HUMAN RESOURCES CAPACITY IN THE MINISTRY OF HEALTH AND SOCIAL SERVICES IN NAMIBIA

by

MS LINEA AMAKALI

submitted in accordance with the requirements for the degree of

MAGISTER TECHNOLOGIAE

in the subject

PUBLIC MANAGEMENT

at the

UNIVERSITY OF SOUTH AFRICA

SUPERVISOR: MR. ALFRED MATTHEWS

JOINT SUPERVISOR: DR. ZWELIBANZI MPEHLE

JUNE 2013

DECLARATION

Student number: 40546381

I declare that Human Resources Capacity in the Ministry of Health and Social Services in Namibia is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

_____ _____

SIGNATURE **DATE**

MRS. LINEA AMAKALI

ACKNOWLEDGEMENTS

I would like to thank my supervisors, Mr. Alfred Matthews and Dr. Zwelibanzi Mpehle for their support and guidance during this study. This would never have been possible without their help.

I would also like to thank the Namibian government through the Ministry of Health and Social Services for granting me financial assistance to complete this study.

My appreciation also goes to my husband Jeremia and my daughter Talohole for the support they gave me to complete my study.

HUMAN RESOURCES CAPACITY IN THE MINISTRY OF HEALTH AND SOCIAL SERVICES IN NAMIBIA

STUDENT NUMBER: **40546381**

STUDENT: **LINEA AMAKALI**

DEGREE: **MAGISTER TECHNOLOGIAE PUBLIC MANAGEMENT**

DEPARTMENT: **PUBLIC ADMINISTRATION AND MANAGEMENT, UNIVERSITY OF SOUTH AFRICA**

SUPERVISOR: **MR ALFRED MATTHEWS**

JOINT SUPERVISOR: **DR. ZWELIBANZI MPEHLE**

ABSTRACT

The purpose of this study was to examine the extent to which human resources capacity of the Ministry of Health and Social Services (MoHSS), Namibia, influences health care services delivery to the Namibian population. A qualitative research model using exploratory and descriptive study designs was adopted. Data were collected through semi-structured interviews with 46 health workers from two referral hospitals and two directorates in Windhoek District.

The study found that there is severe staff shortage in the MoHSS, which has resulted in high workload and poor health care. Health worker migration, new services and programmes, emerging diseases, and population growth were reported to have contributed to staff shortage and high workload in the MoHSS.

Study findings suggested a need to create more posts to accommodate emerging needs, and to introduce an effective retention strategy to attract and retain health professionals with scarce skills, and those working under difficult conditions.

KEY CONCEPTS

Public health sector, quality health care, staff turnover, health worker migration, shortage of health professionals, workload, retention strategy

Table of Contents **Page**

List of Tables

List of Figures

List of Appendices

CHAPTER ONE: OVERVIEW OF THE STUDY

1.1 INTRODUCTION

Managerial and operational human resources are the most valuable assets of an organisation, as they contribute to the achievement of organisational objectives (Mamoria & Gankar, 2010:5). The most significant component of any health system is its skilled health personnel. Without a foundation of skilled personnel, health care systems cannot function effectively and efficiently. However it is widely acknowledged that health systems in Africa, not excluding Namibia, are not producing the desired outputs of health interventions due to various factors (Padarath, Chamberlain, Mccoy, Ntuli, Rowson & Loewenson, 2003:5). These factors include an overall lack of personnel in key areas of the health sector, inequitable distribution of the people who are available, and a significant attrition of trained personnel from the health sector and from the region (Padarath *et al.* 2003:5).

The availability of trained health personnel in Africa is considerably worse than in other regions of the world, and it is one of the stumbling blocks to the delivery of effective and efficient healthcare. The availability of skilled personnel in the Namibian health sector has wider implications for the delivery of health and social welfare services to the Namibian population. Without sufficient health workers to render services, patient care is inevitably compromised. The overall objective of the Ministry of Health and Social Services (MoHSS) in Namibia is to improve and maintain the physical and mental health status of all Namibians and to improve and maintain the social wellbeing, self reliance and coping capacities of individuals, families and communities. This objective can be achieved only if well trained people are available at all levels in the health sector (MoHSS, 2009:5).

1.2 BACKGROUND TO THE STUDY

Sub-Saharan Africa is faced with the challenge of a shortage of health workers. The average is one physician per 8,000 people in the region (Mills, Schabas, Volmink, Walker, Ford, Katabira, Anema, Joffres, Cahn & Montaner, 2008:1). This is often due to emigration and internal migration within countries from public to private

sectors and from rural to urban areas. The HIV/AIDS epidemic is one of the non-migration factors causing shortage of health workers due to increased workloads resulting from the introduction of new service packages and programmes, without increasing the number of existing health workers (MoHSS, 2008:12). The staffing situation in developed countries is not the same as in sub-Saharan Africa. The United Kingdom has over 100 times more physicians than has Malawi, where there is one physician per 50 000 population. Most of the doctors working in the United Kingdom are from Africa (Mills *et al*. 2008:1).

As previously noted, shortage of health workers is a challenge in Sub-Saharan Africa, including Namibia. After independence in 1990, Namibia was faced with the challenge of inadequate skilled people to provide the required health care services. To address this predicament, the MoHSS initiated a two year pre-service training programme for sub–health professionals. These categories include enrolled nurses, pharmacy assistants, medical laboratory technicians, environmental health assistants, and radiographic assistants. This programme is offered through the Training Network comprising of the National Health Training Centre and four Regional Health Training Centres. The University of Namibia (UNAM) has also been, and still is, training some of the health professionals, especially in the area of pre-service training and continuous education. Pharmacists, doctors and dentists are being trained in other countries such as South Africa, Kenya, Tanzania, Ghana, Russia, Cuba and Algeria (Ministry of Health and Social Services, 2008:44). The School of Medicine was introduced at UNAM in 2009, with its first intake in 2010, to train doctors and pharmacists (University of Namibia, 2010:4).

Table 1 is a summary of health- related students who completed training during the period 1990-2009 in Namibia and abroad. The Table indicates that the MoHSS has been making training efforts to address the challenge of staff shortage in the public health sector.

Table 1: Health-Related Students who Completed Training during the Period 1990-2009

Professional category	Number of students completed training
Doctors	129
Pharmacists	32
Dentists	22
Registered nurses	1590
Social workers	139
Radiographers	60
Physiotherapists	10
Environmental health officers	39
Pharmacy assistants	80
Environmental health assistants	50
Enrolled nurses	2844
Radiographic assistants	29
Medical laboratory assistants	19
Orthopaedic technical assistants	28
Medical engineering technicians	10
Medical rehabilitation assistants	16
Total	**5097**

Source: MoHSS (2011: 23)

Despite the Ministry's training efforts to produce more health professionals, the public health sector has been struggling with the challenge of inadequate staff, especially in the discipline of medicine, nursing and pharmacy.

The Namibian public health sector consists of 1,150 outreach points (mobile points where health care services are provided to communities without fixed health facilities), 265 clinics, 44 health centres, 30 district hospitals, 3 intermediate hospitals and 1 national referral hospital. A total of 844 private health care facilities are registered with the Ministry of Health and Social Services. These facilities comprise 13 hospitals, 75 primary care clinics, 8 health centres, and 557 medical practitioners (MoHSS, 2008:32). Health workers leaving the public health sector in Namibia usually join the private sector locally, while a considerable number leave the country. Most of the health workers who migrated from the public health sector, especially registered and enrolled nurses, joined the local private health sector. Only a small number of nurses left the country for the United Kingdom and other developed countries. Of 71 registered nurses who resigned from Katutura State Hospital in Namibia during the period 2002-2005, 60 migrated to the local private health sector, while 9 migrated to the United Kingdom. Of 50 registered nurses who resigned from

Windhoek Central Hospital during the same period, 44 migrated to the local private sector, while 6 migrated to the United Kingdom (MoHSS, 2005:6).

Table 2 presents a summary of health professionals who served in the public and private sectors during the 2009/2010 financial year. Note that there are more key health professionals in the private sector than in the public sector. These are pharmacists (89%), dentists (86%) and doctors (75%). This may impact on the delivery of health care services to the Namibian population in terms of accessibility and affordability.

Table 2: Summary of Health Professionals who Served In the Public and Private Sectors during the 2009/2010 Financial Year

Professional category	**Health professionals registered with the Health Professional Council during the 2009/10 financial year**	**Public health sector**		**Private health sector**	
	No.	**No.**	**%**	**No.**	**%**
Doctors	677	172	25	505	75
Pharmacists	298	33	11	265	89
Dentists	134	18	13	116	86
Registered nurses	3211	1700	53	1511	47
Social workers	305	79	26	226	74
Radiographers	107	32	30	75	70
Environmental health officers	143	63	44	80	56
Pharmacy assistants	174	67	39	107	84
Environmental health assistants	62	48	77	14	23
Enrolled nurses	3359	2375	70	984	29
Radiographic assistants	62	33	53	29	47
Occupational therapists	153	17	11	136	89
Total	**8685**	**4637**		**4048**	

Source: MoHSS Annual Report 2009/2010

The Namibian public health sector has suffered high levels of attrition in the past decade. A study by Pendukeni (2004:38) revealed that the MoHSS lost 234 staff in 2003. The main reasons for staff attrition were resignations (35%) and death (26%). Nurses accounted for about 17% of the staff attrition. The study also indicated that the vacancy rate stood at 36% in 2003.

Namibia continues to be faced with a critical shortage of health professionals to address many challenges including the HIV/AIDS pandemic, the emerging chronic conditions and the urgency to achieve Millennium Development Goals. The MoHSS annual report of 2007/2008 noted that the ministry lost 388 staff members, of whom 249 were from key occupational categories. The attrition was reported as being high in the professional categories of registered nurses and enrolled nurses as they represent a high percentage of staff members. The main reasons for staff attrition were resignation (65%), retirement (20%) and death (9%). The report also revealed that the MoHSS reflected a vacancy rate of 29 % (MoHSS, 2008:12). The high level of staff attrition may be attributed to the fact that the conditions of service have not been adequately updated.

It should be realised that high employee turnover must inevitably have a negative influence on the morale of the remaining employees, and this may in turn affect the delivery of quality health care to patients. The Ministry of Health and Social Services should therefore focus on adopting strategies for retaining and attracting skilled health professionals, such as introducing special incentives for working in remote areas.

Table 3 presents the number of health professionals who served in Namibia during the 2007/2008 financial year, and compares registered health professionals in the Namibia health sector. It shows that there is an unequal distribution of health workers between the public and the private sector.

Table 3: Summary of Selected Health Professionals in Namibia during the 2007/2008 Financial Year

Professional category	Number registered with the Health Professional Council	Number in the public health sector per population		Number in the private health sector per population	
Doctors	1238	190	1: 9,633	1048	1:1,746
Pharmacists	214	44	1: 42,598	170	1:10,766
Dentists	106	13	1:140,795	93	1:19,680
Radiographers	76	31	1: 59,043	45	1:40,674
Registered nurses	2096	1658	1:1,104	438	1:4,178
Physiotherapists	83	20	1: 91,516	63	1:29,052
Social workers	236	76	1: 24,083	160	1:11,439
Health inspectors	142	34	1: 53,833	108	1:16,947
Dieticians	12	1	1:1,830,330	11	1:166,393
Clinical psychologists	32	2	1: 915,165	30	1:61,011
Total	**4235**	**2069**		**2166**	

Source: MoHSS Annual Report 2007/2008

The Table shows that the public health sector finds it difficult to compete with the private sector for the scarce health professionals. The private sector has more health professionals, with the exception of registered nurses cadres, although the public sector serves a bigger portion of the population. As the private health sector is not accessible to a large proportion of the population who live in rural areas and do not have medical aid, the health worker to population ratio in the public health sector is likely to be very high. This may result in long waiting hours to receive health care services, and compromising on quality of services. Additionally, public health facilities may turn away patients if there are inadequate health professionals to attend to them.

1.3 PROBLEM STATEMENT

Health systems in Africa are faced with many challenges. One of these is the shortage of human resources in key areas of the health sector. Another is maldistribution of the available human resources for health and migration of health workers from the public to the private sector, and from the SADC region to other regions in the world. As a result, there are fewer key health workers in Africa than in other parts of the world. This hampers the effective delivery of adequate and quality health care services (Padarath *et al*. 2003:5). The shortage of health workers in

many places is among the most significant constraints to achieving the three health-related Millennium Development Goals: to reduce child mortality, improve maternal health, and combat HIV/AIDS and other diseases (Mrara, 2010:17).

The researcher intends to investigate the extent to which the human resource capacity of the Ministry of Health and Social Services in Namibia influences the delivery of health care services to the Namibian population. This is because of the impression that the existing human resource capacity of the MoHSS can no longer meet the health service demands of the Namibian population. The researcher identified the following factors as having contributed to the problem:

1.3.1 New Services and Programmes

Many countries in sub-Saharan Africa, including Namibia, are experiencing staff shortage due to the increased burden of diseases such as HIV/AIDS, TB and Malaria. The prevalence of HIV/AIDS has put heavier loads on the nurses in health facilities (Mrara, 2010:5). As a result, there is a need for governments in sub-Saharan Africa to introduce new programmes to curb the disease.

The introduction of new programmes in the fight against the HIV/AIDS pandemic, such as Prevention of Mother to Child Transmission (PMTCT) of HIV and Antiretroviral Therapy (ARV) in Namibia has increased the burden on the health system. By March 2007, PMTCT services had been rolled out to 189 of 331 public health care facilities. Consequently, there has been an increase in the demand of additional health workers to deal with clients who are in need of these services because the existing staff can no longer cope with the workload (MoHSS, 2008:1-10).

1.3.2 Staff Establishment

The staff establishment of the Ministry of Health and Social Services in Namibia was last reviewed in 2003. The number of posts allocated no longer meets the service demands at national, regional, district and clinic levels because of new developments and programmes. Again, the number of staff recruited annually is very small due to the insufficient number of graduates and a lengthy process in recruiting expatriates, which requires several steps (MoHSS, 2008:47).

Table 4 shows that the percentages of posts filled in some categories remain low. For example in 2009/10 the percentage of posts filled for Orthopaedic Technologists was 25, Occupational Therapists 40%, Social Workers 55% and Environmental Health Assistants 59%. It can be deduced that the Ministry structure is inadequate, in terms of numbers and skills of health workers, to address the needs of the health system.

Table 4: Trend of Health Workers over the Past Five Years

Categories	Posts Allocated	Posts Filled per year (%)				
		2005/ 2006	2006/ 2007	2007/ 2008	2008/ 2009	2009/ 2010
Doctors	252	176 (62)	183 (64)	190 (67)	201 (71)	172 (68)
Medical Specialists	78	29 (62)	33 (70)	35 (74)	36 (77)	60 (77)
Dentists	20	9 (56)	11 (42)	13 (62)	18 (86)	18 (90)
Pharmacists	53	18 (38)	27 (59)	44 (96)	34 (76)	33 (62)
Pharmacist Assistant	77	53 (74)	65 (85)	63 (83)	70 (92)	67 (87)
Registered Nurses	2143	1552 (75)	1626 (78)	1658 (80)	1659 (80)	1700 (79)
Enrolled Nurses	2557	1688 (70)	1884 (76)	2151 (87)	2314 (93)	2375 (73)
Physio/Occupational Therapist	42	11 (44)	15 (37)	20 (50)	29 (69)	17 (40)
Social Worker	143	73 (53)	76 (49)	76 (49)	79 (51)	79 (55)
Radiographers	41	30 (67)	27 (66)	31 (78)	38 (93)	32 (78)
Radiographic Assistants	41	34 (85)	32 (80)	31 (78)	30 (78)	33 (80)
Orthotists/Prothetist	4	2 (50)	4 (100)	3 (71)	1 (25)	3 (75)
Env. Health Officer	63	31 (46)	37 (56)	34 (52)	39 (57)	46 (73)
Env. Health Assistant	82	43 (54)	37 (44)	31 (36)	39 (46)	48 (59)
Orthopaedic Technician	22	12 (55)	25 (96)	25 (96)	26 (100)	20 (91)
Orthopaedic Technologist	8	2	4 (57)	8 (75)	6 (60)	2 (25)

Source: MoHSS, Annual Report 2010/2011

Mrara (2010:6) pointed out that any organisation that is not functioning at full staff complement faces the challenge of not providing services at the required standard. In most cases, posts are created according to the needs of the organisation and if the gap is not closed, there could be serious consequences.

The vision of the MoHSS is to be the leading public provider of quality health and social welfare services in Africa. However, this vision can only be realised if adequate numbers of qualified personnel are available at all levels in the public

sector to provide accessible, affordable, quality health and social welfare services responsive to the needs of the Namibian population. It appears that the shortage of skilled people in the Namibian public health sector will remain a challenge in implementing the vision of the MoHSS, unless actions are taken to improve the situation.

1.3.3 Resources

Although Namibia seems to have a good health worker population ratio compared to other African countries, there is, as noted earlier, a maldistribution of health workers serving the private and public health sectors. In the private sector the ratio is 8.8 health workers per 1,000 population, while the public sector barely has 2.0 health workers per 1,000 population. This is below the WHO standard of 2.5 workers. The public health system requires more personnel to cater for new services that are being provided (MoHSS, 2008:7).

Health care facilities owned and operated by the Ministry of Health and Social Services are poorly maintained. This is mainly due to inadequate funding and lack of supervision of public health facilities due to unclear lines of responsibilities between the MoHSS and the Ministry of Works. The conditions of these facilities are demoralising to staff members and this impacts on productivity, output and outcome (MoHSS, 2008:90).

Legodi (2008:51) suggests that the improvement of quality in primary health care services requires the support and commitment of all stakeholders. This involves the provision of adequate facilities, adequate staffing, proper skill mix, proper and functional equipment and instruments, good management skills, skilled service providers, as well as availability of standards and protocols. Legodi (2008:35) further suggests that to succeed and be effective, primary health care services must form partnerships with other departments that are essential to the provision of quality services, such as departments for water and electricity supply, maintenance and communication.

It should be noted that a poor working environment may result in employees being attracted to organisations that offer competitive working environments and conditions. Therefore the researcher suggests that if public health sectors want to

attract and retain their skilled health professionals, they should provide congenial working environments and better conditions of service.

1.3.4 Quality Services

Mæstad,Torsvik & Aakvik (2010:1) made the obvious point that the shortage of health workers in many low-income countries poses a threat to the quality of health services. They further assert that when the health worker population ratio decreases, health care service delivery to patients is compromised.

The challenge of staff shortage in Namibia has been intensified by the increase in hospital visits of people suffering from opportunistic infections as a result of HIV/AIDS. Tuberculosis, a situation compounded by HIV/AIDS and a major problem in Namibia, has been on the increase. In 2006 there were 15 771 cases of Tuberculosis reported in the country and this has contributed to the high workload (MoHSS, 2008:67).

Awases (2006:12) observed that many nurses in the health facilities in Namibia who are supposed to be the backbone of health services are overworked and demoralized, and show signs of burnout. As a result there is a growing concern about the poor quality of services rendered to the population, even though the MoHSS vision advocates improved quality of services to be provided at health facilities throughout the country. It appears however that the problem of increased workload due to staff shortage is likely to continue impacting on the public health sectors' ability to provide quality services, unless concerted efforts are made to remedy the situation.

1.3.5 Accessibility

Du Toit (2002:108) notes that citizens have a legitimate right to equal access to services, and public servants must not withhold that right from them. In this context, accessibility refers to the distance patients have to travel for health care, the availability of skilled health service providers, and the availability of medical equipment and instruments.

Table 4 presents a distribution of health professionals between urban and rural public health facilities for the 2004/2005 financial year.

Table 5: Urban/Rural Distribution of Health Professionals

Professional category	Total no. registered in 2004/2005	Urban		Rural	
		No	%	No	%
Doctors	598	457	76.4	141	24
Nurses	6214	3767	61	2378	39
Dentists	113	101	89	12	11
Pharmacists	288	198	68	92	32
Physiotherapists	68	67	98.5	1	1.5
Occupational Therapists	30	28	93	2	7
Environmental Health Officers	240	107	45	133	55
Social Workers	270	230	85	40	15
Psychologists	68	67	98.5	1	1.5

Source: MoHSS (2008:47)

Table 4 shows that there is a maldistribution of health workers between urban and rural areas. For instance, 76% of doctors employed by the MoHSS are serving in urban areas, compared to 24% of doctors serving in rural areas. Health professionals are understandably more willing to work in urban than in rural areas. This may be attributed to difficult working conditions such as poor infrastructure, isolation of rural health facilities and lack of support from tertiary level.

Namibia's Ministry of Health and Social Services has set the goal of improving access to health care and health facilities, especially in previously under-served regions. This goal can be achieved only if more resources, both human and capital, are channelled to poor rural and urban areas.

1.4 PURPOSE OF THE STUDY

The proposed study focuses on exploring the extent to which human resources capacity influences health care delivery to Namibia's population. The aim is to

determine whether the existing human resources capacity will enable the MoHSS to achieve its vision of being the leading public provider of quality health and social welfare services in Africa.

1.5 OBJECTIVES OF THE STUDY

The proposed study aims at achieving the following specific objectives:

- To determine the state of staffing and performance of the MoHSS;
- To examine factors that influence staffing and performance of health workers in the Ministry of Health and Social Services, Namibia;
- To assess how health workers perceive and experience human resources capacity;
- To ascertain the influence of staffing on the performance of the MoHSS; and
- To make recommendations on how to improve the current staffing situation.

1.6 RESEARCH QUESTIONS

From the above, the following research questions have been framed:

- What is the state of staffing and performance in the MoHSS?
- Which factors influence staffing and performance in Namibia's Ministry of Health and Social Services?
- To what extent does staffing influence the delivery of health care services as stated in the MoHSS vision?
- How do health workers perceive and experience human resource capacity?
- Which strategies could be recommended to improve the current staffing and performance situation?

1.7 ETHICAL CONSIDERATIONS

Permission to conduct this study was granted by the Ministry of Health and Social Services.

Ethics clearance was sought from the Department of Public Administration's Ethics Committee, but the Committee could not grant clearance because the application was submitted after the research had commenced. In terms of Unisa Ethics Policy, an application for Ethics Clearance has to be submitted once the research proposal has been approved, and before any research commences.

It should however be noted that all the ethical requirements, as stipulated in the Unisa Ethics Policy, were complied with as regards data collection, interviews, informed consent with cautionary warnings, and the research.

1.8 TERMINOLOGY

Terminology involves defining key concepts referring to the key features of the phenomenon to be investigated. The terms that need to be defined are those outside the field of study that readers might not understand (Technikon South Africa, 2001:163). For the purpose of this study the following terms are defined:

Staffing: A process of bringing into an organisation people who will not only fit into a particular job but also into the business of the organisation (Amos *et al*. 2008:157).

Turnover: Any permanent loss from an organisation of employees who have to be replaced (Grobler *et al*. 2006: 555).

Health: Jirojwong & Liamputtong (2009:5) define health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

Health system: According to the World Health Organisation (2004:5) a health system is made up of all organisations, people and actions primarily intended to promote, restore or maintain health.

Health Professional: For the purpose of this study health professionals include doctors, nurses, pharmacists, radiographers, social workers and environmental health officers.

1.9 OVERVIEW OF CHAPTERS

The study is presented in five chapters. Chapter One introduces the topic of the study by giving background information about human resources in the Namibian health sector. The chapter also provides trends of human resources movement in the public health sector and how these movements affect the delivery of health care services to the Namibian population. The current challenges, namely, new services and programmes, outdated staff establishment and inadequate resources, facing the public health sector are also outlined in this chapter.

Chapter Two outlines the literature related to human resources in the health sector. The chapter focuses first on staffing and its processes, namely, human resource planning, recruitment, selection, placement, and induction and orientation. It then discusses staff turnover and its effect on service delivery. Migration of health workers and its impact on service delivery is also discussed. The chapter concludes by discussing factors influencing human resource distribution and availability, and performance of employees.

Chapter Three presents a research methodology to be used in the research. Detailed information about the population and sample, method of data collection and analysis is presented in this chapter.

Chapter Four presents and analyses the data based on the interviews.

Chapter Five presents conclusions and recommendations. Results are discussed and compared, and conclusions are derived from the results.

1.10 CONCLUSION

Human resources are the most significant component of any health system. For health systems to function effectively there has to be a foundation of skilled human resources. However the staffing situation in sub-Saharan Africa, Namibia included makes it difficult for health systems to deliver the desired health care services.

This chapter provided background information about human resources in the Namibian health sector. The chapter also provided trends of human resources movement in the public health sector and its effect on the delivery of health care services to the Namibian population. The current challenges, namely, new services and programmes, outdated staff establishment and inadequate resources, facing the public health sector are also outlined in this chapter.

Chapter Two presents a review of the relevant literature.

CHAPTER TWO: LITERATURE REVIEW

2.1 INTRODUCTION

Human resource management is concerned with the acquisition of appropriate human resources, developing their skills and competencies, motivating them for best performance and ensuring their continued commitment to the organisation to achieve organisational objectives. Human resources are very important for the success of any organisation, because without human effort, organisations cannot accomplish their objectives (Mamoria & Gankar, 2010:5).

This chapter covers areas relating to human resources in the health sector. It first explains the concept of staffing and its processes, namely, human resource planning, recruitment, selection, placement, and induction and orientation. Staffing aims at deciding what employees are to be recruited, and this is done through the above-mentioned processes. The chapter also explains the concept of staff turnover and how it affects services delivery. Types of turnover, namely, involuntary, voluntary, dysfunctional, functional, uncontrollable and controllable, and reasons for turnover are also highlighted and explained.

Various factors contributing to the loss of human resources in the public health sector are discussed. These include push factors, pull factors, stick factors and stay factors. Factors influencing the loss of human resources for health in sub-Saharan Africa are discussed. These include HIV/AIDS, poor working conditions, low remuneration, increased workload, and lack of support systems at work places. The chapter also focuses on health worker migration and its impact on service delivery in sub-Saharan Africa. Policy interventions on migration are highlighted.

The chapter concludes by discussing factors influencing the performance of health workers. These include motivation, job satisfaction, working conditions and environment, and remuneration and incentives. It emphasises that in order for the performance to be satisfactory, employers should provide a congenial working environment in which employees' performance is properly rewarded and efforts put into the work are valued.

2.2 STAFFING

Staffing refers to the processes involved in finding, assessing, placing and evaluating individuals at work (Ploychart, Schneider & Schmidt, 2006:1). Mamoria & Gankar (2010:35) argue that the staffing process is a flow of events which results in a continuous manning of organisational positions at all levels, from top management to the operational level. The staffing process includes human resource planning, recruitment, selection, placement, and induction and orientation. These processes are explained further in the following paragraphs.

Human resource planning. Human resource planning refers to the process of analysing the present and future vacancies that may occur as a result of retirements, discharges, transfers, promotion, sick leave, leave of absence, or other reasons, and an analysis of present and future expansion in the various departments (Mamoria & Gankar, 2010:35). The next step in the staffing process is recruitment.

Recruitment. This is a process of searching for and obtaining applicants for jobs, from among whom the right people can be selected. Thus if organisations want to minimize staff turnover, they have to make sure that the right people are hired. The recruitment process ends with the receipt and screening of applications so as to eliminate those who are not qualified for the job (Aswathappa, 2010: 167). Selection follows after recruitment.

Selection. This is a process of evaluating and deciding on an individual's suitability for a particular job. This is normally done through interviews and tests. The overall objective of the selection process is to gather enough information about each individual to make a decision. It is suggested that each candidate should be assessed against selection criteria (Lucas, Lupton & Mathieson, and 2006:127). It is imperative that care be taken when selecting, so as to not reject suitable applicants and end up hiring employees who may not make meaningful contributions to the organisation. Once the selection process has taken place and the right candidate is identified, the next process is placement.

Placement. Placement involves placing an employee in a job for which he or she is best fitted, taking into consideration the job requirements, his/her qualifications and

personality needs (Mamoria & Gankar, 2010:35). The placement process is followed by induction and orientation.

Induction and orientation. Induction and orientation are concerned with the introduction of employees to the organisation and the job by giving them all the relevant information about the organisation's history, objectives, philosophy, policies, future development opportunities, and also introducing them to the employees with whom and under whom they will work (Mamoria & Gankar, 2010:35). The induction session must include all the necessary information to enable new employees to work effectively and efficiently.

Ploychart *et al*. (2006:4) stress that the staffing process is influenced by the organisation in which that process exists and the organisation is influenced by the outcomes of the staffing process. The best staffing programs specify the kind of people who will be effective and satisfied with the job and the organisation into which they are hired, and the kind of people required by the organisation today and in the future to promote long-term organisational effectiveness.

Ploychart, *et al.* (2006:4) maintain that most staffing systems attempt to identify the individual characteristic that will increase the probability that people hired will be able to do the work they are hired for and will enjoy the work at least long enough to repay the organisation's investment in hiring and training them.

The following section discusses staff turnover, with emphasis on types of and reasons for turnover.

2.3 STAFF TURNOVER

As defined earlier, turnover is defined as any permanent loss from an organisation of employees who must be replaced (Grobler, Warnich, Carrell, Elbert & Hatfield, 2006: 555). For the purpose of this study turnover refers to the number of doctors, pharmacists, radiographers, environmental health officers, social workers and nurses who left the public health sector.

Gaspar (2007:12) mentions that staff turnover can have negative impacts on the services rendered by an institution. Grobler *et al*. (2006: 125) add that excessive

turnover creates an unstable workforce and increases human resources costs and organisational ineffectiveness. When an institution loses its employees this not only lowers the productivity level but can also be costly, as employees who leave the institution must be replaced. Turnover may also result in disruption in programmes and projects as managers and administrators leave. However, it should be noted that turnover could have a positive impact. When employees who are not making positive contributions to the achievement of organisational objectives leave, they make room for better-performing employees. Mrara (2010:26) states that it is imperative for managers to continue interacting with the employees and by observing the behaviour of employees who are valuable assets, efforts can be made to persuade employees intending to quit to remain with the organisation.

2.3.1 Types of Turnover

There are different types of turnover. Mathis & Jackson (2008:84) identify six: involuntary, voluntary, functional, dysfunctional, uncontrollable and controllable turnovers.

- **Involuntary turnover:** Employees' services are terminated due to poor performance or violation of work rules;
- **Voluntary turnover:** Employees leave the organisation by choice;
- **Dysfunctional turnover:** Individuals and high performance employees leave at critical times;
- **Functional turnover:** Lower performing, less reliable or disruptive employees leave the organisation;
- **Uncontrollable turnover:** Employees leave the organisation for reasons outside the control of the employer, for example to stay at home with younger children or elderly; and
- **Controllable turnover:** Employee turnover is influenced by the employer. For example, employment is terminated as a result of company downsizing.

2.3.2 Reasons for Turnover

Torrington & Hall (2005:168) stress that people leave jobs for different reasons, many of which are outside the control of the organisation. Retirement has been identified by these authors as one. Voluntary resignation has also further been identified as the reason for leaving and is normally caused by outside factors: a situation in which employees leave the job for reasons that are not work related. This includes moving away when a spouse or partner is relocated, the wish to fulfil a long-term ambition to travel, family and illness-related issues. Mrara (2010:30) suggests that to limit family as a reason for employees to leave the organisation, companies may employ spouses of employees as a strategy for attracting and retaining top talented employees, particularly in technical positions. However, it should be mentioned that hiring spouses may have some disadvantages. If one spouse is dismissed, for example, it may result in both partners leaving the organisation.

The study conducted by Lephalala (2006:93-94) found that nurses commonly resigned due to retirement, ill-health, better remuneration and better working conditions elsewhere. Lack of motivation due to low remuneration, being overworked due to staff shortage, insufficient supplies and equipment, unsafe working environment and poor service conditions were found to be the main cause of turnover.

Research conducted by Gaspar (2007:40) in Angola has revealed that high turnover of nursing staff in some public hospitals in Luanda was the cause of staff shortages, resulting in overload for the remaining nurses and poor service delivery. The study also found that the most common reasons for the resignation of nurses were retirement, ill health, and better remuneration and working conditions elsewhere. The present writer believes that nurses, who are the backbone of the health system, should be encouraged and motivated to contribute to the delivery of quality health care services by providing them with a safe working environment and improved conditions of service.

Thompson (2008:37) identifies the major determining factors for employees' turnover with regard to rural workers. These include professional support, contacts with colleagues, proper resources, professional development opportunities, quality and

style of supervision. A study by Pendukeni (2004:38) on the impact of HIV/AIDS on health care provision revealed that nurses in Namibia had problems concerning their work, but the support system was not supportive enough to solve their problems. The researcher therefore suggests that health systems should consider developing support systems at the workplace to provide counselling services to employees, to reduce employee turnover.

It is recognised that health worker attrition is more prevalent in sub-Saharan Africa than in other regions of the world. According to Southern Africa Development Communities (SADC) (2006:10) almost all countries in the East and Southern Africa regions have experienced health worker attrition, although the specific cadres affected and the responsible factors for losses vary from country to country. The major categories affected in this regard are mainly doctors, nurses and pharmacists, who form the core of health service delivery. The reasons for leaving their countries include difficult working conditions, heavy workloads, lack of equipment, poor salaries and diminished opportunities for advancement.

Iipinge, Dambisya, Loewenson, Chimbari, Ndetei, Munga, Sibande & Lugina (2009:8) stress that countries such as Zimbabwe, Malawi, Lesotho, Swaziland and Zambia are facing the major problem of outward migration of health workers. These authors further stress that mortality and illness due to HIV/AIDS has contributed to high attrition rates. The same trend is experienced in Namibia, which is partly blamed for inadequate health workers.

Another feature in sub-Saharan Africa health systems is the maldistribution of health workers between the public and the private sectors. For example, Padarath *et al*. (2003:7) stated that in South Africa, where the private sector consumes 58% of the total health expenditure, private health services capture a higher proportion of all types of personnel (except nurses) than the public sector. In 1998, 52.7% of all general practitioners and 76% of all specialists worked in the South African private sector. By 1999, 73% of general practitioners were estimated to be working in the private sector in South Africa, despite the fact that this sector catered for less than 20% of the population. This may be due to the fact that most people utilise public health services as they cannot afford the fees charged in the private sector.

2.3.3 Effects of Turnover on Health Care Service Delivery

The impact of the loss of human resources in terms of skills and numbers in relation to the total size of the health workforce cannot be overemphasised. For small countries the loss of even one skilled health worker can precipitate an absolute shortage and inability to maintain basic services. The loss of health workers undermines the ability of countries to meet global, regional and national commitments, such as the health- related United Nations Millennium Development Goals and even their own development (WHO, 2004:1). The loss of health workers in Namibia has also affected a number of health facilities in adequately providing the required quality health care to patients. The study by Pendukeni (2004:52) indicates that staff shortage in Namibia has resulted in poor quality patient care. The available nurses in the hospitals are failing to cope with increased workload; as a result they are experiencing stress and burnout.

Mills *et al.* (2008:2) noted that the number of nurses has decreased in recent years due to migration to other parts of the world. In Malawi, for example, a 12% reduction in available nurses due to migration has been reported, while in Ghana, 500 nurses left the country in 2000. The number of pharmacists living in sub-Saharan Africa has also been reported to be declining compared to other regions of the world. For example, in Liberia the pharmacist population ratio is one for every 85,000 people, 377 times lower than that in the United States of America (Mills *et al.* 2008:3).

A study by Yearwood (2007:1) showed that migration, insufficient number of trained health workers, poor working conditions and working environments, longer working hours and large numbers of sick patients have created health care crises in developing countries. This has resulted in inequity in health care service delivery and poor health outcomes. The migration of nurses to other countries has affected many sub-Saharan countries. The study further reported that nurses migrate to other countries to earn more money, access better education and advanced technology skills, provide for their families, and improve their overall quality of life. However, the gap that these nurses create in the healthcare system of their countries of origin is negatively affecting those in need, mostly children and psychiatric patients, because health workers providing mental health services are scarce, and with the migration of

health workers to other countries the situation becomes even worse (Yearwood, 2007:1).

Yearwood (2007:1) further noted that migration of health workers has resulted in fewer healthcare services provided to individuals and families, and longer waiting periods for patients to receive services. Those services that are available provide only basic care rather than primary and tertiary preventive services.

Buerhaus (2005:214) on the other hand underscored the fact that nursing shortage is a major problem affecting the provision of quality care in non-hospital settings such as sub-acute and long-term care facilities, home and community settings, ambulatory clinics and centres, and school and student health services. The study also found that nursing shortage impacted on time for collaboration with teams, early detection of patient complications, and ability of nurses to maintain patient safety and nurses' time for patients. These factors have the potential to undermine quality health service delivery if proper measures are not put in place.

It can be concluded from the above discussions that poor working conditions in Africa are major factors contributing to health workers migration and this is negatively affecting health care delivery to patients. It is thus obvious that if health sectors in sub-Saharan Africa want to retain their employees, they should continuously improve working conditions. In the next section the focus will be on factors which contribute to the loss of human resources in the public health sector.

2.4 FACTORS CONTRIBUTING TO THE LOSS OF HUMAN RESOURCES IN THE PUBLIC HEALTH SECTOR

Several factors impact on the movement of health care workers, and they arise both within and outside the health system. They include push factors, pull factors, stick factors and stay factors. These factors are discussed below.

2.4.1 Push Factors

Push factors are those that encourage health workers to leave their countries or location of work. Push factors are subdivided into endogenous and exogenous factors. The latter are directly related to circumstances outside the health system,

such as quality of life, crime, and lack of education opportunities. Endogenous factors are directly related to the health system. They include low remuneration, lack of job satisfaction due to poor health care infrastructure and bad health management, and work- associated risks such as HIV/AIDS and TB (Padarath *et al*. 2003:10). According to the 2007/2008 annual report of the MoHSS, the human resource situation in the Namibian public health sector is impacted severely by non-migratory factors such as the HIV/AIDS epidemic. The report further states that the epidemic has drastically increased the workload in health facilities at all levels through the introduction of new service packages and programmes, without corresponding increases in the number of health workers (MoHSS, 2008:11).

2.4.2 Pull Factors

Pull factors are those that attract workers to recipient countries. As with push factors, pull factors are divided into endogenous and exogenous factors. Endogenous pull factors include better remuneration, more satisfying working conditions, safer working environment, and better educational and career development opportunities. Exogenous pull factors include higher quality of life in recipient countries, freedom from political persecution, freedom of speech, and educational opportunities for children (Padarath, *et al.* 2003:10).

Other factors that lead to a movement or migration of health personnel are stick factors and stay factors.

2.4.3 Stick Factors

Padarath *et al*. (2003:12) stress that for push and pull factors to lead to a movement or migration of health personnel, they have to overcome various stick factors. Stick factors are, predictably, those that encourage workers to remain in source countries. They include high level of morale among health workers, rewards and incentives, and social values such as family bonding, and strong social and cultural ties. As pointed out by these authors, such factors will contribute to increased retention of health personnel.

2.4.4 Stay Factors

Once people have moved or migrated to work abroad, they may choose not to return, due to a variety of stay factors. These include development of new social and cultural bonds, the risk of disrupting the education of children, or reluctance to disrupt new lifestyle patterns (Padarath *et al.* 2003:12-13).

The next section focuses on factors influencing the loss of human resources for health in sub-Saharan Africa.

2.5 FACTORS INFLUENCING THE LOSS OF HUMAN RESOURCE FOR HEALTH IN SUB-SAHARAN AFRICA

Many factors influence the loss of human resource for health in sub-Saharan Africa. These factors relate not only to international migration, but also to the internal distribution of health workers and other forms of loss, for example to sectors other than health, to the private sector and movement from rural to urban areas (Commonwealth Secretariat, 2003:7). According to the Commonwealth Secretariat (2003:7), factors such as HIV/AIDS, poor working conditions, low remuneration, and increased workload have contributed to the loss of human resources for health in sub-Saharan Africa. These are discussed below.

HIV and AIDS: The HIV/ AIDS epidemic is an important factor in the movement of staff, with direct and indirect effects on the retention of health workers. It is reported that countries in sub-Saharan Africa have experienced a situation whereby health workers refuse to work in certain care areas such as labour wards, for fear of becoming infected.

Poor working conditions: Poor working conditions are one of the most common factors in the loss of human resources. Poor working conditions under which health professionals, especially nurses, operate is cited as the main cause of migration. High levels of occupational risks and hazards which result from lack of adequate equipment and protective clothing have contributed to a feeling of insecurity and a desire amongst health workers in the region to move to safer and more protected working environments.

Low remuneration: Low remuneration is a perceived factor in a healthcare worker's decision to migrate. There is a discrepancy between salaries of professionals in the private and the public health sector. Doctors are paid higher salaries than nurses. This might be due to the nature of work that doctors perform compared to that of nurses. The number of years that it takes a doctor to be trained may also be a decisive factor for high compensation.

Increased workload: Workload has been identified as one of the factors contributing to the loss of human resources in sub-Saharan Africa. Workload has been reported to be on the increase as a result of migration of health workers and death rate among health workers in many parts of the region. Unemployment or delayed employment of newly qualified health workers, resulting from poor planning and excessive bureaucracy, also contributes to increased workload.

Other factors: Other factors include lack of support systems such as counselling services for health workers, not valuing the role and contributions of health workers, especially in rural areas. The following section discusses health workers' migration (Commonwealth Secretariat, 2003:7).

2.6 HEALTH WORKERS' MIGRATION

Migration of health professionals from the Southern African region is one of the most critical issues facing the region (SADC, 2006:10). Connell, Zurn, Stilwell, Awases & Braichet (2007:1) note that migration of skilled health workers from sub-Saharan African countries has significantly increased in this century, with most countries becoming sources of migrants. The existing data indicate that the key destination countries are the United States of America (USA) and the United Kingdom (UK), and that major sources are South Africa and Nigeria. Almost 10% of doctors working in the UK are from Africa (Mills *et al*. 2008:1).

Within the SADC region, health workers migrate to richer countries, due to variation in wealth and remuneration in their countries of origin. For example health workers from South Africa, the richest country in the SADC region, migrate to countries such as the UK, Canada, and Australia (Padarath *et al*. 2003:10).

Padarath *et al.* (2003:14) identified three points that need to be noted about the pattern of health personnel flow and migration:

- The rates and volumes of health personnel flow and migration vary between different cadres of health personnel. In some countries cadres such as nurses, doctors and radiographers are mostly affected by migration.
- Health personnel movement and migration is bi-directional. The migration and movement of health personnel is from rich to poor countries and from rural to urban areas.
- There is temporary and permanent migration. In many cases, health personnel migrate for a short time and return to their country of origin. This temporary migration has been viewed as beneficial to source countries as healthcare professionals return with more experience, skills and personal resources than when they left.

The migration of skilled health workers within SADC countries, especially to South Africa, has also been reported and has raised concerns about regional 'brain drain'. Statistics have shown that in a sample of 400 skilled foreigners in South Africa, 41% were from Africa, of which 18% were from SADC countries. Approximately 200 doctors from Zimbabwe emigrated to Botswana and South Africa in 1992 (Padarath *et al*. 2003:15).

Push factors have been identified to have prompted professionals to leave their poor countries and settle in higher-income countries. Negative factors in the source countries include insufficient suitable employment, lower pay, unsatisfactory working conditions, poor infrastructures and technology, lower social status and recognition, and repressive governments.

Pull factors have been identified to have attracted professionals to wealthier countries. These include training opportunities, better living standards, better practice conditions and more sophisticated research conditions (Hagopian, Thompson, Fordyce, Johnson & Hart, 2004:4).

The migration of health professionals has prompted a policy response within SADC to limit the regional recruitment of health personnel in higher income SADC countries (Padarath *et al*. 2003:15). In 1995, South Africa banned the recruitment of doctors from other Organization of African Unity (OAU) countries (Hagopian *et al*. 2004). Since then, South Africa has implemented a system of not issuing visas to health professionals from developing countries within and outside SADC. As a result, official immigration into South Africa has been reported to have come down, both from within SADC and from other parts of the world (Padarath *et al*. 2003:15). The next section explores how migration impacts on health service delivery.

2.6.1 Impacts of Migration on Health Services Delivery

Migration of health professionals from developing countries to developed countries contributes to worldwide health imbalances that may be detrimental to the health systems of source countries. Many doctors trained in Africa migrate to higher income countries on completion of their training in search of better careers, leaving their countries struggling with chronic and infectious illnesses (Hagopian *et al.* 2004:2).

The migration of nurses to other countries has affected many sub-Sahara countries. It is perceived that nurses migrate to other countries to earn more money, to provide for their families, access better education and advanced technology skills, and improve their overall quality of life. While one cannot blame such migrants, the gap created in the healthcare system in their country of origin negatively affects those groups of people most in need. Without enough nurses, hospitals may be forced to close units or turn away patients. It is reported that migration has negatively impacted on economies of most countries, depleted workforces, diminished the effectiveness of health care delivery and reduced the morale of the remaining workforce (Connell *et al*. 2007:1).

The migration has resulted in loss of income invested in training the migrated health workers. The rapid migration of health workers has raised concern and prompted the need for immediate intervention to this problem. In the next section the focus is on policy interventions for managing health worker migration.

2.6.2 Policy Interventions on Migration

There is increasing realisation that a lot more efforts need to be placed by home countries to retain their health professionals. Many doctors and nurses feel that life at home is always better than in foreign countries. These doctors and nurses have also realised that the tendency to stay for long periods in the host countries tends to disadvantage their countries of origin. Several policy interventions are proposed towards better management of health professional migration by their countries of origin (SADC, 2006:10).

Iipinge *et al*. (2009:7) highlighted some of the decisions taken by SADC ministers of health at the SADC Ministers of Health Conference held in 2006. These were:

- Development of a national system of continuing professional development aimed at promoting on- the- job and team- based training;
- Development of financial and non-financial strategies to encourage retention of health professionals;
- Development and strengthening of innovative mechanisms for staff recruitment based on norms that are reviewed on a regular basis; and
- Adopting a strategy on how to replace health workers that have been or are being lost due to migration.

In addition, SADC, in line with its protocol of health of 1999, developed a strategic plan for human resources for health covering the period 2007-2019 to address the brain drain crisis in the SADC region (Iipinge *et al*. 2009:7). The strategy is aimed at addressing the following major issues:

- Migration of health professionals from developing countries to developed countries, as well as from rural to urban areas;
- A mismatch between supply and demand for health workers;
- Poor workforce planning capacity;
- Negative effects of privatisation and HIV/AIDS on health workers;

- Developing policies and strategies for retaining health professionals and improving salaries;
- Developing a regional qualification framework on health;
- Identifying, establishing and developing centres of specialisation by 2009;
- Facilitating continuous training through exchange programmes and attachments; and
- Ensuring that adequate numbers of health workers are trained and retained in their jobs during the period 2010-2020.

This section discussed policy interventions by SADC governments to manage health workers migration. In the next section the factors influencing the performance of health workers are explored.

2.7 FACTORS INFLUENCING THE PERFORMANCE OF HEALTH WORKERS

Many factors are believed to influence the performance of heath workers. These include motivation, job satisfaction, working conditions and environment, and remuneration and incentives. They are discussed below.

2.7.1 Motivation

Mathis and Jackson (2008:70) define motivation as a desire within a person causing that person to act.

Nel, Werner, Haasbroek, Poisat, Sono & Schults (2008: 336) state that in the context of an organisation, motivated people are those who work hard, take initiatives, apply their skills where needed and put in extra effort to achieve the organisational goals. Motivated people go the extra mile to achieve what is required and are always aware of the fact that a specific goal must be achieved. Nel *et al.* (2008:336) further state that what motivates someone may not be the motivating factor for another. These authors identify the following set of Maslow's hierarchy of needs that exist in every human being:

- Physiological needs- include needs for food, water and warmth;

- Safety needs- include needs for security, stability and protection from physical and emotional harm;
- Social needs- include needs for love, acceptance and friendship;
- Ego needs- include needs for self respect, self esteem, respect and approval from others; and
- Self actualization needs- include needs for growth, self fulfilment and achieving one's potential.

Burke (2007:335) argues that the order and practical importance of Maslow's hierarchy of needs depends on the degree to which each need is satisfied, because the degree of satisfaction constantly changes. Maslow (1954) as cited by Burke (2007: 335) believed that people have a desire to grow and develop, and by using and developing their capacities people begin to self actualise and experience satisfaction and enjoyment. Self actualisation is the highest need and when this need is satisfied it is replaced by other needs.

Nel *et al.* (2008:338) further state that management commonly uses money, service benefits and job security as the strategy to motivate people. This is aimed at satisfying both physiological and safety needs. Once these needs are satisfied, they no longer act as a motivator. Burke (2006: 336) has concluded that earnings are only a motivating factor for a short time. This means that even if employees are paid well, they will be motivated for only a short period until the new salary becomes their norm.

Burke (2007:333) maintains that the performance of an individual depends on his or her ability and commitment. In this context ability refers to the personal qualities and competencies a person brings to the job. These are qualities or skills that enable a person to perform a task and to cope with the demands of the job. Commitment on the other hand refers to the willingness of an individual to complete the task. The point should be made that unlike ability, commitment is not a fixed commodity; it changes depending on the circumstances and situations.

Du Toit, Knipe, van Niekerk, van der Waldt & Doyle (2002:184) on one hand suggest that in the public sector, where the aim is to render efficient and effective service,

employers should look into what motivates employees and then compensate them appropriately. Employers should also realise that the workforce has changed and thus there is a need to apply different motivational and compensation techniques. Human resource managers should therefore be aware of these changes in order to keep up with the changing labour situation.

On the other hand Nel *et al*. (2008: 339) add that organisations should have control mechanisms in place to ensure that employees are continually performing according to the required standards. These standards include strict supervision, policy, rules and regulations.

Job satisfaction will be explored in the next section.

2.7.2 Job Satisfaction

Job satisfaction is defined by Mathis & Jackson (2008:70) as a positive and emotional state resulting from evaluating one's job experience. The results of the study conducted by Pendukeni (2004:44) indicate that many nurses in the Namibian public health facilities do not get any satisfaction from their work. They are exhausted from stressful working conditions.

Mathis & Jackson (2006:70) indicate that many people want security and stability, interesting work, a supervisor they can respect and competitive pay and benefits. If these elements are not provided, employees are likely to be less motivated to contribute towards achieving organisational goals and see fewer reasons to give loyalty to the employer. These authors further state that job dissatisfaction occurs when one's expectations are not met. One may therefore assume that job dissatisfaction may contribute to high staff turnover because when employees are dissatisfied they would consider leaving the organisation as the only option.

Christie (2008:2) argued that job satisfaction is about how one perceives the work environment; when the work environment changes, the perception may also change. Job satisfaction can either be positive or negative and depends on different facets within a person's job and the attitude the person has towards the job. A person with

a positive attitude towards a specific aspect of his or her job is more likely to react favourably to other aspects of the job than other people.

Du Toit *et al.* (2002:185) pointed out that employers may not be able to satisfy the needs of each individual, but may create a climate in which employees are happy and value the efforts they put into their work.

Downing (2010:151-164) investigated the level of job satisfaction among critical care nurses in Hawaii and also explored the relationship between socio-demographics and job satisfaction. The study revealed that extrinsic rewards, support from colleagues and interaction opportunities were found to be the motivating factors for critical care unit nurses in Hawaii. Professional opportunities, family and work balance, and control and responsibility were not found to be motivating factors for critical care unit nurses in Hawaii.

A similar study by Chen (2008: 20) found changes in work conditions to be predictive of job satisfaction but not predictive of psychological distress and somatic complaints. Social support from supervisor, reward, and control over work were the strongest predictors of job satisfaction, while work and time pressure and physical demands were the strongest predictors of emotional exhaustion.

According to SADC (2006:14) satisfaction can be expressed by the health workforce and is based on or influenced by a number of factors, including the provision of social benefits. The extent to which professionals feel valued is also dictated by the way health authorities communicate and are seen to seek advice from them.

It should be noted that in most cases employees become dissatisfied when things are not the way they should be. From the discussions above, it is clear that job dissatisfaction generally depends on working environment and conditions of service. The best approach for managers to reduce job dissatisfaction would then be to create rewarding and satisfying working environments for their employees. The next section focuses on working conditions and environment.

2.7.3 Working Conditions and Environment

Du Toit *et al.* (2002:96-97) are of the opinion that the efficiency, effectiveness and economy of service delivery depend on the environment in which those services have to be delivered. These authors further noted that the environment or an aspect of it influences, positively or negatively, government institutions and their ability to deliver services. The workplace is where employees spend most of their time. If the environment is not congenial, for example untidy and inadequate in space, this will have a negative influence on service delivery and may lower productivity. Mrara (2010:23) claims that employee turnover can be minimised if employees can be exposed to a healthy workplace environment that will assist in fostering happiness, and in the process, enhance their motivation.

Padarath *et al*. (2003:17) on one hand state that working conditions such as poor management, lack of medicines and equipment, inadequate support and communication with health personnel have been identified as factors that contribute to dissatisfaction among public sector health workers, especially in the rural areas. It is therefore imperative that employers provide suitable working conditions and environment to ensure that employees perform according to the set standards.

At independence, most of the SADC governments have inherited poorly planned health facilities and most were in unsatisfactory states of preservation. These facilities posed a serious challenge in terms of the environment that health professionals demand. The ministries of health need to work to improve the physical and management environment of these facilities so that they are conducive to the services of the health workforce (SADC, 2006:12). Remuneration and incentives are explored in the next section.

2.7.4 Remuneration and Incentives

Swanepoel, Erasmus & Schenk (2008:475) define remuneration as the financial and non-financial extrinsic rewards provided by the employer for the time, skills and efforts made available by the employee in fulfilling job requirements aimed at achieving organisational objectives.

Swanepoel *et al*. (2008:475) stress that remuneration has always been regarded as the key element of the employment relationship. The employment relationship is usually based on economy- motivated process where certain physical and mental behaviour inputs are exchanged for something else that is considered to satisfy individual needs or goals. In this exchange, employees are rewarded by the employer for the time, skills and efforts that they have invested in achieving organisational goals. In addition, rewards such as pay and benefits which people gain from an employment relationship are very important to individuals since they meet many needs, such as food and shelter, achievement, status and power.

Swanepoel *et al*. 2008:504) further state that incentives remuneration, an allowance paid to employees to attract and retain them in an organization, differs from other forms of remuneration in that it constitutes an additional reward for outstanding efforts aimed at achieving organisational goals. It is usually in a financial form and based on the belief that pay is usually a motivating factor to individuals or groups of employees to perform above the required standard of performance and increase organisational effectiveness. Incentives remuneration schemes are devised for the following reasons:

- To increase the organisation's competitiveness in the labour market for attracting and retaining talent;
- To stimulate individual, team or organisational performance by making incentive rewards dependent on agreed targets or work outcomes; and
- To recognise and reward better performance.

Padarath *et al.* (2003:11) added that remuneration and salary levels are the most significant factors contributing to health workers' migration to richer countries.

It is important to acknowledge that health professionals are highly educated members of society who take responsibility when diseases and illnesses strike. They are governed by codes of behaviour standards that other professions in society are not normally subjected to. It is therefore important that health professionals in the public sector are offered additional incentives to support remuneration packages. Health professionals must be remunerated at levels commensurate with the responsibility placed upon them for the provision of health services. Attractive

working conditions must also be provided to enhance their confidence in the public health sector and lead to its being an employer of choice. Remuneration of health workers must be structured in a manner that will promote their retention in clinical settings (SADC, 2006:14).

2.8 CONCLUSION

Human resource management is concerned with the acquisition of human resources, developing their skills and competencies in order to achieve organisational objectives. Without human effort organisations cannot achieve their objectives. Human resources are responsible for different interventions that have lasting competitive advantages for the organisation.

This chapter discussed issues related to human resources in the health sector. The chapter firstly focused on staffing and its processes, namely, human resource planning, recruitment, selection, placement, and induction and orientation. The chapter also looked at staff turnover and its effects on service delivery. Another focus was on migration of health workers and its impact on service delivery. The chapter concluded by discussing factors influencing human resource distribution and availability, and performance of employees.

Chapter Three discusses the research methodology used to conduct the study.

CHAPTER THREE: RESEARCH METHODOLOGY

3.1 INTRODUCTION

This research aimed at determining the extent to which human resources capacity of the MoHSS in Namibia influences health care services delivery to the population. For the project to be completed successfully, a sound research design needed to be employed. According to Bhatia (2009:227) a research design is the overall plan or programme of research. It contains an outline of what the researcher will do, from writing the hypothesis and its operational implications to the final analysis of data.

This chapter presents the research methods used, and covers the following areas:

- Nature of Research
- Method of Data Collection
- Data Analysis
- Reliability and Validity of Data
- Ethical Consideration

3.2 NATURE OF RESEARCH

The study followed a qualitative research model using exploratory and descriptive study designs to generate qualitative data. According to Orb, Eisenhauer & Wynaden (2001:93), the purpose of qualitative research is to describe a phenomenon from the participants' point of view through interviews and observation. The intention of the researcher was to listen to the voice of participants or observe them in their natural environments. The researcher has chosen this model in order to listen to health workers who have been working under presumed inadequate staffing conditions. The researcher believes that qualitative research is a suitable method of obtaining valuable information that could assist the Ministry of Health and Social Services in Namibia to plan, develop and implement strategies for improving the state of staffing and performance in the public health sector.

3.2.1 Qualitative Research Design

A qualitative research design is defined as a disciplined attempt to address questions and/or solve problems through the collection and analysis of primary data for the purpose of description, explanation, generalisation and prediction (Stephanus, 2009:4).

According to Liamputtong (2010:11), qualitative research is concerned with in-depth understanding of the issue under examination. It relies heavily on individuals who are able to provide rich accounts of their experiences, and it usually works best with small numbers of individuals.

It is further asserted by Maxwell (2005:115) that qualitative researchers usually study a single setting or a small number of individuals or sites, using theoretical or purposeful rather than probability sampling, and they rarely make explicit claims about the generalisability of their accounts. The researcher believes that the use of purposive sampling in this study enables the obtaining of crucial information from respondents. Liamputtong (2010:11) further explains that qualitative research is important when researchers have little knowledge about the phenomenon under investigation, and when there is a problem or issue that needs to be explored. This exploration will in turn allow researchers to hear a larger number of silenced voices. By using a qualitative research method, the researcher has been able to explore from health workers how the staffing level of the MoHSS influences health care service delivery to the Namibian people.

3.2.2 Exploratory Research Design

Exploratory research studies strive to gain familiarity with a phenomenon or to achieve new insights into it (Kothari (2004:2). In this study, the researcher strove to understand how health workers perceive the state of staffing and performance in the MoHSS.

According to Elahi & Dehdashti (2011:2) exploratory research design applies when the research objectives include the following:

- Identifying problems;

- Developing a more precise formulation of a vaguely identified problem;
- Gaining perspective regarding the breath of variables operating in a situation;
- Establishing principles regarding the potential significance of various problems; and
- Gaining management and researcher perspectives concerning the characteristic of the problem situation.

The application of an exploratory research design, according to the researcher in this study, enabled the identification of problems associated with presumed staffing inadequacy in the MoHSS. The researcher also gained insight into the MoHSS staff perspectives on how the staffing inadequacy influences the delivery of health care services to the Namibian population.

The advantage of an exploratory research method is that it allows for in-depth exploration of the phenomenon under investigation, including its manifestation and related factors (Awases, 2006:23). It was therefore important that the researcher employed an exploratory study that would provide more information on the staffing levels and performance in the MoHSS.

3.2.3 Descriptive Research Design

Descriptive research studies aim at portraying accurately the characteristics of a particular individual, situation or group in real life situations. Descriptive research study includes surveys and fact–finding enquiries of different kinds (Kothari, 2004:2). By means of this research method, researchers strive for a better understanding of the current situation through a data collection process that enables them to describe the situation in more detail and more extensively (Technikon South Africa, 2001:12). The researcher deemed it necessary to use a descriptive research design to better describe how health workers perceive and experience human resource capacity of the MoHSS. It is essential to indicate how data for this study were collected. This is detailed in the following section.

3.3 METHOD OF DATA COLLECTION

Kothari (2004:95) explains that the task of data collection begins after a research problem has been defined and research design has been drawn up. The researcher thus has to consider which method is the most appropriate in the light of the research problem involved and the particular population in question. According to Struwig & Stead (2001:98), there are numerous ways of collecting data in qualitative research studies. These include interviews, focus group interviews, observation, and unobtrusive measures. In this study methods of data collection employed were personal interviews and document analysis. A detailed discussion of these methods is presented in the next section.

3.3.1 Sampling Method

Decisions about where to conduct the research and who to include are essential parts of research methods. One cannot study everyone everywhere, hence sampling is essential. Sampling is defined as the selection of a relatively small group of individuals from whom the researcher obtains data in order to be able to generalise about a larger group (Paul *et al.* 2007:102).

Van der Waldt, van Niekerk, Doyle, Knipe, & du Toit (2002:292) state that there are two types of sampling: probability sampling and non-probability sampling. Probability sampling is a type of sampling whereby each element in the population has a known probability of being included in the sample (Struwig & Stead, 2001:111). According to Greenfield (2002:189) the advantage of probability sampling is that it enables the avoidance of selection biases and that it permits the precision of estimates to be assessed, using only information that is collected from the selected sample.

Non-probability sampling is when certain members of the population are chosen because of a judgment on the characteristics of the population (Van der Waldt *et al*. 2002:292). As expanded further by Kothari (2004:59), in non-probability sampling, the researcher purposively chooses particular units of the universe for constituting a sample on the basis that the small mass that they so select out of a huge one will be typical or representative of the whole. Accidental samples, purposive samples, quota samples and snowball samples are non-probability samples (Huysamen, 1994:37).

This study used a non-probability purposive sampling technique to select research participants. The use of non-probability purposive sampling in this study enabled the researcher to select study participants who were able to provide crucial information, on behalf of other similar officials, that can be used to improve the current state of staffing and performance in the MoHSS.

The study was conducted in Khomas Region, Windhoek District, in Namibia. Participants in the study were selected from two public hospitals: Windhoek Central Hospital, and Intermediate Hospital Katutura, and two directorates: Directorate Khomas Region, and Directorate Human Resource Management and General Services.

The two selected hospitals are public national referral points. They render health care services to patients in Windhoek District and neighbouring farms. They also receive patients referred from other health facilities across the country. The two directorates are national directorates coordinating human resource activities at national level in the Ministry. The duties these officials perform are the same as for the other similar officials in the MoHSS.

On this basis the researcher is of the opinion that the information provided by health workers in the selected hospitals and directorates is representative of other health workers in the other health facilities in the MoHSS.

A sample of 46 health workers was selected from a population of 995 health workers (medical superintends, nurses, and human resource practitioners) to participate in the study. One medical superintendent, one nurse manager, twelve registered nurses and enrolled nurses, were selected from each hospital. Human resource practitioners were selected as follows: five from Windhoek Central Hospital, three from Intermediate Hospital Katutura, seven from Directorate Human Resource Management and General Services, and three from Directorate Khomas Region. The sample represented the following three population groups:

- Two medical superintends and two nurse managers: these are senior officials who manage the hospitals and are directly involved with planning, monitoring, implementing hospital related policies and decisions, and supervising staff at lower levels. They are also involved in human resource activities such as

requesting filling of vacancies, motivating for additional staff, participating in the recruitment and selection process, and monitoring staff movement at the hospital level.

- Twenty four registered nurses and enrolled nurses: these are health workers who are directly involved in delivering health care to patients on daily basis; and
- Eighteen human resource practitioners: these are officials who are directly involved in coordinating and performing human resource activities in the MoHSS, including managing staff records of selected hospitals' employees.

According to Struwig & Stead (2001:111), in non-probability sampling, a sample may be selected on the basis of expert judgement. Respondent selection thus depends on the researcher's judgement. For this study, Participants with five or more years of experience in the services of the Ministry of Health and Social Services were purposively selected, based on their positions and experience in their areas of service delivery. The researcher believes that health workers who have worked for five years or more may be in a better position than other employees to understand the staffing levels and their influence on health care service delivery.

The staff establishments of the selected hospitals and directorates were used to select study participants. Duty sheets were obtained from the nurse managers of the two hospitals to determine the availability of nurse participants working day and night shifts. Contact details of the selected participants were obtained from nurse managers to set up interview appointments. Participants were informed in advance of the dates and venues for the interviews.

3.3.2 Sources of Information

As previously noted there are numerous ways of collecting data in qualitative research studies. These include interviews, focus group interviews, observation, and unobtrusive measures. Data for this study were collected through the following sources:

3.3.2.1 Primary data

Primary data are those which are collected for the first time, and thus happen to be original character (Kothari, 2004:95). Primary data for this study were gathered through conducting personal interviews with research participants.

The method of collecting information through personal interviews is usually carried out in a structured way and these are referred to as structured interviews. Structured interviews involve the use of predetermined questions and of highly standardised techniques of recording (Kothari, 2004:98). The semi-structured interview is another method of collecting information. In this method, the interviewer has in mind a number of questions that he/she wishes to put to the interviewees, but which do not have to follow any specific predetermined order (Grix, 2004:127).

According to Gillham (2005:70), a semi-structured interview implies that the same questions are asked of all those involved, approximately equivalent time is allowed in each case, questions are open, and probes are used to gain more information from the interviewee. Grix (2004:127) states that a semi-structured interview is the most important way of conducting a research interview because it allows a certain degree of flexibility and allows for the pursuit of unexpected lines of enquiry during the interview.

Interview questions were semi-structured. A semi-structured interview schedule was used to obtain personal information and responses from research participants. An interview schedule for the study consisted of thirteen open-ended questions and four closed-ended questions. According to Gillham (2005:73) open-ended questions, mean that the response is open to the respondent's free choice, results in a data set which is almost unanalysable. The researcher believes that open-ended questions allowed participants in the study to share more information on their experiences of staffing situation in the MoHSS. Closed-ended questions were asked to generate biographical details of study participants.

Interviews were conducted over a period of three weeks, from 5-24 November 2012. Each interview lasted for about 15-30 minutes. Interviews were conducted by the researcher in English, audio recorded and transcribed. Field notes were taken to record non-verbal responses that may assist in understanding how participants felt

about particular issues. Interviews for human resource practitioners and nurse managers were conducted in participants' offices, while nurse managers made their offices available for the nurses' interviews. This was done to make participants feel more comfortable and also to avoid noise disruption.

Study participants were interviewed in-depth. The researcher employed in-depth interview methods to allow direct interactions with study participants.

Liamputtong (2010:62) states that in-depth interviewing is a major means of exploring the ways in which research participants experience and understand their world. The method provides a unique opportunity for researchers to access the lived experiences of the participants who are able to describe their world in their own words. Paul *et al.* (2007: 153) add that in-depth interview techniques offer an opportunity to probe extensively for sensitive information from potentially evasive individuals, tailoring each interview so the interviewee feels as comfortable as possible and is encouraged to provide the required information. The researcher therefore believes that employing in-depth interview methods in this study enables the obtaining of important information that can be used to improve the state of staffing and performance in the public health sector.

3.3.2.2 Secondary data

Secondary data are those which have already been collected by someone else and have already been passed through the statistical process (Kothari, 2004:95). In other words secondary data are those data that have been collected for some other purpose than the problem at hand. Secondary data were collected through analysis of the MoHSS documents, such as annual reports and strategic plans. Dissertations and journals were also accessed to collect secondary data.

3.4 ANALYSIS OF DATA

Data analysis is the process of grouping raw data together and processes them in a variety of ways to show what they mean and to facilitate their interpretation (Paul *et al*. 2007:48).

Data analysis is used to clarify and refine the concepts, statements or theories in the research, especially when there is an existing body of literature. The task of the analyst is to bring out the hidden meanings in the text (Technikon South Africa, 2001:61).

Data for this study were analysed according to the predetermined themes as well as emerging themes. The researcher repeatedly analyzed the content in order to determine main themes and categories. The data were then interpreted by the researcher according to these themes.

3.5 RELIABILITY AND VALIDITY OF DATA

According to Technikon South Africa (2001:27) reliability means that the measuring instruments must yield comparable results in the same or similar circumstances using the same or similar research groups. Validity means that the measuring instruments must measure what they are supposed to measure.

The researcher ensured the validity and reliability of the results of the study by developing an interview schedule in consultation with the supervisor, and pilot-tested the interview schedule with staff members who were not part of the study, to investigate the feasibility of the proposed study and to detect possible flaws in conducting the study, such as inadequate time.

Gillham (2005:73) states that the pre-piloting stage requires careful planning in the selection of those on whom the researcher is experimenting. They should be the same kind as the research group but not the same people, briefing them as to the purpose of the exercise and asking them to make any comments they see fit. Gillham (2005:73) further states that pilot-testing enables the researcher to ensure that all aspects of the interview are as they are intended to be in the main study.

3.6 ETHICAL CONSIDERATIONS

Qualitative studies are frequently conducted in settings involving the participation of people in their everyday environments. Any research that includes people therefore

requires an awareness of the ethical issues that may derive from such interactions (Orb, *et al.* 2001:93).

3.6.1 Permission and Approval

Permission to conduct the study was granted by the Ministry of Health and Social Services, Namibia. Ethics clearance was sought from the Department of Public Administration's Ethics Committee but the Committee could not grant clearance because the application was done after the research had already commenced. In terms of Unisa's Ethics Policy, an application for Ethics Clearance has to be submitted once the research proposal has been approved, and before any research commences.

It should however be noted that all the ethical requirements, as stipulated in the Unisa Ethics Policy, were complied with as regards data collection, interviews, informed consent with cautionary warnings, and the research.

3.6.2 Informed Consent

Huysamen (1996:180) indicates that informed consent of prospective subjects to participate in research should be obtained beforehand. This consent is especially important if subjects are to be subjected to physical or psychological discomfort.

Informed consent was obtained from the research participants before the research commenced. Participants selected to participate in the study signed consent forms asserting that they had agreed to take part in the study.

3.6.3 Privacy

Participants were informed that information they provided would be treated confidentially. Pseudonyms were used to protect the identities of study participants.

3.6.4 Voluntary Participation

Participants were told that their participation was voluntary and that they had the right to withdraw at any time if they so wished.

3.7 CONCLUSION

This chapter discussed the research methods used in the study. Such methods conform to a qualitative research model using exploratory and descriptive study designs. The chapter also outlined the study population and sample. The sample was drawn from health workers (medical superintendents, nurse managers, registered nurses, enrolled nurses, and human resource practitioners) with five or more years of work experience in the Ministry of Health and Social Services.

The manner in which information was gathered and analysed was explained in this chapter. Ethical considerations were also highlighted.

Chapter Four presents an analysis of the data obtained.

CHAPTER 4: DATA ANALYSIS AND INTERPRETATION

4.1 INTRODUCTION

The purpose of this study was to explore the extent to which human resources capacity of the MoHSS in Namibia influences health care service delivery. This was done with the aim of suggesting ways of improving the state of staffing and performance in the MoHSS.

This chapter presents a demographic profile of study participants, and the results of the study. Data collected are analysed and interpreted in this chapter. The results of the study are based on the following four predetermined themes:

- Staffing and performance;
- Absenteeism and turnover rate;
- Workload; and
- Motivating factors.

Other themes that emerged during interviews are also discussed. These are:

- Communication and support system at the workplace;
- Equipment and supplies; and
- Recruitment of nurses from abroad.

4.2 PARTICIPANTS' DEMOGRAPHIC PROFILE

A brief demographic profile of study participants is provided in this section. The demographic profile includes characteristic variables and geographical distribution of study participants.

4.2.1 Characteristic Variables of Study Participants

Of the 46 participants, 24 were nurses, 18 were human resource practitioners, and 4 were hospital managers. Fourteen (14) participants were at middle management level and years of management experience ranged from 2-20 years. Sixteen (16) participants were at supervisory level, and 16 were at operational level. Ten had worked for 5-10 years, 14 for 10-15 years, 5 for 15-20 years, 6 for 20-25 years, and 11 for 25-30 years. See Table 6.

Table 6: Characteristic Variables of Study Participants

Job Category	**No.**
Nurses	24
Human Resource Practitioners	18
Hospital Managers	4
Total	**46**
Employment Level	
Top Management	0
Middle Management	14
Supervisory Level	16
Operational Level	16
Total	**46**
Years of Experience	
5-10 years	10
10-15 years	14
15-20 years	5
20-25 years	6
25-30 years	11
Total	**46**
Years of Management Experience (n= 14)	
2-5 years	5
5-10 years	3
11-15 years	2
16-20	4
Total	**14**

4.2.2 Geographical distribution of study participants

Of the 46 participants, 19 were from Windhoek Central Hospital, 17 from Intermediate Hospital Katutura, three (3) from Directorate Khomas Region and seven (7) from Directorate Human Resource Management and General Services. See Table 7.

Table 7: Geographical Distribution of Study Participants

Category	Windhoek Central Hospital	Intermediate Hospital Katutura	Directorate Khomas Region	Directorate Human Resource Management & General Services
Registered nurse	6	6	0	0
Enrolled nurse	6	6	0	0
Human resource practitioner	5	3	3	7
Nurse manager	1	1	0	0
Medical superintendent	1	1	0	0
Total	**19**	**17**	**3**	**7**

4.3 RESULTS OF THE STUDY

The results of the study are based on the following four predetermined themes:

- Staffing and performance
- Absenteeism and turnover rate
- Workload
- Motivating factors

Quotes have been used throughout the presentation of results to reflect the participants' responses. Such quotations are indented, italicised, and placed between inverted comas to separate the researcher's interpretations from participants' statements. Participants were given pseudonyms to protect their identities. For example, Registered Nurse 8 refers to a registered nurse participant number eight in the study.

4.3.1 Staffing and Performance

All 46 participants were asked to give their opinions about the state of staffing and performance in the MoHSS, and to describe how the staffing level in the MoHSS influences health care service delivery to the Namibian population, as well as its effect on health workers' personal lives.

In response to this question, of the 46 participants, 45 (97.8%) indicated that there is a severe shortage of staff in the MoHSS. The remaining one (1) participant (2.2%)

was of the opinion that the staff is adequate but there is a need to improve on staff development and quality of service.

Of the 46 participants, 21 (45.7%) showed concern on the impact of staffing on service delivery. They indicated that the staff shortage has severely affected the productivity level of health workers and the quality of care expected is no longer achieved. The following expression by Registered Nurse 32 describes the situation:

> *"We are treating our community, we help them up to the level we can. Sometimes the ward is full then you are not attending to all the patients, like sometimes you are working only two in the ward and you neglect the patients".*

It was, however, encouraging to know that despite the challenge of staff shortage, there are some health workers who are trying their level best to deliver the required nursing care. This is confirmed by a statement made by Registered Nurse 11:

> *"Even though we have a shortage of staff, the few who are there are really trying the best to deliver and the community understands. I am talking about the field where we are, what we give to them they understand".*

4.3.1.1 Level of posts filled

Participants were asked to indicate whether all key health professionals' posts on MoHSS staff establishment were filled. This question was put to participants in the job categories of human resource practitioners, nurse managers and medical superintendents (n=22). Figure 1 shows the responses of participants on level of posts filled.

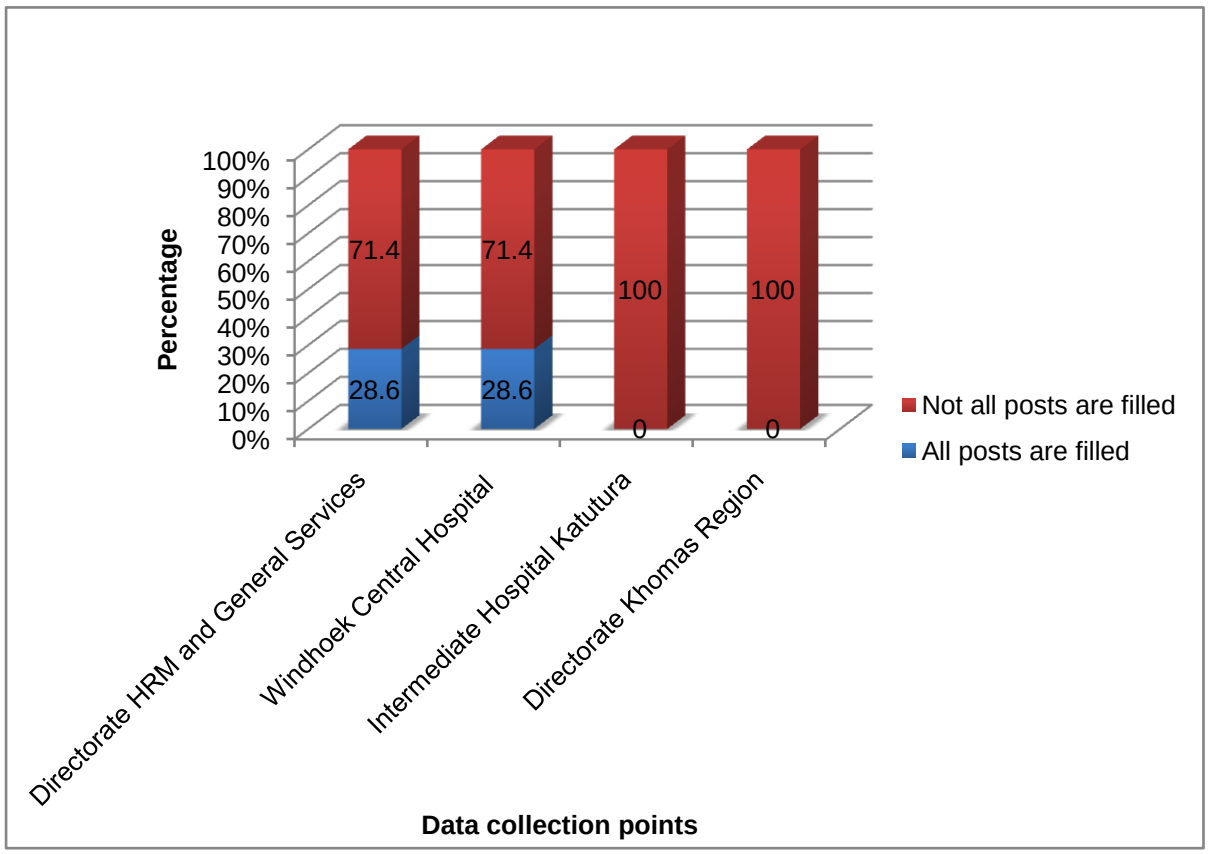

Figure 1: Participants' responses on level of posts filled

As shown in Figure 1, the majority of participants in each of the data collection points indicated that not all posts were filled. This could imply that the MoHSS is understaffed and this may affect service delivery.

Reasons given for non-filling of posts include:

- No qualified Namibians are available to fill the posts;
- Namibians mostly go to the private sector for better conditions of service;
- Salary structures do not attract people;
- Scarce skills professionals are not easy to find; and
- Work permits take too long to be approved and some expatriate applicants end up declining job offers.

It can be concluded that better conditions of service and congenial working environment are important factors in attracting and retaining health workers.

4.3.1.2 Vacancy rate

Participants in the job categories of human resource practitioners (n=18) were asked to indicate the vacancy rate in their hospitals/directorates' staff establishments. Participants' responses are indicated per directorate/hospital as follows:

- **Directorate Human Resource Management and General Services (n=7):** Five participants stated that they had no idea, one indicated that about 2000 posts are vacant, and the remaining one responded that 70% of posts were vacant.

- **Windhoek Central Hospital (n= 5):** Two participants indicated that they had no idea, one indicated that 7% of posts were vacant, one indicated approximately 27% of posts were vacant, and the remaining one indicated that about 100 posts were vacant.

- **Intermediate Hospital Katutura (n=3):** Two indicated that 45% of posts were vacant, while the remaining one indicated that 80% of posts were vacant.

- **Directorate Khomas Region (n=3):** One indicated that she had no idea, one indicated that 15% of posts were vacant, while the remaining one indicated that less than 15% of posts were vacant.

In response to this question, of the 18 participants, 7 responded that they did not know the vacancy rate in their respective hospitals/directorates. This might be due to the fact that not all the human resource practitioners work with the staff establishments; therefore they may not know the vacancy rate. The remaining 11 participants gave different responses, ranging from 7% to 80%. This may be due to the fact that the vacancy rate differs from one hospital/directorate to another.

The MoHSS Human Resource Development annual report of 2009/2010, however, indicates that the MoHSS staff establishment of selected key health professionals categories (doctors, pharmacists, dentists, radiographers, radiographic assistants, social workers, registered nurses, medical specialists, environmental health officers, environmental health assistants, radiographers, enrolled nurses, physiotherapists,

occupational therapists, orthopaedic technologists, orthopaedic technicians, and clinical psychologists) altogether stood at 5629, of which 4707 posts were filled. This translates into 84% of posts filled and 16% vacancy rate for these job categories (MoHSS, 2010:4).

It appears that the number of staff allocated is not adequate to cater for the population service needs because, although 84% of key health professional posts are filled, health workers seem to be still experiencing severe staff shortage. Note should also be taken that this figure may have changed over the past two years due to staff turnover. It should be pointed out that if an organisation is not functioning at full staff complement it may face the challenge of not providing services at the required standard.

4.3.1.3 Requests for additional posts

Participants in the job category of human resource practitioners were asked to state whether they had received any requests for additional staff from hospital management in the past two years.

Of the 18 participants, 16 (89%) indicated that they received requests for additional staff from hospital management. Reasons given were mainly that the staff establishment is outdated and the number of staff allocated to health facilities is no longer adequate to serve the community. Because of population growth and new services introduced due to emerging diseases, requests were received for creating additional posts to cater for these changes.

The study also found that in the past, doctors and pharmacists worked on a pool system, but with the introduction of new services and programmes, and growing numbers of patients, health workers believe that there is a need for each department to have a doctor and a pharmacist to cover the workload.

It also emerged from the study that with the establishment of the School of Medicine in Namibia there was a need to employ more specialists and other health professionals such as doctors, nurses, pharmacists, and radiographers to supervise students doing practical work at the teaching hospitals.

Awases (2006: 216) emphasised that to ensure that quality health care is provided to patients it is important that adequate numbers of health workers with appropriate skills are available at all levels. It can therefore be concluded that the availability of adequate human resources is an important aspect of service delivery.

4.3.1.4 Complaints from health workers regarding staffing

Nurse managers and medical superintendents (n=4) were asked whether they had received any complaints from health workers regarding staffing in the past two years. All four participants stated that they received complaints. The participants indicated that some health workers complain that there are too many patients, and there is a shortage of staff because many health workers left the MoHSS due to insufficient salaries; hence more staff is needed for service delivery.

4.3.1.5 Efforts made to fill vacancies

All participants were asked to state whether efforts are made or mechanisms put in place to fill vacancies. The study revealed that the following measures were put in place:

- External advertisements are being done through media and internet to attract foreign nationals;
- Head hunting (approaching people);
- Medical and Pharmacy schools were established in Namibia to train doctors and pharmacists locally;
- MoHSS established health training centres where enrolled nurses are trained for a period of two years;
- Salaries for medical doctors were upgraded to retain them and attract more doctors into the public sector;
- Agreements were signed with other countries such as Cuba and Kenya to recruit doctors, dentists, pharmacists and nurses;
- Health facilities are being renovated and upgraded to make the working environment more congenial;
- MoHSS conducted an incentive study to attract and retain health professionals with scarce skills in the public sector;

- Health professionals are allowed to participate in remunerative work outside the public service to supplement their income. For example doctors and pharmacists do part-time lecturing at local academic institutions;
- The MoHSS has recruited some staff under the funding of global partners; and
- The MoHSS is in the process of restructuring the staff establishment to create more posts.

It is satisfying to note that the MoHSS is trying its level best to address the challenge of staff shortage in public health facilities.

4.3.1.6 Effects of staffing level on the community and health workers' personal life

The shortage of staff is presumed to have an adverse effect on the community and health workers' personal life. When asked to describe the extent to what the staffing level of the MoHSS influences health care services delivery to the Namibian population, participants described the staffing level of the MoHSS as inadequate to the extent that patients are no longer getting proper and adequate nursing care. Registered Nurse 33 said the following:

> *"Patients are more than the staff. Let me say you will find there is 46 patients in the ward but the staff are just three or four, especially in the afternoon. In the morning we try to be five or four. Most of our staff are not enough, you will find in the medical ward, I am now talking about my ward, you have 10 or they can go up to 16 bedridden patients who cannot help themselves. You have only four staff, these patients need to be washed, fed, mobilized and most of our investigations are done outside the hospital. Those are the same staff who are escorting patients to other hospitals for investigations, so the staff is not enough"*

The shortage of staff is perceived to have caused a lot of health problems, both physical and emotional since health workers are working under pressure. When asked how the staffing level of the MoHSS affects health workers' personal lives, participants described themselves as being overworked due to working long

overtime hours. As a result they end up sick, exhausted, stressed, burnt out and unable to give proper attention to their families. Registered Nurse 11 said:

> *"When you come from duty you are tired and exhausted, you don't even want to listen to anybody because the work was too much".*

Being understaffed appeared to have affected health workers' social life. This is supported by a comment from Registered Nurse 42:

> *"I do not socialize outside because I do not have much time. I don't hang out with friends; I am most of my life at work".*

Others explained that the staff shortage is affecting their health as sometimes they work without eating because of too many patients to attend to.

4.3.1.7 Strategies for improving the current state of staffing and performance

Participants were asked to recommend strategies that they thought could improve the current state of staffing and performance in the MoHSS. The following strategies were suggested:

- Fill all vacant posts;
- Review the MoHSS staff establishment;
- Speed up the restructuring process to create more posts;
- Train another category of nurses from Grade 10 school leavers to do basic nursing care;
- Appoint more staff, especially doctors and nurses;
- Improve salary benefits and other conditions of services;
- Provide congenial working environment to attract and retain health professionals;
- Introduce bonding agreements for health professionals;
- Introduce hardship allowance and other incentives to attract and retain health professionals;
- Staffing norms to be in place to determine the workload and number of staff to be allocated at each health facility;
- Introduce performance appraisal systems to adequately monitor performance; and

- Empower supervisors to do proper supervision.

By looking at the strategies recommended by participants, it can be assumed that more needs to be done to improve the state of staffing and performance in the MoHSS.

4.3.2 Absenteeism and Turnover Rate

All 46 participants were asked to indicate the level of absenteeism and turnover in their respective hospitals by rating from very high to very low.

4.3.2.1 Absenteeism rate

Of the 46 participants, 37% rated absenteeism very high, 28.2% rated moderate, 15.2% rated high, 11% rated low, and 8.6% rated very low. See Figure 2.

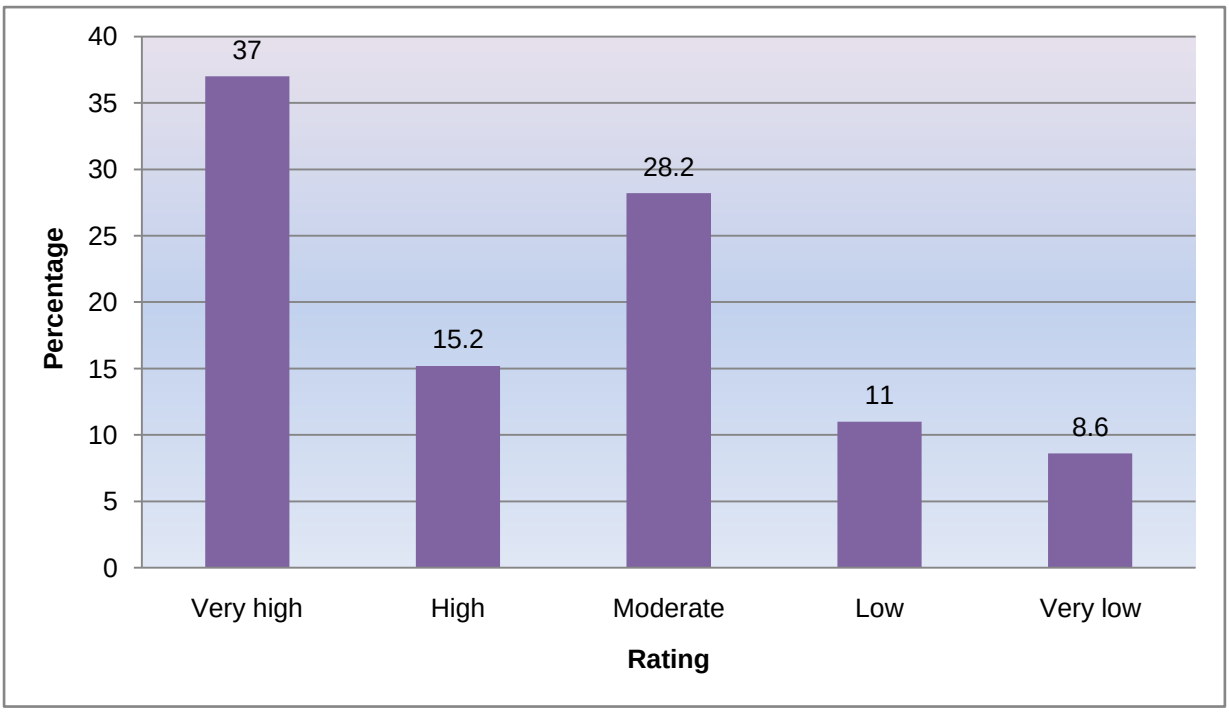

Figure 2: Participants' perceptions of absenteeism rate

It can be assumed that the absenteeism rate is increasing. It should be pointed out that high levels of absenteeism may lead to an imbalance in nurse/patient ratio, with the inevitable effect on service delivery.

Participants were asked to give the main reasons for absenteeism. These are indicated in Table 8 in order of importance per job category.

Table 8: Reasons for absenteeism

Nurses	Human Resource Practitioners	Hospital Managers
▪ Sickness ▪ Exhaustion ▪ Compassionate leave (attending funerals, caring for sick family members) ▪ Financial problems ▪ Personal problems ▪ Alcohol abuse	▪ Sickness ▪ Compassionate leave ▪ Vacation leave ▪ Study leave ▪ Alcohol abuse ▪ Personal problems ▪ Lack of motivation ▪ Maternity leave	▪ Sickness ▪ Exhaustion ▪ Compassionate leave (attending funerals and caring for sick family members)

As can be seen in Table 8, sickness was ranked number one by all three job categories participating in the study. This may imply that there is a high workload in the MoHSS and health workers are overworked, and as a result they end up sick. This would leave the other health workers on duty to have to cope with the workload to compensate.

It is also shown in Table 8 that sometimes health workers may be unable to come to work due to financial problems such as not having taxi money. This is substantiated by the following comment by Enrolled Nurse 39:

> *"We work overtime but the money they are not come on time. Sometimes the transport money finish that time, sometimes your transport money is not enough, sometimes you want to come to help, you are off, sister call you to come to help but you do not have transport money"*

This could be an indication that the salaries of health workers are not sufficient and as a result they cannot cope with the living standard. In the end, performance and service delivery are affected when health workers do not turn up for work.

4.3.2.2 Staff turnover rate

Of the 46 participants, 22 (48%) rated the staff turnover very high, 15 (32.6%) rated high, 8 (17.3%) rated moderate, and 1 (2.1%) rated low. This could demonstrate that more health workers are leaving the MoHSS and this may result in severe staff shortage. See Figure 3.

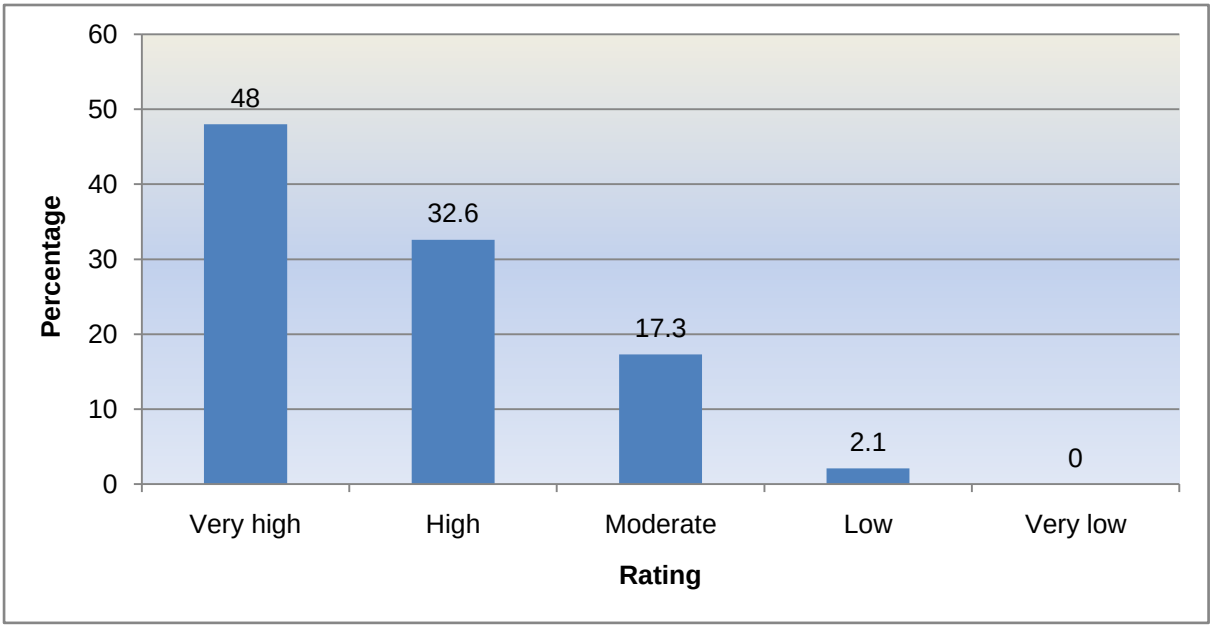

Figure 3: Participants' perceptions of staff turnover rate

Participants were also asked to give the main reasons for staff turnover. These are indicated in Table 9 in order of importance per job category. Participants stated that many health workers migrated to the private sector in search of better salaries and conditions of service. Others were of the opinion that health workers left due to high workload. It was reported that the workload is too much and health workers are not coping. The participants perceived that if nurses went to work in the private sector they would work comfortably because staff shortage in the private sector is not as high as in the public sector.

Others expressed the opinion that health workers leave the public sector because of lack of respect and appreciation by the employer. They feel that in the private sector the work is more valued and one is appreciated for contributing to the institution, unlike in the public sector where people are working in an environment that is not congenial.

Table 9: Reasons for staff turnover as given by participants

Nurses	Human Resource Practitioners	Hospital Managers
▪ Better salaries ▪ Workload ▪ Further studies ▪ Lack of respect from higher authorities ▪ Inadequate equipment ▪ Burnout	▪ Better salaries ▪ Further studies ▪ Better working environment and conditions of service ▪ Retirement ▪ Workload ▪ Absence of retention strategies ▪ Lack of appreciation	▪ Better salaries ▪ Further studies ▪ Retirement ▪ Discharge due to ill-health

As it can be seen in Table 9, the most common reasons for staff turnover are better salaries, better working environment, and further studies. These were ranked among the top five by all three categories of participants interviewed. This could demonstrate that health workers are not satisfied with the conditions of service in the public health sector. It can be concluded that the absence of an effective retention strategy for health workers could be the contributing factor in the challenge of the MoHSS to retain its health workers.

4.3.3 Workload

Nurse participants were asked whether there had been any change in the workload in the MoHSS over the past two years. All nurses interviewed said that the workload had increased. Registered Nurse 42 stated:

> *"The change which is there is that the workload has become more because on a daily basis on a monthly basis nurses are leaving the MoHSS. Some are going to study to become doctors because what is happening now people want to become doctors. I don't know whether they are all born doctors or they just go for the status which I am worried is the case, so at the end of the day the workload becomes more".*

One nurse from Intermediate Hospital Katutura said that there were too many referrals from other health facilities, even when it was not necessary, and this contributed to high workload. One such example is that hospitals refer even terminally ill patients who are supposed to be discharged for home based care.

Registered Nurse 44 described the situation as being overwhelming and expressed herself this way:

> *"We receive patients from health facilities in all thirteen regions in Namibia, even if they are not referred. As a result the community is feeling the impact since the population is very huge and patients are no longer receiving the service that they are supposed to receive".*

Migration of health workers to the private sector was also cited as one of the contributing factors to high workload. Participants stressed that many nurses left the public service due to unhappiness about the conditions of service and working environment in the public health sector.

Exhaustion and burnout also surfaced as the reasons for high workload. Participants indicated that nurses and doctors are physically exhausted and burnt out because of working long overtime hours. This is said to have contributed to an increased number of sick leaves. Nurses also indicated that sometimes they have to run around getting staff members who are off duty to come and work, and as a result they end up exhausted.

The study also revealed that there has been an increase in number of people moving from rural to urban areas in search of work. It was also reported that the number of patients from other countries such as Angola, China and Zimbabwe has increased. As a result workload has increased on a daily basis.

Another issue that emerged was the increase in number of private doctors using private health facilities to admit their patients under the care of public health workers. This scenario was observed among private patients who are on the Government medical aid scheme since it is not sufficient to cover private hospital fees. This situation is said to have contributed to high workload.

Diseases, new services and programmes were also said to have contributed to high workload. Participants stressed that diseases are increasing because of climate change, and lack of food due to poverty. As a result there has been an increase in number of patients seeking health care services. It also emerged that new services and programmes were introduced with no increase in number of staff.

From the results of the study, it is apparent that the workload in the MoHSS has drastically increased. This is attributable to factors such as migration of health workers to the private sector due to poor working conditions, population growth, emerging diseases, and new services and programmes. High workload is seen to have an adverse effect on service delivery and health workers' personal lives. This calls for immediate intervention by the MoHSS.

4.3.4 Motivating Factors

Participants were asked to indicate whether any policy measures aim at attracting and motivating health workers to work in the MoHSS are in place. Figure 4 presents participants 'perceptions on motivating factors.

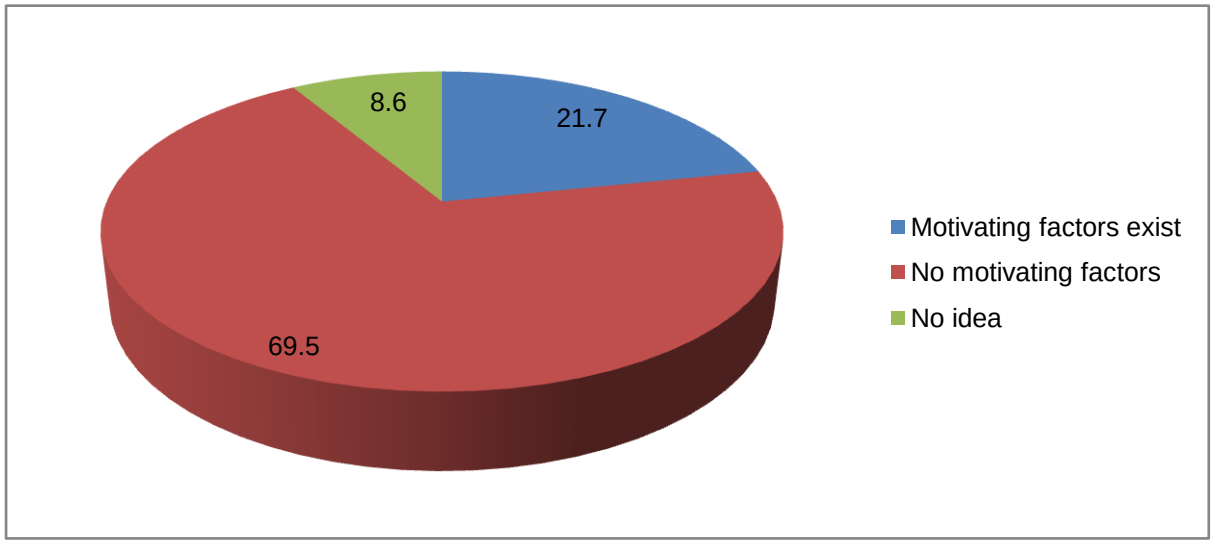

Figure 4: Health workers' perceptions on motivating factors

As can be seen in Figure 4, the majority of study participants (69.5%) are of the opinion that there are no motivating factors and measures to attract health workers to work in the MoHSS.

Participants who responded *yes* indicated that the following policy measures and motivating factors were in place to attract and motivate health workers to work in the MoHSS:

- Fixed overtime for medical doctors;

- Opportunities for further studies. An example given is that enrolled nurses are being sent for further studies on full remuneration to upgrade themselves to become registered nurses;
- Housing allowance; and
- Inexpensive medical aid which can be used even after retirement.

Some of the participants who responded that no policy measures and motivating factors were in place stressed that they work only to earn an income since they have nowhere to go. Others indicated that they were about to reach retirement age, therefore it was pointless to look for jobs elsewhere.

The study also found that some health workers were working under difficult conditions, with no incentives or rewards to motivate them. Registered Nurse 11 expressed herself as follows:

> *"This is an area where your life is in danger, when you are in this building your life is in danger. If there could be something that can attract people to work here because not everybody wants to work in psychiatry because it is a danger area".*

Participants were also asked to state what motivated them to work in the MoHSS. It became evident that nursing is a calling. Most of the nurses interviewed shared similar views that they joined the nursing profession for the love and passion to serve the nation. The following comment by Registered Nurse 42 confirms the findings:

> *"I have got a passion. I like taking care of people, be it emotionally, psychologically and physically, especially where I am, I feel honoured to take care of patients. It gives me the motivation to work".*

Some nurses felt that if they all left the MoHSS poor people who could not afford private health services would suffer. The following statement was made by Registered Nurse 8:

> *"What keeps me here is that I want to serve my community because not all the community members can afford to go to the private and if all of us are leaving state hospitals our community will suffer, because tomorrow it can be*

one of your family member, your mother or your father and instead of being there and look after them then you are at the private hospital".

Years of service appeared to be a motivating factor to some health workers. Some participants explained that long periods of service have motivated them to stay on. Others indicated that they love what they do and want to grow professionally.

The results of this study clearly show that many health workers in the MoHSS are not motivated. It was, however, inspiring to know that there are some health workers who are rendering services for the love of the community.

4.5 OTHER THEMES

Participants were asked to indicate whether there was any other information they wanted to share. In response, the following themes emerged:

4.5.1 Communication and Support System at the Workplace

Generally there should be a support system for addressing problems that may arise in work situations. From what came to light during the study, health workers have problems concerning their work but they feel management does not take them seriously. Participants said there should be better interpersonal relations among employees so that patients receive quality nursing care. Participants are of the opinion that if better communication exists between health workers and management, the service delivery would improve.

Other participants suggested that health workers should be consulted and informed when changes are made in the way things are done. This is supported by Mrara(2010:81), who points out that involvement in the decision- making processes of an organization goes a long way to retaining the best talents; therefore health professionals must be involved in decisions that affect them.

It should be emphasized that if employees are not sufficiently informed of what is happening in the workplace, they may not actively participate in improving the service. It can be concluded that good interpersonal relations have a positive impact on service delivery.

4.5.2 Equipment and Supplies

The availability of equipment and supplies appeared to be a challenge in the MoHSS. Of the 46 participants, 5 (11%) were of the opinion that materials and supplies were insufficient, and that equipment was not in good working order. This was reported to affect service delivery. Lack of proper equipment and supply frustrated health workers. This is supported by a statement by Registered Nurse 8:

> *"The hospital structure is not conducive, equipment are old, sometimes they are not functioning well, and sometimes they are not there at all. Like in some wards, there are no beds, imagine now we are used to be forced to put patients on the floor and now this thing of nursing a patient on the floor is frustrating, is not even professional".*

Participants emphasized that management needs to provide them with modern and new equipment and that speedy repair and maintenance of equipment is essential.

The outcome of this study suggests that not all health facilities have the necessary equipment and supplies that would enable them to render effective health care. It should therefore be pointed out that the availability of equipment has a significant effect on the performance outcome of health workers.

4.5.3 Recruitment of Nurses from Abroad

The researcher found that the MoHSS, in an effort to address the challenge of staff shortage in the public sector, has signed agreements with countries such as Kenya and Botswana to recruit nurses from abroad. Some participants were concerned about the fact that after 22 years of independence the country is still relying on foreigners. They showed unhappiness about the MoHSS decision to recruit nurses from abroad. They are of the opinion that this is a costly exercise since the MoHSS has to spend a lot of money in paying flight tickets, salaries, accommodation, and separation gratuities for these nurses.

Participants thus suggested that foreigners should be recruited to train nurses and not to work, and then the money spent by the MoHSS on recruiting foreigners could be used to train more nurses locally.

Some participants indicated a need to introduce another category of nurses to add to the existing two categories of registered nurses and enrolled nurses, so that the three categories could complement each other.

To address the challenge of staff shortage, it is suggested that the MoHSS should focus on accelerating the training of nurses, especially those categories that can be trained in a short time.

4.6 SUMMARY OF THE STUDY FINDINGS

The purpose of this study was to determine the extent to which the human resource capacity of the MoHSS influences health care services delivery to the Namibian population. The aim was to suggest ways of improving the state of staffing and performance in the MoHSS.

The findings of the study are based on the four predetermined themes: staffing and performance, absenteeism and turnover rate, workload, and motivating factors. Other themes, namely communication and support systems at the workplace, equipment and supplies, and recruitment of nurses from abroad also emerged from the study. This section presents a summary of study findings based on the themes of the study.

4.6.1 Staffing and Performance

The study found that there is a severe shortage of staff in the MoHSS and Social Services, and as a result the quality of service being rendered is no longer as expected by the community. This was confirmed by 97.8% of study participants.

Another finding was that although the literature reviewed by the researcher shows that 84% of key health professional posts are filled, health workers are still experiencing staff shortage. This was indicated by 89% of study participants in the job category of human resource practitioner (n=18), who indicated that they received requests for additional posts from hospital management because of staff shortage.

4.6.2 Absenteeism and Turnover Rate

The study found that absenteeism rate in the MoHSS is increasing. Sickness, exhaustion, and compassionate leave were highlighted as the main reasons for absenteeism.

It was also found that more health workers are leaving the MoHSS. This was confirmed by 48% of study participants who rated the turnover as very high, and by 32.6% who rated staff turnover as high. Migration to the private sector in search of better salaries and conditions of service, high workload, further studies, and lack of respect by the employer were cited as some of the contributing factors to health workers leaving the MoHSS.

4.6.3 Workload

The study revealed that there is high workload in the MoHSS. Migration of health workers from the public sector was reported to have increased the workload in the MoHSS. It was found that many nurses left the public service due to unhappiness about the conditions of service and working environment in the public sector.

New services and programmes that were introduced without increasing the number of staff, emerging diseases, and population growth were also reported to have contributed to high workloads in the MoHSS. As a result health workers are physically exhausted and burnt out because of working longer overtime hours, and this has resulted in an increased number of sick leaves.

4.6.4 Motivating Factors

The majority of study participants (69.5%) were of the opinion that there are no motivating factors and measures in place to attract and motivate health workers to work in the MoHSS. It was, however, found that most of the nurses joined the nursing profession for the love and passion to serve the nation.

4.6.5 Communication and Support System at the Workplace

The study shows that health workers have problems concerning their work, which they feel management does not take seriously. They attribute this to poor interpersonal relationships between management and health workers. It was also

found that health workers are not consulted and informed when changes are made in the ways things are done.

4.6.6 Equipment and Supplies

It was reported that materials and supplies are insufficient and that equipment is not in good working condition. This is reported to be affecting health service delivery.

4.6.7 Recruitment of Nurses from Abroad

The study revealed that the MoHSS has signed agreements with other countries to recruit nurses from abroad. This was done in an effort to address the challenge of staff shortage in the public sector.

The researcher learned during the study that health workers are not happy with the MoHSS's decision to recruit nurses from abroad. They are of the opinion that the MoHSS should recruit expatriates to train nurses locally rather than to work as nurses. Health workers were also of the opinion that there is a need to introduce another category of nurses to add to the existing two categories of registered nurse and enrolled nurse so that the three categories can complement each other.

4.7 CONCLUSION

This chapter presented the results of the study conducted. Data analysis and interpretation was also provided in this chapter. The results were based on the four predetermined themes: staffing and performance, absenteeism and turnover rate, workload, and motivating factors. Three other themes that emerged from the study were also discussed. These are communication and support system at the workplace, equipment and supplies, and recruitment of nurses from abroad.

According to the results of the study, staff shortage and high workload came out strongly as a challenge to quality service delivery. Migration of health workers to the private sector, population growth, emerging diseases, and new services and programmes were identified as contributing factors to staff shortage and high workload in the MoHSS. The chapter concluded by presenting a summary of study findings.

Chapter 5 presents conclusions and recommendations.

CHAPTER 5: CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

This chapter presents conclusions and recommendations. The primary aim of conducting this study was to explore the impression that the existing human resources capacity of the MoHSS can no longer meet the health service demands of the Namibian population.

The conclusions and recommendations are made with regard to the research objectives, focusing mainly on the predetermined themes and other themes that emanated from this study. These are staffing and performance, absenteeism and turnover rate, workload, motivating factors, communication and support system at the work place, equipment and supplies, and recruitment of nurses from abroad.

The study concluded that there is a shortage of staff, and as a result health services being rendered are no longer of the required standard. It was also established that absenteeism and turnover rate is high and this has resulted in high workload. Lack of motivating factors such as better working conditions and better salaries were reported to drive health workers away from the public health sector.

Other factors that are believed to have increased the workload were also identified. These are new services and programmes that were introduced without increasing the number of staff, population growth, and emerging diseases. The study also found that there is poor interpersonal relationship between management and health workers and as result performance is negatively affected. Materials and supplies were also reported to be insufficient, and equipment is not in good working condition.

Findings of this study point to a need for creating more posts to accommodate emerging needs. Findings also suggest a need to introduce effective retention strategy to attract and retain health professionals with scarce skills and those working under difficult conditions.

5.2 CONCLUSIONS

The following conclusions are made with regard to the research objectives.

5.2.1 Staffing and Performance

One of the objectives of this study was to determine the state of staffing and performance in the MoHSS. The majority of participants, 97.8%, acknowledged that there is a shortage of staff. As a result health services being rendered are no longer of the expected standard. It was, however, established that despite the challenge of staff shortage, health workers are trying their level best to deliver the required health care services.

It can be assumed that the number of staff allocated is not adequate to meet the service demands of the Namibian population. This is supported by 89% of participants in the job category of human resource practitioner, who indicated that requests for additional staff due to inadequate staff were received from hospital management.

The study also revealed that not all key health professionals' posts in the MoHSS staff establishment are filled. This was indicated by 100% of human resource practitioner participants in Intermediate Hospital Katutura, and Khomas Region, as well as by 71.4% of human resource practitioner participants in the Directorate Human Resource Management and General Services, and Windhoek Central Hospital who were asked this question.

Reasons given for non-filling of posts included poor working conditions in the public service, poor salaries, lack of skilled health professionals to fill vacancies, and longer process in acquiring work permits by foreign nationals.

It can be concluded that salaries and other benefits that are offered by the MoHSS are not competitive enough to attract and retain health workers.

5.2.2 Absenteeism and Turnover Rate

The results of this study show that there is an increased rate of absenteeism in the MoHSS. Of the 46 participants, 37% rated absenteeism very high, 28.2% rated

moderate, 15.2% rated high, 11% rated low, and 8.6% rated very low. Sickness emerged as the main reason for absenteeism.

One can conclude that there is high workload in the MoHSS and health workers are exhausted; as a result they end up sick since they cannot cope with the workload.

The study also revealed that more health workers are leaving the MoHSS. When asked to rate the turnover, 22 (48%) rated the staff turnover very high, 15 (32.6%) rated high, 8 (17.3%) rated moderate, and 1 (2.1%) rated low. Reasons for staff turnover indicated by participants include better salaries, better conditions of service, high workload, and further studies.

It can be concluded that there is no effective retention strategy in the MoHSS and as a result health workers are leaving the MoHSS in search for better salaries and conditions of service.

5.2.3 Workload

It is evident that there is high workload in the MoHSS. All nurses interviewed were of the opinion that the workload has increased. Poor working conditions and low salaries were believed to have driven health workers away from the public sector and this has resulted in increased workload. Other factors believed to have increased the workload were population growth, urbanization, increase in number of private doctors seeing their patients in public health facilities, emerging diseases, and new services and programmes.

The findings of the study are consistent with a study conducted by the Common wealth Secretariat (2003:7), which indicated that factors such as poor working conditions, low remuneration, increased workload and lack of support systems have influenced the loss of human resources for health in sub-Saharan Africa.

5.2.4 Motivating Factors

It has been pointed out that employers should look into what motivates employees and then compensate them appropriately (Du toit, Knipe, van Niekerk, van der Waldt& Doyle, 2002:184). However, when asked whether there are any policy measures aimed at attracting and motivating health workers to work in the MoHSS,

32 (69.5%) participants indicated that no motivating factors and measures are in place, 10 (21.7%) participants indicated motivating factors and measures do exist to attract and motivate health workers to work in the MoHSS. The remaining 4 (8.6%) indicated that they had no idea if any measures and motivating factors do exist to attract and motivate health workers to work in the MoHSS.

The conclusion can be drawn that there are no motivating factors and measures to attract and retain health workers to work in the MoHSS. It should be noted that if employees are not motivated, turnover rate will rise and productivity will decrease. It was however inspiring to learn from the study that many nurses have joined the nursing profession for the love and passion to serve the nation.

5.2.5 Communication and Support System at the Workplace

Support system in the workplace is an important factor in improving service delivery. It is, however, of great concern to note that health workers in the MoHSS have problems concerning their work, which management seems to ignore. It is also discouraging to learn that health workers are not consulted by management regarding changes in the way things are done. It should be emphasized that if employees are not sufficiently informed of what is happening in the workplace, they may not actively participate in improving the service.

One can conclude that there is poor interpersonal relationship between health workers and management. It should be noted that if communication within a workplace is poor, quality service delivery will be compromised.

5.2.6 Equipment and Supplies

Of the 46 participants, 5 (11%) are of the opinion that materials and supplies are insufficient and that equipment is not in good working order. This is reported to be affecting service delivery.

The assumption can be made that not all health facilities have the necessary equipment and supplies to enable health workers to render effective health care. It should therefore be pointed out that the availability of equipment plays an important role in the performance outcome of health workers.

5.2.7 Recruitment of Nurses from Abroad

It was discouraging to note that after 22 years of independence the country still relies heavily on expatriates to render health care services. The researcher found that the MoHSS, in an effort to address the challenge of staff shortage in the public sector, has signed agreements with countries such as Kenya and Botswana to recruit nurses from abroad.

It can be concluded that there are too few health workers with appropriate skills in the MoHSS, hence the need to accelerate the training of more health workers.

5.3 RECOMMENDATIONS

The following recommendations were made based on the findings of the study.

5.3.1 Interventions Recommendations

- The MoHSS should speed up the restructuring process to create more posts based on the current staffing needs.
- Staffing norms should be in place to determine the workload and number of staff to be allocated at each health facility.
- There is a need to introduce effective retention strategy to attract and retain health professionals with scarce skills and those working under difficult conditions.
- The MoHSS should introduce bonding services to retain health professionals in the MoHSS.
- The MoHSS should provide a congenial working environment to attract and retain health professionals.
- Salaries and other benefits should be improved to retain and attract health professionals with scarce skills and those working under difficult conditions.
- The MoHSS should introduce the training of another category of nurses to add to the existing two categories of registered nurses and enrolled nurses to reduce the workload on existing nurses.

- Health workers at all levels of employment should undergo a course on interpersonal skills to enhance their communication skills.
- The MoHSS should ensure the availability and maintenance of basic equipment and supplies.
- There is a need to establish an Employee Assistance Programme at the workplace to help employees overcome their personal and work-related problems.

5.3.2 Recommendations for Further Research

- Future research may look into determining a need for the establishment of an Employee Assistance Programme in the MoHSS.
- There is also a need to conduct further research on improving performance in the MoHSS through succession planning.

5.4 CONCLUSION

This chapter discussed conclusions and recommendations. The conclusions were based on the objectives of the study, focusing mainly on the predetermined themes and other themes emerging from the study. Interventions recommendations and recommendations for further research were provided in this chapter.

The study established that there is severe shortage of staff in the MoHSS and as a result the quality of health service delivery is below the acceptable standard. Workload in the MoHSS was also reported to be increasing and negatively affecting performance. Factors such as migration of health workers to the private sector, population growth, emerging diseases, and new services and programmes were identified as contributing factors to staff shortage and high workload in the MoHSS.

It was also established that there is a high level of staff turnover in the MoHSS, and poor working conditions and low salaries were identified as the main reasons for health workers to leave the MoHSS.

The findings suggested a need to create more posts to accommodate emerging needs. Findings also suggested that there is a need to introduce an effective retention strategy to attract and retain health professionals with scarce skills and those working under difficult conditions.

LIST OF REFERENCES

Amos, T., Ristow, A., Ristow, L. & Pearse, N. *Human resource management.* 2008. Cape Town: Juta.

Aswathappa, P. 2010. *Human resource management;* Text and Cases*.* New Delhi: Tata McGraw Hill.

Awases, H.A. 2006. Factors affecting performance of professionals in Namibia. PHD (Health Studies) dissertation. Pretoria: University of South Africa.

Bhatia, R.C. 2009. *Business Communication*: 2nd Edition. Delhi: Ane Books Pvt. Ltd.

Buerhaus, P.I., Ulrich, B.T., Norman, L., Williams, M. & Dittus, R. 2005. Hospital RNs' and CNOs' perceptions of the impact of the nursing shortage on the quality of care. *Nursing Economics,* 23. From http://content.healthaffairs.org/cgi/content/full/26/3/853 (accessed 8 November 2010)

Burke, R. 2007. *Project management techniques*. United Kingdom: Burke Publishing.

Chen, Y. "Nurses' work environment and job satisfaction". Ph.D. diss., University of Maryland, Baltimore, 2008. In Dissertations & Theses: Full Text [database on-line]; available from http://www.proquest.com (publication number AAT 3304005; accessed January 27, 2011).

Christie, T. "Nurses' perception of job satisfaction and sense of belonging in a critical care environment". M.Sc.N. diss., Laurentian University (Canada), 2008. In Dissertations & Theses: Full Text [database on-line]; available from http://www.proquest.com (publication number AAT MR44846; accessed January 27, 2011).

Commonwealth Secretariat. 2003. *Human resources for health. Report of a Commonwealth Workshop in the East, Central and Southern Africa Region*. Johannesburg. South Africa.

Connell, J., Zurn, P., Stilwell, B., Awases, M. & Braichet, J.M. 2007. Sub-Saharan Africa: Beyond the health worker migration crisis? *Social Science & Medicine,*

64,1876-1891.http:/www.sciencedirect.com/science/article/B6VBF-4N3H13X-1/2/09cc2b5d1fe7738d1bcea2fa39f874ab (accessed 06 November 2010)

Downing, H. "A quantitative correlational study of job satisfaction among critical care nurses in Hawaii". Ed.D. diss., University of Phoenix , 2010. In Dissertations & Theses: Full Text [database on-line]; available from http://www.proquest.com (publication number AAT 3414991; accessed August 19, 2010).

Du Toit, D., Knipe, A., Van Niekerk, D., Van der Waldt, G. & Doyle, M. 2002. *Service Excellence in Governance*. Cape Town: Heinemann.

Elahi, M & Dehdashti, M. 2011.Classification of researches and evolving a consolidating typology of management studies. London. http://www.cibmp.org/Papers/Paper622.pdf (accessed June 03, 2012)

Gaspar, M. "Reasons for high turnover of nursing professionals at public hospitals in Angola". M.A. diss., University of South Africa (South Africa), 2007. In Dissertations & Theses: Full Text [database on-line]; available from http://www.proquest.com (publication number AAT 0669139; accessed June 9, 2010).

Gillham, B. 2005. *Research interviewing: the range of techniques*. New York: McGraw- Hill Education.

Greenfield, T. 2002. *Research methods for postgraduates*: 2nd Edition. London: Arnold.

Grix J. 2004. *The foundation of research*. New York: Palgrave Macmillan.

Grobler, P., Warnich, S., Carrell, M.R., Elbert, N.F. & Hatfield, R.D. 2006. *Human Resource Management in South Africa;* 3rd Edition. London: Thomson Learning.

Hagopian, A., Thompson, M.J., Fordyce, M., Johnson, K.E. & Hart, L.G. 2004. The migration of physicians from sub-Saharan Africa to the United States of America: measures of the African brain drain. Journal of Human Resource for Health 2004, 2:17. From http://www.human-resources-health.com/content/2/1/17 (accessed 10 November 2010)

Huysamen, G.K. 1996. *Methodology for the social and behavioural sciences*. Johannesburg: International Thomson Publishing.

Iipinge, S., Dambisya, Y.M., Loewenson, R., Chimbari, M., Ndetei, D., Munga, M., Sibandze, S. & Lugina, H. 2009. Policies and incentives for health worker retention in East and Southern Africa: Learning from country research. University of Namibia, Training and Research Support Centre, University of Limpopo, EQUINET, ECSA-HC, EQUINET Discussion Paper 78 EQUINET: Harare

Jirojwong, J. & Liamputtong, J. 2009. *Population, health, communities and health promotion.* New York: Oxford

Kothari, C.R. 2004. *Research methodology: Methods and techniques*. New Delhi: New Age International (P) Limited Publishers.

Legodi, E.M. 2008. The perception of community members on the quality of care rendered in Limpopo, in terms of the Bath Pele principles. MA (Health Studies) dissertation. Pretoria: University of South Africa.

Lephalala, R.P. 2006. Factors influencing nursing turnover in selected private hospitals in England. MA (Health Studies) dissertation. Pretoria: University of South Africa.

Liamputtong, J. 2010. *Qualitative research methods*. South Melbourne: Oxford.

Lucas, L., Lupton, B. & Mathieson, H. 2006. *Human resource management in an International Context*. London: Chartered Institute of Personnel and Development.

Mæstad, O., Torsvik, G. & Aakvik, A. 2010. Overworked? On the relationship between workload and health worker performance. *Journal of Health Economics,* In Press, Corrected Proof. From http://www.sciencedirect.co/science/article/B6V8K-506RCMC-1/2/5b3f1696d8b2a005743f68aab2a1d5 (accessed 30 October 2010)

Mamoria, C.B. & Gankar, S.V. 2010. *Human Resource Management*. New Delhi: Himalaya Publishing House.

Mathis, R.L. & Jackson, J.H. 2008. *Human resource management*; 12th Edition. Mason: Thomson South Western.

Maxwell, J.A. 2005. *Qualitative research design: an interpretive approach:* 2nd Edition. California: Sage Publications Inc.

Mills, E J., Schabas, W.A., Volmink J., Walker R., Ford N., Katabira E., Anema A., Joffres M., Cahn, P. & Montaner, J. 2008. Should active recruitment of health workers from sub-Saharan Africa be viewed as a crime? *The Lancet,* 371. From http://fieldresearch.msf.org/msf/bitstream/10144/29332/1/Mills Crime.pdf (accessed 8 November 2010)

Ministry of Health and Social Services, 2008. *Human resource strategy 2008-2012*. *In:* Development, P. P. A. H. R. (Ed.). Windhoek: Government Printers

Ministry of Health and Social Services. 2005. *Summary of the human resource challenges faced by the public health sector and strategies to address them*. Windhoek: Government Printers.

Ministry of Health and Social Services. 2008. *Annual Report 2007/2008*. Windhoek: Solitaire Press Limited.

Ministry of Health and Social Services. 2008. *Human Resource Development Annual Report 2007/2008*. Windhoek: Government Printers.

Ministry of Health and Social Services. 2008. *Health and social services system review*. Windhoek: Government Printers.

Ministry of Health and Social Services. 2009. *Strategic plan 2009-2013*. Windhoek: Government Printers.

Ministry of Health and Social Services. 2010. *Annual Report 2009/2010.* Windhoek: Government Printers.

Ministry of Health and Social Services. 2010. *Human Resource Development Annual Report 2009/2010.* Windhoek: Government Printers.

Ministry of Health and Social Services. 2011. *20 years of progress. 1990-2010*. Windhoek: Government Printers.

Mrara, M.T. 2010. An investigation of turnover and retention factors of health professional staff within the Eastern Cape department of health. MA (Business Administration) dissertation. Grahamstown: Rhodes University.

Nell, P.S., Werner, A., Haasbroek, G.D., Poisat, P., Sono, T. & Schults, H.B. 2008. *Human resource management*; 7th edition. Cape Town: Oxford.

Orb, A., Eisenhauer, L. & Wynaden, D. 2001. Journal of Nursing Scholarship. Sigma Theta Tau International.

Padarath, A., Chamberlain, C., Mccoy, D., Ntuli, A., Rowson, M. & Loewenson, R. 2003. Health personnel in Southern Africa: confronting mal-distribution and brain drain. EQUINET, Health Systems Trust, South Africa, MEDAT, United Kingdom, EQUINET Discussion paper 3. http://www.queensu.ca/samp/migrationresources/braindrain/document/equinet.pdf (accessed 8 November 2010)

Paul, S.G., Williamson, D.A., Karp, D.A. & Dalphin, J.R. 2007. New York: Cambridge University Press.

Pendukeni, M. 2004. The impact of HIV/AIDS on health care provision: perceptions of nurses currently working in one regional hospital in Namibia. MA (Public Health) dissertation. Cape Town: University of Western Cape.

Ploychart, R.E., Schneider, B. & Schmidt, N. 2006. *Staffing organisation: Contemporary Practice & Theory*. New Jersey. Lawrence Erlbaum Associates.

Southern Development Communities (SADC). 2006. *Regional policy guidelines for attracting and retaining health professionals in the SADC region*. Gaborone. Botswana.

Southern Development Communities (SADC). 2006. SADC Human resources for health strategic plan; 2007-2019. Pretoria. South Africa.

Stephanus, D. 2009. *Qualitative Research in international setting*: *A practical guide*. New York: David Stephanus.

Struwig, F.W. & Stead, G. B. 2001. *Planning, designing and reporting research*. Cape Town: Masker Miller Longman.

Swanepoel, B.J., Erasmus, B.J. & Schenk, H.W. 2008. *South African human resource management: theory & practice*. Cape Town: Juta.

Technikon SA. Department of Public Management and Development. 2001. Research and Information Management IV & Research Methodology. Only study guide for RE1401PE and REM101QE. Florida.

Thompson, J.A. 2008. Explaining and predicting rural turnover intentions and behaviours in Charleville, Austraria. PHD (School of Business) Thesis. Lismore: Southern Cross University.

Torrington, D., Hall, L. & Taylor, S. 2005. *Human resource management*. Harlow: Pearson Education.

University of Namibia. http://www.unam.na/faculties/MEDICINE-2010.pdf (accessed June 8, 2010)

Van As, M. & van Schalkwyk, M. 2001. Research and Information Management IV & Research Methodology: Study guide for RE1401PE and REM101QE. Florida. Technikon South Africa.

Van der Waldt, G., Van Niekerk, D., Doyle, M., Knipe, A. & Du Toit, D. 2002. *Managing for results in government*. Cape Town: Heinemann.

World Health Organisation (WHO). 2010. *Increasing access to health workers in remote and rural areas through improved retention.* Geneva. Switzerland. World Health Organisation.

World Health Organization (WHO). 2004. Recruitment of health workers from the developing world. http://apps.who.int/gb/ebwha/pdf-files/EB114/B114-5en.pdf. (accessed December 7, 2011).

Yearwood, E.L. 2007. The crisis of nurse migration in developing countries. Journal of Child and Adolescent Psychiatric Nursing 20, no. 3, (August 1): 191-2. http://0-www.proquest.com.oasis.unisa.ac.za/ (accessed October 17, 2010).

APPENDIX A

Mr. Kahijoro Kahuure
Permanent Secretary
Ministry of Health and Social Services
Private Bag 13198
Windhoek
Namibia

16 February 2011

Dear Mr. Kahuure

RE: REQUEST FOR PERMISSION TO CONDUCT RESEARCH FOR ACADEMIC PURPOSES

My name is Linea Nghipundjwa (Amakali), a distance learning student at the University of South Africa. I am studying towards an M-Tech Degree in Public Management. Part of the requirements for my studies is to conduct research.

I am hereby requesting permission from the Ministry of Health and Social Services to conduct a study. I am planning to carry out a qualitative study on human resources capacity in the Ministry of Health and Social Services in Namibia. The sample of my study will be drawn from two public hospitals in Khomas Region, namely Windhoek Central Hospital, and Intermediate Hospital Katutura, and two directorates namely Directorate Human Resource Management and General Services, and Directorate Khomas Region.

The proposed study has been approved by UNISA Research Committee. Attached please find a proposal for the proposed study, approval letter from UNISA Research Committee and the MoHSS registration of research project form.

Ethical consideration will be applied throughout the study as indicated in the proposal. Results of the proposed study will be forwarded to the Permanent Secretary of the Ministry of Health and Social Services upon completion of the research project.

Yours sincerely

Linea Nghipundjwa (Amakali)
Mobile No. 0812684604

APPENDIX B

The Acting Director
Directorate Human Resource Management and General Services
Ministry of Health and Social Services
Windhoek

19 October 2012

Dear Ms Nashixwa

RE: REQUEST FOR PERMISSION TO CONDUCT RESEARCH ON HUMAN RESOURCE CAPACITY IN THE MoHSS

My name is Linea Nghipundjwa (Amakali), a distance learning student at the University of South Africa. I am studying towards an M-Tech Degree in Public Management. Part of the requirements for my studies is to conduct research.

I am planning to carry out a qualitative study on human resources capacity in the Ministry of Health and Social Services in Namibia. The objective of the study is to determine the extent to which human resource capacity of the Ministry of Health and Social Services influences health care services delivery to the Namibian population. The proposed study has been approved by UNISA and the Permanent Secretary of the Ministry of Health and Social Services (copies of approval attached).

The sample of my study will be drawn from two public hospitals, namely Windhoek Central Hospital, and Intermediate Hospital Katutura, and two directorates which are Directorate Human Resource Management and General Services, and Directorate Khomas Region.

I intend to conduct personal interviews with a total of 7 human resource practitioners from your directorate. I am therefore applying for permission from your office to conduct such interviews, starting in November 2012.

Yours sincerely

MS LINEA NGHIPUNDJWA
MOBILE NO. 0812684604

APPENDIX C

The Director
Khomas Regional Health Directorate
Ministry of Health and Social Services
Windhoek

19 October 2012

Dear Ms Muremi

RE: REQUEST FOR PERMISSION TO CONDUCT RESEARCH ON HUMAN RESOURCE CAPACITY IN THE MoHSS

My name is Linea Nghipundjwa (Amakali), a distance learning student at the University of South Africa. I am studying towards an M-Tech Degree in Public Management. Part of the requirements for my studies is to conduct research.

I am planning to carry out a qualitative study on human resources capacity in the Ministry of Health and Social Services in Namibia. The objective of the study is to determine the extent to which human resource capacity of the Ministry of Health and Social Services influences health care services delivery to the Namibian population. The proposed study has been approved by UNISA and the Permanent Secretary of the Ministry of Health and Social Services (copies of approval attached).

The sample of my study will be drawn from two public hospitals, namely Windhoek Central Hospital, and Intermediate Hospital Katutura, and two directorates which are Directorate Human Resource Management and General Services, and Directorate Khomas Region.

I intend to conduct personal interviews with a total of 22 officials from Khomas Regional Health Directorate, namely a senior medical superintendent, a nurse manager, twelve registered nurses and enrolled nurses, five human resource practitioners from Intermediate Hospital Katutura, and three human resource practitioners from Khomas Regional office. I am therefore applying for permission from your office to conduct such interviews, starting in November 2012.

Yours sincerely

MS LINEA NGHIPUNDJWA
MOBILE NO. 0812684604

Cc: Dr. G. A. Judman
Senior Medical Superintendent: Intermediate Hospital Katutura

APPENDIX D

The Director
Tertiary Health Care and CSS
Ministry of Health and Social Services
Windhoek

19 October 2012

Dear Ms Nghipandulwa

RE: REQUEST FOR PERMISSION TO CONDUCT RESEARCH ON HUMAN RESOURCE CAPACITY IN THE MoHSS

My name is Linea Nghipundjwa (Amakali), a distance learning student at the University of South Africa. I am studying towards an M-Tech Degree in Public Management. Part of the requirements for my studies is to conduct research.

I am planning to carry out a qualitative study on human resources capacity in the Ministry of Health and Social Services in Namibia. The objective of the study is to determine the extent to which human resource capacity of the Ministry of Health and Social Services influences health care services delivery to the Namibian population. The proposed study has been approved by UNISA and the Permanent Secretary of the Ministry of Health and Social Services (copies of approval attached).

The sample of my study will be drawn from two public hospitals, namely Windhoek Central Hospital, and Intermediate Hospital Katutura, and two directorates which are Directorate Human Resource Management and General Services, and Directorate Khomas Region.

I intend to conduct personal interviews with 19 officials from Windhoek Central Hospital, namely a senior medical superintendent, a nurse manager, twelve registered nurses and enrolled nurses, and five human resource practitioners. I am therefore applying for permission from your office to conduct such interviews, starting in November 2012.

Yours sincerely

MS LINEA NGHIPUNDJWA
MOBILE NO. 0812684604

Cc: Dr. S. Shalongo
Senior Medical Superintendent: Windhoek Central Hospital

APPENDIX E

INFORMED CONSENT FORM

Dear participant,

My name is Linea Nghipundjwa (Amakali). I am currently studying at the University of South Africa undertaking an M-Tech Degree in Public Management. One of the requirements to be awarded this degree is to conduct a mini- thesis in my area of interest. I have chosen to conduct a research examining the extent to which human resource capacity of the Ministry of Health and Social Services, Namibia, influences health care services delivery to the Namibian population.

You have been purposively selected to participate in this study because of your position and years of experience in your area of service delivery. The interview will take approximately 30 minutes.

The information you provide is totally confidential and will not be disclosed to anyone. It will only be used for research purposes. Your name will not appear in the report, and only a code will be used to connect your name and your answers without identifying you. Your participation is voluntary and you can withdraw from the study after having agreed to participate. If you have any questions about this research you may ask me.

Signing this consent indicates that you understand what will be expected of you and are willing to participate in this research. Please put an X where appropriate.

Read by Respondent [ ] Interviewer [ ]

Agreed [ ] Not Agreed [ ]

Respondent: _____ Date: __ /__/__

Interviewer: _____ Date: __/__/__

APPENDIX F

INTERVIEW SCHEDULE FOR HOSPITAL SUPERINTENDENTS AND NURSE MANAGERS

TITLE: HUMAN RESOURCE CAPACITY IN THE MINISTRY OF HEALTH AND SOCIAL SERVICES (MoHSS) IN NAMIBIA

NAME OF DISTRICT: _____

NAME OF DIRECTORATE/HOSPITAL: _____

Dear Sir/Madam

The aim of the study is to examine the extent to what human resource capacity of the Ministry of Health and Social Services, Namibia, influences health care services delivery to the Namibian population.

You have been purposively selected to participate in this study because of your position and years of experience in your area of service delivery. The interview will take approximately 30 minutes. Your participation is voluntary and you can withdraw from the study after having agreed to participate. If you have any questions about this research you may ask me.

Please answer the questions to the best of your ability. Your accurate and objective response in answering questions is of vital importance as it will be used to determine the state of staffing and performance in the MoHSS in Namibia.

NB: THE INFORMATION YOU PROVIDE WILL REMAIN STRICTLY CONFIDENTIAL. IT IS THEREFORE NOT NECESSARY TO GIVE YOUR PARTICULARS IF YOU WISH TO REMAIN ANONYMOUS.

A: Biographical Details: Please put an X where appropriate.

1. What is your employment level?

Top Management	Middle Management	Supervisory level	Operational level
01	02	03	04

2. How long have you been employed in this hospital?

5-10 years	10-15 years	15-20 years	20-25 years	25-30 years
01	02	03	04	05

3. Years of management experience

B: Staffing and Performance

4. What is your opinion about the state of staffing and performance in this hospital? Does this hospital have adequate staff to deliver quality health care services to its population?

_____

_____

5. Are all the key health professionals' posts (doctors, nurses, pharmacists, radiographers, physiotherapists, occupational therapists, psychologists, environmental health officers, and social workers) in this hospital's establishment filled?

Yes	No
01	02

Please explain your answer

_____

_____

6. If the answer above is No what efforts or mechanisms were put in place to fill these posts?

_____

_____

7. Did you receive any complaints from health workers regarding staffing in the past two years?

Yes	No
01	02

Please explain your answer

_____

_____

8. To what extent does the staffing level in this hospital influence health care service delivery to the community it serves?

_____

_____

9. How does the human resource capacity in this hospital affect health workers' personal life?

_____

_____

10. Which strategies do you think could be recommended to improve the current state of staffing and performance in this hospital?

_____

_____

C: Staff Absenteeism and Turnover Rate

11. What is the level of absenteeism in this hospital?

Very High	High	Moderate	Low	Very Low

12. What are the most common reasons for absenteeism? List them in order of importance.

_____

_____

13. What is the level of staff turnover in this hospital?

Very High	High	Moderate	Low	Very Low

14. What are the most common reasons for staff turnover in this hospital? List them in order of importance.

_____

_____

D: Motivating Factors

15. Are there any policy measures that aim at attracting and motivating health workers to work in this hospital?

Yes	No	Don't know
01	02	03

Please explain your answer

_____

_____

16. What motivates you to work in this hospital?

_____

_____

17. Do you have any other information that you would like to share?

_____

_____

Thank you for your participation and cooperation.

APPENDIX G

INTERVIEW SCHEDULE FOR HUMAN RESOURCE PRACTITIONERS

TITLE: HUMAN RESOURCE CAPACITY IN THE MINISTRY OF HEALTH AND SOCIAL SERVICES (MoHSS) IN NAMIBIA

NAME OF DISTRICT:_____

NAME OF DIRECTORATE/HOSPITAL: _____

Dear Sir/Madam

The aim of the study is to examine the extent to what human resource capacity of the Ministry of Health and Social Services, Namibia, influences health care services delivery to the Namibian population.

You have been purposively selected to participate in this study because of your position and years of experience in your area of service delivery. The interview will take approximately 30 minutes. Your participation is voluntary and you can withdraw from the study after having agreed to participate. If you have any questions about this research you may ask me.

Please answer the questions to the best of your ability. Your accurate and objective responses in answering questions is of vital importance as it will be used to determine the state of staffing and performance in the MoHSS in Namibia.

NB: THE INFORMATION YOU PROVIDE WILL REMAIN STRICTLY CONFIDENTIAL. IT IS THEREFORE NOT NECESSARY TO GIVE YOUR PARTICULARS IF YOU WISH TO REMAIN ANONYMOUS.

A: Biographical Details: Please put an X where appropriate.

1. What is your employment level?

Top Management	Middle Management	Supervisory level	Operational level
01	02	03	04

2. How long have you been employed in this ministry?

5-10 years	10-15 years	15-20 years	20-25 years	25-30 years
01	02	03	04	05

3. Years of management experience

B: Staffing and performance

4. What is your opinion about the state of staffing and performance in this hospital? Does this ministry have adequate staff to deliver quality health care services to its community?

_____

_____

5. Are all the key health professionals' posts (doctors, nurses, pharmacists, radiographers, physiotherapists, occupational therapists, psychologists, environmental health officers, and social workers) in this ministry's establishment filled?

Yes	No
01	02

Please explain your answer

_____

_____

6. If the answer above is No what efforts or mechanisms were put in place to fill these posts?

_____

_____

7. What is the vacancy rate in this ministry?

_____

_____

8. Did you receive any requests for additional staff from the hospital management in the past two years?

Yes	No
01	02

Please explain your answer

_____

_____

9. To what extent does the staffing level in this ministry influence health care service delivery to the community it serves?

_____

_____

10. How does staffing in this ministry affect health workers' personal life?

_____

_____

11. Which strategies do you think could be recommended to improve the current state of staffing and performance in this ministry?

_____

_____

C: Absenteeism and Turnover Rate

12. What is the level of absenteeism in this ministry?

Very High	High	Moderate	Low	Very Low

13. What are the most common reasons for absenteeism? List them in order of importance.

_____

_____

14. What is the level of staff turnover in this ministry?

Very High	High	Moderate	Low	Very Low

15. What are the most common reasons for staff turnover in this ministry? List them in order of importance.

_____

_____

D: Motivating Factors

16. Are there any policy measures that aim at attracting and motivating health workers to work in this ministry?

Yes	No	Don't know
01	02	03

Please explain your answer

_____

_____

17. What motivates you to work in this ministry?

_____

_____

18. Do you have any other information that you would like to share?

_____

_____

Thank for your participation and cooperation.

APPENDIX H

INTERVIEW SCHEDULE FOR REGISTERED NURSES AND ENROLLED NURSES

TITLE: **HUMAN RESOURCE CAPACITY IN THE MINISTRY OF HEALTH AND SOCIAL SERVICES (MoHSS) IN NAMIBIA**

NAME OF DISTRICT:_____

NAME OF DIRECTORATE/HOSPITAL: _____

Dear Sir/Madam

The aim of the study is to examine the extent to what human resource capacity of the Ministry of Health and Social Services, Namibia, influences health care services delivery to the Namibian population.

You have been purposively selected to participate in this study because of your position and years of experience in your area of service delivery. The interview will take approximately 30 minutes. Your participation is voluntary and you can withdraw from the study after having agreed to participate. If you have any questions about this research you may ask me.

Please answer the questions to the best of your ability. Your accurate and objective responses in answering questions is of vital importance as it will be used to determine the state of staffing and performance in the MoHSS in Namibia.

NB: **THE INFORMATION YOU PROVIDE WILL REMAIN STRICTLY CONFIDENTIAL. IT IS THEREFORE NOT NECESSARY TO GIVE YOUR PARTICULARS IF YOU WISH TO REMAIN ANONYMOUS.**

A: Biographical Details: Please put an X where appropriate.

1. What is your employment level?

Top Management	Middle Management	Supervisory level	Operational level
01	02	03	04

2. How long have you been employed in this hospital?

5-10 years	10-15 years	15-20 years	20-25 years	25-30 years
02	03	04	05	06

3. Years of management experience

☐

B: Staffing and Performance

4. What is your opinion about the state of staffing and performance in this hospital? Does this hospital have adequate staff to deliver quality health care services to its population?

_____

_____

5. How does the staffing level in this hospital influence health care service delivery to the community it serves?

_____

_____

6. How does staffing in this hospital affect your personal life?

_____

_____

7. Which strategies do you think could be recommended to improve the current state of staffing and performance in this hospital?

_____

_____

C: Absenteeism and Turnover Rate

8. What is the level of absenteeism in this hospital?

Very High	High	Moderate	Low	Very Low

9. What are the most common reasons for absenteeism? List them in order of importance.

_____

_____

10. What is the level of staff turnover in this hospital?

Very High	High	Moderate	Low	Very Low

11. What are the most common reasons for staff turnover in this hospital? List them in order of importance.

_____

_____

D: Workload

12. In your opinion, has there been any change in the workload in this hospital over the past two years?

Yes	No
01	02

Please explain your answer

_____

_____

13. Has the workload increased or decreased?

_____

_____

14. What do you think are the reasons for this increase/decrease?

_____

_____

E: Motivating Factors

15. Are there any policy measures that aim at attracting and motivating health workers to work in this hospital?

Yes	No	Don't know
01	02	03

Please explain your answer

_____

_____

16. What motivates you to work in this hospital?

_____

_____

17. Do you have any other information that you would like to share?

_____

_____

Thank you for your participation and cooperation.