Perceptions of health workers about conditions of service: A Namibian case study

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Executive summary

Human resources for health have become a topical issue at local, regional and global levels. In Namibia health worker mobility remains a concern for those in human resources planning. Achieving equity in this area needs a concerted effort from all sectors involved. However little is understood about the role that conditions of service play in influencing health professional mobility in Namibia.

This study was implemented as part of the EQUINET theme work on Human Resources for Health co-ordinated by Health systems Trust. The study set out to explore and describe the influence of conditions of service on the movement and retention of the health professionals in Namibia. It is a qualitative study targeting mainly professional nurses, doctors, social workers and health inspectors at both operational and managerial levels, in public and private sectors.

Financial, human resource management, occupational and macro-management issues were perceived as both push and retention factors for various health professionals at different levels of care in both public and private health sectors. The findings suggest that fringe benefits are the strengths of the conditions of service in the public sector. However, in the private sector it was more linked to salaries and the macro-environment, which include the “soft issues’ such as recognition and communication.

Appropriate recommendations are provided to improve the retention of the health professionals, especially in the public sector.

1. Introduction and background information

Human resource planners need to take account of the probable losses or attrition from the current manpower supply (Hall et al, 1978:102). The sources of human resource losses are deaths, retirement, emigration, withdrawal from the labour force and changes in occupation (Booyens, 1998:12; Hall et al, 1978:102).

Hall et al (1978:102) state that emigration among physicians is more significant than in other professions. However, the experiences of the researchers indicate that more and more professional nurses are also moving out of their existing working environment; either from rural to urban areas or between state and private health service organisations; they also leave to other social sectors or migrate out of the country.

The tendency of young registered nurses leaving the country for greener pastures became significant in Namibia, following structural, policy and organisational changes (Hofnie, 2003: 13). The issue of skilled nurses leaving the country for better opportunities was voiced in the media where the Deputy Justice Minister suggested the possible introduction of a law to prohibit the exodus of nurses from the country (Amupadhi, 2002: 3 in Hofnie, 2003:13).

This study was implemented as part of the EQUINET theme work on Human Resources for Health co-ordinated by Health systems Trust. The focus of the study is the impact of condition of services and movement of health workers between the public and the private health sector. *Tables 1* and *2* illustrate the magnitude of the losses and human resources distribution in Namibia. More than half of the pharmacists, doctors, medical technologists and dentists are in private practice leaving the public sector with a skeleton service in these categories.

Table 1: Distribution of health workers between various sectors, 2000

Professional category	MoHSS	Others	Missions	Private	Total	% MoHSS	% Private
Doctors	201			305	506	40	60
Pharmacists	21	1		135	156	13	87
Dentists	14			54	68	21	79
Radiographers	20		1	23	44	45	52
Registered Nurses	1554			144	1698	92	8
Physiotherapists	10			34	44	23	77
Occupational therapists	4			17	21	19	81
Social workers	98			87	185	53	47
Health inspectors	35			35	70	50	50
Medical technologists		7	5	67	79		85

Source: MoHSS, 2000.

Table 2 shows that the training output does not correlate with available vacancies, implying an inadequate number of staff in existing posts in the public sector. It also

shows the critical shortage of staff of some professional categories such as pharmacists, radiographers and dentists.

Table 2: Current health professional supply vs. the MoHSS's establishment per professional category

Professional category	Establishment	Posts filled	Vacancies	Students in training	Completed training 2004	Namibians in posts
Doctors and specialists	333	242	91	105	9	80
Pharmacists	45	21	24	16	0	4
Pharmacists assistants	76	56	20	18	6	56
Registered nurses	2080	1588	492	468	81	1582
Enrolled Nurses	2480	1495	985	691	205	1495
Environmental health officers	86	40	28	18	6	38
Environmental health assistants	80	57	23	12	13	57
Radiographers	41	29	12	26	3	19
Radiographer assistants	40	35	5	7	2	35
Dentists	21	12	9	4	0	10
Social workers	154	78	76	79	14	76
Total	**5418**	**3575**	**1765**	**1444**	**439**	**3452**

Source: MoHSS (2005)

2. Problem statement and purpose of the study

Human resource losses are due to deaths, retirement, emigration, withdrawal from the labour force and changes in occupation (Booyens, 1998:12; Hall et al, 1978:102) For Namibia these losses occur due to the movements of health professionals from the health sector to other sectors, urban to rural, public to private and vice versa as well as leaving for greener pastures overseas.

Research done by Padarath et al (2003) identified 'pull and push factors' determining the movement of personnel. The 'push factors' that make health professionals leave are low remuneration and salaries, lack of job satisfaction, work associated risks, as well as lack of career advancement opportunities. The 'pull factors' that attract health professionals to employment are the opposite of these push factors (Padarath et al, 2003). These factors reflect the fact that conditions of service in general are strong determinants of the movement of health professionals. However, little is known about whether conditions of service are a reason for the movement of the health professionals in Namibia. This study therefore sets out to answer the following question: What conditions of service or otherwise could encourage health professionals in Namibia not to leave the health public sector?

The purpose of the study is to explore and describe the influence of the conditions of service on the movement and retention of health professionals and to make appropriate recommendations. The specific objectives were to:

- describe the perceptions of health professionals regarding current conditions of service in Namibia;
- describe their suggestions to improve conditions of service in Namibia; and
- make appropriate recommendations directed at improving conditions of service.

This study is very important because the results could be used to influence and shape the development of the Human Resource Development Policy in the Ministry of Health and Social Services as well as in other sectors. The study could also facilitate the development of strategies that could avoid the loss of skilled health personnel from the public to the private sector as well as to the outside world.

3. Research methodology

A qualitative design, using explorative and descriptive research strategies was employed (Seaman, 1987:169; Sarantakos, 1993:42; Burns et al, 1997:542; Mouton, 1996:102). The study aimed to answer the following questions:

- What do you think are the reasons that health professionals are moving?
- What are the reasons that some health professionals stay?
- What do you think should be done to prevent them from moving?
- What do you know about the Human Resources Policy?

The researchers then classified the responses provided under the conditions of service.

3.1. Study area and study populations

The area of study was the Khomas region, one of the thirteen political regions of the country. All the health professional boards and three of the private hospitals in Namibia are in Windhoek, which makes it useful for this type of study. There are twelve public health facilities (nine urban; three rural) and eight private facilities plus various private doctors' consulting rooms in Khomas region. The target health professionals for this study include state registered nurses, medical doctors, health inspectors (environmental officers) and social workers at operational levels and in managerial positions.

3.2. Data collection and sources of data

Data was collected through nine focus group discussions (with five to nine participants) and ten individual in-depth interviews with some individuals. Qualitative data was analysed manually using the Tesch technique. The validity and reliability of the data was ensured through a pilot study done in Rehoboth district. The pilot study resulted in alterations to the questions used during the main study.

3.3. Ethical considerations

Permission was obtained from the MoHSS to conduct the study. Personal consent was obtained from the individuals to participate in the study after the purpose and significance of the study was explained to the participants. Participation in the study was voluntary; individuals could withdraw from interviews at any time if they wished.

4. Research findings

This section describes why health professionals are moving (push factors) and why they are staying on (retention factors) with regard to working conditions in the public and private health sectors at some of the public and private health facilities Khomas region. The contextual factors, such as health sector reform that took place after independence in 1990, and how these affected and impacted on the working conditions are described. The last part of this section looks at how to improve working conditions, and gives recommendations with a view to facilitating staff retention especially in the public sector.

4.1. Reasons health professionals leave

Different professional categories of health workers such as doctors, nurses, social workers and health inspectors were interviewed on separate occasions as well as top- and mid-level managers in the MoHSS and the private sector. The main question asked of all participants was: "What do you think are the reasons that health workers are moving?" The answers to this question reflected on the main aspects of 'Conditions of Service':

- financial issues;
- Human Resource management issues, including staff development and occupational issues; and
- macro-environmental issues.

Financial issues

Personal financial obligations

One of the most significant complaints pointed out by most categories of health professionals were personal financial burdens, which forced them to resign and claim their pension. As one nurse said "resign and get your pension to fulfill family responsibilities such as pay school fees, outstanding debts."

Insecurity regarding pension pay-outs

Pension is also claimed due to the insecurity, felt by health workers that they will not get it by the time they retire as the government invests pension money into institutions which are not financially secure. One nurse said: "We are resigning to claim our pension money while it is available, because one is not sure you will get it later."

Better salaries in the private sector, especially for doctors

Health professionals resign to look for better opportunities; one chief professional nurse said "nurses resign for greener pasture in terms of salaries". Social workers also said they leave "for better salaries outside the public sector". These trends were confirmed by a top MoHSS manager who said of doctors and health inspectors: "After completing the basic internship, they look forward to go private where they will earn three times more."

The abovementioned complaints were linked by the participants to the changes brought about by health reforms, especially the establishment of the Wages and Salary Commission (WASCOM) in 1996. This exercise resulted in the vocational re-classification, salary restructuring and the phasing out of automatic promotions.

The complaints provided by health workers with regard to health sector reform, matched the analysis conducted by Kolehmanen-Aitken (1997) on the impact of decentralisation on human resources. For example he mentioned that in the Philippines decentralisation threatened benefits that health workers were entitled to, under centrally set labour agreements and salary increases, mandated under a national salary. Good salary and promotional opportunities are known to reduce the rate of turnover within an organisation (Lawler, 1973). This study found that although the salary offered in the public sector compared well with other countries in the region, promotional opportunities are limited for most people and this causes them to look for better opportunities.

Human Resources management issues

The different issues relating to staff development are classified under: career movement, career development, staff appraisal and in-service education.

Career movement

The findings suggest limited career movement opportunities exist due to restructuring and the absence of a performance appraisal system. Hospital managers interviewed blamed the restructuring exercise for the limited career movement in the public health sector such as the removal of the automatic promotion for registered nurses after three years: “People are sitting in positions for years, no promotion after three years. If one reach maximum of the pay structure eventually one will be forced to resign.”

Nurses and the top MoHSS management tend to agree with the hospital managers that there is now “no career ladder” after the senior registered nurse post was abolished by WASCOM. A lack of a career pathway was also cited as a problem in Ghana and in Zimbabwe (Awases et al, 2004). A manager pointed out: “There are limited promotional post possibilities for health inspectors in the public sector that is why most of them move to local authorities where they can receive double payments and other good benefits”.

Doctors also felt affected by these changes as they have to spend many years as junior doctors after internship. As one said “I am now ten years working as a medical officer and for many years I will stay like that. Therefore, there is no clear position for us, as a result you are forced to go either for an administrative post or leave for private practice to support the family.” Another one said: “I am now ten years after my basic qualification and I am just a Medical Officer (MO) and will be an MO for many years to come.”

Martineau et al (1996) mentioned that while there are always multi-level career structures for doctors and nurses, there is usually only a very modest structure for other health cadres such as technicians, and little or nothing at all for other staff. This may condemn individuals to a small or even no possibility of more than one promotion in their whole life. A further problem exists in public health and health management as the career prospects are markedly less attractive to equivalent clinical tracks it is difficult to attract people into these areas (ibid). Dovlo (1998) proposed that common grades and titles and career pathways should be established to allow non-clinical cadres to reach the highest levels of remuneration.

Favoritism also seems to feature. One middle level manager said: “Career movement is for some people. You feel like you have reached a cul-de-sac, you feel restricted and stagnant in one position. People are favoured that is why some of them hardly leave the system and some leave.”

Career development
Nurses interviewed felt staff development opportunities were limited and that there was no reward for staff member's who complete training, except a once off bonus. New skills acquired by the staff are not recognised by placing them in departments where these skills can be used, making the training irrelevant. A nurse said: "No one appreciates the new skills acquired at all, you are only recognised by the management when you behave badly". The doctors agreed that there is no active career programmes for them either, especially in the clinics, where "we have nobody here that gives us academic refresher courses or meeting[s]".

Social workers have a different perception on this point. They felt that they are not given opportunity to utilise their skills because they have less power to make decisions in the hospital settings, for example when patients are discharged. "The public perception is that the hospital is for doctors and nurses. As a result they don't ask for social workers. Clients expect the social workers to fulfill their needs such as providing food", said one.

A study in Zimbabwe found that other reasons for moving out of the public sector include insufficient opportunities for promotion and self-improvement Crush (2005). This indicates that health professionals move out to go private where opportunities for self development and promotional opportunities are available. However, in Namibia the main reason for moving to the public sector is for self-development rather than promotion.

Staff appraisal
One of the top MoHSS officials felt there is no positive staff reinforcement, motivation or reward in the public health sector. Top management agreed that the lack of regular feedback between supervisors and subordinates on work performance causes frustration: "There is even no meeting between the supervisors and subordinates and this causes a lot of frustrations." Other researchers recommended that similar concerns are overlooked, but if reinforced may enhance staff performance. Martineau et al (1996) recommend providing attractive rewards, whilst maintaining overall cost reductions, to enhance staff performance.

In-service education
One hospital manager interviewed said they have problems with regard to human resources development (HRD) as a result of a shortage of competent staff. She also commented that they lack coordination with the continuous education program offered by the National Health Training Centre. She emphasised that this has a tremendous effect on poor performance in that specific hospital.

Doctors interviewed agreed with the hospital mangers that there is no continuous education, such as refresher courses for medical doctors, in Namibia. One stated that there is: "No academic development for doctors, thus you cannot grow. What you have learned at the University you will forget it".

Doctors at clinics felt neglected compared to those in hospitals: "We at the clinic are not exposed to specialist[s] [like] those at the hospitals. There is no one to give us refresher courses and have academic meetings." This could result from there being no medical school in the country. In this regard, some social workers in the public sector expressed feelings of isolation due to limited exposure unlike those working for NGOs. According to

Martineau et al (1996) apart from doctors and nurses, there is little or no assistance for most staff to achieve the extra skills and qualifications that will merit promotions.

Martineau et al (1996) point out that good performance requires, among other things, the capability to do the job. They further mentioned that reforms demand new skills - often management-related - but emphasised that this depends on taking new initiatives.

Traditional training providers may not have the capacity to cater for such a heavy and intensive training load (ibid). This highlights the need for special capacity building teams to be established to provide people with new skills.

Occupational issues

Occupational health issues include work stress, stigma, and fear and risk of infection.

Work stress

Work stress was perceived as related to increased workloads due to changes in disease patterns and staff shortages. Nurses and doctors described the workload emanating from increased numbers of patients to be the main cause of work stress. When nurses were asked to describe why the number of patients had increased, they attributed this to the duration of stay of patients in hospital: “Patients have increased because they are lying on the floor and stay long in the hospital than before.” Nurses also felt there were too few nurses to manage the workload. These feelings appear to result from there now being more patients with chronic diseases and HIV/AIDS than in the past, which led to patients having to stay longer in hospital. Namibia now ranks as one of the top five countries in the world in terms of HIV infection rates MoHSS (2004).

A study comparing 100 oncology nurses and 103 nurses in hospitals caring for HIV/AIDS patients in the United Kingdom (UK), found high levels of stress and burn out factors in both populations. Other studies show that stress and anxiety is experienced even faster in AIDS carers than among oncology nurses (Miller, 1995; Awases et al 2004).

Nurses interviewed also indicated that there is a severe shortage of staff created by the upgrading course for nursing assistants to become enrolled nurses; this is in addition to the various new programs implemented, such as Prevention from Mother to Child Transmission (PMTCT), Highly Active Anti-Retroviral Therapy (HAART), which took staff from the existing pool. This could mean that patient numbers did not necessarily increase but the demand of caring for a patient might be more taxing.

The nurses also blamed the fact that the MoHSS is not reviewing the numbers of staff posts based on the current workload. Medical doctors agreed with the nurses that the staff establishment should be reviewed in line with the workload. The doctors also told the researchers that, as a result of work stress they experience burn out and sometimes resort to alcohol abuse, which results in constant absenteeism because there is no workplace programme to support them when feeling low. They described the stress and burn out in this way: “We are overloaded and this can cause people to loose interest in the profession. We don’t even have time for our loved ones.”

Social workers and health inspectors seem not to experience staff shortages, and therefore did not comment. Social workers however, indicated burn out emanates from the routine work they face. No private sector workers expressed these sentiments at all.

Pendukeni (2004) conceptualises occupational burn-out as a particular type of stress occurring principally in professional contexts, especially those of an interpersonal nature, where work demands lead to chronic emotional exhaustion, depersonalisation and reduced sense of personal accomplishment. Burnout results in high staff turn over, absenteeism and reduced productivity, all of which have serious repercussion for organisations, services and individuals (Pendukeni, 2004).
Similar issues are reported from Zimbabwe (Crush, 2005). There, health professionals expressed dissatisfaction over the patient load which they regarded as extremely high and still increasing. The current movement of health professionals can therefore be seen as both the cause of the migration (by increasing the workload of the remaining staff) and its effect (due to the reduction of the available health professionals).

Stigma
Another factor raised was the issue of stigma related to poor health which could be linked to work stress and exhaustion. As one nurse stated: "Nurses with poor health status are booked off frequently leaving the wards with a skeleton staff and such health workers are suspected to be suffering from HIV/AIDS which implies stigmatization". To avoid such stigma the staff choose to work on even if they are not feeling well and sometimes are even 'given names based on their on and off work'. Pendukeni (2004) similarly found that emotional exhaustion can lead chronic conditions which might be wrongly suspected and linked to HIV/AIDS. In their communities people start talking among themselves about the nurse being too long on sick leave. To avoid such experiences, some health workers choose to leave the public sector and go where there is light work which would be good for their health

Fear and risk of infection
Medical doctors at the MoHSS felt that the risk of infection was relatively higher due to the poor ventilation system in one hospital. This was supported by the nurses who said they had to use mobile fans in theatre as the air-conditioning was out of order; they said poor ventilation in their workplace could pose a risk of communicable diseases. They are therefore looking for jobs with is low risk of infection. Awases et al (2004) reported staff in the six African countries worried about getting infected with HIV through work-related conditions and injuries. This confirms Pendukeni's (2004) finding, where health workers in one region in Namibia indicated that they fear contracting HIV/AIDS through work-related conditions such as lack of gloves and performing procedures such as wound dressing unprotected and unsafe.

Macro-environment issues
Issues related to the macro-environment include physical facilities, communication and interpersonal relations, management support and motivation, and job satisfaction.

Physical facilities, equipment and supplies
Both groups of nurses and doctors interviewed indicated a lack of equipment and supplies in all public health facilities causes staff frustrations. They attributed this to inefficiency in ordering medicines and other supplies and the theft of basic equipment such as sphygmomanometers. They also blamed budget cuts, as hospitals cannot even buy linen for patients. One professional said, "It is better to work under the tree than doing bush nursing in the hospital". One private hospital manager acknowledged that health staff from the state hospitals are resigning and leaving for the private sector where they have enough equipment and supplies.

One of the top management commented that despite some improvement in the macro-environment some "health facilities are not very pleasant to work in". In addition, the work pace for renovations was slow, creating inconvenience and causing staff frustration. Some nurses felt that despite some improvement, changes were "as yet not enough". Lack of accommodation and other infrastructure in the rural areas also frustrates health professionals. Medical doctors emphasised poor living conditions faced by junior doctors forced them to find jobs in urban areas with better infrastructure.

The literature indicates that frustration resulting from a lack of basic equipment such as BP machines and ENT sets in the public sector is quite common (Awases et al, 2004; Dovlo, 1996). Awases et al (2004) also reported that poor working conditions were cited in six other African countries as a reason for emigrating. This finding supports Crush's (2005) reports that health professionals in Zimbabwe indicated that they lacked basic equipment in the public health institutions such as injections and thermometers. The absence of such basic equipment hinders health professionals from providing quality care to their clients, consequently affecting morale. Stillwell et al (2004) said Nigerian doctors migrate in search of better opportunities for professional development in countries with better medical infrastructures.

Communication and interpersonal relationships

Almost all respondents said there are poor interpersonal relationships between health professionals at operational and management levels and that MoHSS communication is top down and instructional. It was reported that communication is directive with no positive information-sharing and formal feedback. It was suggested that many leave their workplace due to personal conflicts with colleagues and/or management. Health workers at both public and private health facilities expressed this sentiment. This supports Awases et al's (2004) findings that poor management was a reason for health worker migration in six African countries, especially in Ghana.

Management support and motivation

Lack of management support was characterised by lack of motivation, a non-caring culture and no professional or social recognition. There is a perception that there is no management support and motivation for staff from those in positions of authority. This was believed to create a non-caring culture, expressed in the following ways:

- "We'll get someone else if you resign."
- "Nobody takes[s] accountability at the top for monitoring."
- "There is no support for caregivers, say for providing counselling to staff when they have personal social problems."
- "No top management support, they only come when there are problems."
- "Decision makers do not know what it means to work as doctors, they work 7.30-17.00 while doctors work around the clock."

Participants also said there was not enough supervision - top management felt that the system does not motivate its staff through any informal rewards and recognition for example "special nurse or cleaner of the year, or the best district". Nurses felt that management do not give recognition or appreciation of further studies or the good job they are doing and this de-motivates them: "After completion of studies one needs to be praised and or rewarded, but here you are seen as a threat."

Lack of job satisfaction
Some nurses felt there is no job satisfaction because of the frustration due to lack of equipment, e.g. in theatre the lights and air-conditioning are not working, doctors are screaming at nurses. It was also felt that being in the role of an "acting" high position for an unlimited period without being appointed in that position results in a lack of job satisfaction. Even the top management agreed that the lack of regular feedback between supervisors and subordinates on work performance causes frustration.

4.2. Reasons health professionals stay (retention factors)

Respondents were also asked to give their views on why health workers stay in the public or private health service. Respondents mentioned factors such as financial aspects, job security, loyalty, fear of the unknown and convenience.

Financial issues
Amongst the financial issues, respondents mentioned matters such as salary and fringe and social benefits.

Salary
The top MoHSS management felt strongly that Namibia offers competitive salaries to qualified professional nurses compared to other SADC countries. They assumed this could be the reason why the country has no serious brain drain with regard to key health professionals. Some health professionals also mentioned salary as a reason to stay in the private sector, however, the health professionals in the public sector did not support this. Better remuneration has been reported as a reason for remaining in your workplace in six other African countries (Awases et al, 2004).

Fringe and social benefits
Nurses and social workers felt that many health professionals stay in the public health sector because, compared to the private sector, government offers the best and cheapest medical aid and housing subsidies. Nurses also affirm that they need to build up their pension package, which can only be done by staying in the public health sector:
- "Government medical aid is the best and overtime is good."
- "The Labour Act provide[s] good overtime."
- "Some stay to pay off their housing bond."

Private health professionals shared these perceptions:
- "Medical aid in the private sector is expensive."
- "The overtime on Sundays is best in the public sector."

Loyalty and patriotism
Interviews with both management and nurses at operational levels clearly indicate that some stay in the public health sector because of their loyalty and commitment to the government and a sense of patriotism. Staying in the public sector gives them satisfaction and courage to serve more people:
- "If we all leave, who will do the job?"
- "I am here because I am used to problems. It is part of life, someone has to be here."
- "We still get dedicated people who get satisfaction to practice the profession for the people".

It is encouraging to still find those who are patriotic and loyal to the government and these types of feelings should be nurtured to keep such health professionals.

Job security

Interviews also revealed that most people stay in the public sector for job security, linked to fringe and social benefits: "One stays on to pay off the housing bonds and take care of family commitment." However, some of those in the private sector looked at the job security afforded by the public sector in a different way: "You must have done something terrible before you are dismissed in the State." This sentiment is frightening and indicates some loopholes in the management system that need to be eliminated through better supervision and management.

Health professionals in the private sector stay there because of small incentives not provided by the public sector. One top private sector manager stated: "In the private sector people stay because you get the green cross shoes and other uniforms … You are known by name and birthdays are remembered".

Fear of the unknown

Doctors, social workers and nurses interviewed indicated that fear of unknown dissuaded people from leaving the public sector. This was linked to fear of going for interviews, lack of skills required in the market especially computer skills, or being too old to move. One nurse said: "Those who stay are pure cowards they don't have the guts to go … old ones are not marketable." Social workers feel the same way: "We have a fear of going for interview because after fifteen years you know what you have but going for interview you don't know what you are letting yourself into … there is fear of the unknown despite the frustration".

One mid-level manager felt that lack of vision and complacency also stopped people from climbing the career ladder. Nurses felt similarly: "Some people have no where to go and they have a feeling that they have reached a cul-de-sac."

Career path

While nurses and doctors emphasised financial improvements as pull factors which would make them remain in the public sector, social workers and health inspectors emphasised career development issues. They felt there were more career paths in the public health sector than the private sector due to limited posts outside. Social workers also felt that study leave and fellowships offered by the public sector encouraged them to stay on.

Doctors felt that the public sector offers a wide spectrum of experience in practice, exposing them to many different medical conditions, which benefits them and enables them to gain more experience before they move to the private sector: "It is the risk takers that move to the private sectors without enough experience". Mid-level management cadres also supported this view, especially the health inspector. Health professionals in the private sector also agreed that one gets more practical experience in the public sector, which has specialised departments, unlike private hospitals.

4.3. Retention strategies suggested by interviewees

An attempt was made to find out if health workers had suggestions on how the system can retain them. Suggestions centred on aspects related to finance, human resource management and macro-environmental issues and these are described below.

Financial issues

Nurses and doctors have a strong feeling that salaries should be reviewed by adding more incentives such as a car allowance for medical doctors to compensate for high consumption of petrol when they are on call. Nurses suggest that incentives like fixed overtime for senior nurses and incentives for those nurses who work in the high risk departments should be designed. Other suggestions were salaries linked to performance appraisal and market-related salaries based on qualifications.

Nurses working in clinics have different suggestions. They felt neglected because they do not benefit from overtime payments, as there is no room to work overtime in the clinic setting. They therefore suggested the system should open up overtime opportunities at the clinic level.

Human resource management issues

Strategies for human resource management are described under the headings of career development, career paths, shortage of staff, motivation strategies and communication as a support system.

Career development

One hospital manager suggested that compulsory continuous education should be enforced to encourage health professionals to acquire more knowledge and skills. This was in line with suggestions from top management that the system should create more opportunities for health professionals to attend workshops for new programs. She also felt there should be a mechanism designed to monitor and evaluate the impact resulting from training attended. Another suggestion was that staff members receiving promotion should receive training in line with their new functions. One manager suggested that local institutions should introduce different specialisation courses for nurses to address their training needs in their particular area of work. One middle manager proposed that each division should have a plan which includes staff refresher courses.

The group of nurses interviewed also indicated that one retention strategies could be improved career advancement by opening up the opportunity for those who have diplomas to go on to study for Masters degrees. Nurses emphasised that enrolled nurses who wish to upgrade themselves to become professional nurses should be granted study leave as a motivation strategy. They believe this will motivate them to come back to the public sector once they have completed their training.

Two top managers said there is a need to train more people in the Health Management Service to boost the supervision and support system. Curricula could be strengthened to impart management knowledge and skills to students while on training and even as part of their employment induction. They also suggested that directors should do regular supervisory visits, and provide on the job training and face-to-face feedback.

Career path
The social workers suggested that diversification would encourage them to stay in the system, as would creating more specialities in the profession. Top management expressed the same sentiment: "There is not enough diversification; one comes back in the same position, no diversity in levels." This means that those with specialised skills should be fully utilised, not just by their individual units, but across the board. Nurses indicated that there is need to revisit the system and re-introduce automatic promotion based on years of service. The regional management team supported this.

Addressing staff shortages
One top manager indicated that to address the issue of staff shortage, all the vacant posts should be filled, based on the new staff establishment. The regional management team, nurses and doctors also suggested: "Staff establishment should be looked at because the patient population is growing with the same staff, and possibly also re-evaluate the amount of caring needed for today's patients."

The top management respondent, like the nurses, also felt that the University of Namibia should increase the yearly student nurse intake. Nurses also felt that the old system of employing the student nurses should be re-introduced to guarantee their posts are already secured in the public sector. This should be combined with the bonding of their study loans. They also indicated that if new programmes are introduced, extra staff should be appointed rather than taking them from the existing, depleted pool of staff.

Motivation strategy
Privation packages would help motivate health professionals to work in the rural communities. Performance appraisal with merit rating is also perceived to be a motivation strategy. The Hertzberg motivation theory claims that money alone does not motivate but it can keep employees' morale and productivity at an acceptable level; other motivators should be used to supplement it (Booyens, 1998). Acknowledgement and a system of non-financial rewards could serve as motivators and be used to improve the quality of the lives and work of staff (Otaala et al, 2004).

Communication as a support system
The group of nurses believed that a system where individuals can have one-to-one positive feedback discussion with their supervisors might boost their motivation to stay in their job. The same group of nurses also suggested establishing a work forum as a way to voice their concerns. One middle level manager also said there supervisors needed to learn to accept ideas from subordinates and involve them in decision-making. This, he believed, could build trust and confidence between the supervisor and the subordinates in the long run. One top manager suggested that the MoHSS change its old style of giving directives in circulars and capitalise on giving regular feedback through roundtable discussions: "We are still using the old style of circulars which may not reach all levels; these are directive rather than calling for discussion feedback".

It was also suggested that directors should do supervisory visits regularly and provide on-the-job training. The reason they do not do this could be that supervisors do not understand their responsibilities. Otaala et al (2004) suggest that there is need for training, especially for managers, to understand what it means to be a manager in an institution. It could assist mangers if there are proper systems in place such as supervision guidelines, job descriptions and induction programmes.

Macro-environment issues
The strategies suggested for improving the macro-environment include: recognition, support system, training support, conditions of service and marketing.

Recognition
Nurses felt they needed professional recognition in wider society: "Society should recognise us for example if I go to the bank and other social institutions, one needs to be given special care to enable us to go back to work …this could be a big incentive for health workers." Social workers also raised concerns about lack of professional recognition for their contributions in multidisciplinary teams and lack of acknowledgment of them professionals by the society at large.

Support system
Continuous management support in terms of supervision, infrastructures and equipment should be in place and be done in correctly. Nurses felt that supervision and support is done the wrong way round as it mostly only happens when there is problem. One mid-level manager suggested that supervisors should accept and acknowledge the skills of sub-ordinates rather than just criticise: "If a supervisor is given a report then comes back without any feedback or comment, but just saying this is not a report and does not give guidance."

Other top managers suggested that support be given to health staff summoned for disciplinary hearings by identifying contributing factors that could serve as mitigating factors rather than looking for mistakes only. Issues that contribute to this negligence should be addressed by setting up a system which protects health workers.

Supportive management structures were also seen in terms of physical infrastructure and equipment. The social workers felt there is a need to look into the infrastructure that forms the support system to the programs, such as transport which enables them to conduct home visits. One private hospital manager also indicated that the public health sector should improve equipment supply. However one top manager felt that resources did get allocated to those who are proactive therefore she encourages managers to be proactive rather than blaming the system.

Condition of service and marketing
One mid-level manager suggested that the MoHSS should inform employees about the benefits to which they are entitled via booklets. This was also indicated by one private hospital manager who also suggested that the private health sector should also provide favourable medical aid and housing allowances similar to what the government offers. In addition, one mid-level manager suggested that the MoHSS should talk to the media to market their product, thus attracting people to the different employment fields.

5. Conclusions and recommendations

This study has explored the perceptions of health professionals about conditions of service in Namibia, at both operational and managerial levels.

5.1. Conclusions

The study found that financial factors, human resource management issues, and occupational and macro-environmental issues are perceived as both push and retention factors for various health professionals at different levels in both the public and private sectors. The findings of the study show that fringe benefits such as housing assistance, overtime payment, medical aid, pension and retirement benefits are the strengths of the conditions of service in the public sector. However, in the private sector attractive conditions of service were more linked to salaries and the macro-environment such as recognition and communication - 'soft issues.' The shortcomings of conditions of service were linked to salaries and career management in the public sector, as compared to the lack of fringe benefits only.

Researchers are of the opinion that apart from the salary package and macro-environmental issues, respondents did not experience problems with the general conditions of service. The aspects identified as push factors were mainly associated with interpersonal relationship supervision, support and physical facilities in the public sector, whereas human relations and physical facilities are the pull factors in the private sector.

The researchers are also of the opinion that there is a gap between existing policy on human resources development and the dissemination of this policy to health professionals, especially those in the public sector who are the beneficiaries.

5.2. Recommendations

The researchers would like to make recommendations based on the findings that might have policy implications.

Service benefits

The researchers recommend that the remuneration package needs revision to include the privation allowance for those health professionals working in high risk units and remote areas.

Another recommendation linked to conditions of service is related to pensions. Health professionals need to be sensitised and educated with regard to the purpose and use of pension benefits. A policy could be implemented to allow staff to borrow a certain percentage from their pension to ease their financial burden. This will have a dual benefit for the staff in that they would not deplete their pension and at the same time relieve their financial crisis.

Human Resources development

The policy on career development needs to be reviewed to implement a performance appraisal system to facilitate capacity building and promotion. The current promotion system should be revisited to improve the quality of work-life among health professionals.

The Public Service Commission should explore the possibility of horizontal diversification for optimal utilisation of specialised skills of relevant health professionals. In-service training needs to be reactivated in most of the health facilities and a proper monitoring

system developed to facilitate capacity development. Training opportunities should be open to all health staff to facilitate continuous professional development as prescribed by the Nursing Act 8 of 2004.

For any person promoted, an induction session should be undertaken to orient them to the new job and environment. It is recommended that a standing induction programme be established for new employees and those who are promoted or transferred.

Pre-service training

To attract and retain newly qualified health personnel, a bonding system should be introduced through a government bursary or loan scheme. The MoHSS remains the major employer of health professionals in Namibia and they could test whether it could have an impact on the movement of the health workers.

Management systems

There is a need to put management systems in place such as appraisal performance, supervision guidelines and job descriptions for all managers. It should then be expected that managers utilise such systems to improve their own performance.

To care for health workers each profession needs to establish a work programme that takes care of its workforce in terms of motivation and also to compile information about the human resources available to them.

To address problems with regard to living conditions, and lack of infrastructure, supplies and equipment, multi-sectoral structures at all levels need to be established. Different ministries need to be educated to appreciate the needs of the health sector when it comes to improving financial remuneration and working conditions of health workers.

Improving information and its dissemination

The MoHSS should determine staffing needs according to the Public Service Norms and implement this accordingly with the aim of curbing the staff shortage. Such an approach would facilitate recruitment, allocation and effective utilisation of appropriate personnel in the implementation of new health programmes

There is a need to create awareness among health professionals, especially in the public sector, on conditions of service. This can be done during the induction process of the new recruits and possibly by developing an information booklet for staff. There is also a need to provide further information about the human resource development policy of which most health professionals appeared to be ignorant. However, health professionals should also make their own efforts to access information on these matters.

Despite the fact that the major push factors are linked to finances, macro-environmental issues need to be addressed to increase the motivation and morale of the health professionals in general. Humanistic theories emphasise the influence of working conditions and social relations on productivity and motivation (Booyens, 2001).

A formal collaboration between public and private health sector is recommended to address unequal distribution of health resources related to human resource distribution and equipment sharing.

5.3. Issues for further research

The researchers have also identified some areas for further research:

- evaluating the impact of increased workloads brought about by the shortage of human resources on productivity;
- creating a database on the health information profile of the whole health workforce;
- assessing the motivation and morale of the health professionals before and after the implementation of various incentives to determine their impact on the workforce; and
- costing, in monetary terms, the loss of human resources to the public sector.

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***Equity in health** implies addressing differences in health status that are unnecessary, avoidable and unfair. In southern Africa, these typically relate to disparities across racial groups, rural/urban status, socio-economic status, gender, age and geographical region. EQUINET is primarily concerned with equity motivated interventions that seek to allocate resources preferentially to those with the worst health status (vertical equity). EQUINET seeks to understand and influence the redistribution of social and economic resources for equity oriented interventions, EQUINET also seeks to understand and inform the power and ability people (and social groups) have to make choices over health inputs and their capacity to use these choices towards health.*

EQUINET implements work in a number of areas identified as central to health equity in the region:
- Public health impacts of macroeconomic and trade policies
- Poverty, deprivation and health equity and household resources for health
- Health rights as a driving force for health equity
- Health financing and integration of deprivation into health resource allocation
- Public-private mix and subsidies in health systems
- Distribution and migration of health personnel
- Equity oriented health systems responses to HIV/AIDS and treatment access
- Governance and participation in health systems
- Monitoring health equity and supporting evidence led policy

EQUINET is governed by a steering committee involving institutions and individuals co-ordinating theme, country or process work in EQUINET: Rene Loewenson, Rebecca Pointer TARSC; Firoze Manji, Patrick Burnett Fahamu; Mwajumah Masaiganah, Peoples Health Movement, Tanzania; Itai Rusike CWGH, Zimbabwe; Godfrey Woelk, University of Zimbabwe; TJ Ngulube, CHESSORE, Zambia; Lucy Gilson, Centre for Health Policy South Africa; Di McIntyre, Vimbai Mutyambizi Health Economics Unit Cape Town, South Africa; Gabriel Mwaluko, Tanzania; John Njunga, MHEN Malawi; A Ntuli, Health Systems Trust, Scholastika Iipinge, University of Namibia, South Africa; Leslie London, UCT, Nomafrench Mbombo, UWC Cape Town, South Africa; Riaz Tayob, SEATINI, Zimbabwe; Ireen Makwiza, Sally Theobald, REACH Trust Malawi.

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