion (Table 2) were also applied to ensure fulfilment of the aim of this study and manual scanning of abstracts was undertaken for the purpose of checking article suitability.

Table: 2. showing criteria for inclusion and exclusion of articles

Inclusion	Exclusion
The registered nurses who are willing to participate in the study.	Primary centres/ public health /nursing homes/ military Nursing.
Nurses who are present at the time of conducting the study.	All government hospitals
Nurses in wards, OPDs and critical care units	

3.2 Study design:

A cross sectional survey study was conducted in a few of the corporate/ private hospitals across the region of Delhi, NCR. The study on the causes of nurse attrition explored all the possible causes for the attrition through review of literature from secondary databases.

3.3 Variables:

Both dependent and independent variables were used in this research survey. The independent variables include age, sex, qualification, marital status, total experience, etc whereas the dependant variables include all the possible causes responsible for the attrition of nurses like insufficient compensation, incentives, international opportunities, conflicts, maternity, peer-group relations, distance, hostel facilities, etc.

3.4 Population and sample size:

The target population included all full-time registered staff nurses of the selected hospitals of Delhi, NCR region. A non-probability convenient sampling was adopted to select the samples for the study. A total of 120 questionnaires were distributed among various wards of the selected hospitals of Delhi, NCR. Data were collected over a period of 1 month.

3.5 Ethical considerations and Data collection techniques:

The data for the study was gathered through survey method. Data collection began after approvals were obtained from the study organisation. Then the nursing superintendents of the respective hospitals were contacted for approval for survey followed by scheduling of dates for administering the survey.

3.6 Instrument/Questionnaire:

A self-reported questionnaire was developed through secondary research reviews. The first part included the independent variables (demographic details) whereas the second part was divided into two sections: section A mentioning all the possible causes (23 causes) of attrition among nurses and Section B describing the reaction of nurses to certain situation (20 possible situations) if arises on an organisation.

All the survey questionnaires were administered directly to the nurses and returned back in the same manner. The cover letter indicated that all the data would be used for research purpose only, all information was confidential and their participation was voluntary.

A total of 120 questionnaires were distributed and 112 were returned back which results to a response rate of 93.33%. Out of the 112 samples received, 8 samples were rejected due to the inadequate/partial fulfilment of the data remaining with 104 usable samples.

The responses of the respondents were made on a 3 and 4 point likert-type scale for Sec – A and Sec – B respectively.

3.7 scoring keys:

Table: 3. The scale for the causes of attrition (sec A)

scale	score
Major reason	2
Minor reason	1
Not at all a reason	0

Table: 4. The scale for the second part of the Sec – B

scale	score
I shall remain in the current job	1
I shall intend to leave my current job as soon as I find a better one	2
I will actively look for a new job	3
I would like to quit my current job immediately	4

3.8 Data analysis:

The data collected was entered in the statistical package for social sciences (SPSS) version 16.0 for further analysis. The reliability of the scales has been measured by Cronbach alpha.

An initial analysis was carried out with frequency and percentage distribution which was later followed with factor analysis. An average of all the scores of the data collected was taken to rule out the factors to be considered. The factors with an average of more than 1.5 and 2.5 for sec A and sec B respectively were considered as influential factors and were carried for ward for factor analysis.

3.9 Scope of the study:

The study was limited to only four major Corporate Hospitals in Delhi, NCR region and no government hospitals were included. The samples were constrained to major 3 areas viz. OPD, IPD and Critical Care Units (including OTs and ICUs). The study was time bound (for a period of three months).

4. CHAPTER – III: RESULTS AND FINDINGS

4.1 Demographic Findings:

Total number of Staff Nurses in the selected 4 hospitals for the survey was 4212.

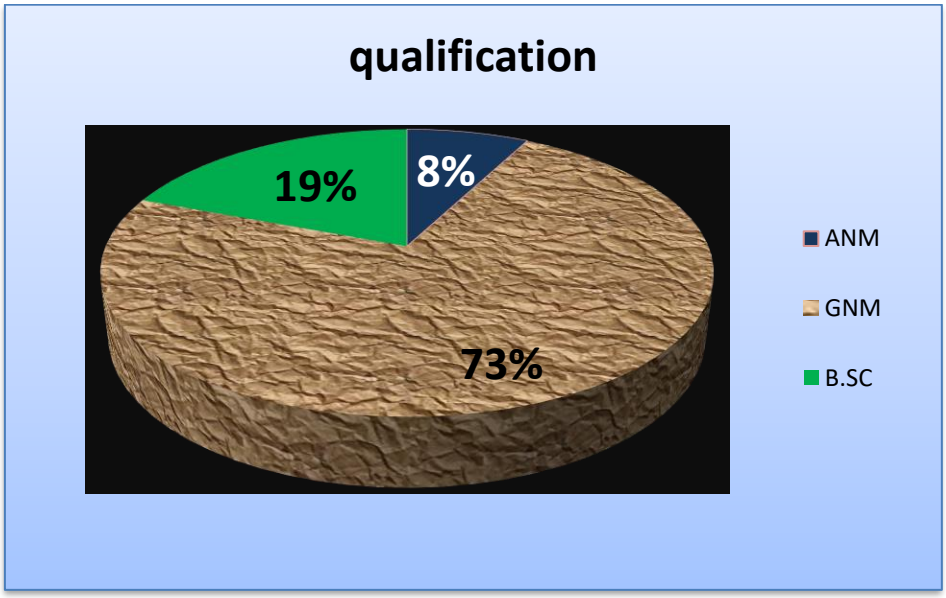
Table: 5. Frequency and percentage distribution of demographic variables.

Demographic variables	Frequency	Percent
Age		
20-30	84	80.8
31-40	20	19.2
Sex		
Male	15	14.4
Female	89	85.6
Qualification		
ANM	8	7.7
GNM	76	73.1
B.Sc	20	19.2
Marital status		
Married	29	27.9
Single	75	72.1
Present department		
OPD	27	26
IPD	30	28.8
Critical care	47	45.2
Past department		
OPD	24	23.1
IPD	41	39.4
Critical care	39	37.5
Total experience		
Less than 5yrs.	76	73.07
5-10yrs	24	23.08
More than 10 yrs	4	3.85

Out of 104 samples participating in the study, majority of the sample (80.8%) belongs to an age group of 20-30yrs while the rest (19.2%) are from an age group of 31-40yrs.

About 15 respondents were male and rest (89) were female. Most of the staff nurse had a qualification of GNM (73.1%) and the rest of the samples had a qualification of ANM and B.Sc.

Graph: 1. Demonstrating Qualifications of the samples involved in the study.



Majority of the samples (73.07%) had an experience of less than 5yrs and 59 samples (23.07%) ranges with in an experience from 5-10yrs where as only 3.85 of the sample have an experience of more than 10yrs.

Graph: 2. Demonstrating Experience of the samples involved in the study.

The table 6 below describes the frequency and percentage distribution of all responses of the possible causes for attrition.

4.2 **Analysis of the factors involved in Sec – A:**

Table: 6. Frequency percentage and average distribution of samples (Sec-A).

		not a reason	minor	major	average
Work profile was not satisfactory	frequency	62	30	12	1.03
	percent	59.6	28.8	11.5	
Insufficient Compensation	frequency	36	42	26	1.81
	percent	34.6	40.4	25	
Other incentives	frequency	71	25	8	0.79
	percent	68.3	24	7.7	
Extended working hours	frequency	52	28	24	1.46
	percent	50	26.9	23.1	
Lack of training & development opportunities	frequency	73	21	10	0.76
	percent	70.2	20.2	9.6	

Lack of regular appraisals/ promotions/recognition	frequency	56	36	12	1.14
	percent	53.8	34.6	11.5	
Multiple reporting	frequency	83	18	3	0.47
	percent	79.8	17.3	2.9	
Conflict with immediate supervisor/manager	frequency	73	29	2	0.64
	percent	70.2	27.9	1.9	
Conflict with co-workers	frequency	94	9	1	0.21
	percent	90.4	8.7	1	
International opportunities	frequency	63	31	10	0.99
	percent	60.6	29.8	9.6	
Work overload	frequency	59	22	23	1.29
	percent	56.7	21.2	22.1	
Family issues	frequency	86	12	6	0.42
	percent	82.7	11.5	5.8	
Spouse on a transferable job	frequency	83	18	3	0.43
	percent	79.8	17.3	2.9	
Health issues	frequency	83	20	1	0.43
	percent	79.8	17.3	2.9	
Sole earner	frequency	85	17	2	0.40
	percent	81.7	16.3	1.9	
Maternity	frequency	94	5	5	0.29
	percent	90.4	4.8	4.8	
No childcare facilities in the organization	frequency	85	12	7	0.51
	percent	81.7	11.5	6.7	
Lucrative/better job opportunity	frequency	33	39	32	1.96
	percent	31.7	37.5	30.8	
Salary/position enhancement in the other organization	frequency	32	33	38	2.13
	percent	31.1	32	36.9	
Relationship between peer group	frequency	50	28	26	1.52
	percent	48.1	26.9	25	
Distance between home and workplace	frequency	80	13	11	0.68
	percent	76.9	12.5	10.6	

Absence of transport facility	frequency	89	13	2	0.33
	percent	85.6	12.5	1.9	
Lack of Safety and security	frequency	86	15	3	0.41
	percent	82.7	14.4	2.9	

From the Table 1: it was observed that though work profile was not a major reason for attrition of nurses but when looking at the overall reasons of attrition it account for nearly 40%, which cant be ignored.

Insufficient compensation and other initiative provided were also responded by some nurses but that does not make a good bulk of response so can be neglected.

Conflict with co workers and family issues were least reported responses registered during the interviews. That means these issues barely contribute to attrition.

Distance between workplace and home and absence of transportation was never a problem for most of the nurses as they might be living in nearby areas and transportation is never a big problem in metros. So these responses also do not contribute to attrition.

Women safety was thought to be a important factor before the study but at the end of study it is found that this is not a challenge for nurses at least in metro cities as very few nurses considered it a factor for attrition.

Maternity and childcare facilities are also among the least recorded response4s and hence can’t raise significant issues.

Spouse on transferable job, family issues and or health issues are also not good reasons for attrition as very few nurses have reported them as factor responsible and cause of there concern.

To be sole earner is also not a good reason to shift the job as soon as he/she is ok with job. Very few nurses registered this as an issue.

International opportunity was considered an important factor before the study but results shows that very few nurses are actually considering it a reason to shift the job.

Any type of conflict either with supervisor or with co-workers was not recorded much in responses. Although conflict with supervisor showed some good responses than co-worker but still both reasons account for few responses, hence can be ignored.

Lack of training and development and other initiative are among the few factors which are reported very less as it is widely practiced in hospitals now a days.

Increases in salary and better job opportunities and problem between peer groups are among the strong factors in the study as due to heavy work load and less compensation t5here is always a cloud of tension between nurses and they try to shift if provided good profile and increment.

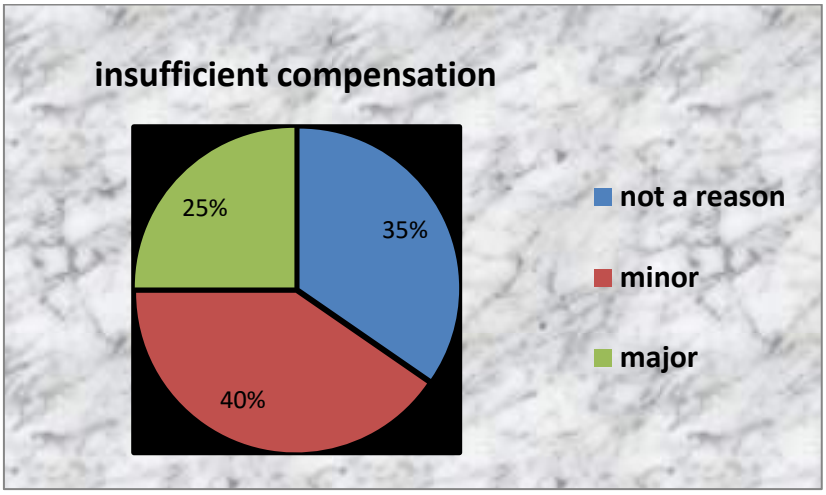
Extending working hours and heavy Work load are also among the common reason to shift the job as nurses in hospital are doing clinical and administrative job. They are expected to work overtime with no increase in compension and this becomes the reason for job shifting.

Multiple reporting is also not a big issue for nurses as it is being minimized in hospitals now days. Our study also reported few responses regarding that.

Lack of regular appraisals/ promotions/recognition is a important factor for attraction as nurse work in most cases being ignored and not valued. This was an important factor before the study also.

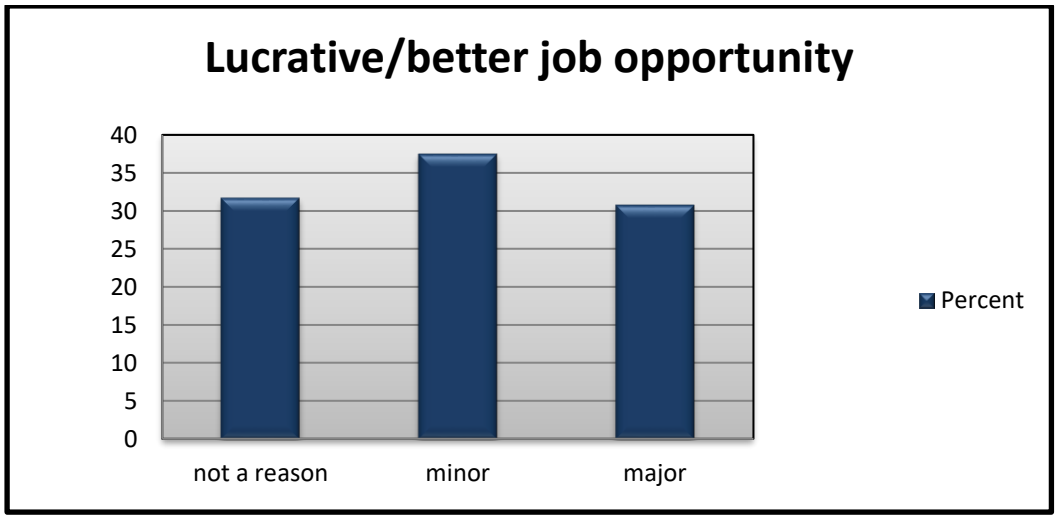
About 65% of the samples regard insufficient compensation to be a cause (25% major and 40% minor) for attrition.

Graph: 3. Demonstrating Factor- insufficient compensation of the samples involved in the study.



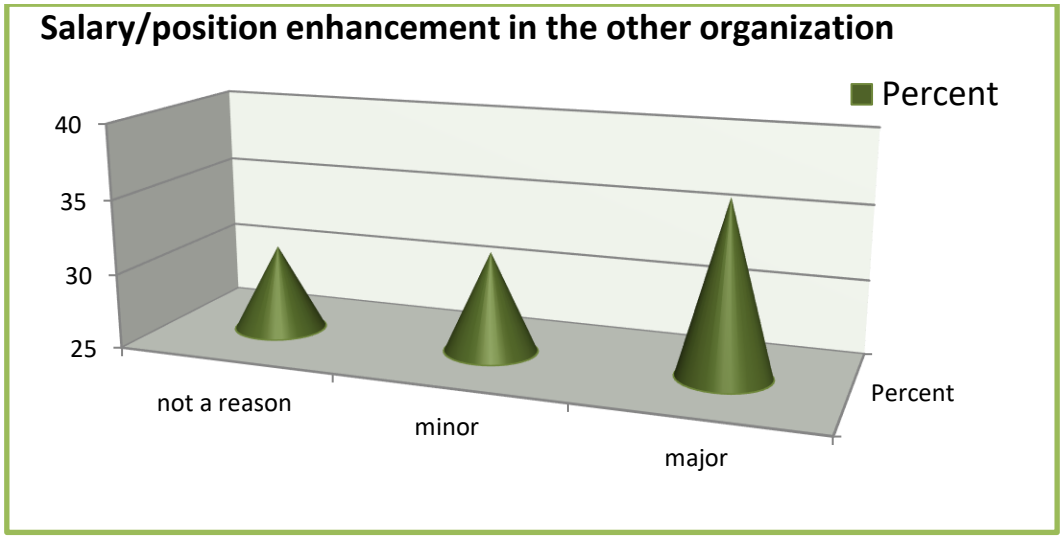
About 68.3% of the samples regard Lucrative/better job opportunity to be a cause (30.8% major and 37.5% minor) for attrition.

Graph: 4. Demonstrating Factor- Lucrative/better job opportunity of the samples involved in the study



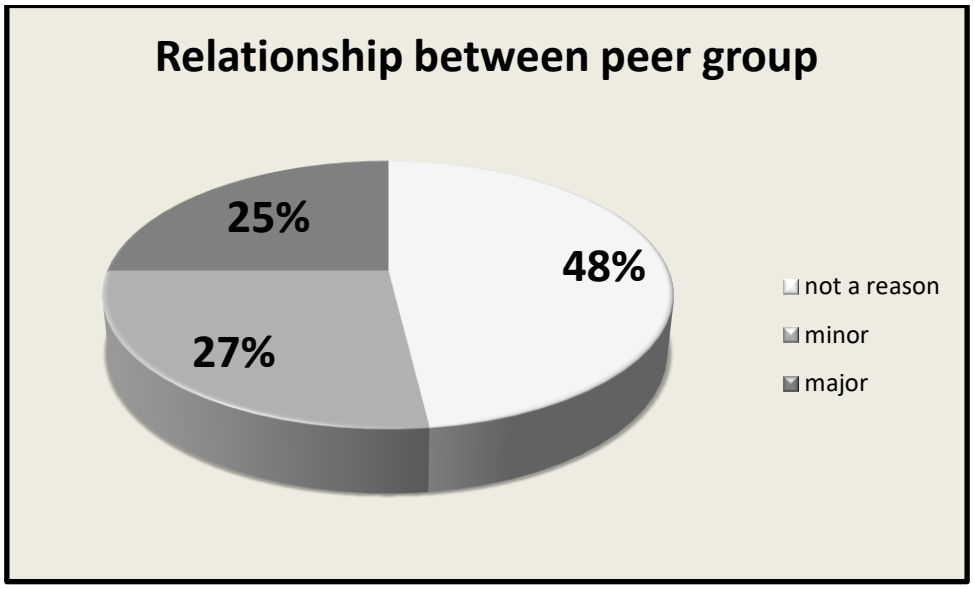
About 68.9% of the samples regard Salary/position enhancement in the other organization to be a cause (36.9% major and 32% minor) for attrition.

Graph: 5. Demonstrating Factor-Salary/position enhancement in the other organization of the samples involved in the study



From the graph below it can be interpreted that 25% (26 respondant) of the samples regards the particular cause to be major and 27% (28 respondant) as minor cause for attrition which can be combinedly interpreted as 52% (50 respondant) of the cases regards the peer group relationship to be a cause for attrition.

Graph: 6. Demonstrating Factor-Relationship between peer groups of the samples involved in the study



So, from the above graphs and table it can be interpreted that most of the attrition with in india occurs as a result of lucrative opportunities, salary or position enhancement in other organisations, lack of compensation in present organisation and peer-group relations.

Work overload and the extended working hours also play a quite important role in nunse's turnover.

On the contrary, it is seen that certain factors like being a sole earner, multiple reporting, maternity issues and having childcare facilities hardly influence that nurses for turnover.

Further, an exploratory factor analysis was carried out with the factors which has a mean of 0.4 and above.

The total variance explained in the analysis is 55.8%.

Through the factor analysis the eight factors which were reduced from the 23 causal factors were further narrowed down to three component : lack of job satisfaction, growth opportunities and working enviroment.

Table: 7. Total Variance Explained (Sec-A) of samples.

Total Variance Explained

	Initial Eigen values			Extraction Sums of Squared Loadings			Rotation Sums of Squared Loadings		
Component	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	2.045	25.564	25.564	2.045	25.564	25.564	1.548	19.349	19.349
2	1.295	16.189	41.752	1.295	16.189	41.752	1.513	18.909	38.257
3	1.131	14.131	55.884	1.131	14.131	55.884	1.410	17.626	55.884
4	.942	11.770	67.654						
5	.880	10.995	78.649						
6	.717	8.957	87.606						
7	.519	6.490	94.096						
8	.472	5.904	100.000						

Extraction Method: Principal Component Analysis.

Table: 8. Variables merged into factors through Factor analysis (Sec -A).

Sl No.	Variables	Factor	Factor Loading: Regression Weights Estimates	Cronbach's α
1	work profile not satisfactory Lack of regular appraisals/ promotions/recognition International opportunities	Lack of job satisfaction	.704 .656 .580	.417
2	Lucrative/better job opportunity Salary/position enhancement in the other organization	Growth opportunities	.834 .784	.558
3	extended working hours Work overload Relationship between peer groups.	Working environment	.770 .629 .637	.503

So, from the over all analysis it can be concluded that lack of job satisfaction, growth opportunities and working environment are the three components responsible for the job change of staff nurses in India.

4.3 Which cause employee attrition?

Table: 9. Frequency percentage and average distribution of samples (Sec-B).

	average
Challenging tasks faced daily	1.81
Routine work leading to boredom	2.09
Lack of growth opportunities and personal goals	2.45
Lack of appraisals/promotions	2.36
No clear definition of work profile	2.29
Inadequate Salary increment/s	2.61
No appreciation of work done	2.34
Lack or absence of flexibility/autonomy	2.31
No Job Security	2.97
Working environment not conducive to personal and professional growth	2.17
Health and safety hazards	2.62
Lack of training & development	2.31
Lack of Transparency and equality	2.61
No support, and guidance	2.54
No/Lack of team work	2.43
Lack of welfare activities	2.44
Salary/position enhancement in the other organization	2.67
Conflict with immediate supervisor/manager	2.51
No credit/Appreciation of work done	2.48
Use of abusive language by supervisor/manager/coworker	3.15

Here in the table the factors which have an average value of 2.5 or more is considered to be an influential cause for attrition.

Use of abusive language by supervisor/manager/coworker, No Job Security, and Salary/position enhancement in the other organization are among the most common and vital factors in the attrition of nurses. These need to be considered first and foremost.

Inadequate salary in the present organisation and lucrative salary are also among the common and vital factors in the attrition of nurses. As they are out of their home and expect decent profile and good salary.

Health and safety is a major area of concern which came out of study as hospitals are always a place for health related risk. Something immediately is required to be done to watch this.

Routine work, poor appraisal, poor salary and lack of growth and opportunity combined factor which make the work place worse for nurses and they are left with no option other than shifting.

Issues related to profile like poor flexibility, poor salary, workload, no defined profile are common cause of unhappiness in job. But are not very strong reasons to quit the job.

Lack of support, loose team work, poor appraisal and in equality is the loopholes of administration associated to nursing staff. These reasons may leads to job shift but at very adverse stage so they can be given second priority.

Lack of job security and conflicts with supervisor are also among the common factors for their thought to shift the job as working environment is negative in such circumstances.

An exploratory factor analysis was carried out with the factors which has a mean of 2.5 and above.The total variance explained in the analysis is 72.48%.

Table: 10. Total Variance Explained (Sec-B) of samples.

Total Variance Explained

	Initial Eigen values			Extraction Sums of Squared Loadings			Rotation Sums of Squared Loadings		
Component	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	4.023	44.701	44.701	4.023	44.701	44.701	2.316	25.735	25.735
2	1.420	15.781	60.482	1.420	15.781	60.482	2.199	24.435	50.170
3	1.080	12.002	72.484	1.080	12.002	72.484	2.008	22.314	72.484
4	.597	6.633	79.118						
5	.544	6.049	85.166						
6	.480	5.331	90.497						
7	.450	4.997	95.494						
8	.253	2.808	98.302						
9	.153	1.698	100.000						

Extraction Method:

Principal Component Analysis.

Through the factor analysis the nine factors which were reduced from the 20 factors were further narrowed down to three component : Organisational culture and financial security, Personal security and attitude of seniors and colleague. These 3 major components are to be taken into major consideration in formulating the retention strategies.

Table: 11. Variables merged into factors through Factor analysis (Sec -B).

Sl. No.	**Variables**	**Factor**	**Factor Loading: Regression Weights Estimates**	**Cronbach's α**
1	Inadequate Salary increment/s Lack of Transparency and equality Salary/position enhancement in the other organization	Organisational culture and financial security	.853 .719 .745	.713
2	No Job Security Health and safety hazards. No support, and guidance	Personal security	.739 .853 .773	.768
3	No credit/Appreciation of work done Conflict with immediate supervisor/manager Use of abusive language by supervisor/manager/co-worker	Attitude of colleague/seniors.	.75 .514 .932	.706

CHAPTER – IV: DISCUSSION

The main aim of the study is to find out the prevalent causes for the attrition of nurses in india and to consequently formulate the retention strategy.

From the analysis three causal component viz. lack of job satisfaction, growth opportunities and working environment are the dominating ones influencing the staffnurses to leave their job. When the related literature is considered, it is seen that satisfaction with work itself, pay, promotional opportunities and immediate superior were all negatively and strongly correlated with turnover intention. Weak negative relationships were observed between work environment, fringe benefits, and satisfaction with co-workers and turnover. Overall there is a negative relationship between job satisfaction and employee turnover intention (Wei (Amy) Tian-Foreman, 2009). The findings here also agree with a number of studies which have reported a consistent negative relationship between job satisfaction and turnover (Price, 1977, 2001; Mobley, 1982).

From the second section of analysis three components have been derived: Organisational culture and financial security, Personal security and attitude of seniors and colleague. So the sub factors of these components are to be taken into consideration while formulating the retention strategies.

5.1 Considerable factors for retaining the nurses:

Retention strategies focus on both retaining current nurses and encouraging those who have left nursing careers to re-enter the workforce. Some retention strategies include the following:

- Improve workplace conditions and enhance the education and professional development of nurses.

Competitive Wages: Nursing salaries are competitive, are market adjusted, and recognize outstanding performance and professional commitment.

Control of Nursing Practice: The organizational, administrative, unit and staff activities should be structured to facilitate maintenance of nursing standards of care.

Safety of the Work Environment: The facility should demonstrate a concern for the health and safety of nurses.

Transparency and Equality: The facility should demonstrate transparency and equality to all nursing staffs.

Systems Exist to Address Patient Care Concerns: The facility has systems for evaluating and addressing issues related to nursing practice quality.

Nurse Orientation: The facility can demonstrate that it has an orientation program which is needs and competency based as evidenced by nurse-specific orientation plans that consider the education, experience and identified strengths and weaknesses of the nurse being oriented.

Chief Nursing Officer: The activities of the Chief Nursing Officer in management of nursing services are supported by hospital administration.

Professional Development: The facility has a professional development program to facilitate ongoing educational needs to maintain and/or further develop professional expertise.

Nurse Recognition: The facility should recognize individual nurses' merit and excellence.

Balanced Lifestyle: The facility should recognize the need of nurses to balance work and non-work life.

Zero Tolerance Policy for Abuse of Nurses: The facility should not tolerate physician abuse of nurses.

Middle Management Accountability: The organization facilitates leadership competency among supervisors of direct care nurses and middle management through a delineated leadership program.

Quality Initiatives: The facility should demonstrate a commitment to evidence based practice.

- Provide safer working conditions for nurses including maintaining appropriate staffing levels based on competency and skill mix applicable to patient mix and acuity levels of care, prohibiting long work hours that jeopardize the nurse's ability to provide safe patient care, establishing policies and strategies to prevent and address harassment and violence in the workplace.

- Continue to increase wages for nurses to be adequate for the performance and competency (skill mix).

CHAPTER – V: CONCLUSIONS

The study has explored the various influential causes responsible for the turnover of nurses in Delhi, NCR as well as the factors which may help to retain the same by using the convenient random samples of various corporate and private hospitals in Delhi and NCR regions.

Additionally, the strategies that might be adopted in order to retain the nurses is mentioned in this study.

First, these results are consistent with earlier studies of the job satisfaction – turnover relationship (Cotton and Tuttle, 1986; Price, 2001; Hayes et al., 2006; Shields and Ward, 2001) showing that satisfaction with work itself; with pay; promotional opportunities; immediate superior and co-workers were all significantly and negatively related to employee turnover intention. They are also consistent with other Chinese studies, supporting the generally agreed notion of a negative association between job satisfaction and employee turnover (Lam et al., 2001; Tzeng, 2002; Yin and Yang, 2002; Yang, 2008; Zhou et al., 2009; Jiang et al., 2009). It is therefore reasonable to conclude that regardless of the differences between Western, Chinese and Indian culture (and not withstanding the contrary findings of Chen (2005) and Wong et al. (2001), job satisfaction, growth opportunities and working environment in general negatively affects Indian employees' work-related attitudes and behaviours in a similar way to the western and Chinese employees.

Overcoming global shortage of nurses is one of the priority areas of International Council of Nurses (ICN 2007). The nursing shortage faced in developed countries is leading to large scale movement of nurses from the developing to the developed nations. ICN acknowledges the right of nurses to migrate. However it condemns the practice of recruiting nurses by the country where the authorities have not been able to carry out requisite human resource planning or addressed the reasons behind the shortage of nurses. It is imperative that nursing should be considered as an integral part of HRH (Human Resources in Health).

Nurses should be considered as prime members of the health team, in terms of not only providing services, but also as a part of the decision making processes, so that it is possible for her to participate in providing holistic and comprehensive health care to the patient.

The nursing education programme in India should be strengthened. The standard and quality of education should be strengthened and maintained periodically. Uniformity of the curriculum is also another factor responsible for the enhancement of the quality of care in hospitals. The government should take initiatives to create and empower leaders from the nursing fraternity itself. Moreover, there should be efforts to provide adequate infrastructure, remuneration and working conditions to the nurses. Efforts should be made by the government to retain qualified nursing personnel in the country.

6.1 Limitations of the study:

The results should be interpreted with the following limitations in mind.

First, the nature of the sample (largely young and majority of samples are female) and the small sample size may limit the generalisation of this study. The samples were limited to only four corporate hospitals of Delhi, NCR region. It is possible that the findings may have limited external validity, and it may not be appropriate to generalise the findings across other populations or settings (for example industries that are male dominated)

.

The second limitation concerns the use of an opinion survey questionnaire for data collection. Opinion survey questionnaires have well-known limitations (for example, systematic biases and sampling errors) (Gill and Johnson, 2002), and the conclusions would be more robust if for example interviews or focus groups were used to gather data.

Thirdly, the study excluded some important variables such as job performance and organisational commitment that may have explained additional variation in turnover behaviour (Clegg, 1983; Sager et al., 1988; Griffeth et al., 2000) which it would be worthwhile including in a study to further the development of a predictive model of turnover.

6.2 Practical implications:-

The results provide insight regarding the various causes responsible for turnover intention among the staff nurses in India. For instance, human resource managers, the nursing supervisors and nursing administrators/leaders could regularly assess job satisfaction to predict likely attitudes toward turnover. This study also illustrates the peoples' behaviour to various situations and some of the retention strategies that could be adopted which could be helpful to retain the nurses.

6.3 Recommendation for further study:

- A replication of the present study can be conducted with large subjects.
- A similar study can be conducted in various zones of the country.
- An exploratory study can be conducted to find out the reason for the departmental shift of the nurses.

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ANNEXURE

Annexure 1:

STRUCTURED QUESTIONNAIRE TO ASSESS THE NURSE ATTRITION QUESTIONNAIRE

I am a student of the MBA hospital management program at IIHMR, Delhi and am carrying out a research on the attrition rate of nurses and factors to promote retention in various healthcare facilities.

I hereby declare that the data collected would solely be used for academic purpose and not be shared to any other organizations or research projects.

DEMOGRAPHIC PROFILE

Name:
Age:
Sex:
Marital status:
Qualification:
Total experience in years:
Name of organization currently working:
Department:
Working since:
Name of previous working organization:
Department:
Date of joining in previous organization:

SECTION 'A': Reasons for leaving the previous job. (If this is your first job then go directly to section B)

Sr. No.	Factors	Major reasons	Minor reasons	Not a reason at all
1.	Work profile was not satisfactory			
2.	Insufficient Compensation			
3.	Other incentives			
4.	Extended working hours			
5.	Lack of training & development opportunities			
6.	Lack of regular appraisals/promotions/ recognition			
7.	Multiple reporting			
8.	Conflict with immediate supervisor/manager			
9.	Conflict with co-workers			
10	International opportunities			
11	Work overload			
12	Family issues			
13	Spouse on a transferable job			
14	Health issues			
15	Sole earner			
16	Maternity			
17	No childcare facilities in the organization			
18	Lucrative/better job opportunity			
19	Salary/position enhancement in the other organization			
20	Relationship between peer group			
21	Distance between home and workplace			
22	Absence of transport facility			
23	Lack of Safety and security			

Any other reasons please specify:

_____

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Section: 'B': If you were to face any of the following issue/s in your present role, what would be your reaction?

Sr. no.	Factors (please mention these factors in the order of importance)	I shall remain in the current job	I shall intend to leave my current job as soon as I find a better one	I will actively look for a new job	I would like to quit my current job immediately
1	Challenging tasks faced daily				
2	Routine work leading to boredom				
3	Lack of growth opportunities and personal goals				
4	Lack of appraisals/promotions				
5	No clear definition of work profile				
6	Inadequate Salary increment/s				
7	No appreciation of work done				
8	Lack or absence of flexibility/autonomy				
9	No Job Security				
10	Working environment not conducive to personal and professional growth				
11	Health and safety hazards				
12	Lack of training & development				
13	Lack of Transparency and equality				
14	No support, and guidance				

15	No/Lack of team work				
16	Lack of welfare activities				
17	Salary/position enhancement in the other organization				
18	Conflict with immediate supervisor/manager				
19	No credit/Appreciation of work done				
20	Use of abusive language by supervisor/manager/coworker				

Any other reasons please specify:

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_____

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