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An investigation into the causes of Understaffing of Registered Nurses in Mission Hospitals: A case for Mashoko Mission Hospital

BY

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DEDICATION

The project is dedicated to my father who passed on in 1993 whose wish was to see all his children develop academically and succeed in life. Unfortunately his death was so untimely and left a gap that no one can fill.

ABSTRACT

The study presents an informative investigation on the understaffing of nurses in mission hospitals a case for Mashoko Mission hospital. The purpose of the study was to determine the cause, effects and solutions to understaffing of nurses. Literature review was done on global perspective, continental regional zeroing to Mashoko Mission hospital, where understaffing of nurses was discovered to be a chronic health personnel problem. The causes, and solutions proved to be different with continents and regions, but the effects are similar, mostly poor health service delivery. The researcher used qualitative research method. On the ground the researcher applied a case study research design to discover in-depth information on understaffing of nurses. The researcher used a purposive sampling of health personnel of 50 subjects, one human resource, 47 nurses, and 2 doctors at Mashoko Mission hospital. Data were collected from hospital statistical records. A questionnaire was used to collect information from participants for analysis. Data was presented using tables and figures. The findings revealed that understaffing was caused by poor working conditions, geographical location and bureaucratic leadership style to mention a few. The findings reflected a chronic health personnel understaffingand the recommendations from participants were that the government should improve working conditions for nurses, be transparent on deployment of nurses. Mashoko Mission hospital should also be flexible with its religious policies.

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CHAPTER ONE: THE PROBLEM AND ITS CONTEXT

1.0 INTRODUCTION

The study focused on the causes of understaffing of Registered General nurses at Mashoko Mission Hospital in Bikita district in Masvingo Province. Understaffing of nurses in hospitals has created untold suffering of patients, waiting for too long in queues and having minimal attention at the hospital. The purpose of the study was to discover the causes, effects and the solutions to understaffing of nurses in Mission hospital a case for Mashoko Mission hospital. The chapter focused background of the study, statement of the problem, research questions, o the significance of the study, limitations and delimitations.

1.1 Background to the study

Understaffing of nurses has been a subject of much debate and research over the few decades (Yoder 2004). Many government Ministries such as Health, Education, and Defence were experiencing the understaffing in their relative departments as a result of various reasons. The levels of understaffing had reached an alarming rate and one wonders as to why it is so. Mission Hospitals had been neglected in terms of staffing that they operate with skeleton staff . One of the major causes was brain drain (Patricia ,2001). African countries were trying to improve the functioning of health care delivery systems to ensure that the population they served received timely quality care. Health care in Africa faces difficult challenges such as understaffing of health workers in health institutes, increased workloads, mixing of skills, locum, poor service delivery, unfavourable working conditions for health workers due to migration of skilled health personnel. Lower nurse to patient ratios led to more complications and poorer patient outcomes (Needleman et al. 2002). In Intensive Care Units, variation in mortality rates could be partly explained by excess workload .Inadequate nurse staffing was associated with adverse occurrences such as medication errors, decubitus ulcers, pneumonia, and infections both post-operative and urinary tract . In addition it had been shown by an increase in adverse events increases the number of nursing hours required (Cohen et al.

1999). Nurses were the primary surveillance system of the hospital and as a consequence, understaffing or a decrease in hours of care per patient day can lead to 'failure to rescue', defined as the recognition of an impending or actual complication and prompt intervention.

1.2 Staffing issues of nurses

Health personnel perform their duties 24 hours a day in shift rotation ,365 days a yearhence the need for hospitals to be well staffed according to nurse patient ratio (Statutory Instrument of 2006). Nurses rotate shifts and were sometimes forced to work over time if the department was not covered .This could sometimes cause stress and burnout in nurses. In a department that was run by 8 nurses, the breakdown of shifts was as follows: 2 nurses would be on night duty, 2 nurses would be on nights off, 1 nurse would be off duty, 2 nurse would be on early duty from 0715 hours to 1600 hours, 1 nurse would be on late duty from 1230hours to 2000hours. Given this scenario, it showed that nurses at 8 nurses in a department would not on for vocational leave.

1.3 The nursing workforce

On the supply side, the profile of the nursing workforce was undergoing significant changes. Decreasing enrolments had been evident for some time in the whole world as a result of economic, political and technological transformation(O'Brien-Pallas & Baumann 1999). However, enrolments for 2014 had increased and time would tell whether this trend was sustained in this country.This was exacerbated by the increasing number of aged students entering into nursing (Parliamentary Debate, 2014). The high recognition given to Zimbabwean nurses and their preparation worldwide showed that in this country the supply side of the equation was uncertain (O`Brien-Pallas 2002). The literature above gave a gloomy picture of nursing workforce as long as other countries open their boarders for nurses from Zimbabwe.

1.4 Workload and work environment

Workload and work environment were two of the most important factors contributing to the nursing shortage and understaffing. Unacceptable and unsafe work environments characterised by safety issues such as bullying and harassment as well as inaccessibility, impact negatively on retention of nurses (Duffield & O'Brien-Pallas 2002). Nurses worldwide report job demands/workload exceeds their capacity to take on work (Fagin, (2001). Nursescomplained of excessive workload and burnout, lack of recognition for work done, lack of autonomy, lowmorale, job dissatisfaction and safety issues to name but a few(Zimbabwe Nurses Association Annual General Meeting ,2014).Dissatisfaction and burnout increased as nurses' ability to provide basic nursing care required by patients' declined and job dissatisfaction became a significant factor in their decision to leave for greener pastures. Once staff shortages occurred, there was an increased in workload for those who remained (Baumann et al. 2001). Working understaffed inevitably increased workload, double shifts or split shifts, one would come to work at 0715 hours knock off at 1200 hours and would come back to work again at 1600 hours and would knock off at 2000 hours.

1.5 Policies and concepts of the Ministry of Health

Policies were long-range statements of organizational objectives, a hospital or clinic set standards (Dee, 1994). The Ministry of Health as such has policies that deal with staffing as was discussed in Parliament on staff establishment (Parliamentary debate, 2014). During the debate it came out that the establishment of nurses in all hospitals was last reviewed in 1980. The legislators had in light of their debates not considered the disease trends and traits in relation to staffing. They had also not considered the population growth that had doubled from 1980 to 2014. In 1980 the population was7.2 million and in 2014 the population was 14.1 million, (IMF 2014). The health services board was advocating for review of nursing staff establishment to alleviate work stress and burnout (Parliamentary debate ,2014) .The observation was that currently the authorized establishment for nurses was at 20623 which was inadequate against the disease pattern, burden, population growth, and World Health

Organisation guidelines to nurse patient ration that stands at 1:4 at maximum. The Ministry has requested for an additional 5276 nursing posts from treasury, with the hope that understaffing of nurses would bealleviated and issues of work stress, staff burnout,

unnecessary patient deaths would also be alleviated (Parliamentary Debate, 2014). From the above observation it was mandatory for the Ministry to come up with a bill of rights for nurses to promote safety and security for nurses or else they risked being abused by employers by working beyond the allowed hours as a result of understaffing.

1.6 Nurse Training in Zimbabwe

Zimbabwe produce nurses throughout the year from all nurse training school across the country. In Masvingo province there were five nurse training schools with an average of 15 students per group. This meant that yearly the province has the capacity to produce 60 nurses. With the figure in mind one would conclude that the issue of understaffing may be farfetched. Treasury sacrificed all nurses that had been produced since 2012 due to freezing of post to try and cut the running costs of the Ministry of Health at the expense of the patients who were nolonger receiving the care that they expected.

1.7 Consumer Expectation

Patients in this case were theconsumers, they expected to receive high quality nursing care, delivered promptly by nurses(Patricia, 2001). Nursing care was the holistic care provided to a patient or a group of patients during a defined working time .The care covered physical, emotional, social and technical needs of patients. The duties that the nurses performed were diversified ranging from feeding, bathing, dressing wounds, nursing patients from theatre and nursing those with chronic conditions. It was imperative that the nurse patient ratio be revised as a matter of urgency.

1.8 Deployment of Qualified Nurses from training in Zimbabwe

The deployment was done by the Ministry of Health since the department was responsible for recruitment of student nurses. Mission hospitals had the obligation to train nurses using the guideline from the Ministry of Health but the institutes had little influence on deployment.

The students were requested to choose three provinces of their own choice not hospitals. The provincial managers would decide on the deployment in their provinces, they also in turn deployed students to districts and the district leaders would decide on the hospitals to deploy those nurses. The training hospital had no influence what so ever over deployment of students. Mashoko Mission hospital at times would get nurses that they did not train.

1.9 District Profile

Bikita District is found in Masvingo Province and it falls in Region 4and 5 of Zimbabwe. It is located in the Eastern side of the Province about 80km from Masvingo town along Mutare road. The district to the North is Gutu District, to the West is Zaka District, to the South is Chiredzi District and to the East is Manicaland Province. The District has two Mission Hospitals namely Mashoko Christian Hospital and Silveira Mission (District profile 2014). The two mission hospitals train nurses as one of the services that they provide. Mashoko train Registered general nurses for three years who would be deployed to various health care centers throughout Zimbabwe. The hospitals recruit students from all walks of life in Zimbabwe. The other services that were provided by the health institute were, maternity services, orthopedics, surgery, pediatric, rehabilitation, pharmacy, outpatient, laboratory, psychiatry services. Opportunist Infection treatment and Anti Retroviral Therapy services Zimbabwe Expanded Programme of Immunisation services as well as transferring of patients to other health centers. These hospitals also act as referral center for all the clinics in the district.Bikita District's health policy is based on the principles of primary health care that include equity, community involvement and intersectoral collaboration. The Ministry of Health and Child Care plays the stewardship role as it is entrusted with the formulation of policies and strategic plans, mobilization of resources and allocation of external relations. The District has a Health Management Teams that oversee service delivery in a total of two Mission Hospitals and 44 Clinics which are the main entry points in the delivery of health services, although there are 1150 outreach points.

1.10 Statement of the Problem

Despite the fact that Mashoko Mission hospital had a nursing training school it had experienced nurse understaffing significantly. The understaffing of nurses at Mashoko Mission Hospital has undermined efforts of sustainable delivery of public service in Zimbabwe. Health care delivery is highly labour-intensive, hence the understaffing of Nurses at Mashoko Mission Hospitals has compromised the quality of health service delivery in Bikita District. It is essential that there is balance between demand and supply of health workers, a decline in quality of health services, and long queues of clients and patients waiting to be seen proclaim deterioration of service delivery, (Awases, 2004).

1.11 Research questions

The study will seek to answer the following specific research questions:-

1. What is the trend, and levels of understaffing of nurses at Mashoko Mission Hospital?
2. What are the causes of understaffing of nurses at Mashoko Mission Hospital?
3. What are the effects of understaffing of nurses at Mashoko Mission Hospital?
4. What should be done to reduce the current understaffing of nurses at Mashoko Mission Hospital?

1.12 Assumptions

The study assumed that understaffing of nurses at Mashoko Mission Hospitals really exists.

The researcher also assumed that the people approached would give genuineinformation.

The researcher also assumed that the respondents would also cooperate by giving and posting back questionnaires given to them.

The researcher also assumed that his organisation/managers would give maximum support towards the completion of the study.

1.13 Significance of the Study

The findings of the study were of benefit to nurses at Mashoko Mission. The authorities used the findings and recommendations to solve the problem of nurse understaffing. This study was important because no previous research had been documented in Zimbabwe concerning understaffing of nurses at Mashoko Mission Hospital in Bikita District. In addition, the Public Service Commission, which was the employer of all public servants, and was tasked with developing policies to do with the establishment of staff including nurses in both private and public institutes would come up with strategies to alleviate the problem of understaffing, hencemaintainance of a health workforce, especially the nursing personnel problems would be solved.

In view of the current demands on nursing personnel at health facilities to provide timely and quality health services, the study would enhance and improve performance system which could contribute to the improvement ofquality of service delivery by nurses atMission Hospitals. The patients will benefit greatly since they would receive timeous health care services.

This study would support nurses in management positions and professional nurses to identify factors that caused understaffing of nurses in Mission Hospitals in Bikita District. It would also encourage and motivate them to contribute to the achievement of organizational goals. The study would also be significant to the researcher in that it was a practicing framework for the researcher and other researchers could use it to identify other grey areas and would add to existing knowledge, improve research skills and attain a Masters degree in Education.

1.14 Limitations

The research was self sponsored hence limited resources interfered with the research process through compounding the researcher`s mobility to visit respondents and printing materials needed for the project.

Time also was limited because the researcher in question was both a student and an employee, italso limited the scope and depth of the study.

The society could be polarized, have different opinions that could lead to difficulties in reaching a general conclusion.

1.15 Delimitations

Bikita district was a big district that lied between Zaka district Chiredzi district, Gutu district, and Buhera district.

The researcher was going to carry out the project in Bikita district alone at Mashoko Mission Hospital.

The researcher took views only from health personnel at Mashoko Mission Hospital

The researcher used nurse doctors and human resource personnel of the population if the population at Mashoko Mission hospital

1.16 Definition of Terms

Health in this study was defined as "health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity", WHO(2004) in the context of this study the meaning of health would be the general wellness of a human-being.

Nursing is both an art and a science (Yoder, 2003). It involved the caring of the well and the sick through offering physical care, psychological care, emotional care and support where necessary. In this study nursing was viewed as the holistic care of individuals both sick and well.

The term Registered General Nurse in this study, was a person registered with the nurse regulatory and registering authority of Zimbabwe after completing a three year nurse training and passed the examinations set by the Nurses Council of Zimbabwe. Professional nurses were trained at higher education level with the training period between 3-4 years. Professional nurses were also called registered nurses because they were registered by the nurses' council and were working in clinical areas, nursing services and educational institutions (Oulton,2005).

Understaffing in this study was defined as a mismatch between supply and demand. Nursing understaffing was usually defined and measured in relation to a country`s historical

staffing levels, resources and estimates of demand for healthcare services (Buchan & Aiken, 2008). Thus, understaffing of nurse could be defined in terms of professional imbalance betweennurses that are needed to provide quality servicesversus the number of patients that need to be taken care of.

1.17 Summary

The chapter focused on the background information on understaffing of nurses at Mashoko Mission Hospital. The training of nurses at Mashoko Mission Hospital is supposed to alleviate understaffing. This chapter has highlighted the background to the study, the statement of the problem, the significance of the study, research questions, delimitation and limitations to the study. The next chapter reviewed related literature on understaffing of nurses in general in order to orient the study.

CHAPTER TWO: REVIEW OF RELATED LITARETURE

2.0 Introduction

The previous chapter looked at the background of understaffing of Nurses in Mission Hospitals, the training of nurses expected to as a solution to the understaffing of nurses in Bikita District. In this chapter the researcher discussed related literature at global, continental, regional and national perspective of understaffing of nurses. The chapter will looked at the causes of Nurse understaffing,impacts, the solutions to the problem of Nurse understaffing in relation to related literature. The information will be from primary source that's published works and from secondary sources such as internet, journals, and reports from organisations which collaborate with World Health Organisation and the Ministry of Health and Child Care in Zimbabwe.

2.1 Understaffing of nurses in general

The widespread nursing understaffing and nurses highturnover has become a global issue that has attracted attention from many organisations (Dee, 2001).This is of increasing importance to both the developedand developing countries if the countries were to provide quality nursing care to their patients as expected by the patients (Hancock, 1998). In light of this, concern about recruitment and retention of nursing staff was increasing in a number of countries both developing and developed countries to try and solve the problem of understaffing (Lundh, 1999). Nurse understaffing was usually defined and measured in relation to a country`s historical staffing levels, resources and estimates of demand for healthcare services so as to come up with reasonable establishments (Buchan & Aiken, 2008). Thus, nurse understaffing may be defined in terms of professional capacity standards ,shortage of nurses that are needed to provide quality services or from an economical perspective ,not enough nurses available to fill open positions. Recruitment and retention of nurses were persistentproblems associated with job satisfaction. It was vital for one tounderstand how nurse understaffingcame about if strategies to alleviate shortages are to be implemented successfully. According to Chikanda,(2005), the nurse understaffing

today was more complicated because ,there is both greater supply and demand than before. Chikanda ,(2005),further explained that previous nurse understaffing were caused by either an increase in demand or decrease in supply, however, today`s society was affected by a decrease in supply that could not meet the increased demandbecause of new disease trends such as diabetes, hypertension, arthritis, cardiovascular disease, and mental health (CDC, 2008). Examples of increased demand and decreased supply were, an aging workforce, shrinking applicant pool, failure to train many nurses, unfavorableworkingconditions, poor economic conditions, poor political and international relations. In addition, there was an understaffing of other health professionals as well as nurses occurring simultaneously (Chikanda, 2006). Buchan and Aiken (2008) mentioned, that nurse understaffing could be caused by, a shortage of nurses willing to work as nurses under the present conditions. The shortage can further be defined in terms of absolute and relative shortage. An absolute shortage was a situation where nurses are not available for a specific vacancy .In contrast, (Munjanja, 2005). A relative shortage was a situation where nurses were available for the vacancy; however, the Public and Private employer was incapacitated to absorb the qualified nurses. This was the problem that Zimbabwe is facing regardless of the number of patients in hospitals and nurses being produced every year. Other examples of relative shortage may include; geographical location, equity considerations, recruitment and retention challenges and meeting the demand for replacements (Yoder, 2003).

2.2 Historical Background of Mission Hospitals

Christian missionaries established medical missions both because they regarded the ministry of healing as an integral part of the Christian witness andbecause they viewed medical missions as an important evangelistic agency. Forthese reasons, at some mission stations where a trained doctor was not available, some missionaries practiced as amateur doctors(Zvobgo.E,1986). The first permanent medical mission staffed by a medical doctor

began when Dr W. L. Thompson, a medical missionary of the American Congregational Church,

opened a dispensary at Mount Selinda in 1893 (Zvobgo,E, 1986). A fellow American medical missionary, of the American Board of Commissioners for Foreign Missions, Dr William T Lawrence, opened a small hospital at Chikore mission in 1900. In 1928 the government decided to give grants for the first time to missionary societies engaged in medical work among Africans. government Notice No. 543 of 10 August 1928 stated that ,in future and until further notice, government would give grants to missionary societies employing qualified medical missionaries and/or certificated nurses engaged in bona fide medical workamong Africans towards: (a) salaries of medical missionaries and nurses; (b) maintenance of mission hospitals; (c) establishment of training schools for African probationer-nurses, male and female; and (d) purchase of drugs and dressings, including the upkeep of outdoor dispensaries. In addition, the Government would pay: half the salary of every registered medical practitioner(Zvobgo,E, 1986).

At Mount Selinda, a three year-training course for African nurses, with Standard IV as the minimum entrance qualification, was launched in 1930 with seven student nurses in training. This was done to alleviate understaffing of nurses in mission hospitals. A detailed course and syllabus were unveiled in1931. The Wesleyan Methodists began medical work among Africans in colonial Zimbabwe when they opened their first hospital at Kwenda mission in 1913 (Zvobgo,E, (1986). The Government offered £200 towards the cost of building the hospital The Government undertook not only to pay the doctor's salary as soon as he arrived at Kwenda mission but also to defray the cost of drugs, surgical instruments and general equipment. A medical missionary, Dr Sidney Osborn, arrived at Kwenda mission in May 1913. In 1928, four student nurses, Esther Maketo, Barbara Benn, Dinah Mgugu and LilianTyeza began a training course in nursing at Waddilove hospital, (Zvobgo, E, 1986).

The training of the above mentioned nurses was to alleviate nurse shortage at Waddilove hospital.

2.3 Mashoko Christian Hospital

Mashoko is a mission hospital that is situated hundred and sixty kilometers from Masvingo city under Bikita District on the peripheries close to Chiredzi. Mashoko Christian Hospital was founded by Dr . Dennis Pruett, a preacher and medical doctor from North Carolina in the US, in 1958 as a center for medical evangelism. The present building was opened in 1961. Many missionary medical workers from the United States of America have worked at Mashoko Christian Hospital over the years. The first Zimbabwean medical missionaries to work at Mashoko Christian Hospital wereDr.Zindoga and Dinah Bungu .They started work there on the 26th of September 1986 and finally took over directorship of the ministry in 1992 when Dr. and Mrs David Grudds retired. The hospital had 200 beds that cover medical, surgical, obstetrics, gynecology, andpediatrics. The hospital started training three year Registered General Nurses, in 2006 and has so far produced more than 500 nurses. The organisation has developed from being a small rural health center to a district referral center with a nurse training school.

2.4 GlobalTrends onNurse Understaffing

Understaffing is the shortage of nurses that may be relative or absolute. Australia, New Zealand, Canada, and the United States have all experienced minor to significant understaffing in domestically trained physicians and nurses leading to importation of nurses from developing countries(Bourassa Forcier, Simoens, &Giuffrida, 2004).At present, all depend heavily on foreign-trained health professionals to fill important gaps in the supply of health human resources. If all foreign-trained physicians were to leave these countries today, one-fifth to one-third of all posts would become vacant.According tothe Bureau of Health Resources and Services Administration (HRSA) 2006 report, the United States` nursing shortage would grow to more than one million nurses by the year 2020.Within America, the nursing shortage wasnot caused by lack of qualified potential

applicants, it was caused by lack of training resources especially finance. The government imported nurses from developing countries because it was cheap, (Fox & Abrahamson,2009).

One other factor that was affecting the United States as far as nursing understaffing was concerned were , nursing schools`inability to increase enrollment due to scarcity of nursing school faculty (Oulton, 2006). This implied that if training of nurses was done it had the capacity to alleviate nurse understaffing. Additional factors causing the US understaffing were, changing patient demographics, insufficient staffing raised stress level, and high nurse turnover and vacancy rates (Clark & Allison, 2011) .According to Oulton, (2006) the United States would need more than 800,000 new nurses for nursing positions available by year 2020. Downsizing in the United States resulted in more hospital administrators and increased salary costs while the number of nurses declined (Kramer 1998).The United States had tried to offset the nursing shortage by hiring international nurses as a solution to nurse understaffing (Rosenkotter&Nardi, 2007). In the United State it was clear from literature review that nurse understaffing was not a fantasy but a reality (Oulton ,2006). This was compromising the ability of those countries to adequately address their own health care needs in as far as nurse understaffing was concerned. United States was trying to solve nurse understaffing by employing nurses from other countries,however in the event that those nurses decide to leave America the problem would be too big to solve. The United States, Canada, United Kingdom face the same problem of nurse understaffing relying heavily on external sources for nurses.

2.5 Regional Trends of Understaffing of Nurses

African health care systems suffer severely from all patterns of migration of health professionals. Physicians and nurses based in rural and poor areas move to cities for better workingconditions and environments (Patricia, 2001). Urban-based physicians and nurses move from thecritically under-equipped andunder-funded publicsector to the private sector (Gerein, Green, & Pearson, 2006). African countries were trying to improve the functioning

of health care delivery systems through policy revising, collaboration with Non-Governmental Organisations, adaptation of the Primary Health Care concept and improving working conditions of health care providers to ensure that the populations they serve received timely quality care. Health care was labour-intensive, making human resources one of the most important inputs in health care delivery (WHO 2004).

The health care challenges that Africa was facing were, shortage of health workers and understaffing, increased case loads for health workers due to migration of skilled health personnel, and the double burden of disease and the HIV/AIDS pandemic that affected both the general population and health personnel. It was vital for a well-functioning health system to have a well-motivated staff that carried out their work according to standards set by the organization (Nyoni, &Chatora 2004). This implied that human input in terms of work by well-motivated and productive human beings would yield the required results and the best timeously. There were many complex reasons for the deterioration of health systems in the African region; however, the main cause was the neglect of the health workforce (High-Level Forum on MDGs,2004) neglect led to critical understaffing of nurses in the continent.

The human resource capacity in developing countries was insufficient to absorb and deliver health interventions offered by many new health initiatives such as the millennium development goals and this has led to demand for more nurses and other health personnel. According to Sullivan (1998), development partners formerly believed that training was the best way to improve performance hence and to counter the challenges of supply versus demand hence the training of nurses was continuous throughout the continent in abide to alleviate shortage and understaffing.

2.5.1 Understaffing of nurses in Ghana

Vacancy levels in the Ghana Health Service demonstrate a health care system in crisis, (Yoder, 2004). In 2002 there was nearly 50 per cent shortfall in doctors and 57 per cent shortfall in professional nurses, (Mensah et al, 2005). A 2002 memorandum issued on the matter by the Director General of the Ghana Health Service indicated that more Ghanaian

doctors worked outside of Ghana than within. Although the government had increased expenditure on its health sector by 30 per cent in recent years, it had not prevented increases in understaffing of nurses (Dovlo, 2004). The predominant countries of destination of Ghanaian doctors, ranked in order, were the United States, South Africa and Canada. For nurses leaving the country the destination was the United States, Canada and South Africa. One article reported that in the past decade the country had lost 50 per cent of its nurses to Canada and the United States (Mensah et al, 2005).Surprisingly the total number of applications for nursing training has risen significantly in Ghana. For example, in one school the number of qualified applicants rose from 400 in 2003 to 2,000 in 2004 (Mensah et al, 2005). It was suggested in this report that the rapid rise was due to individuals being increasingly informed about the opportunities and scope for migration. Indeed, better qualified women were going into nursing than before, as an investment in leaving the country to go and work in other countries leaving Ghana with the challenge of shortage and understaffing of nurses (Mensah et al., 2005) The situation in Ghana showed that training does not alleviate shortage and understaffing but most probably change of policies and review of nurse establishment regularly.

2.6. Understaffing of Nurses Sub-Sahara Africa

2.6.1Understaffing ofnurses inSouth Africa

According to Munjanja (2005), the International Nurses Council (INC) identified factors contributing to the nursing understaffing in South Africa as , migration of health workers from SSA(Sub-Saharan Africa) thereafter, a limited supply of new nurses from training schools of nursing and other health workers coming into the workforce in SSA, poor HHR (health human resources) management systems, attrition due to HIV/AIDS believed to be affecting health workers in serious numbers .Other factors that were believed to have contributed significantly to the shortage and understaffing were, limited career and professional opportunities resulting in frustration and consideration of health professions.

The National Human Resource Plan (NHR) of the Department of Health (DoH) (2006) reported that South Africa was experiencing a serious crisis due to the increasing nursing shortage ,understaffing and proposed a need for the national production of 21000 nurses by 2011 which was a very big challenge in terms of resources. Human Resources Development Review(2001) , estimated overall gap between nursing supply and demand as 18,758 nurses between 2001 and 2011. The National Department of Health (2001), has also reported that, in recent years there was a shortage of Registered Nurses in general and post basic nursing respectively, and developed a Provincial Nursing Strategy aimed at addressing nurse understaffing.

However, the South African health system was still experiencing a shortage and understaffing of nurses as a result of attrition and HIV pandemic ,migration to developed countries looking for greener pastures(Munjanja,2005). There was also need to verify the statistics of SANC, for instance not all professional nurses who were registered as professional nurses were working as nurses and delivering care. In addition, Africa has highest prevalence of HIV/AIDs rates in the world (Munjanja&Dovlo,2005). South Africa is not training nor producing sufficient nurses to deal with its health needs, which affects the quality of service delivery . Delays of 12 to 18 months in hiring have been reported for some ministries of health in Sub-Saharan Africa (Dovlo,2005) , this observation showed that understaffing was at times not as a result of attrition ,migration or not training but as a result of the employer failing to absorb all the trained cadres as in the case of Zimbabwe. Significant bureaucratic and regulatory delays identified in other countries as well (Jordan Times,2009). Government policies regarding mandatory retirement also led to forced unemployment, representing a loss of health professionals who might otherwise be able to help meet health service delivery needs.(Dovlo, 2005). In this case leadership style also may cause understaffing of nurses. He states that reasons for emigration were “need for further professional training, social unrest/conflict, low salaries, and poor working

conditions." Another factor that influenced nurses was increased burden of disease, HIV/AIDS, TB, malaria (Munjanja, 2005).

2.6.2Understaffing of nurses Namibia

The Ministry of Health and Social Services (MOHSS) in Namibia had the same concern as other African countries which were to ensure that a well-functioning health system was available to promote the health and social well-being of all Namibians (MOHSS, 2004) The main human resources for health issues and challenges identified included, the imbalances in the geographical distribution of human resources for health,shortages and understaffing in rural areas in comparison with urban areas. Inequalities in available skills, especially at district level, poor human resource management, lack of management skills at all levels, movement of health workers from public to private sector led to understaffing of nurses. The effects led to public outcry about poor performance of health personnel resulting in poor quality of services. This impacted on motivation of health workers, and a general feeling of despondency among health workers was created WHO,(2000:1). To address these challenges, the National Human Resources for Health Strategic Plan was developed (MOHSS, 2000). It identified insufficient trained health personnel, especially the lack of management skills at all levels of health care, as the main constraint in the provision of effective health care services delivery. Another challenge is providing health care to the widely dispersed population. Producing well motivated and skilled health personnel was compromised by the emergence of HIV/AIDS as a disease affecting the economically active populations in sub-Saharan Africa. Namibia was among the most affected countries in Southern Africa, with a prevalence rate which increased from 4% in 1992 to 22.5% in 2001 (WHO 2004:2). Mission hospital were established in rural areas and marginalized zones of Namibia hence its difficult for leadership to encourage nurses to take up post in the remote areas.

2.6.3 Understaffing of nurses in Malawi

Malawi is in the Southern region of Africa and it was also facing shortages and understaffing of qualified nurses as a result of migration, increasing demand of health care service and new

disease trends complicated by the use of nurse establishments of the 1970s. The use of obsolete establishments has created the problem of understaffing for Malawi despite the other factors such as migration (Pearson ,Green, 2006). Additionally, countries with relatively small work-forces and inflows, such as Malawi, could be hugely affected by even numerically small outward flows (Gerein, Green, & Pearson, 2006a). Pushed out by poor working and living conditions in Malawi and pulled in by far better conditions in wealthier countries, the exodus of physicians and nurses from Malawi left its population, already bearing the greatest burden of disease and highest rates of poverty, with crippled health care delivery. Malawi was among the countries that were also affected by poverty, poor government policies, migration, poor training facilities and economical structural adjustments. It was vital for Malawi to come up with strategies to alleviate the problem of shortage and understaffing, however they were also scaling up their nurse training intakes.However, literature on the strategies to alleviate understaffing of nurses in Malawi could not be discovered.

2.6.4 Understaffing of Nurses in Zambia

Zambia International migration of skilled nurses and other health personnel increased rapidly in the last 10 years (Awases ,2004). The health sector was the most affected by the brain drain. A series of recent reports issued by the Ministry of Health showed that the loss of health workers in the public sector was reaching high levels of 65%. In 2003 only slightly over half of the medical, nursing and paramedical posts were filled in public health establishments (Awases, 2004). Another 2003 study conducted by USAID suggested that, out of the more than 600 doctors trained in the years after independence in 1964, only 50 remained in the country (Awases, 2004). Initially the main destinations of Zambian health workers were more advanced countries in the region, such as South Africa, Botswana and Namibia. These countries continued to attract, growing numbers of health workers who moved directly overseas to Europe, North America, Australia and New Zealand. The country currently had only half the doctors and nurses it needed and would only be able

to build up its reserves again if working conditions are improved (Chikanda, 2005) .The International Monetary Fund required Zambia to restrict its government payroll bill to 8 per cent of Growth Domestic Product so that they would access loans for development ,partly to prevent professionals from leaving the country, and to retain desperately needed health professionals such as nurses and Doctors. Zambia got funds from the Netherlands government to the tune of US$10 million to pay for more nurses and teachers to keep the wage ratio within IMF prescribed guidelines (Gaynor, 2005). In this case Zambia managed to return its nurses by improving the conditions of service through donor funding. The programme was not a home grown programme that could be rolled out by the funders in the event they fallout with the Donor`s conditions.

2.6.5 Local Trends of Understaffing of nurses

Zimbabwe was losing more nurses than could be replaced through migration, poor Government policies, poor working conditions and poor structural adjustment programmes (Parliamentary Debate, 2014). Given the effects of overwork, such as poor health care standards, increasing mortality and morbidity and increasing demands on nurses elsewhere, the potential for patient error, not to mention the implications of poor motivation for nursing staff, were overwhelming. Zimbabwe lost many physicians and nurses to migration over the last few decades at an alarming rate, with little signs of slowing down (Chikanda, 2005). In 2004 Zimbabwe had a 40 per cent vacancy rates for nurses and 55 per cent for physicians (Gerein et al., 2006). This translated into a heavy workload for the fewnurses posted in rural areas where there was no electricity, no good sanitation, poor resources such as medicines and health equipment. Because of such factors, health professionals in rural areas moved to urban areas for better pay therefore fringe benefits would influence them to remain working in the country. The high rate of migration from Zimbabwe had led the government to adopt several measures to try and contain the problem(Parliamentary debate, 2014). The first was the introduction of bondingof newly qualified nurses. All nurses and doctors who started training in 1997 were bonded by the government for three years or the

period equivalent to the number of years of training. A second measure was the introduction of a nursing grade and training of Primary Care Nurse who trained for one and half years (Chatora and Nyoni 2004). This lowered the production cost and time, and reduced the likelihood of being able to be registered abroad.Another measure was the introduction of salary reviews intended to cushion health professionals from the harmful effects of the country's high cost of living(Chikanda,2006b). However, with the country's current hyper-inflation,these salary reviews were constantly lagging behind.Finally, call allowances were introduced to allow professionals work extra hours due to staff shortages and understaffing, with better allowances offered in rural areas.

Call allowances helped to retain staff, although there had been complaints about unpaid allowances, and doctors hadgone on strike action over unpaid allowances (Chikanda, 2006) .Apart from the hyperinflation and chaotic political environment of present-day Zimbabwe, another push factor was the country's comparatively low spending on health and incapability to absorb all trained nurses. This was as a result of poor governance and bureaucratic system of leadership where nurse establishments were done post-independence like in Zambia (Awases, 2004).

2.7 Theoretical frame work

Max Weber (1864-1920)

Max Weber was a German intellectual who advocated for bureaucracy as a leadership style that was more appropriate for complex institutions. He described bureaucracy as having a well defined hierarchy of authority, division of work based on specialization, highly specific rules governing workers` duties and rights detailed policies and procedures which could not be changed without managerial approval (Patricia, 2001). The approach was the one that the Ministry of Health in Zimbabwe was applying and it had taken the Ministry 35 years without reviewing the nursing post establishment (Parliamentary debate, 2014). In as much as it created stability in organisations it appeared as if it was too rigid to respond to today`s rapid social changes in line with nurse staffing in Mission Hospitals. In every orgarnisation

leadership was important in its growth and development as well as in strategic management of problems such as nurses shortages hence the application of Max Weber in this research project. The relevance of this theory was in coming up with solutions to the problem of understaffing at Mashoko Mission hospital.

2.8 Global Causes of Understaffing of nurses

Shortage and understaffing of nurses had a wide range of causes and they differ with countries, political situations, economic situations, management systems as was reflected by related literature. Global trends identified change in disease patterns, demography and booming economy as major causes of understaffing of nurses. Improvement in economy led to many people seeking medical attention (Munjanja,2005) The developed countries such as United States, Canada and Australia experienced nurse understaffing as a result of establishment of old people`s homes. The patients expected quality nursing care because they had money .Many nurses left government hospitals to work in such nurses homes (Yoder,2003) Literature in this study showed that these above causes are specific to the concerned countries.

Regionally the causes were different with each country that was studied by other researchers where the causes of understaffing of nurses appeared to be specific for each country. Literature showed that causes varied from migration, brain drain, political chaos, economic recession poor working conditions and leadership style (Dovlo, 2005) Literature review showed that no study of understaffing of nurses at Mashoko Mission hospital was done hence the causes were perculliar to Mashoko Mission.

2.9 SUMMARY

The chapter reviewed related literature on understaffing of nurses in general. Literature on nurse shortage in the United States, Australia and Canada was reviewed globally. The study went on to look at regional literature for Ghana, and Sub-Sahara African countries like South Africa ,Namibia, Malawiand locally scaling down to Mashoko Mission hospital. Several studies were highlighted in the study identified the theoretical framework of Max Weber. The

causes, impacts and solutions to understaffing of nurses were discovered. The next chapter dwells on the research methodology that was used by the researcher.

CHAPTER THREE: RESEARCH METHODOLOGY

3.0 Introduction

The previous chapter looked at the literature review on the cause of understaffing of nurses in United States, Canada, and United Kingdom, Africa, South Africa,Ghana Namibia, Malawi, Zimbabwe and Mashoko Mission Hospital. This chapter looked at research methodology thus the use of a descriptive investigation on the causes of understaffing of nurses at Mashoko Mission Hospital. The chapter described methods used in the study which included the following: Research design, study settings, study population, sampling method, sample size, data collection instrument, validity, reliability, data collection procedure, clearance from responsible authority Medical Superintendent at Mashoko Christian Hospital, pilot study, ethical considerations and work plan.

3.1 Research Design

Research design is a blue print for conducting a study that maximizes control over factors that could interfere with validity of the findings (Burns and Groves, 2005). The study used the qualitative research paradigm. A case study design was used since it involved an intensive exploration of a single unit of study. In this study it was more appropriate because the researcher was interested in finding out in-depth issues that caused understaffing of nurses at Mashoko Mission. A case study used a small number of sample and the subjects may have multiple views and opinions that have an impact on my study. The researcher solicited for information from 47 nurses, 1 human resources officer and 2 Doctors. Respondents were drawn from all departments,outpatientdepartment, male ward, female ward, theatre, opportunist infection, pharmacy, home based care department at the hospital. The researcher chose this design (case study design) because it provided a picture of the situation, on what we saw and interpretation of data was carried out easily. Case studies explore and interpret

the phenomenonof interest that existed, practices that prevailed, effects that are felt and trend developing, Best and Khan (1997). This design was also chosen because it was less expensive and it was suitable when dealing with human behavior and attitude which was unpredictable.

The importance of using this design was that, it provided information on wide range of people's characteristics and professional situations. It also provided relatively easy and simple approach to studying attitudes, values, beliefs and motives. Issues of understaffing deal with attitudes, values, beliefs and motives of individual members (Burns and Groove, 2005). Results obtained were easily generalised unlike other research designs.

The case design therefore provided the most suitable ground for this study. The case study explored and described phenomena in real life situations (Morse, 2000) hence the application of descriptive method to explore the causes, effects and solutions to understaffing of nurses in Mashoko Mission Hospital.

3.2 Study Population

According to Nabors and Grooves (2001), a study population is all elements (individuals, objects or substances) that meet certain criteria for inclusion in a given universe. It is the entire aggregation of cases that meet a designated set of criteria as alluded by Burns and Groove (2007). In this particular study, the study population is all Health personnel excluding auxiliary staff at Mashoko Mission hospital. The nurses at the hospital were 51, doctors were 2 and human resource officer was 1.

3.3 Sampling

Sampling is that part of statistical practice concerned with the selection of an unbiased or random or subset of individual subjects within a population (Yoder, 2003) The individuals provide some knowledge about the problem of interest, especially for the purpose of making predictions (Yoder, 2003)**.** A sampling method refers to a process used to select a portion of the population to represent the entire population which is homogenous (Burns and Grooves,2005). In this study, purposive sampling method was used because the health

personnel had in-depth knowledge and experience at Mashoko Mission hospital and were directly affected by understaffing of nurses. The selected participants included human resources, nurses and doctors because they have the characteristics and information useful to the research project. Sampling ensures that every element of the population has an equal opportunity for being included in the sample (Burns and Grooves 2005). The researcher prepared 51 cards for nurses, 47 cards were written YES and 4 were written NO. All the cards were put in a small box and nurses were requested to pick a card to participate in the project. As for the human resources and doctors a convenient sampling was used the three participants are representative of their categories. Those who picked a NO were exempted from participating. Convenience and purposive sampling technique were used. This type of sample design presents the researcher with the opportunity of access to the population. The researcher selected participants from all departments eligible to participate in the research project until the desired sample size of 50was reached. The participants were supposed to be Health personnel of MashokoMission Hospitalscatchment area. This sampling technique also saved time.

3.4 Sample Size

Power is the deciding factor to determine sample size (Burns and Grooves, 2005). Power is the capacities of the study to detect relationships that exist in the population and also the capacity to correctly choose a representative group, (Cohen, 1988). Sample size is compromise between the desirable and what is feasible. The sample composed of 50 subjects representing the Health personnel selectedfrom Mashoko Mission Hospital. This is supported by Polit and Hungler(1991), scientists work with samples rather than with population because it is more economical and more efficient to work with small groups of elements assumed to have the same information deemed vital by the researcher. The selection of participants was done using card and box system and questionnaires were distributed to those who had picked a YES. Nurses were 47, doctors were 2 and human resource officer was one.

3.5 Research Instruments

A data collection instrument is a tool which the researcher uses to collect data from the subjects. It is meant to provide sufficient information for the respondent to make decision (Burns and Susan ,2007). In this study, data were collected from statistical records from information department thus documentary analysis. It was a process of critically examining recorded information (Chatora, 2003). In this study documentary analysis helped the researcher to get a clear picture of what had been the situation of understaffing of nurses at Mashoko Mission hospital so that findings would be generalized. A questionnaire was also used to solicited information from subjects. It was a printed self-report form designed to get in-depth information through written response from the subjects of the study. Questionnaires were at times referred to as surveys (Burns and Susan,2007).In this study it was more appropriate since all the participant were able to read and write and were within Mashoko Mission hospital. In this study, a questionnaire was used to collect quantitative and qualitative data. The questionnaires elicited information on the views of Health personnel on the problems, factors that caused nurse understaffing atMashoko Mission Hospital. The instrument sought to get information from participants on the strategies that could be implemented to alleviate nurse understaffing. Open ended questions were used to get comprehensive information about the variable understudy. Closed ended questions were used to help to capture specific and guided responses. The instrument was in English assuming that all nurses, doctors' students and human resources officers understood English since all training of these cadres was done in English.

3.6 Validity

Validity refers to the degree to which the instrument measures what it is supposed to measure without bias (Best and Khan, 2004). The instrument was made very simple so that participants will understand the demands of the questionnaire. It was submitted to the research project experts for scrutiny and necessary adjustments were made. More so, in order to determine the content validity, a panel of experienced researchers such as other lecturers

was also allowed to analyse the questionnaire developed by the researcher. The researcher reviewed literature prior to the use of the instrument. A pilot study was done at Msiso Mission Hospital to assess the validity of the instrument.

3.7 Reliability

It is the degree of consistency and accuracy of measurements by which an instrument measures what it is intended to measure giving constant results (Burns and Groove, 2005). More so, the researcher reviewed literature prior to formulations of the instrument. The questionnaire was distributed to 10 people at random at Msiso Mission Hospital to test andcheck on the correctness', ambiguities and consistence of the questionnaire. The set up of Msiso Mission hospital was the same as for Mashoko Mission hospital and the findings after pilot study were the same.

3.8 Pilot Study

Burns and Groove (2005) defined pilot study as a small version of a proposed study conducted to refine methodology. It helped the researcher to identify potential problems in the proposed study. This was conducted at Msiso Mission Hospital using a sample size of 10 participants for reliability and validity of the instrument to be used

3.9 Ethical Considerations

Ethical consideration is the protection of subject`s rights and the right of others in the setting who participated in the project (Burns and Groove ,2005) These were values and believes that are put in place for observation by researchers to protect the participants from harm physically, mentally or in any form (Burn and Susan, 2007). The researcher asked for permission from Hospital authority as well as the District Medical Officer, to ensure that ethics were observed the letter of permission was attached at the back of the project.

One of the fundamental principles was that of beneficence, in this research, the researcher made sure that he promoted good for the respondents by keeping the filled in questionnaires under lock and key. In fact, the research would provide direct benefits to the participants.

They could benefit from the research findings of the study to improve the health care system in Zimbabwe, in particular, policy making.

Non-malificence would not be overlooked. There should be no harm to participants psychologically, physically or in any form (Burn and Susan ,2007) .The participants were given the autonomy to willingly take part. Participants were advised that they could refuse to answer any question or any part of the question, at any time. To minimize any sense of insecurity, the participants were informed to fill in the questionnaires in a location preferred by the respondents. The researcher was prepared to terminate the study prematurely if there was any suspicion that continuation would result in harm to the participants.

The issue of privacy and confidentiality was also very vital in research to ensure that information was kept strictly for the purpose of the study, therefore the participants were not to identify themselves in any way on the questionnaire or any part of the project. It was the researcher's role to keep in confidence the private information shared by the respondents. Questionnaires were kept locked up in the researcher's cupboard where nobody had access to throughout the study. The subjects in the study are treated as autonomous agents, instead, each respondent is assigned a participants identification number. The participants are allowed to decide voluntarily whether to participate or not. The clients would, "…exercise free power of choice without the intervention of any element of force, fraud, duress, coercion…"(Yoder, 2003)

Clearance and permission to carry out pilot and actual studies was sought from the District Medical Officer and Medical Superintendent of Mashoko Mission Hospital. The studies were carried out at this Hospital after written permission was granted. Data was managed through saving information in a flush disk, saving on my laptop with a password all rough work was destroyed after use. Only the researcher had access to the data.

3.10 Data Collection Procedure

Data is the term used to describe information gathered in a research study that has not been processed, (Burns and Susan, 2007).Data were collected from statistical records from information department. Questionnaires were distributed to all subjects who were selected to participate in the study. The challenge was that some of the chosen participants were off duty, however the heads of department took it upon themselves to distribute questionnaires to the members who were off duty. The support by Heads of departments ensured the researcher's visits were pleasant and fruitful. The data collected was, arranged and chronologically put in order according to sections of the questionnaire, with the desire of searching for recurring themes or patterns and trends that represented the participants' ideas.

The aim of data collection procedure was to get accurate, reliable data which were meaningful and which would answer the study research questions (Burns and Groove, 2005). The type of data influenced the type of instrument to be used. According to Chagwesha (1985) data could be facts, attitudes, and opinions and practiced skills. Data collection was done using a structured questionnaire which was distributed to the selected sample of Health personnel to participate in the project. A total of 50 questionnaires were distributed

3.11 Data Analysis Plan

According to Pattern,L. (2004) data analysis refers to the process of breaking down, examining, comparing, conceptualization and categorization of data. The results from the field of study were analysed using various analytical tools such as tables (Tab), figures (Fig), pie charts and bar graphs. The narrative and descriptive methods were used to analyse data collected and presented.

3.12 Summary

This chapter covered the research design which used the qualitative and quantitative research designs in particular a case study design, population and sample. Information was obtained from nurses, doctors and human resources of Mashoko Mission hospital. Data were collected

by use of questionnaires which were distributed to 50 participants and data from records. Data collection procedures and data analysis plan were outlined.

CHAPTER FOUR:PRESENTATION, ANALYSIS AND DISCUSSION

4.0 INTRODUCTION

The chapter focused on the data presentation using graphs and pie charts, data analysis, discussion and a summary was drawn at the end of the discussion. Data were collected through questionnaires and review of statistical records from information department to have a clearer picture of the situation. A total of 50 questionnaires were distributed to nurses, doctors, and human resources. The distribution of the questionnaires was as follows, 1 human resources personnel, 2 Doctors, and 47 Nurses at Mashoko Mission Hospital in Bikita.

The study aimed at investigating the causes of understaffing of Registered General Nurses at Mission Hospitals a case for Mashoko Mission Hospital. The study aimed at answering the following research questions:-

1) What is the trend and level of understaffing of nurses at Mashoko Mission Hospital?

2) What are the causes of understaffing of nurses at Mashoko Mission Hospital?

3) What are the effects of understaffing of nurses at Mashoko Mission Hospital?

4) What should be done to curb understaffing of nurses at Mashoko Mission Hospital?

4.1 Data Presentation and Analysis

The data collected were presented in tables and pie charts according to sections of the questionnaire and findings were divided into:-

1) Biographic data'

2) Hospital statistical records from information department.

3) Causes of understaffing of nurses.

4) Effects of understaffing of nurses.

5) Strategies to curb understaffing of nurses.

6) Any other comments from participants.

4.2 SUMMARY OF RETURN RATE

n=43

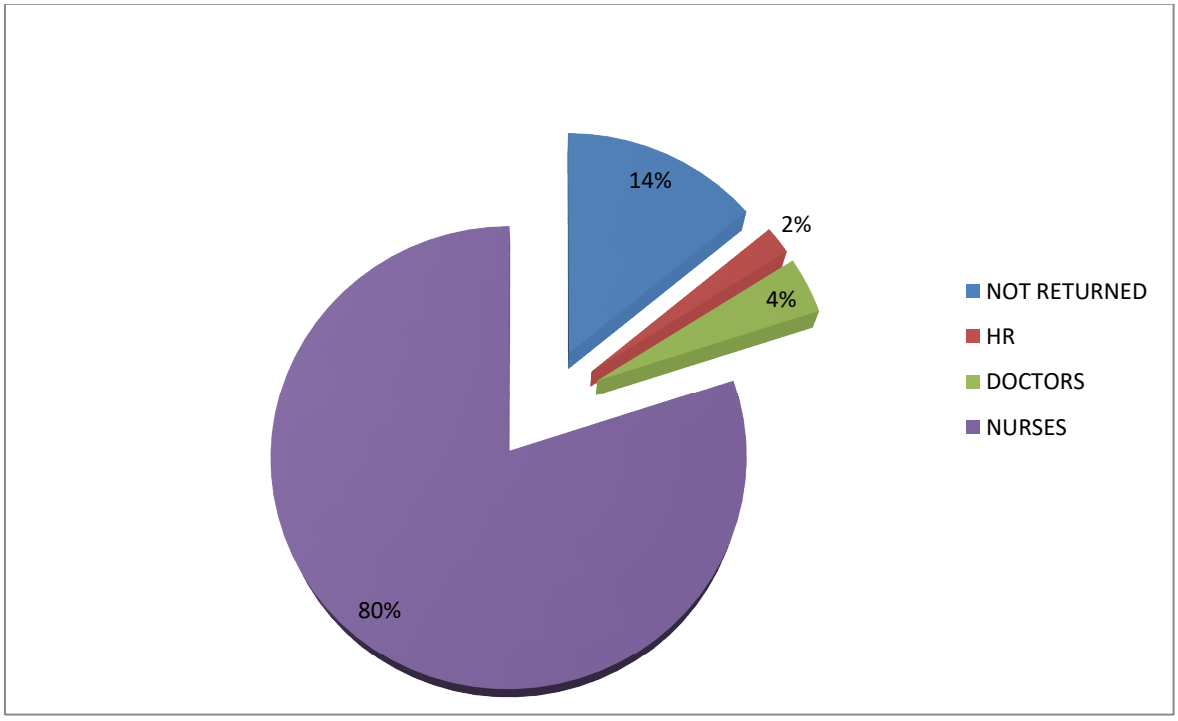

Figure 4.0 SUMMARY OF RETURN RATE

Fig 4.0 reflected that there were more nurses at Mashoko Mission hospital than doctors, and the return rate of 86% showed a positive return rate hence the progress made by the researcher. The non- return rate was low hence it did not interfere with the findings. The questionnaires were self administered and collected by the researcher. The doctors and human resource officer returned the questionnaires but 7 of the nurses did not return the questionnaires amounted to 14% non-return rate.

4.3 SECTION A

Table 4.0 BIOGRAPHIC DATAOF RESPONDENTS

CATEGORY	NUMBER	%age
MALES	13	26%
FEMALES	30	60%
NON RETURNED	7	14%
TOTAL	50	100%

BELOW 40 YEARS	40	80%
ABOVE 40 YEARS	3	6%
NON RETURNED	7	14%
TOTAL	50	100%
BELOW 15 YEARS OF SERVICE	40	80%
ABOVE 15 YEARS OF SERVICE	3	6%
NON RETURN	7	14%
TOTAL	50	100%

The table showed that 60% were females and 26% were males. The statistics showed that there were more females than males at Mashoko Mission hospital, this reflected that nursing was female dominated. The statistic also explained one of the causes of understaffing where nurses transferred to urban areas to be with their spouses. Another category in terms of age revealed that Mashoko Mission hospital was manned by nurses who were below the age of 40 years which was 80% of the staff. The situation reflected that these nurses were newly qualified who had no choice but to accept their fate of deployment. The same percentage manifest that , the respondents were below 15 years of service yet Mashoko Mission hospital was established in 1961 so where were the old members of staff. The reflection was that the old members had left either seeking for greener pastures, retirement, transferring to government or to join their spouse as was revealed in the questionnaires.

4.4 HOSPITAL STATISTICAL DATA FROM 2010 - 2015

Tab 4.1 HOSPITAL STATISTICAL DATA FROM 2010-2015

CATEGORY	**NUMBER**
NURSES	51
DOCTORS	2

ESTABLISHED POSTS FOR NURSES	44
SECONDED NURSES AT MASHOKO	7
NURSES ON MAN POWER DEVELOPMENT	3
SECONDED NURSES FROM MASHOKO	2
NURSES WORKING IN OTHER DEPARTMENTS	13
TRANSFERS	6
RESIGNATIONS	5
HEADS OF DEPARTMENTS	2
AVERAGE BED OCCUPENCY	75
OUT PATIENT ATTENDANCE/DAY ON AVERAGE	90
NURSE PATIENT RATIO	1:20

From Mashoko Mission Hospital documents

Table 4.1 showed the statistics of nurses and doctors at Mashoko Mission hospital as from 2010 to 2015. The establishment has remained static at 44 from 1980 as was revealed by the records .The statistics also showed that the number of nurses working in other departments was very high. The number of heads of departments was very low only two ,yet the hospital had more than seven departments that was male ward, female ward, maternity, pharmacy, opportunistic infection , paediatric ,out patients and waiting mother`s shelter. The situation exposed nurses to high volumes of workloads. The nurse patient ratio was unbelievable, one nurse taking care of 20 patients that definitely compromise the quality of nursing care.

4.5 STATISTICAL PRESENTATION OF WORKING SHIFTS

Tab 4.2

CATEGORY	NUMBER OF NURSES	PERCENTAGE
NURSES	51	100

NIGHT DUTY	7	13,7%
NIGHTS OFF	7	13,7%
SECONDED FROM MASHOKO	2	3,9%
SECONDED TO OTHER DEPARTMENTS	13	25,5%
DAY OFF	9	17,6%
MAN POWER DEVELOPMENT	3	5,9%
DAY AND EVENING SHIFT	10	19,7%

From Mashoko Mission hospital documents

The table 4. above illustrated the shifts in relation to the number of nurses as described above. The highest percentage about 27,4% of nurses were absorbed by night duty and nights offs. This was followed by 25,5% of nurses seconded to other departments other than the wards. The situation was that in-patients would not receive the quality of nursing care that they expected because almost half of the number of nurses had been absorbed in other departments. Nurses on day off took about 17,5% of the total number of nurses. Combining the above ,70,5% of nurses would not be available at the hospital at any given day . The situation revealed that action needed to be taken to address the anomaly which affected the nursing care delivery services as was revealed by respondents. The situation reflected that understaffing at Mashoko Mission hospital was great and it needed urgent attention.

4.6 SECTION B

Hundred percent of the respondents agreed that Mashoko Mission Hospitals is suffering from understaffing of Nurses hence the quality of nursing was compromised. They also pointed out that patients stayed in the queue for about 1 hour to 2 hours before they were attended to by a qualified nurse. The fact that the patient waited for this long in queues called for action to be taken to ensure that patient got services early.

4.7 SECTION C
CAUSES OF UNDERSTAFFING OF NURSES AT MASHOKO MISSION HOSPITAL

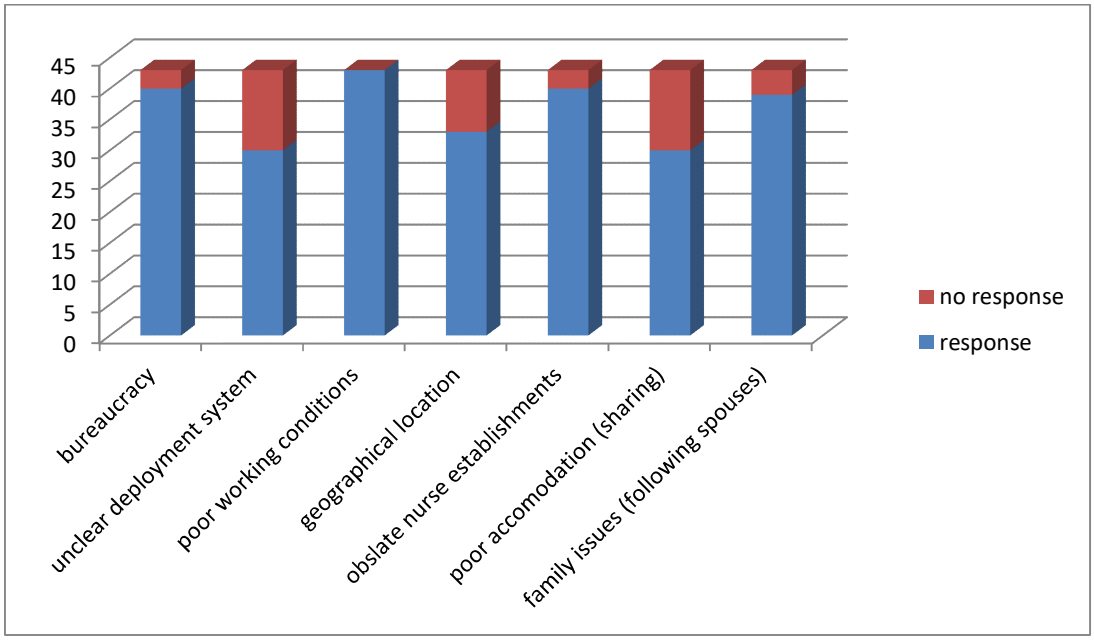

Figure 4.1 causes of understaffing of nurses at Mashoko Mission hospital

The Fig 4.1 above showed the causes of understaffing of nurses from the response of the participants .It came out that over 30 participants believed that the number one cause of understaffing was poor working conditions, followed by obsolete establishment, bureaucracy and family issues, geographical location, poor accommodation were also sited as major causes.

4.8 SUGGESTED SOLUTIONS
Table 4.3 suggested solutions

SOLUTIONS	NO OF RESPONDENTS	%age
Improving working conditions	43	100%
Training of more RGNs	15	34%
Unfreezing of nurse post	40	93%
Review of establishments	40	93%

Mission hospitals to hire contract nurses	30	69,7%
Change of leadership system(bureaucracy)	30	69,7%
Provide conditions that allow couples to move in together	10	23,2%

The Table 4.3 above illustrated the suggested solutions to the problem of understaffing at Mashoko Mission hospital. All the participants sited improvement of working condition as the main solution to the researcher`s problem. About 93% of the respondents sited unfreezing of nursing posts and review of establishment as second solutions. This implied that the problem of understaffing at Mashoko Mission is artificial. The population had doubled from 7,2million in 1980 to 14,15million (IMF, 2015) but the establishment had remained at 44 nursing post. 93% of the respondents agreed that reviewing of establishment would address the problem of understaffing. The Establishment of nursing posts had remained static at 44 nurses for the past 35 years. Change of bureaucratic leadership and allowing MashokoMission hospital to hire more nurses that they pay would help curb the problem of understaffing. Only 23% and 34% of participants revealed that providing conditions that allow couples to move in together and continued training of nurses would solve the problem of understaffing at Mashoko Mission hospital. The implication here was that the problem of understaffing at Mashoko Mission hospital could be solved by the authorities.

4.9 SECTION D:Any other comments

Table 4.4 any other comments

Category	**No**	**%age**
Mission hospitals to be allowed to return some of their students	5	11%
Mission hospitals to give incentives to their nurses	2	4%

Nurses should not be forced to attend church service	7	15,5%
All mission nurses to be absorbed by the government	30	66,6%

The section on any other comments received little attention from respondents, only for issues were sighted as shown on the table above. The only issue that featured prominently was the absorbing of nurse by the government, 30 respondents believed that Ministry of Health should take over management of nurses.

It also came out from respondents that Mission hospitals should allowed to return a number of the nurses trained at Mission hospitals about 11% advocated for the mentioned fact as well as also nurses to be absorbed by the government, 60,6% responded in favour of the mentioned fact . The issue of compulsory attendance of church services received 15% against it.

4.10 ANALYSIS AND DISCUSSION

4.10.1Age and Gender

There was gender imbalance in nursing as was revealed in table 4.0 which showed that 60% of respondents were females. The imbalance had the capacity to cause understaffing because female nurses would leave Mashoko Mission hospital to join their spouses elsewhere. The point was supported by Chikanda (2005) in his studies on nursing shortage in Zimbabwe. Zimbabwean nurses were migrating to South Africa, Canada, Australia together with their families. Most of the respondents were below the age of 40 years about 80%. This implied that the group was not yet stable hence would move from Mashoko Mission hospital if an opportunity to leave was presented to them.

4.10.2Qualifications of respondents

The breakdown of qualifications showed that 40 of the nurse respondents were holders of Registered General Nurses diploma only. The situation had the effect that many nurses would apply for manpower development as a way to prepare for their exit from Mashoko Mission hospital. This had the impact that the problem of understaffing would be a chronic problem at Mashoko Mission hospital, it reflected that those with high qualifications left Mashoko Mission hospital.

4.10.3Causes of Understaffing of nurses at Mashoko Mission hospital

Shortage and understaffing of nurses had a wide range of causes and they differ with countries, political situation, economic situation and management systems. In this study it came out from respondents that bureaucratic leadership style, poor working conditions, obsolete establishment, unclear deployment system, poor accommodation, freezing of nursing post by govrnment and family issues contributed greatly to understaffing of nurses at Mashoko Mission hospital. This was supported by Munjanja (2005) in his study on migration of health professionals from Zimbabwe. However in this study it appeared that the causes were unique for Mashoko Mission in that migration is localized. Nurses were leaving to join their families elsewhere within Zimbabwe. The other causes were home grown and could be solved.

4.10.4Impacts of understaffing of nurses at Mashoko Mission hospital

The study showed that the most effects were work overload, job stress, burnout, demotivation and poor service delivery, this was cited by 93% of respondents. According to a study by Lee et al (2003) South Korea study showed that understaffing of nurses led to work overload that had negative impacts to nursing care. The study cited absenteeism, job stress poor performance, burnout and the intention to quit work as the main impacts. The study by Lee et al (2003) supported the findings of this study on the impacts of understaffing. Shortage and understaffing of nurses at Mashoko Mission hospital placed stress on existing staff, leading to

increased fatigue, emotional exhaustion, and compromised nursing care. This was cited by 93% of respondents.

4.10.5Solutions to understaffing of nurses at Mashoko Mission hospital

The respondents came up with many suggestions to curb understaffing of nurses at Mashoko Mission hospital. The most cited solutions were improvement of working conditions, unfreezing of nursing posts, reviewing of nurse establishment at Mashoko Mission hospital, change of leadership style and allowing Mashoko Mission to return nurses trained at Mashoko Mission. Shearer (2005) supported the improvement of working condition as a solution to understaffing of nurses in Ghana. Unfreezing of nursing posts, reviewing of establishment and giving rural allowances would curb understaffing as was alluded by Munjanja, (2005). About 93% of the respondents in this study were in agreement with Munjanja`s observation.

4.11 SUMMARY

Mainly the chapter focused on the data collection, data presentation, analysis and discussion of the responses. Results from both the questionnaire and the hospital statistical records were presented as the respondents gave them. Data presentation was done using tables, graphs and pie charts. Analysis was descriptive as reflected on the graphs, tables and pie charts according to sections of the questionnaire in line with research questions. The next chapter looked at summary, conclusions and recommendations.

CHAPTER FIVE: SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.0INTRODUCTION

This chapter looked at the summary, conclusion and recommendations of the research findings. The chapter sought to give a clear summarization of the research as a whole, highlighting the main features of the research project. The conclusion focused on what the research revealed on the causes of understaffing of nurses at Mashoko Mission hospital. Recommendations were made as a way of mapping the way forward in reducing understaffing of nurses at Mashoko Mission hospital.

5.1 SUMMARY

The purpose of the study was to investigate the causes of understaffing of nurses at Mashoko Mission hospital. The study`s main aim was to answer the following research questions:-

1. What is the trend, and levels of understaffing of nurses in Mission Hospitals?
2. What are the causes of understaffing of nurses in Mission Hospitals?
3. What are the effects of understaffing of nurses in Mission Hospitals?
4. What should be done to reduce the current understaffing of nurses in Mission Hospitals?

The research was divided into five chapters.

Chapter 1 pointed to the signs of the existence of understaffing of nurses at Mashoko Mission hospital and the need to find out the causes of this scenario. It was against this background that the researcher was motivated to carry out the study so as to come up with solutions to the problem. The significance of the study to Mashoko Mission as an organisation, policy makers and stakeholder's aspects were articulated and mapping the way forward for the success of the project.

Chapter Two looked at what other authors and researchers said about the understaffing of

nurses in general the world over, in Africa, and other countries in the Sub Sahara zeroing to Mashoko Mission hospital. The understaffing of nurses was found to be in existence in Europe, in Africa and within countries. Nurses were migrating to the United States of America, Canada, and United Kingdom and within Africa in search of greener pastures. In the Least Developed Countries like Africa in particular, there has been tradition of the labour migration. People are moving from Sierra Leone, Somalia, and Liberia to Canada, in search for better employment opportunities. Regionally (SADC), a wave of nurse migration has been observed from Mozambique, Zimbabwe, Malawi and Zambia to South Africa, Namibia,

Swaziland and Botswana, at the same time others are migrating from South Africa to Western countries. Zimbabwe one of the most educated and skilled nations in Africa, runs the risk of losing all its nurses to other countries with better working conditions. Mashoko Mission hospital was suffering the same fate of exodus of nurses to urban areas.

Chapter Three focused on research methodology that was how the researcher would proceed with the project. It explained how the researcher gathered data from a selected number of nurses, doctors and human resource officer The researcher used card and box system. Statistical data were also obtained from documents in the information department at Mashoko Mission hospital. A sample size of 50 was used which represented whole population at the setting. The researcher used questionnaires and statistical data from records to gather data for analysis.

Chapter Four, the researcher presented data using graphs, tables, pie charts and discussed the data gathered through questionnaires and from records. The data gathered was presented qualitatively research paradigm. The chapter discussed the research findings and it provided answers to some of the research questions to the study. Findings revealed that Mashoko was affected greatly with understaffing.

Chapter five focused on the summary of the project, research findings, and recommendations as far as the understaffing of nurses was concerned. The chapter summed up all the data

obtained from literature review, statistical data from information department at Mashoko Mission hospital and the participants.

5.2 CONCLUSIONS

The problem of understaffing of nurses at Mashoko Mission hospital is a reality in relation to what came out from the participants in the project and the danger was that the problem may take ages to solve. The primary cause was leadership, conditions of service, geographical

location and poor remunerations. The project was successful through the assistance of fellow students and the subjects whose contribution was so reach with exciting revelations about causes of understaffing in Mission hospitals.

5.3.0Major Research Findings

Findings revealed that there were a number of factors that contributed towards the understaffing of nurses at Mashoko Mission hospital.

Below were the findings from respondents:

- The understaffing of nurses had been caused by poor working conditions that have led nurses to leaving Mashoko Mission hospital seeking better working conditions in urban areas where they would have opportunities to do part-time jobs.
- Many nurses left because of lack of job satisfaction and frustration due to over work and burnout
- Highly experienced nurses left because of poor recognition for their experience
- Nurses left because of the geographical location of Mashoko Mission it is found in the marginalized zone
- Nurse understaffing was as a result of bureaucratic system of the Ministry of Health and Child Care which had not reviewed the establishment for the past 35 years.
- The government freeze of nursing post indefinitely.
- The high nurse-patient ratio of 1 nurse to 20 patients.
- Deployment criteria wasunknown.

5.3.1 Recommendations

If the Ministry of Health and Child Care does not do something to solve the problem of nurse understaffing in the organisation more attractive and rewarding conditions of service, the problem will continue unabated. The forces driving the people out of theMashoko Mission hospitals are as powerful as the opportunities of pulling the nurses away from Mashoko

Mission hospital. In as much as it is inevitable to restrict labour migration, the Mission hospital should explore strategic ways to retain its nurses and to benefit from the highly qualified nurses. In light of the above, the following recommendations were made for Mashoko Mission hospitals to implement or to be used by policy makers.

5.3.2 To Mashoko Mission hospital authorities

- Mashoko Mission hospital authorities should improve the conditions of service for nurses by providing better accommodation, not forcing nurses to attend church services, addressing pension issues and improve communication and transport infrastructure in collaboration with the government.

5.3.3 To the Government of Zimbabwe

- The government should unfreeze all the nursing posts and absorb all qualified nurses roaming the streets
- The government should review establishment post of nurses in Mission hospitals as a matter of urgent
- The deployment of nurses by the government should be transparent and Mission nurse training hospitals should be autonomous in the process
- The government should give high incentives to nurses in general for their essential service.

To Researchers.

Further research at a large scale would need to be carried out especially a comparative study of government and mission hospital staffing of nurses

REFERENCES

Adams, A., Bond, S.,(2000).Hospital nurses' job satisfaction, individual and organizational characteristics. Journal of Advanced Nursing 32 (3), 536–543.

Ammassari, S. (2005).Migration and Development: new strategic outlooks and practical ways forward - the case of Angola and Zambia Geneva.

Awases, M, Gbary, A, Nyoni,J and Chatora, R (2004).Migration of Health Professionals in Six Countries: A Synthesis Report. WHO-AFRO DHS.November 2004.

Best, J. & Khan, J. V. (1995).Research in Education. Library of Congress; Singapore

Beyers, M. Ask AONE's experts ... about how to reduce overtime and use of per diem staff. Nurse Manage. Dec 1999;30(12):56. Comment.

Bikita District Health Profile (2014) District Health Executive Meeting (unpublished)

Borg, W.R. & Gall, M.D. (1996).Educational Research.Longman; New York.

Burns, N & Grove, SK.(1993).The practice of nursing research.Conduct, critique and utilization.2nd Edition. Philadelphia: W.B. Saunders Company.

Burns, N and Susan, K .G .(2007). Understanding Nursing Research, 4th ed .Saunders ELSEVIER St Louis .Missouri.

Canadian Nurses Association (CAN) (2006) Nurses at the forefront of HIV/AIDS. Report: International Nurses' Forum. August 2006. Toronto, Canada.

Chatora, R. (2003). Migration of Health Pro-fessionals.Presentation at 38th Regional Health Ministers' Conference, Living-stone, ZAMBIA (17-21 November).

Chikanda, A. (2005a). Medical Leave: The Exodus of Health Professionals from ZimbabweCape Town: IDASA.

Cohen, A.(1998). An examination of the relationship between work commitment and work outcomes among hospital nurses. Scandinavia Journal of Management 14,1–17.

Dee Ann Gillies.(1994). Nursing Management A Systems Approach, 3rd Edition, W.B.Saunders Company, Philadelphia.

Dovlo, D. (2005) Migration of nurses from Sub-Saharan Africa – A review of issues and challenges. <http://www.academyhealth.org> (Accessed 28 November 2007).

Fagin, C, M.(2001). 'When Care Becomes a Burden: Diminishing Access to Adequate Nursing', Longman .New York

Forrester, K & Griffiths, D (2001), 'So where will the buck stop? Liability and the move for a more diverse health ,care workforce', Journal of Law and Medicine, vol 9, pp 159-163.

Gerein, N., Green, A., & Pearson, S. (2006b). The Implications of Shortages of Health Professionals for Maternal Health in Sub-Saharan Africa. Reproductive Health Matters, 14, 40-50.

Havelock, R.G. (1993). The change agent`s guide to innovation in education. Eaglewood Cliffs ,NJ: Educational Technology Publications.

Keatings, M. & Smith, O. B. (2000). Ethical and Legal Issues in Canadian Nursing (2nd ed.). Toronto: Elsevier Science/Harcourt.

Mensah, K., Mackintosh, M., & Henry, L. (2005). The 'Skills Drain' of Health Professionals from the Developing World: A Framework for Policy Formulation. London: Medact.

Ministry of Health Ghana (2003).Report of the External Review Team –2002 Health Sector Program of Work.MOH Accra, Ghana.

Ministry of Health Ghana (2004)."The Ghana Health Sector – Annual Programme of Work 2004".

Ministry of Health Zambia (2004). Human Resources for Health: A synop-sis of the current staffing crisis and proposals for action. October 2004. Paper prepared for HLF Forum in Abuja 2004, Lusaka, Zambia.

Munjanja, O. (2003). Mini Survey on Stocks and Flows of Health Workers in ECSA (Unpublished paper)

Needleman, J, Buerhaus, P, (2003) Nurse staffing and patient safety: current knowledge and

implications for action. International Journal for Quality in Health Care; 15: 275-277

O'Brien-Pallas, L, Baumann A, Giovanetti P, , Mallette C, Deber R, Blythe J, Hibberd J, &DiCenso A.(2001), 'Health care restructuring: the impact of job change', Canadian Journal of Nursing Leadership, vol 14.

Oulton, J, (2005). The Global Nursing Shortage.Building Global Alliance III Conference.

Philadelphia, PA, USA.

Polit, D,&Hungler, BP. (1989). Essentials of nursing research methods, appraisal, and utilization, 2nd edition. Philadelphia: Lippincott.

Sullivan, R. (1998). Performance improvement and Johns Hopkins Program for international education in gynaecology and obstetrics. Maryland: JHPIEGO Corporation

World Health Organization (WHO) (2006b).Migration of Health workers.http://www.who.int (Accessed 10 September 2015).

World Health Organization (2004). Addressing Africa's Health Workforce Crisis: An Avenue for Action the High Level Forum on the Health MDGs. Abuja December 2004, WHO, Geneva, Switzerland

Yoder .P.S. (2003).Leading and Managing in Nursing 3rd ed. Mosby, St Louis, Missiouri.

Zambia Ministry of Health (2005). Human resources for health strategic plan (draft) (2006-2010). Republic of Zambia, Ministry of Health.

Zimbabwe Parliamentary Debates (2014) .The Senate,Vol.15,No.21, Official Report (Unrevised)

Zurn, P. Dolea, C & Stilwell, B. (2004). Nurse retention and recruitment: developing a motivated workforce. The Global Nursing Review Initiative.Issue 4. Geneva: International Council of Nurses.

Zvobgo, E. (1986). Medical Missions: A NEGLECTED THEME IN ZIMBABWE`S HISTORY, 1893-1957, University of Zimbabwe.

Appendix 1

QUESTIONNAIRE Ethical Considerations

Nursing research must not only be able to generate or refine knowledge but the development and implementation of such research should be ethically acceptable (Bassoon 1985). The researcher asks for permission from Hospital authority as well as the District Medical Officer and no research will be done without written permission. One of the fundamental principles is that of beneficence, in this research, the researcher makes sure that he promoted good for the respondents. In fact, the research will not provide direct benefits to the participants. They can benefit from the research findings of the study to improve the health care system in Zimbabwe, in particular, policy making. Non-maleficence will not be overlooked. There should be no harm to participants. The primary risks of the study are for participants to give correct honest views against the secrecy Act they signed for before appointment. Participants

are advised that they could refuse to answer any question or any part of the question, at any time. To minimize any sense of insecurity, the participants will be informed to answer the questionnaires in a location preferred by the respondents. The researcher will be prepared to terminate the study prematurely if there is any suspicion that continuation would result in harm to the participants. The issue of privacy and confidentiality is vital. It is the researcher's role to keep in confidence the private information shared by the respondents. The subjects in the study are treated as autonomous agents, instead, each respondent is assigned a participants identification number. The participants are allowed to decide voluntarily whether to participate or not.

Appendix 11

Dear Respondent

I am Mr. Shangwa R., a Masters in Adult Education student at Midlands State University carrying out a study on the topic:- '' **An investigation into the causes of Understaffing of Registered Nurses in Mission Hospitals: A case for Mashoko Mission Hospital**"

You have been chosen to participate in this project because of your experience in the health care systems of Zimbabwe. The findings will be treated as grouped data and used to improve the distribution and deployment of nurses by the Government to Mission hospitals. There is no need to identify yourself any way on this form.

Show your views by a tick in a box [ ] or writing in spaces provided.

_____

_____

_____

SECTION A

Questionnaire for all health workers at Mashoko Mission hospital

1) Demographic Data

Which age group are you in? a) Below 29yrs[ ] b)30yrs-39yrs[ ] c)40yrs-39yrs[ ]d)50yrs-59yrs[ ] e)Above 60yrs[ ]

b)Gender. Female [ ] Male[ ]

c)Which group do you belong?

Doctor [ ] Nurse [ ] Human Resources. [ ] Other specify[ ]

d)How long have you been employed at a Mission Hospital?

_____

e)Do you know how the students are deployed by the Government. Yes[ ]No[ ]

If your answer is yes may you explain briefly the process

_____

f)How long has the school been training Nurses?

_____

SECTION B

2a)Mashoko Mission hospital is affected by shortage of RGNs ,is the statement true[ ] or false[]

If your answer is true may you explain

_____
_____
_____
_____

b) How long do patients wait before they are attended to by a qualified nurse?

_____
_____

SECTION C

1)What do you think are the causes of Nurse shortages at Mashoko Mission Hospital?

_____
_____
_____
_____

2)What are the effects of Nurse shortages at Mashoko Mission Hospital?

_____
_____
_____
_____

3)What are your views as training of nurses at Mashoko Mission Hospitals is concerned?

_____
_____
_____
_____

4)How can the shortage of nurses at Mashoko Mission Hospitals be solved?

_____
_____
_____
_____
_____

SECTION D

Write any other comments you wish to share with the researcher?

Thank you for your support

MIDLANDS STATE UNIVERSITY

FACULTY OF EDUCATION

DEPARTMENT OF ADULT EDUCATION

29 January 2015

TO WHOM IT MAY CONCERN

The bearer SHANEWA RUNERI ..... is a Masters Student in Adult Education. He/She has to undertake research and thereafter present a Research project in partial fulfilment of the Masters Degree programme.

In this regard the University kindly requests assistance in this student' s endeavour.

Your cooperation and assistance is greatly appreciated.

Thank you.

Museva

Museva L
Chairperson: Adult Education

MIDLANDS STATE UNIVERSITY
FACULTY OF EDUCATION
DEPARTMENT OF ADULT EDUCATION
30 JAN 2015
PRIVATE BAG 9055 GWERU
ZIMBABWE TEL: 054-260416/7

Mashoko Christian Hospital,
P. B. 530N, Nyika

September 17, 2015.

Mr. R. Shangwa,
Mashoko Christian Hospital,
P. B. 530N
Nyika.

Dear Mr. Shangwa,

RE: YOUR REQUEST FOR PERMISSION TO CARRY OUT A RESEARCH STUDY AT MASHOKO CHRISTIAN HOSPITAL.

Your request for the above, which was dated August 28, 2015, is hereby acknowledged. Permission has been granted.

Dr. ZTJ Bungu, M.D., Ph.D.
MEDICAL SUPERINTENDENT.

MEDICAL SUPERINTENDENT
Mashoko Christian Hospital
13 OCT 2015
P.O.Box 530N, Nyika
Zimbabwe