

**ASSESSMENT OF JOB SATISFACTION AMONG HEALTH CARE WORKERS IN  
PRIMARY HEALTH CARE CENTRES IN THE FEDERAL CAPITAL TERRITORY,  
NIGERIA**

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## DECLARATION

I declare that the “*Assessment of job satisfaction among health care workers in primary health care centres in the Federal Capital Territory, Nigeria.*” is my own work, that to my knowledge it has not been presented before any degree or examination body in any other university and that all the sources I have used or quoted have been indicated and acknowledged as complete references.

*Adulere*

29/01/16



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## **DEDICATION**

I have dedicated this work to my Husband, Mr. Felix Ogoh and Children, David Adah-Ogoh, Natanya Adah-Ogoh and El-Natan Adah-Ogoh, who have supported me in too many ways for words to mention.



## ABSTRACT

Nigeria is experiencing shortages of health care workers within its national health services, especially with respect to doctors, nurses and pharmacists. These shortages are traceable to, among other factors, low job satisfaction, which leads to health care workers exiting the national health services, as well as reduced entry of health care workers into the health care system. Understanding the nature of job satisfaction and its causes is critical to informing strategies to halt attrition of the health workforce.

The current study surveyed job satisfaction among 180 health care workers, employed in 20 randomly selected primary health care centres in the Bwari Area Council of Abuja in the Federal Capital Territory, Nigeria. An observational, descriptive cross-sectional survey was conducted using the abbreviated form of the Minnesota Satisfaction Questionnaire. Descriptive and inferential statistics were calculated using Epi Info v3.1 statistical software.

The results from the study revealed that more than half of the respondents (53.2%), were dissatisfied to varying degrees with their current employment. Out of the respondents that said they were dissatisfied, 33.3% stated that they were likely to leave their current employment. The most salient causes for job dissatisfaction were:

- (1) Institutional factors such as management support (69%);
- (2) Implementation of policies and procedures (66%);
- (3) Employee benefits including salaries and wages (33%) and other benefits (56%).

It is pertinent to note that issues related to poor implementation of policies and procedures in the work place, and poor conditions of employment need to be addressed urgently to prevent the imminent loss of a third of the workforce to either private health institutions in the country or international migration.

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# CHAPTER 1

## INTRODUCTION

### 1.1 Global human resources for health

Human resources are the foundation of an efficient health system and a key prerequisite to improving health outcomes (World Health Organisation [WHO], 2007). Achieving universal health coverage and improved health outcomes depends critically on human resources for health, as health care is by nature labour intensive (Campbell et al., 2013). WHO estimates that about 4.3 million more health care workers are required to meet the health-related Millennium Development Goals (MDGs). The shortage of human resource in the health sector affects developed and developing countries but the developing countries suffer more because they have a much smaller workforce and their health needs are so much greater (WHO, 2007). Africa, for example, bears 25% of the global burden of disease, yet has only 3% of the global health workforce, and only 1% of the global financial resources to meet this challenge (WHO, 2007). In the report by WHO on the global situation of health care workers, 186 countries were assigned to low, medium and high worker density clusters (below 2.5, between 2.5 and 5.0, and above 5.0 workers per 1,000 population, respectively). The low and high-density groups were further sub-divided according to high and low mortality in under five -year olds. Among the countries classified by WHO as low-density countries, 45 of them are in the low-density/high-mortality cluster. These countries located mostly in sub-Saharan Africa experience twice the crisis of rising death rates as a result of weak health systems when compared to the countries in the low density/ low mortality cluster. This trend is also reflected in some of the health care indices where in addition to health care workforce shortages, there are also other challenges like high disease burden within the health care system. Some of the health care indices show that only about 19% of African countries have up to 80% of their populations immunised for measles; also on average, 910 women die per 100,000 live births (WHO, 2007).

Human resource for health (HRH) shortage is attributable to several factors that cause increased exit and reduced entry of healthcare workers into the health sector. An important exit factor is poor job satisfaction; which leads to increased staff turnover and subsequent health care worker shortages (Kinfu, 2009). Other exit factors include poor education and inadequate health care management systems. Some of the issues identified with reduced entry



of health care workers into the health care system include backlog and clogging of training pipeline for health care workers, and qualified applicants are not gaining entrance to professional schools. There are also challenges of insufficient numbers of instructors, limited clinical sites, and budgetary constraints contributing to the production of qualified health care workers leading to shortages in the health care system.

Shortage of health care workers as a result of resignation disrupts the continuity of care, and the quality of care provided to individuals who require medical attention (Dovlo, 2004). This disruption in continuity and quality of care occurs when there is a time lapse between the time a position of a health care worker becomes vacant and the time it takes for the recruitment of replacements who may require training to provide the same level of care.

The challenge of shortages in the health workforce is complicated by many global disease burden issues such as changes in health trends, shifts in health needs and demands. The declining resources as well as changes in global economic, political and technological situations has also increased the amount of pressure on the already depleted health workforce (Grange, 2007). Global economics impact on the health sector has resulted in the reallocation of scarce resources to other emerging areas of priority like security and climate control at the expense of the health sector. Addressing these challenges requires inter-sectoral cooperation as in many instances the precipitating factors for employee turnover are outside the direct control of the health sector (WHO, 2007). The reason for this inter-sectoral collaboration stems from the fact that Human Resources for Health (HRH) presents one of the biggest reform challenges to the health sector. There is pressing need to re-organise, align and re-orientate HRH planning, management and development systems and functions across all three tiers of government to ensure efficiency and effectiveness in the overall health service delivery system.

In general, health care worker shortage significantly affects the service provision and quality of care by decreasing availability, accessibility, quality and utilisation of health care services (Forcier, Simoens & Giuffrida, 2004).

## **1.2 Human resources for health in Nigeria**

There are some challenges facing the health system in Nigeria - one of which is the acute shortage of competent health care providers. Nigeria has 13 doctors, 92 nurses/midwives and 64 community health care workers (CHWs) in the public sector per 100,000 population (Grange, 2007). These ratios are below the recommended WHO standard for patient/health care worker ratio (Grange, 2007). The shortages in human resources for health are argued to have contributed significantly to declining critical health indices in Nigeria where life expectancy dropped from 53.8 to 48.2 years for females and 52.6 to 46.8 years for males in 2001 (Grange, 2007). The infant mortality rate (IMR) similarly rose from 87.2 per 1,000 live births in 1990 to 105 in 1999 (Grange, 2007).

In Nigeria, there is a disproportionate concentration of health care workers in urban areas compared to rural areas (Uneke et al., 2007). This uneven distribution means that while access to medical personnel is readily available in cities, rural dwellers often have to travel considerable distances to obtain treatment. An urban resident in Nigeria has access to three times more doctors and twice as many nurses/midwives, compared to a rural resident. Doctors and nurses are reluctant to relocate to remote areas and forest locations that offer poor communications with the rest of the country and provide few amenities for health professionals and their families (Raufu, 2002). Urban areas in Nigeria are more attractive to health care professionals for their comparative social, cultural and professional advantages. Large metropolitan centres in the country offer more opportunities for career and educational advancement, better employment prospects for health professionals and their family (namely, spouse), and easier access to private practice. Also, the low status often conferred to those working in rural and remote areas further contributes to health professionals' preference for settling in urban areas, where positions look more prestigious compared to rural areas. This perception has significant consequences for the health of the inhabitants of rural areas where 70% of Nigerians dwell. The unavailability of physicians and nurses within proximity in the rural areas often leads to the delaying and postponing visits by health care seekers to health care facilities until the condition becomes unbearable or complicated. Transportation of the patients on treacherous roads from the rural areas in cases of referrals to urban centers may take several hours, and this could mean life or death, further plummeting the health indices of the population.

### **1.3 Causes of brain drain**

Brain drain is closely related to the problem of the geographical distribution of health care professionals (Uneke et al., 2007). Migration of health care workers, also known as 'brain drain', is defined as the movement of health personnel in search of a better standard of living and life quality, higher salaries, access to advanced technology and more stable political conditions in different places worldwide (Stilwel et al., 2004). Brain drain may be within countries (internal brain drain) or between countries (external brain drain). Internal brain drain refers to health care worker shortage resulting from the lack of productivity of many of the students who are graduating from schools on an annual basis. Many of these young people are graduating without the prerequisite skills to be productive in the workplace. However, in most cases, brain drain takes the form of cross-border or international migration and is often from developing to developed countries – external migration (Yusuf et al., 2010). The problem of brain drain leads to a situation where a sizeable number of physicians, nurses and other medical professionals are lured away to developed countries in search of fulfilling and lucrative positions. Migration depletes the workforce in the developing countries who already in many instances have poorer health indices when compared to a more advanced economies whose population health indices are relatively stable. There are often multiple reasons adduced as to why health care workers leave their countries of origin, the so-called 'push and pull' factors. Higher education is one of the reasons for which medical graduates of Pakistan emigrate to the West: In Pakistan, there is the long-standing belief that young doctors who train outside their home country are superior to those trained locally. The international education is said to be a mark of achievement and as a result, there is an expectation of bigger remuneration for the foreign trained doctors (Aly & Taj, 2008). Other negative motivators for health care worker migration include lack of opportunities for career advancement and personal development, high unemployment in healthy labour markets and a deplorable state of health care in most developing countries. Medical schools in developing countries encourage brain drain when they openly express pride in having trained students who are practicing in developed countries.

#### **1.4 Job satisfaction and health care worker motivation**

Multiple factors which influence job satisfaction include employee benefits, organisational culture, the opportunity for growth and development of the health care worker within the workplace (Grange, 2007). In most cases, a combination of these elements is linked to job satisfaction, though a single factor may be the difference between retention and attrition for a health care worker in a few instances.

As a matter of urgency, many countries need to improve poor work environments, create monetary as well as non-financial incentives to retain and motivate health care workers (Bhatt, 2008). They should aim to provide a stimulating environment and a vibrant intellectual community for professional growth to achieve this objective of improving job satisfaction.

In Nigeria, some of the possible reasons put forward for lack of job satisfaction among healthcare workers are inadequate mobilization, allocation and utilization of health resources. These reasons are fragmented among different players that do not visibly impact the health sector (Grange, 2007). The various actors who have access to these resources divert them to other areas which tend to have an adverse impact on the health sector. Activities of private sector health providers are also poorly coordinated with little or no emphasis on employee development and personnel training, which negatively affects staff motivation and utilisation, and seems to contribute to reduced job satisfaction leading to the increased exit of the health care workers. There are no set standards to guide staffing or staff utilisation for both the private and public sector. The public sector seems to be more affected by the lack of standardized staffing model and, therefore, is more prone to increased exit of the health care worker. Stemming from the lack of clarity of purpose in the deployment of staff as a result of poor job descriptions, worker productivity and output in the public health sector is very poor. Many private sector health practices seem to suffer from poor work quality because of long hours at work and inequitable work-life balance leading to low entry levels and high exit rates from the health profession (Uneke et al., 2007).

## **1.5 Problem statement**

In Nigeria, information on HRH in the various agencies of government responsible for data management is captured in multiple databases (Federal Ministry of Health, Department of Statistics and Personnel, State Ministry of Health, Local Government Secretariat) in various locations. Apart from the general problem that most data sets are neither complete nor entirely comparable, and they are often underused, limited (in that they often provide only general information on attrition) and not real time (Uneke et al., 2007). These data also do not offer any in-depth analysis of job satisfaction, distribution and trends of attrition in HRH. This challenge with data management is one of the major barriers to effective HRH planning (Grange, 2007).

Discussions with stakeholders in the Bwari Area Council confirm that there is no information which is specific to factors assessing job satisfaction among healthcare workers. There is data on date of hire, staff appraisal and staff exit; however none of the data sets are up-to-date or provide comprehensive information to enable assessment of factors that affect job satisfaction. Without this data, it is hard to know the factors that have contributed to job satisfaction directly and thus influencing attrition amongst health care workers; it is also difficult to try to work towards providing solutions that could address health care worker attrition in this area.

## **1.6 Aim and objectives**

The aim of the current study was to describe job satisfaction and the factors associated with job satisfaction among healthcare workers in the Bwari Area Council of the Federal Capital Territory, Nigeria.

The objectives of the study were to:

- Describe job satisfaction among these health care workers.
- Determine the relationship between institutional factors and job satisfaction among healthcare workers.
- Determine the relationship between work environment and job satisfaction among healthcare workers.
- Determine the relationship between employee socio-demographic factors and job satisfaction among healthcare workers.

## **1.7 Outline of mini thesis**

Chapter two focuses on a literature review of factors associated with job satisfaction among healthcare workers.

Chapter three describes the research methodology and ethics procedures observed in the study.

Chapter four presents the results of the study.

Chapter five discusses the results of the study and how these relate to the literature.

Chapter six provides the conclusion and recommendations from the study.



## **CHAPTER 2**

### **LITERATURE REVIEW**

#### **2.1 Definition of job satisfaction**

One of the definitions of job satisfaction is the degree of favourableness with which employees view their work (Mowday, 2004). It is a concept that affects the lives of all workers, including health professionals and also a factor that is considered to be important in the determination of an employee remaining in a position or seeking employment elsewhere (Uneke et al., 2007). Job satisfaction of health care workers is highly important in building up employee motivation and efficiency, as higher job satisfaction determines better employee performance, lower employee turnover and a higher level of patient satisfaction (Stewart, 2003).

The study of the relationship between job satisfaction, job performance and employee turnover has a controversial history. The Hawthorne studies, conducted in the 1930s, are often credited with making researchers aware of the effects of employee attitudes on performance and turnover. Shortly after the Hawthorne studies, researchers began taking a critical look at the notion that a 'happy worker is a productive worker.' Most of the earlier reviews of the literature suggested a weak and somewhat inconsistent relationship between job satisfaction, performance and turnover. An examination of the literature in 1985 indicated that the statistical correlation between job satisfaction and performance was about 0.17 (Iaffaldano & Muchinsky, 1985). Thus, these authors concluded that the presumed relationship between job satisfaction, performance and employee turnover was a 'management fad' and 'illusory.' This study had a significant impact on researchers, and in some cases on organisations, with some managers and HR practitioners concluding that the relationship between job satisfaction, performance and employee turnover was not significant

However, further research does not agree with this conclusion. Organ (1995) suggests that the failure to find a strong relationship between job satisfaction, performance and employee turnover is due to the limited means often used to define job satisfaction. Organ argued that when satisfaction is defined to include critical behaviours not reflected in performance appraisals, such as organisational citizenship behaviours, its relationship with employee

improves. Research tends to support Organ's proposition that job satisfaction correlates with organisational citizenship behaviours (Organ & Ryan, 1995).

Also, in a more recent and comprehensive review of 301 studies, Judge, Thoresen, Bono and Patton (2001) found that when the correlations are appropriately corrected (for sampling and measurement errors), the average correlation between job satisfaction and job performance is a higher. Furthermore, the relationship between job satisfaction and employee turnover was found to be higher for complex (for example, professional) jobs compared to less complex jobs. As hypothesised, data from 170 employees of a Dutch firm showed that the quality of leader-member exchange mediated positive relationships between leader-rated innovative job performance and job satisfaction. This data led to the concept of using job satisfaction, which is thought to be one of the results of effective quality management in organisations, being named as one of the critical factors in shaping employee turnover intentions (Liden & Maslyn, 2004). Thus, contrary to earlier reviews, it does appear that job satisfaction is, in fact, predictive of performance and employee turnover intention, and the relationship is even stronger for professional jobs like health care workers.

A cross-sectional survey was conducted from March to October 2009 in Jimma University Specialised Hospital (JUSH) in Addis Ababa for 160 health care workers (Yami et al., 2011). The result showed dissatisfaction among sixty-seven (46.2%) of the health care workers with their job. The principal reasons reported for their dissatisfaction were a lack of motivation, inadequate salary, insufficient training opportunities and a small number of human resources. Only sixty (41.4%) health professionals were satisfied with their job, the principal reasons given were obtaining satisfaction from helping others and professional gratification. The results also revealed that only twenty-three (15.9%) of the respondents in the study planned to continue to work in the hospital for another five or more years.

A health facility based cross-sectional study conducted and published (Geleto et al., 2015) among 405 randomly selected health care providers in Harari regional state, Eastern Ethiopia. Self-administered structured questionnaires were used to collect data was. The results showed that less than half (44.2%) of the respondents were satisfied with their current job. Organisational management system, salary and payment and working environment were among the factors that affected the level of job satisfaction. Standard human resource management practices such as performance appraisal and the provision of job descriptions were not present in many cases. Health care workers felt that they were inadequately



supervised, with no feedback on performance which was the reason many of their colleagues had left in previous years.

## **2.2 Factors that influence job satisfaction among health care workers**

Some of the factors that contribute to employee job satisfaction are categorized as conditions of service (employee benefits, remuneration, rewards), institutional factors (work environment, organisational values, performance management system, employee development opportunities and career advancement). Other factors include employee socio-demographic attributes (intelligence and aptitude, family ties, gender, interests, age and length of service) (Uneke et al., 2007).

The factors that impact job satisfaction may also be categorised into extrinsic and intrinsic (Hann et al., 2011). Intrinsic factors relate to the work (such as the ability to develop one's skills, a sense of autonomy, success, achievement and control); whereas extrinsic factors are not directly related to work (such as salary, benefits, conditions of service or relationships with colleagues). In addition to autonomy and cohesion with colleagues, many factors such as task variety, feedback, promotional opportunities, task identity (professional status), working conditions, collaboration with the staff and strength of the organisational culture have been associated with job satisfaction (Roelen et al., 2008). Demographic variables, job characteristics and corporate environment factors also influence job satisfaction (Dogan, 2009).

### **2.2.1 Conditions of service**

Terms and conditions of employment are necessary for job satisfaction because they provide clarity of the work itself. It entails, a full description of the duties and responsibilities, knowledge of remuneration as well as other additional benefits, working conditions, job location, plus the organisation's values, mission and vision (Torrington et al., 2008). Based on the terms and conditions of service, an individual can evaluate the options available and determine whether they can align their goals to that of the organisation and check if they are

comfortable with the terms and conditions provided. An individual's decision to work for an industry may be based largely on the conditions of service.

Sound collaborative conditions of service explain how employees are treated when they come to work and how they are enforced to perform their duties (Ramayah, 2001).

### *Employee support and supervision*

A cross-sectional study done in Ghana in May 2013 took data from 144 sub-district community health care workers in the Volta Region of Ghana (Bempah, 2013). Supervision and recognition recorded higher levels of satisfaction with about 78% and 72% of respondents being satisfied respectively. Working conditions were rated low compared to others with 14% not satisfied, about 33% being indifferent and 63% satisfied. Pay and benefits relating to work were the lowest rated factor with only 37% satisfied. The rating of overall job satisfaction depicts that most respondents were not satisfied with about 73% of the respondents were not satisfied and 10% satisfied.

In another study to investigate the effects of perceived supervisory support provided by registered nursing staff on job stress and job satisfaction among nurse aides working in long-term care done in 2007 among 222 nursing staff in Ontario, Canada. The results showed that 33% of the total variance in job satisfaction was explained by supervisory support. The study concluded that greater supervisory support is associated with reduced job stress and is a critical determinant of job satisfaction (McGilton et al., 2007).

The Health Systems Strengthening for Equity project used several well-established tools, validated in both high income and low resource settings including Africa, and critical incident interviews to assess both personal and workplace related contributors to job satisfaction and the intention to leave one's current position. The study conducted among doctors and mid-level providers delivering emergency obstetric care in hospitals and health centers in Malawi, Mozambique and Tanzania. The Health Systems Strengthening for Equity study revealed that between one-quarter and one-third of staff surveyed had seriously thought about leaving their current positions, the percentage was higher in Malawi (33%) than in Mozambique (29%) and Tanzania (27%). In Malawi, 22% of staff surveyed indicated that they were actively seeking other employment. The statistics were considerably higher than the corresponding

figures for Tanzania (14%) and Mozambique (8%). In Malawi, only 32% of the health workers surveyed indicated that they received formal supervision. In Tanzania, 38% received formal supervision. By contrast, more than 60% of health workers in Mozambique reported receiving formal supervision. In Malawi, almost 30% received no supervision and a further 20% indicated that they received only negative supervision. In Tanzania, these figures were lower with 15% showing that they received no supervision and 15% stating that they received only negative supervision. In Mozambique, 16% said they received only negative supervision. A quantitative survey measured health care workers' job satisfaction in Malawi, (Manafa et al., 2009) showed that health care workers were particularly dissatisfied with what they perceived as unfair access to workplace benefits and adequate supervision.

### *Remuneration*

Remuneration is a motivating factor for employees in organisations and serves as a basis upon which individual employees assess the value their employer places on them (Slugoski, 2000; Samuel & Chipunza, 2013; Mobley, 1982). Employees who do not earn market-related salaries may feel undervalued by their current employers, which may, in turn, transmit to an intention to leave. This observation is buttressed by Chiboiwa et al. (2010) and Samuel and Chipunza (2009) who found that there is a negative relationship between high rewards and turnover in organisations. Poor salaries were identified as a critical factor in influencing the turnover intentions of academic libraries in Zimbabwe. The findings revealed that academic librarians in Zimbabwe were considering leaving their current employers in search of higher salaries in the Non-Governmental Organisation (NGO) sector where the respondents indicated were paying better. This finding is also in tandem with other research findings (Chiboiwa, et al., 2010; Hillmer, et al., 2004; Jafari, 2011; Moyinhan & Pandey, 2008). The study observes, rewards as a reliable predictor of employee turnover intentions and serves as a basis upon which individual employees assess how the employer evaluate their contribution to the organization. This means that the closer the employee salaries are to the market-related benchmark, the lower the intention for turnover.

As Blomme et al. (2008) puts it “When two or more employees perform similar work and have similar responsibilities, differences in pay rate can drive lower paid employees to quit” (p.21). These differences are seen in the cases of the drift when health care workers from

government facilities migrate to private health facilities where persons with similar qualifications and job descriptions have higher pay rates, thus making private health facilities more attractive to health care workers regarding remuneration. There are gross disparities and distortions in remuneration packages and schemes of service for health care workers at different levels in the public sector, especially for nurses and midwives in Nigeria. The disparities are more pronounced between staff on federal payrolls and their colleagues of similar qualification and experience in the states and worse in the local government systems (Grange, 2007).

A study among health care workers aimed at health sector reforms in Ghana to address the challenge of attrition. The results showed that a 10% increase in wages decreased annual attrition from the public payroll by 1.5 percentage points (from a mean of eight percentage points) among 20-35- year old workers (Antwi & Phillips, 2013). As a result, the ten- year survival probability for these health care workers increases from 0.43 to 0.52 showing that the tendency towards rural, urban migration among the health care workers in the period under study, was reduced by 15%. This reduction was not so among the categories of older health care workers who seemed to be considered as low potential migrant workers.

Even in more developed economies, adequate wages and low wage satisfaction play a role in employee turnover. Results of a study that was done in three countries (Belgium, Germany and Netherlands) showed that employees with a low wage or low wage satisfaction were less likely to express an intention to stay (Steinmetz et al., 2014). This effect of wage satisfaction is not surprising; it confirms that besides a high salary, salary satisfaction is essential.

### *Rewards*

Many scholars also cite rewards as a reliable predictor of employee retention and turnover intentions. A longitudinal cohort study was completed in South Africa to evaluate the effect of the new rural allowance on the short-term career plans of health care workers in the rural area among health care workers in 2002 by Reid (2004). The study carried out in 5 hospitals out of the 30 available in the North West province. The results showed that between 28% of rural health professionals, mostly professional nurses, actually changed their short-term career plans and remained in their jobs because of the new rural allowance. There did not seem to be much difference in the rural/urban migration of the doctors and the junior nurses (nurses who were in service less than two years after graduation). One of the reasons put

forward to explain the exodus of the doctors was that the new allowance did not change the current remuneration much and that the junior nurses had been excluded entirely from the payments. Other factors such as career development, job satisfaction and post-graduate educational opportunities are equally important motivators; especially to younger professionals whose determination to practise the health profession in rural areas comes second to urban practice (Reid, 2004). Several initiatives such as rural and scarce skills allowances, community service and the Occupational Specific dispensation have been introduced in South Africa to alleviate HRH shortages. Research has shown that both the initial rural allowance and the new rural allowance were successful in encouraging roughly a third of health professionals, mainly nurses, to remain in their jobs in rural areas.

Countries such as Fiji, Samoa, Tonga, Vanuatu, Papua New Guinea, Vietnam, Cambodia and Thailand have identified low salaries as a primary reason for job dissatisfaction and migration among health care workers areas (Wibulpolprasert & Pengpaiboon, 2003). In Thailand, there are special hardship allowances provided as incentives for doctors to remain in rural areas (Wibulpolprasert & Pengpaiboon, 2003). The allowance has three tiers based on location: rural districts, remote districts and the most remote districts. Doctors in the most remote areas received US\$500 a month – almost three times their basic salary. A non-private practice allowance of US\$400 a month was given to doctors who agreed not to engage in private practice and individual workload-related payments were implemented for service in non-official hours. This measure has improved the overall numbers of medical doctors working at community level.

When considering all factors that affect employee retention, attention to details like working and commuting times can complement attention to wages and wage satisfaction to increase employees' intention to stay. These findings hold for all three countries, for a variety of health occupations.

### **2.2.2 Institutional factors**

Institutional factors include every resource deployed by an organisation to support an employee's contribution to an organisation and vice versa. These include work environment, organisational values, performance management system and employee development opportunities (Uneke et al., 2007).

### *Work environment*

The work environment refers to the physical space surrounding the employee during his day to day duties and the psychological space associated with the work. A stressful (ergonomically) work setting has often been cited as a primary source of the exit of employees from organisations (Mitchell et al., 2001). Closely tied to the concept of unsatisfactory work environments is the influence of employee organisation fit in shaping turnover intentions.

A study done among health care workers in Islamabad showed that only half of the respondents were satisfied with their working environment, whereas 68% were satisfied with their responsibilities (Kumar et al., 2013). Majority (71%) is dissatisfied with the quality of services they provided to their patients in their jobs; 66% of the participants are dissatisfied due to the trivial tasks assigned and lack of decision-making in their job. About two-thirds of public health professionals were not satisfied with the professional opportunities, resources and the work schedule (Kumar et al., 2013). The study came to the conclusion that people respond unfavourably to restrictive work environments. Therefore, it is imperative for organisations to create incentivised environments that enable the employees to achieve the highest level of job satisfaction. The conditions under which a job is performed can have as much impact on people's effectiveness, comfort and safety as the essential details of the task itself.

Stressful working conditions in the South African public health system were reported in a study done in 2001 as one of the major reasons for emigration by South African nurses (Shisana et al., 2003). A study conducted by the Ethics Institute of South Africa at the Chris Hani Baragwanath Hospital showed that most staff members found their work environment unacceptable and unsafe (Landsman, 2001). Their opinions are based on factors such as neglect, poor maintenance of buildings as well as insufficient and outdated equipment. Workplace conditions for health care workers who were employed in 222 public and private hospitals and clinics across the nine provinces of South Africa were surveyed in a cross-sectional study in 2002. Their opinion was sampled as part of a study on the impact of HIV/AIDS on health care workers (Shisana et al., 2003). The pandemic had introduced several variables to the health sector. The stressful conditions that were reported by the health care workers were underlined by the fact that nearly all the workers were treated for stress and stress related illness. Most of the respondents (84.3%) felt that their workload had

doubled and that absenteeism had increased due to stressful working conditions causing the exit of colleagues from the system. The attrition made the burden of work heavier on those members of staff who reported for work (Shisana et al., 2003).

Regarding work environment, inadequate access to electricity, equipment, transport, housing and the physical state of the health facility were cited as most critical for job satisfaction and retention of health care workers. These factors are seen particularly in Turkana which is a rural area as shown in a study conducted in Kenya by (Ojaka et al., 2014). The majority (67.8%) of the 86 workers that participated in the study responded that the absence of this fundamental infrastructure was the fulcrum behind their intention to leave for other health posts in more urban locations in Kenya, even if they had to take cuts in their wages.

In Nigeria where there is a disproportionate concentration of medical professionals in the rural and urban areas, a study was done on the attraction and retention of qualified health care workers in rural areas in Ogun state in south west Nigeria (Ebuehi & Campbell, 2011). The study found that working conditions (benefits, entitlement and promotions) and appropriate infrastructural issues (workers' office space, adequate equipment and hygiene) are still core factors affecting an individual's motivation to work in a rural area. This study then concluded that mitigating the impact of the problem would entail developing a comprehensive rural health workplace improvement strategy, which incorporates a coordinated inter-sectoral approach involving the partnership among stakeholders in rural health development.

Poor health, as the studies of workers' labour market outcomes suggested, may also lead to the turnover and early retirement. In extreme cases, poor employee health may also lead to premature death, resulting in significant turnover costs to employers from the search for new workers and subsequent training (Greenberg, Finkelstein, & Berndt 1998). Research also demonstrates that exhausted, depressed, sick, or injured workers are not energetic, accurate, or innovative at work, leading to productivity losses. The studies show that poor health reduces workers' productivity at work and that effective medical treatments can reduce productivity losses and may even "pay for themselves" regarding increased productivity (Berndt et al., 1998). Recognition of the impact of health care worker illness and death has led to some health clinics and health insurance to be established for health care workers and their families by their employers, which has shown benefits concerning reduced absenteeism (O'Brien, 2003).



### *Organisational values*

Research on employee-organisation fit done by Blomme (2008) also reveals that the extent to which employees identify themselves with their organisation has a positive impact on their level of satisfaction and thereby their organisational attachment and intention to stay (Blomme et al., 2008). The fit between an employee's values and the values of the organisation might provide the employees with a certain degree of comfort and identification with the organisation, thereby minimising stress and the desire to leave (Zeffane, 1994; Hrebiniak & Alutto, 1992). Additionally, scholars have pointed out that a breach of the psychological contract (employee beliefs and value system) by the employer may result in the employees working in a psychological environment of mistrust, low job security and other mental shocks (Rousseau, 1989). A wide gap between an employee and organisational values will, on the other hand, leave workers pondering their future in the organisation and, therefore, encourage them to consider moving (Blomme et al., 2008). Professional autonomy motivates employees to perform at their best and show commitment to the organisation, enhancing work conditions to support the organisation's mission and thus impacting on job satisfaction.

A study done by Morrow et al. (2005) proposes that one of the primary reasons employees quit is that they are treated poorly by their bosses. Those who remain in their jobs, working for organisations where they are thus poorly treated have lower job satisfaction, lower commitment, psychological distress and subsequently high turnover intentions (Callier, 2011; Balfour & Neff, 1993; Morrow et al., 2005).

### *Performance management system*

Staff motivation and an enabling environment are crucial factors for retaining midlevel providers in the health workforce in the Malawian health system. This conclusion came following a study of 84 health care workers to understand the 'tipping points' that drive staff to seriously consider leaving their jobs. It was found that many of the factors underlying these critical incidents can be addressed by improved management practices and the introduction of fair and transparent policies. Staff in this study desired to have access to equal opportunities for upgrading and promotion. They also concluded that there was the need for a continuous effort to mobilise the resources necessary to fill gaps in basic equipment, supplies and



medicine, as these are critical in creating an enabling environment for health care providers (Chimwaza et al., 2014). The most commonly cited key factors identified were incidents of being treated unfairly or with disrespect, lack of recognition for their efforts, delays and inconsistencies in salary payments, lack of transparent processes and criteria for upgrading or promotion, and death of patients.

#### *Employee development opportunities and career advancement*

The lack of professional development has been cited as a reason for job dissatisfaction among health care workers in rural or remote areas who are often isolated from professional colleagues and support (Uneke et al., 2007). Training and professional progress are important motivational determinants, as they nurture health care workers' personal objectives and their value system. In fact, training as a tool of human resources management can serve several purposes (Mathauer & Imhoff, 2006). It can help health care workers to cope better with the requirements of their job. It can also enable them to take on more demanding duties and positions and to achieve personal goals of professional advancement. Training can have strong motivating effects.

When asked about the impact of training courses they had taken over the past two years, nearly all health care workers in Kenya and Benin mentioned that they felt more comfortable and confident with their work afterwards (Mathauer & Imhoff, 2006). Some health care workers who were part of the study in Kenya, mentioned increased interest and work commitment as a result of capacity building sponsored by the organisation. These answers suggest a considerable impact of training courses on both the 'can-do' and the 'will-do' component of motivation. Overall, respondents were very interested in receiving more continued medical education/continued professional development.

A qualitative study of rural midwives in Australia illustrates that continuing professional development and an organisational culture of ongoing learning are considered to be important strategies for the retention and professionalism among midwives (Fahey, 2005).

### **2.2.3 Employee socio-demographic attributes and turnover**

Qualification and educational status play a significant role in attrition among health care workers as studies have documented higher levels of attrition among doctors when compared to other groups of health care workers (Gomez, 2007). The number of doctors in Zambia declined by 56% between 1999 and 2002 (Onzubo, 2007), of which 62% of them left as a result of resignations for other jobs within the country or outside where they were more in demand, especially doctors with additional qualifications. The study was done in West Nile for six hospitals that combined public and private institutions showed that the average annual attrition rate was highest among the medical officers, followed by the enrolled midwives. The lowest attrition rate was among the other allied health professionals .

In Kenyan hospitals, specialist doctors had much higher rates of attrition, compared to clinical officers, although resignation was the predominant reason for attrition in both cadres. This finding may reflect a recent trend for doctors, who seem to be moving completely away from public service rather than staying on with the dual employment opportunity (often referred to as ‘moonlighting’) that has been on the books for years (Chankova, Muchiri & Kombe, 2009). The differential rates of attrition between doctors and clinical officers may thus reflect that physicians are more likely to emigrate for work in health facilities abroad or to go entirely into private practice or employment in the NGO sector in their home country (which are not opportunities as readily available to clinical officers).

In Nigeria, on average, annual attrition due to all factors among doctors is about 2.4%; nurses and midwives 1.4%; pharmacists and technicians 2.2%; laboratory staff 1.3%; (Uneke et al., 2007). Attrition in rural areas is higher than in urban areas. The attrition rate in rural areas is 3 times greater for doctors and two times higher for nurses than in urban areas. Doctors, nurses and midwives working at the primary health care level have higher attrition rates than those working at the secondary or tertiary level (Grange, 2006).

In January 2014 according to the Bureau for Labour Statistics, the median employee tenure (The median number of years that wage and salary workers had been with their current employer), an indicator of employee turnover, for men was 4.7 years, as compared to that for women which was calculated to be 4.3 years. Among men, 30% of wage and salary workers had ten years or more of tenure with their current employer, compared with 28% for women (Bls.gov, 2016).

Age is one of the socio-demographic factors considered when studying employee turnover intention. Median employee tenure was also seen to be higher among workers who are older when compared to the younger ones biologically. For example, the median tenure of employees aged 55 to 64 years was 10.4 years which is more than three times that of the workers aged 25 to 34 years that was calculated to be 3.0 years. Among workers aged 60 to 64 years, 58% had been employed for at least ten years with their current employer in January 2014, compared with only 12 % of those between 30 to 34 years at the time of the study (Bls.gov, 2016).

In the majority of countries, women are the primary caregivers (Shoemaker & Barbour, 2011). As women make up an increasingly large proportion of the health profession, it is important to consider the different needs of female health care workers as compared with their male counterparts when developing incentives (Shoemaker & Barbour, 2011). Flexible and part-time working hours, flexible leave/vacation time, access to child care and schools as well as planned career breaks are a few of the incentives that may be necessary to female health care workers (Adindu & Asuquo, 2013) . A survey of 271 female general practitioners and 31 female health worker specialists in rural Australia found that 36% of general practitioners and 56% of specialists would prefer to work fewer hours (Hongoro, 2006) Results indicated that incentives to attract and retain women in rural practice include flexible practice structures, acceptance of the rural area by the doctor's family, mentoring by women doctors, and financial and personal recognition.

## **Summary**

Job satisfaction is a function of a number of complex and interrelated variables. An employee may seem satisfied with one or more aspects of his/her job, but at the same time may be unhappy with other facets related to the job and so consider quitting his/ her current employment. This study aims to present some of these factors that affect job satisfaction in Nigeria in a manner that draws attention to each of the individual factors so that they can be considered adequately for intervention. The study also seeks to reiterate that addressing the problems of employee turnover requires a holistic approach where all the factors discussed in this study are considered in their individuality and adequately addressed.

## **CHAPTER 3**

### **RESEARCH METHODOLOGY**

#### **3.1 Description of research setting**

This study was conducted in Bwari, which is the capital of the Bwari Area Council in the Federal Capital Territory Nigeria. There are 25 clinics in the Bwari Area Council, which provide primary health care, out of which 17 are simply health posts providing outpatient services only, including general provisions such as antenatal care, pharmacy services and basic laboratory investigations. These health outposts are only open on weekdays for eight hours. The other eight health care facilities provide a broader range of services including those offered by the other 17 facilities, plus labour and delivery, minor surgeries and inpatient services. These services are available 24 hours a day, including weekends. The health centres included in the study were selected based on location (proximity to the Area Council headquarters and accessibility), the number of staff and type of services offered as adduced above.

The total health workforce in Bwari Area Council as at 12th May 2014 was 672; 31 doctors, 133 nurses and midwives, 198 pharmacists and laboratory staff – with the remaining 310 made up of community health extension workers, cleaners, ward attendants and hospital management.

#### **3.2 Study design**

In the current study, an observational, descriptive cross-sectional survey design was used to compare various factors related to job satisfaction among healthcare workers, as this method is less expensive and less time consuming (Vaisali, 2011). This study design is preferred because it is non-invasive as body samples are not collected from the study population and thus is considered to be ethically safe.

### 3.3 Study population and sampling

The study population constituted all doctors, nurses, pharmacists and laboratory scientists in full-time employment in the 25 primary health care centres in the Bwari Area Council. Based on the staff audit conducted in May 2014, there was 672 staff employed across these 25 centres.

20 out of the 25 primary health care centres in Bwari were randomly selected to form the sampling frame using the lottery approach without replacement. All the health care centres were assigned unique numbers from 1 to 25. The numbers were thoroughly mixed in a bowl from where 20 of these numbers were picked without replacement and those facilities with the numbers selected from the bowl were included in the sample.

The sample size was calculated using a standard formula:

$$\text{Sample Size} = \frac{z^2 * (p) * (1-p)}{c^2}$$

Where: z = z value (for example, 1.96 for 95% confidence level); p = percentage picking a choice, expressed as decimal (0.5 used for sample size needed); c = confidence interval, expressed as decimal (.04 = ± 0.4).

$$\frac{1.96^2 * 0.5 * (1 - 0.5)}{4} = 0.24$$

4

The expression above gives a result of 0.24. This is multiplied by 672, which is the total number of health care workers in the Bwari Area Council. The result is 161 participants; after which an additional 19 to make up for a non-response rate equaling 180 participants.

A simple random sampling of health care workers from the 20 health facilities was carried out to select 180 respondents using the random number generator.

### 3.4 Data collection

Data collection was conducted by the use of self-administered questionnaires. The questionnaire used was the abbreviated form of the Minnesota Satisfaction Questionnaire (MSQ) which measures satisfaction with various aspects of benefits, personal development,

and organisational culture using intrinsic and extrinsic scales (see Appendix 3). This questionnaire has been used in various studies to assess job satisfaction among workers. This questionnaire is well-known, has been pretested and stable over the time; previous researches yielded excellent coefficient alpha values (ranging from .85 to .91); with 20 items, it is a parsimonious scale (in comparison with the 72 items of the Job Descriptive Index, for example). Moreover, the MSQ has been widely studied and validated. (Fields, 2002)

The abbreviated form is used to reduce the amount of time spent on the survey. The MSQ has been shown, through data from various occupational groups, to differentiate job satisfaction at the 0.001 significance level on all scales. It has also shown to be useful in exploring clients' vocational needs, in counselling, follow-up studies and in generating information about job satisfaction. In various studies where it has been used, the MSQ has further demonstrated reliability and validity.

The responses to each question item were captured on the 5-point Lickert scale, ranging from 1 (very satisfied) to 5 (very dissatisfied). Information filled out in the questionnaires included socio-demographic data, information relating to employee benefits, personal development, organisational benefits, and level of satisfaction with the current job and possibility of leaving current job.

The procedure for conducting the survey was essentially the same in all 20 health facilities where an entry meeting with the hospital staff was held on arrival – this coincided with a monthly staff meeting in about 17 out of the 20 facilities; for the rest, an emergency meeting for all staff of the facility was convened. The questionnaires were distributed to the participants during the meeting by the researcher – filling out of the questionnaire lasted 15-20 minutes in most instances, after which the completed questionnaires were collected and put into a secure box. Refreshments were shared with all staff present and the researcher left each health facility with all of the completed questionnaires. The time spent in each facility was about one hour.

### **3.5 Data analysis**

All the questionnaires that were correctly and adequately completed were characterised according to the different categories of health care worker and analysed using the Epi Info v3.1 software for data entry, validation, cleaning and analysis. The questionnaire was loaded

into the form designer after which all the information collected was used to populate the data table in the project.

Information on socio-demographic characteristics (age, sex, level of education, number of years spent working and area of specialisation) and factors that affect job satisfaction in the following areas: employee compensation, institutional factors and personal development, were captured in an excel sheet. The excel sheet was then exported into the Epi Info v3.1 software by creating directories in the software using the form designed to fill the values for the sub-units in the questionnaire, while the data from the questionnaire was entered on one page. All calculations were performed using the check code. Data was analysed using frequencies and percentages for each of the discrete categorical variables to describe basic patient demographic information, plus the responses to the other factors that contribute to job satisfaction. The data collected were presented as frequencies and percentages.

### **3.6 Validity**

Validity of the study was enhanced by minimizing interviewer bias and recall bias. To minimise recall bias, the questions were framed such that answers would not require information that dated back over a long period of time.

To minimise selection bias, two staged sampling was used to select the sample to be included in the study. Efforts were also made to do the sample selection based on the proportion of the various cadres of health care workers in the total population. Out of 180 questionnaires distributed, 156 were correctly completed and handed in.

To minimise interviewer bias, a self-administered questionnaire was employed to enable respondents to provide answers based on their assessment of the questions.

Information bias was minimised by framing questions so that participants would easily understand and provide appropriate answers. The questionnaire was pretested so that poorly worded, ambiguous questions were addressed and corrected before the main study was carried out.

### **3.7 Reliability**



In order to improve reliability, a standardised pretested survey questionnaire based on the Minnesota Job Satisfaction Index was adapted and used for data extraction. The questionnaire was administered solely by the researcher in all but 3 out of the proposed 20 health facilities to aid consistency. This tool was pretested by selecting 5% of respondents (10 participants) to test the tool in order to improve and refine it if necessary. The questionnaire was administered to the health care workers who were able to understand and complete the questionnaire once it was explained to them. They did not have challenges with any of the survey questions; so there was no need to modify any of the questions. This ensured consistency in data collection and minimised errors.

### **3.8 Ethics considerations**

The study did not violate or deviate from the ethics guidelines as set out in The International Ethical Guidelines for Biomedical Research involving Human Subjects and World Medical Association Declaration of Helsinki as prepared by the Council for International Organisations of Medical Sciences (CIOMS) in collaboration with World Health Organization (WHO, 2000; WMA, 2000). An application for ethics approval was submitted to the UWC Senate Research Committee and permission for the study was sought from the Federal Capital Development Authority.

Information about the study's aim, objectives and data security was provided to each willing participant before the administration of the questionnaires (Appendix 1A). Participation in this study was absolutely voluntary and participants were informed that they were free to withdraw at any point if they felt uncomfortable with any aspect of the study. Participants were also informed about the utilisation of the research findings especially regarding the dissemination of study results. Participants were further assured of the confidentiality of the information that was collected and that this information would be used purely for the purposes of research.

Participants who indicated interest in participating in the study were required to provide written consent prior to the administration of the questionnaires (Appendix 2A).





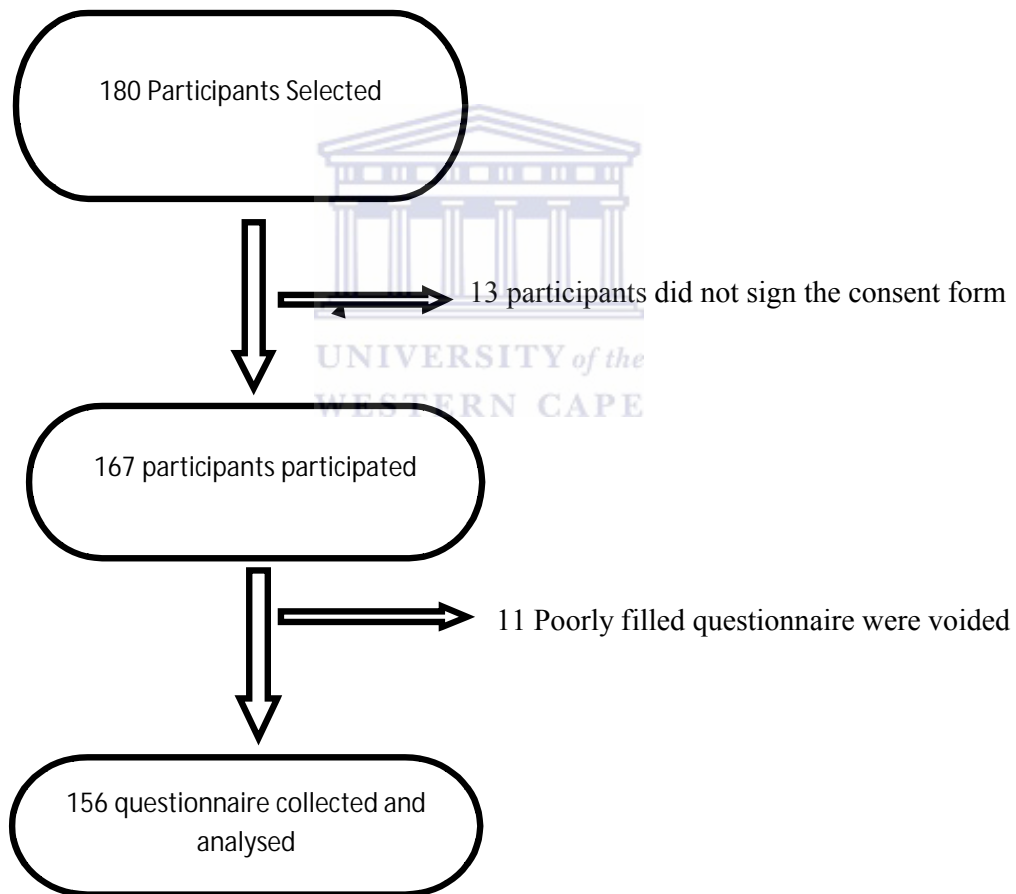
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## CHAPTER FOUR

### RESULTS

#### 4.1 Description of study participants

Out of 180 participants selected for the study, 156 (87%) of the respondents completed the questionnaires correctly, 11 (6%) were voided due to incompleteness and the remaining 13 (7%) did not sign the consent form so could not participate in the survey.



**Figure 4.1:** Realisation of sample

Table 4.1 shows that most (60.3%) 94 of the respondents were male. Most respondents (70.5%) were between the ages of 31-50 years; with 15.4% and 14.1% between 18-30 years and 51 years and older, respectively. The mean of the age of the respondents was 37.7 (SD = 6.1) years with the median age at 34 years.

Just over half (51.9%) of the respondents obtained a diploma certificate as their highest qualification, with 30.2% having obtained a first degree and 17.9% an advanced degree.

The table also shows that 42.9% of the respondents have been worked in the primary health care centre for 1-5 years, 22.4% have worked for between 6 and 10 years, 20.5% (32) have been working there for between 16-20 years and the remaining 10.3% (16) have been working in the health facility for 11-15 years.

Information on the respondents' area of specialisation is also presented in the table 4.1: (40.4%) were nurses, 24.3% laboratory workers, 21.2% doctors and 14.1% pharmacists.

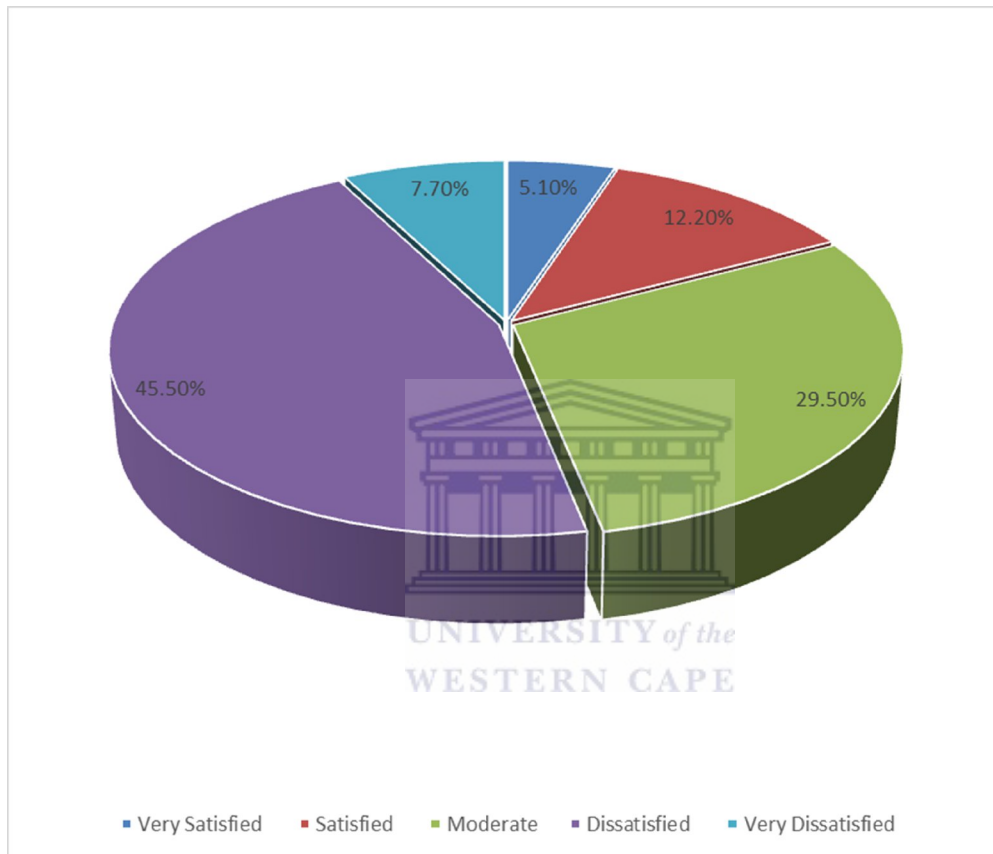


**Table 4.1:** *Socio-demographic characteristics of the respondents (N = 156)*

	<b>Frequency</b>	<b>(%)</b>
<b>Sex</b>		
Male	94	(60.3)
Female	32	(39.7)
<b>Age (in years)</b>		
18-30	24	(15.4)
31-50	110	(70.5)
51 and older	22	(14.1)
<b>Level of Education</b>		
Diploma	81	(51.9)
First Degree	47	(30.2)
Advanced Degree	28	(17.9)
<b>Number of years worked</b>		
1-5	67	(42.9)
6-10	35	(22.4)
11-15	16	(10.3)
16-20	32	(20.5)
>20	6	(3.9)
<b>Health Profession</b>		
Doctor	33	(21.2)
Nurse	63	(40.4)
Pharmacist	22	(14.1)
Laboratory	38	(24.3)

#### 4.2 Levels of job satisfaction

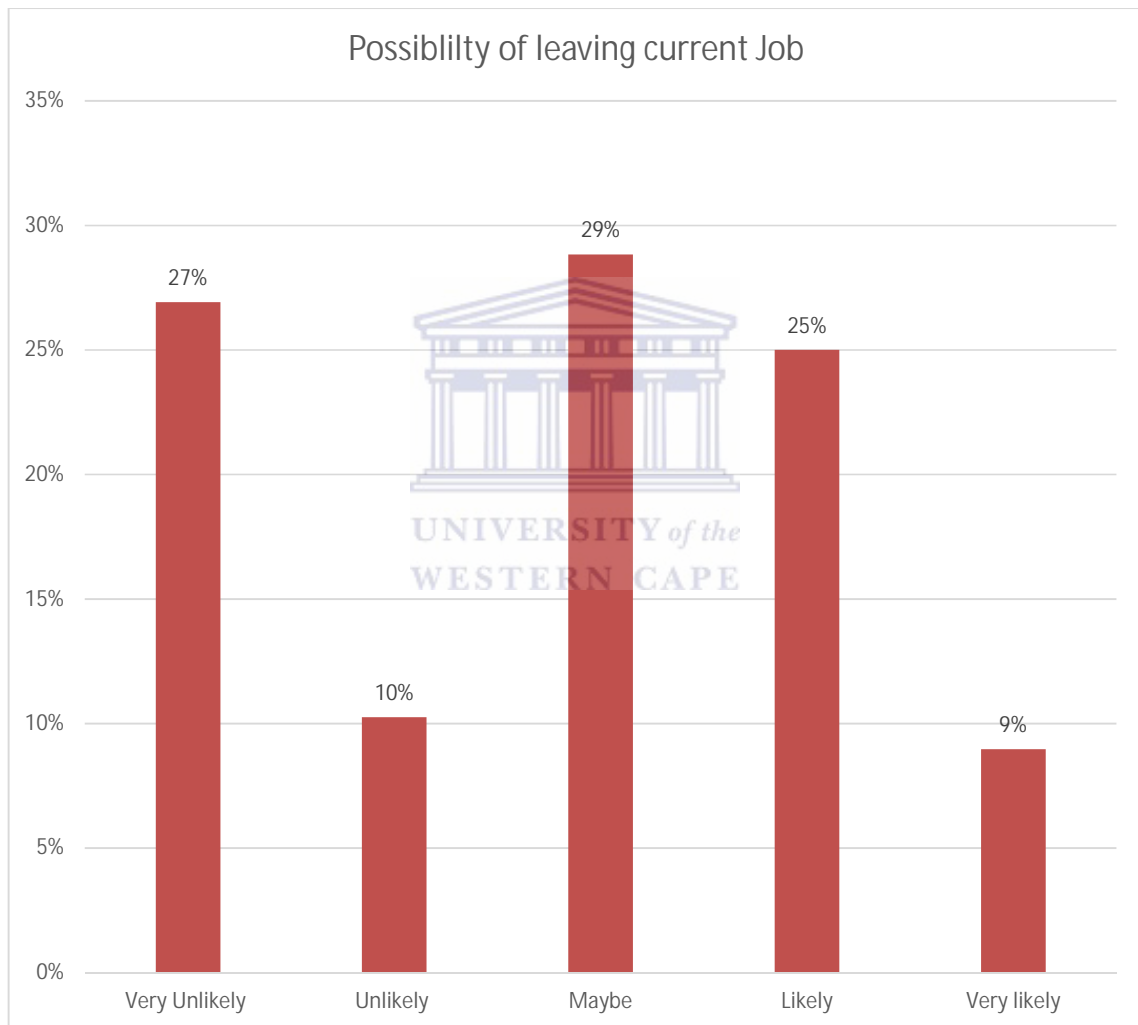
Figure 4.2 below reveals that more than half of the respondents (53.2%) were dissatisfied with their jobs and the remaining 46.8% were satisfied with their current jobs.



**Figure 4.2:** Overall Job satisfaction levels

#### 4.2.1 Intention to leave current job

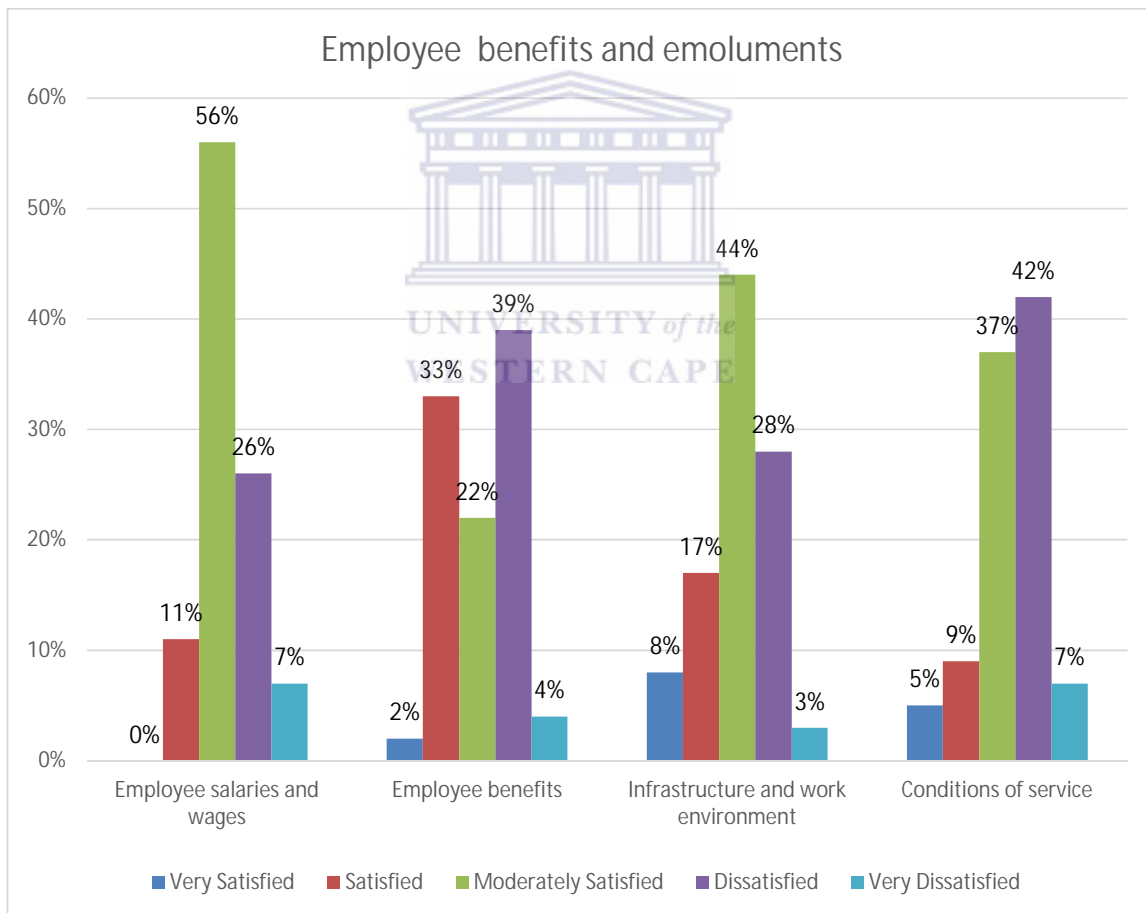
Figure 4.3 shows the results from the respondents when asked about the possibility of leaving their current job: The majority of respondents 62.2% (97) said that there was the possibility that they would leave their current job while the remaining 37.8% (59) indicated that they were not likely to leave their current jobs.



**Figure 4.3:** Possibility of leaving current job

#### 4.2.2 Employee benefits and compensation emolument

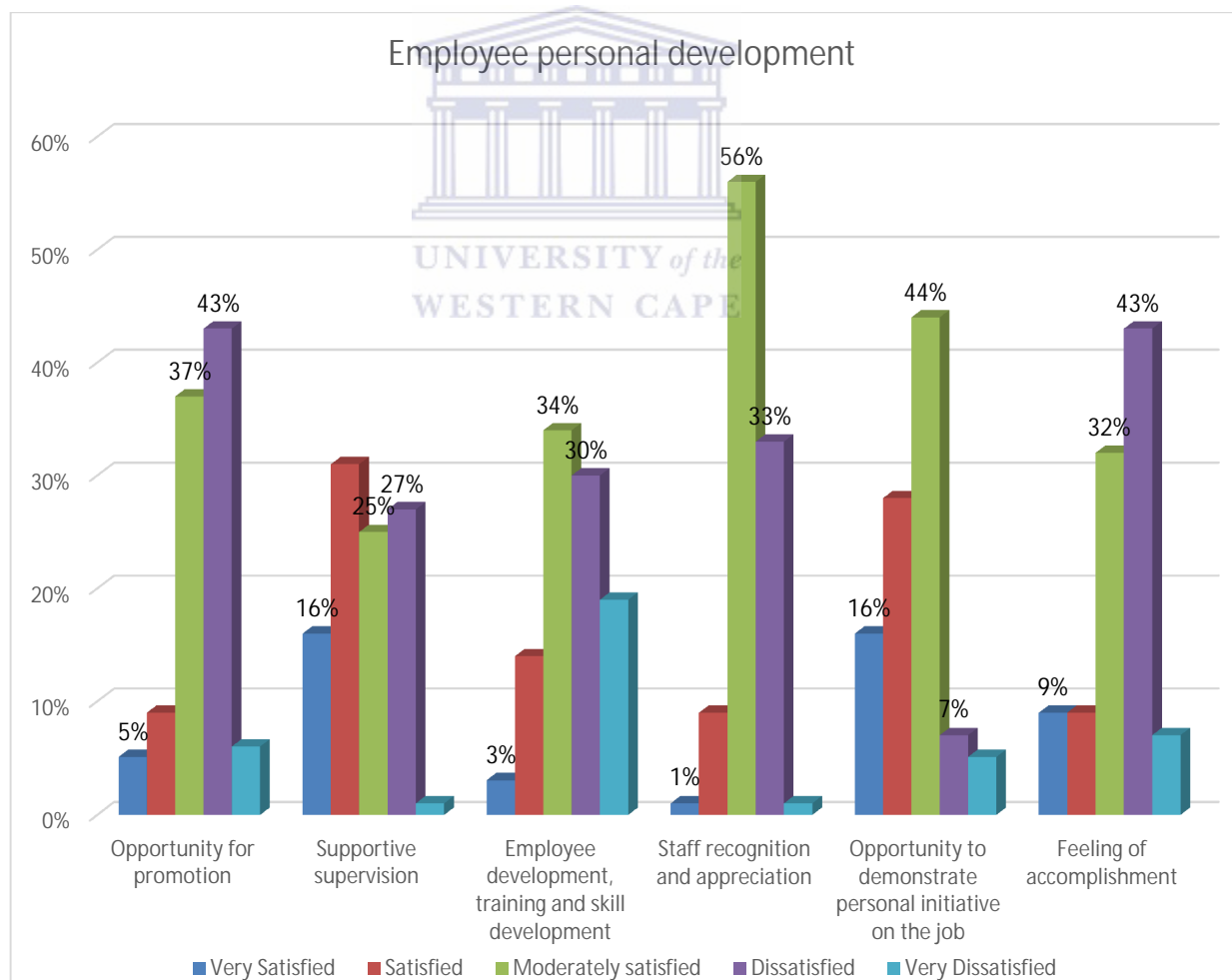
As illustrated in Figure 4.4, more than a quarter of them 33% were dissatisfied with salaries and wages while 67% of them were satisfied to varying degrees. Regarding the employee benefits, more than half of the respondents 57% were satisfied while 43% reported that they were dissatisfied. Concerning infrastructure in the health care facilities, more than half 61% of them reported that they were satisfied though more than a quarter 39% of the study population were not satisfied. With regards to conditions of service, slightly over half of the respondents 51% of them reported that they were satisfied, while the remaining 49% reported that they were dissatisfied. For Employee salaries and wages,



**Figure 4.4:** Employee benefits and emoluments as they affect job satisfaction

### 4.2.3 Employee personal development

Figure 4.5 shows that respondents were satisfied to varying degrees with various aspects of employee personal development. Regarding opportunities for promotion, just a little over half of the respondents 51% were satisfied while the remaining less than half 49% were dissatisfied. In the area of supportive supervision, about three quarters of the respondents 72% said they were satisfied and a little over a quarter 28% reported that they were dissatisfied. For employee development and training, slightly over half 51% of the respondents said they were satisfied while the remaining 49% said they were dissatisfied. In the area of staff recognition, more than half of the respondents 66% were satisfied with while the remaining 34% were not satisfied. Half of the respondents (50%) said they had a feeling of accomplishment on the job while the remaining 50% said they did not have a feeling of accomplishment while performing their jobs

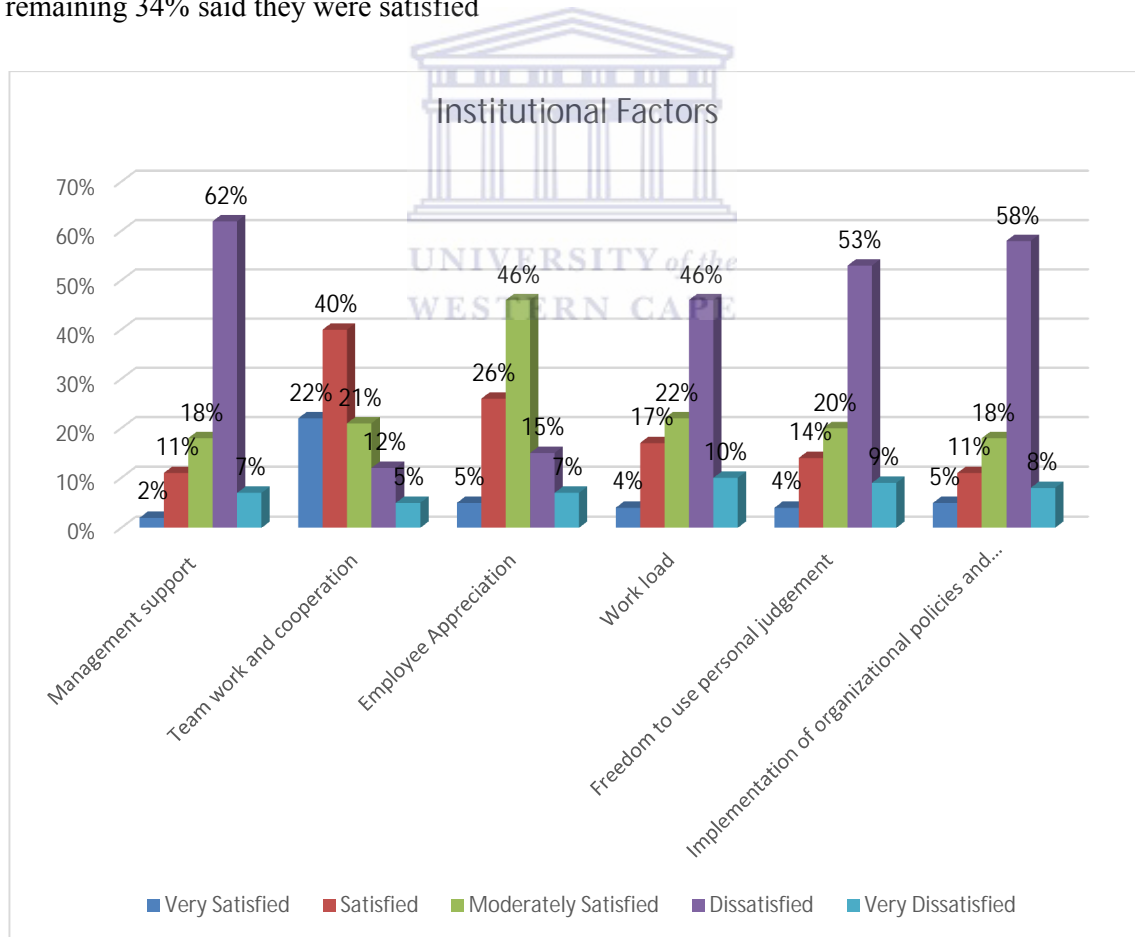


**Figure 4.5:** Employee personal development



#### 4.2.4 Institutional Factors

Figure 4.6 shows a summary of the survey results of the health care workers on their satisfaction on various factors regarding the culture of an organisation. More than half of the workers 63% felt dissatisfied with management support while 37% felt satisfied. Over three quarters of respondents 83% felt satisfied with team work and cooperation and less than a quarter 17% were dissatisfied with team work and cooperation. In the results for Employee appreciation about three quarters 78% of the respondents were satisfied while the remaining 22% were dissatisfied. The employee work load results show that more than half of the respondents 56% were dissatisfied while 44% said they were satisfied. More than half of the respondents 62% said they were dissatisfied with the freedom to use personal judgement on the job and the remaining 38% said they were satisfied. Regarding implementation of policies and procedures, more than half of the respondents 66% said they were dissatisfied and the remaining 34% said they were satisfied



**Figure 4.6:** Factors that reflect institutional factors

#### *4.2.5 Relationship between gender, age, salaries and wages, employee development and job satisfaction*

In this analysis shown in Table 4.2 which follows, there was no difference in the level of job satisfaction between men and women in the study. Among the respondents aged 18-30 years and those between 51-65 years, none of them were satisfied with their jobs, respondents between 31-50 years, 18% (27) of them were satisfied. Of those aged between 18-30 years 15% (24) were satisfied with their jobs. Statistically there is a significant relationship between the two variables (age and job satisfaction) since the p-value is (0.02) which is less than the standard p-value of 0.05.

The table also shows a significant relationship between employee salaries/wages and level of satisfaction with the current job. Most of the respondents 93.4% (114) , who were very dissatisfied with their salary/wages, also indicated dissatisfaction with their current job. However 8 (6.6%) of the respondents said that they were dissatisfied with their wages and salaries while expressing satisfaction with their jobs. The table also illustrates the relationship between employee development and satisfaction with the current job. Most 81.1% or 103) respondents who were dissatisfied with employee development were also dissatisfied with their current jobs; while 18.9% (41) respondents of who were dissatisfied with employee development were satisfied with their current jobs.

**Table 4.2:** Relationship between Gender, age, salaries and wages, employee development and job satisfaction

Variable	Satisfaction with Job				P-Value
	Yes		No		
	n	(%)	n	(%)	
<b>Age (Years)</b>					
18-30	0	(0)	24	(15)	0.02285*
31-50	27	(18)	81	(52)	
51-65	0	(0)	22	(14)	
>65	0	(0)	2	(1)	
<b>Gender</b>					
Male	50	(28)	44	(28)	0.996646
Female	33	(21)	29	(23)	
<b>Satisfaction with Wages</b>					
Yes	8	(5)	114	(73)	0.81234
No	20	(13)	14	(9)	
<b>Satisfaction with Employee Development</b>					
Yes	29	(17)	3	(1)	0.271992
No	16	(10)	108	(72)	

*4.2.6 Relationship between gender, age, salaries and wages, conditions of service and likelihood of leaving current employment.*

In the following Table 4.3, the relationship between gender, age, salaries and wages, conditions of service and the likelihood of leaving current employment is summarised.

A few 10% female respondents indicated that they were unlikely to leave their jobs which is a similar trend to 10% (16) of males. This association is not statistically significant ( $p = 0.81$ ).

All the respondents aged between 18-30 years, and 51-65 years indicated that they were unlikely to leave their current job, which is a different scenario when compared to workers aged between 31-50 years, where about one quarter 24% of them indicated they were likely to leave. This association is statistically significant ( $p = 0.00001$ ).

The table also shows the relationship between employee salaries/wages and the possibility of the health care workers leaving their current job. Less than half 42% of the respondents, who indicated that they were dissatisfied with their salary/wages said they were likely to leave their current job, as compared to 36% of the respondents who responded that they were satisfied with their salary/wages and were not likely to leave their current employment ( $p=0.81$ ).

There is no statistically significant relationship between the conditions of services and intention to leave ( $p= 0.05$ ) as only 9% (16) of the respondents who were dissatisfied with the condition of service said that they were likely to leave as compared to 26% (39) who were dissatisfied with the conditions of service and were not likely to leave their job.

**Table 4.3:** Relationship between gender, age, salaries and wages, conditions of service and likelihood of leaving current employment

Variable	Likely to leave				P-value
	Yes		No		
	n	(%)	n	(%)	
<b>Age (Years)</b>					
18-30	24	(12)	0	(0)	<0.00001
31-50	37	(24)	71	(49)	
51-65	22	(15)	0	(0)	
>65	2	(1)	0	(0)	
<b>Gender</b>					
Male	78	(50)	16	(10)	0.816251
Female	54	(37)	10	(3)	
<b>Satisfied with wages</b>					
Yes	18	(12)	56	(36)	0.810974
No	65	(42)	17	(10)	
<b>Satisfied with conditions of service</b>					
Yes	85	(54)	39	(26)	0.05023
No	16	(9)	16	(11)	

## **CHAPTER 5**

### **DISCUSSION**

#### **5.1 Summary of findings**

The findings of this study indicate that the proportion of respondents who are dissatisfied with their job is greater than the percentage of those who were satisfied. While the doctors were very satisfied with a few aspects of their job, overall, they enjoyed only a moderate level of job satisfaction. These findings are in line with the survey carried out among doctors at the University of Benin Teaching Hospital to assess job satisfaction among doctors (Ofili et al., 2006).

Several noteworthy points emerged from the results (see the tabulated figures in chapter 4). First, a person can be relatively satisfied with some aspect of his or her job and dissatisfied with others, either because they fail to fulfil his or her needs and values or because they do not meet his or her expectations. Second, there is a clear need for improving management, workload, promotion opportunities, and organisational structure, working conditions as well as pay and benefits in the future, as there was clear dissatisfaction with these aspects.

#### **5.2 Factors affecting job satisfaction**

##### *5.2.1 Salaries, wages and job satisfaction*

Reward is a strong predictor of employee retention and turnover intentions as argued by many scholars. This theory is supported by the results of this study where a significant number showed that they were not satisfied with the remuneration and other emoluments. The proportion of those who are happy with the reward system of the organisation is more likely to be satisfied with their jobs. As scholars argue (Slugoski, 2000; Samuel & Chipunza, 2013; Mobley, 1982), remuneration is a motivating factor for employees in organisations and serves as a basis upon which individual employees assess the value their employer places on them. Employees whose salaries fall short of the prevailing wages in the market may feel

undervalued by their current employers and may end up looking for an employer that will pay them what they feel they are worth.

Money rewards are multi-complex and multi-sided job satisfaction factors. Money not only gives people an opportunity to satisfy their primary needs, but also fosters satisfaction of higher levels needs. At the same time, those who make more money are not much more satisfied than those who make considerably less. Moreover, relatively well-paid samples of individuals are only trivially more satisfied than relatively poorly paid samples (Judge et al., 2001). As we found in this study, the greatest dissatisfaction lay in payments and benefits. This finding is similar to those other studies done among nurses in 2006 to establish the highest motivation for job satisfaction (Castle et al., 2006).

### *5.2.2 Infrastructure, work environment and job satisfaction*

The results of the study carried out show that work environment has an influence on job satisfaction among healthcare workers. Almost three quarters 71.2% of the respondents do not feel that their environment is duly equipped to meet their needs since some of the hospitals do not have basic infrastructure like a tables and chairs for staff use, clinics are lacking in basic equipment for diagnosis, hygiene and staff safety. As a result, of lack of necessary infrastructure, the health care workers are reluctant to come to work early and in a hurry to leave even before the end of the day. Most of these staff members are regular absentees at the health facilities, as they feel ill-equipped to deal with their job demands. Managing safe and healthy work environments is another significant environmental challenge facing organisations. Good health and safety bring more benefits as healthy workers are more productive and can produce at a higher quality. According to Maslow's Hierarchy of Needs, meeting physiological needs are the first step towards job satisfaction where as long as the workplace is healthy and safe, it will create a pleasant and secure impression in employees' attitude towards work. This fundamental need seemed to have been overlooked in the scheme of things within the study setting and is of primary concern to the health care workers. Some studies indicate that stress caused by unsatisfactory work environments may play a significant role in employees' decisions to resign their jobs, in spite of enjoying the nature of their work. Closely tied to the concept of unsatisfactory work environments is the influence of employee-organisation fit in shaping turnover intentions (Mitchell et al., 2001).

### *5.2.3 Conditions of service*

Nearly 43.3% half of the respondents of the health care workers in the study have demonstrated that certain factors like the number of paid leave days, paternity leave, staff cooperative societies and access to soft loans are important where job satisfaction is to be considered. These findings were consistent with studies done in rural Vietnam comparing job satisfaction among healthcare workers in rural and urban areas (Fomba et al., 2010). These other conditions of service may not amount to much in terms of monetary value, but they tell a story of care and concern from the employers. Research also reveals that the extent to which employees identify themselves with their organisation has a positive impact on their level of satisfaction and thereby their organisational attachment and intention to stay (Blomme et al., 2008).

### *5.2.4 Area of specialisation as it relates to job satisfaction*

More than half 63.3% of the health care workers that participated in the study are doctors and nurses who are said to be the most likely to change jobs, which is consistent with a study done in a Kenyan hospital. The results showed that doctors had much higher rates of attrition, compared to clinical officers, although resignation was the predominant reason for attrition in both cadres. This finding may reflect a recent trend for doctors, who may be moving entirely away from public service rather than staying on with the dual employment opportunity (often referred to as ‘moonlighting’) that has been on the books for years (Chankova, Muchiri and Kombe, 2009).

Qualification and educational status play a significant role in attrition among health care workers as studies have documented a higher level of attrition among doctors when compared to other groups of health care workers. Results of this study showed a significant p-value greater than 0.5 which means that health care workers who had a qualification additional to their core competencies have more demands to place on the system regarding meeting their needs to keep them satisfied. In a study done in Zambia, the number of doctors in Zambia declined by 56% between 1999 and 2002 (Slavea et al., 2006). The doctors were quick to point out that the biggest motivation for improving their basic qualifications was the hope of having better opportunities and so were prepared to leave current employment as soon as other avenues opened up.



### *5.2.5 Gender considerations*

In the majority of countries, women are the primary caregivers. As women make up an increasingly large proportion of the health profession, it is important to consider the different needs of female health care workers when developing incentives (Adindu & Asuquo, 2013). As can be seen in the results, 40% of the study population were female and they are concerned about flexible and/or part-time working hours, flexible leave/vacation time, access to child care and schools, and planned career breaks, which are significant when discussing job satisfaction. With the current economic situation, more women are joining the workforce and as such, they feel that work place policies should be put in place as a matter of urgency to address this need to reduce absenteeism and the risk of attrition. A survey of 271 female general practitioners and 31 female health worker specialists in rural Australia found that 36% of general practitioners and 56% of specialists would prefer to work fewer hours (Hongoro, 2006). Results indicated that incentives to attract and retain women in rural practice include flexible practice structures, acceptance of the rural area by the doctor's family, mentoring by women doctors as well as financial and personal recognition.

### *5.2.6 Career development*

Professional development was identified by an overwhelming majority of physicians and nurses as the most critical disincentive for doctors to work in remote or rural postings. An overarching theme from all the questionnaires administered was that opportunities for career mobility and further training are currently structured to favour those working in the more urban areas, and hinder those who work in the rural population where the research took place. 85% of doctors who participated in the study describe the municipal as the best places to access specialist training, study leave or international opportunities, and the places where one has the best chance to receive mentoring from specialists and senior doctors. They had a feeling of being left out, as some of their colleagues whom they were employed with at the same time or whom they felt they were senior to on the job, had access to training by being in the private sector. Consistent with the results of this study are the results of a qualitative study of rural midwives in Australia, which illustrates that continuing professional development and an organisational culture of ongoing learning are considered to be important strategies for the retention and professionalism of midwives (Fahey, 2005). In the Pacific

region, most continuing professional development is funded by the fees which health care workers pay to professional associations. However, membership numbers of these associations are often insufficient to enable viable programmes on a regular basis.

### *5.2.7 Mentoring*

Proper supervision and management – including adequate technical support and feedback, recognition of achievements, good communication, clear roles and responsibilities, norms and codes of conduct – are critical to the performance of health systems and the quality of care. Health care workers in remote postings are very conscious of their disadvantage when it comes to receiving mentorship and this is an important source of frustration. Most feel that they have not acquired new skills beyond uncoordinated and inconsistent attempts at self-development. The health care workers feel that there is a great deal of opportunities for mentoring; but for effectiveness, the efforts need to be better structured and coordinated to have more tangible results.

Health care workers in mentoring positions also complain that excessive workload interfere significantly with the task of mentoring the younger ones. They say that even when they want to, they are handicapped regarding demonstration materials or other equipment required for actually transferring knowledge.

## **5.3 Limitations of the study**

This study suffers from some limitations and they include that, although job satisfaction measurement tools used in the survey have been validated for use in many different settings, local construct validation does not necessarily ensure direct comparability of tools for comparative research. Nevertheless, it is encouraging that measurement equivalence of job satisfaction scales has been done in other studies carried out elsewhere and found to be comparable.

The objective of this study was to assess factors affecting job satisfaction in the Federal Capital Territory, so detailed data on possible determinants, actual working conditions or remuneration was not collected in this study. This reasoning implies that the available

variables only explained a small proportion of the variation in job satisfaction in the multiple regression models. Also, like similar health care worker surveys, whether differences in expressed job satisfaction had any real impact on health care worker performance or patient care was not investigated. Further research will be required to explain adequately some of the patterns that have been observed and their significance for health service delivery needs to be investigated.

Finally, like much of the existing HRH literature, this analysis is based on cross-sectional rather than longitudinal data. As a result, actual turnover could not be measured, although there is significant empirical evidence linking job satisfaction and intention to leave employment. Cross-sectional studies may also be biased because they only capture the views of health care workers that have remained in service. More longitudinal HRH research is an urgent priority to address these limitations.



## CHAPTER 6

### CONCLUSIONS AND RECOMMENDATIONS

#### 6.1 Conclusions

Adequate human resources for health are a key requirement for reaching health goals. Quality data and accurate projection of future HRH requirements are needed to inform the health policy planning process. As previously mentioned, in researching and preparing this report, the researcher has had a unique opportunity to learn about this crucial concept. Although this study has focused on factors associated with job satisfaction within specific health care facilities, it should be noted that the results of this effort have indicated that there are some positive features within these same facilities that can be shared with other departments in the Bwari Area Council.

The health care facilities certainly have critical issues that require immediate attention. However, this report indicates that factors contributing to job satisfaction are more numerous than can be handled in the immediate or short term. This report means that Council management as a whole must continue to focus on improving the work environment as well as the safety and employee status of health care workers, which in turn will allow them to concentrate on providing the highest quality of care to the population.

Efforts to improve health care worker satisfaction must protect, promote and build upon the professional ethos of workers. These efforts entail appreciating their professionalism and addressing health care workers' professional goals such as recognition, career development and further qualification. It is important for the government to develop the work environment so that health care workers are enabled to meet personal and organisational goals. Development of work environment requires strengthening health care workers' self-efficacy by offering training and supervision, but also by ensuring the availability of essential means, materials and supplies as well as equipment and the provision of adequate working conditions that enable them to carry out their work appropriately and effectively. Governance and leadership in health must now be expressed as tangible actions that result in senior managers and policy-makers valuing and respecting health care workers. New career and incentives systems must be developed, along with better social and technical support for health care

workers. These recommendations would help to address the human resource challenges in the health sector in Nigeria and other developing countries of similar setting.

## **6.2 Recommendations**

As this study began, it was clear that there were several critical issues need to be focused on to be able to draw some clear impressions of the workings of the health care facilities. Based on the questionnaires distributed to the health care workers, plus the review of studies performed by other researchers and web-based survey, this study has been able to reach consensus on several recommendations for the department. These recommendations have been generated based on the scoring of the responses and comments received from personnel departments. The recommendations are as follows:

1. Develop a career ladder for all employees within the health care sector. This career ladder is not limited to a focus on retaining new employees but geared towards retaining quality employees that have been employed for some years. Standards for promotion should be clear to all and consistently applied.
2. Investigate methods to improve the current work schedule structure. Items to be considered: incentives for not utilising sick time, the flexibility of schedule, alternatives to the eight-hour strict schedule, additional staff, reduction of the thirty (30) month waiting period for shift bidding.
3. Develop a reward and recognition programme for all health care workers irrespective of the cadre of staff to reduce the feeling of being in an ‘animal farm’ where some employees feel that they are more equal than the others. An emphasis of this programme should include an increased presence of the administrative staff.
4. Improve the work environment, safety and employee status at each facility. Many individuals are concerned with their safety and felt that they were ill-equipped to manage their job schedules.
5. Introduce multiple incentives to make working in unattractive areas more appealing which will include more generous benefits, such as health insurance and vacation time. Other advantages may include tuition reimbursement, work flexible hours, bonuses based on

experience or length of commitment, study and recreation leaves, employment opportunities for doctors' spouses, better accommodation facilities and improvements in educational institutions for doctors' children.

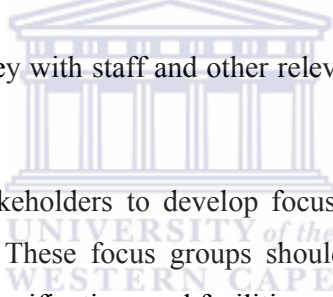
6. Ensure that training and continuing education is precisely mapped out so that the workers have a sense of direction based on an inclusive sense of need. Training curriculum should include a rotation of away training, with on-site training at the facilities based on an up-to-date education curriculum.

7. Share best practices from facilities where employees have positive staff satisfaction, as well as examine what those facilities are doing well and how it could be applied to other services. This plan includes the cataloguing and sharing of lessons learned.

8. Specifically, examine factors that contribute to the high turnover rate of temporary employees and try to provide solutions to ameliorate this situation.

9. Share the results of this survey with staff and other relevant stakeholders especially those in decision-making positions.

10. Work with the relevant stakeholders to develop focus groups in order to address the recommendations listed above. These focus groups should consist of a diverse group of individuals from differing job classifications and facilities.



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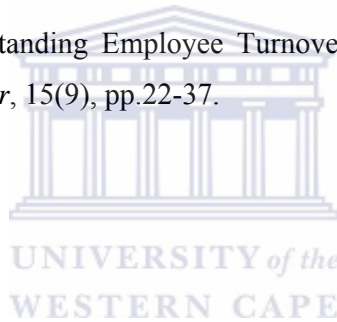
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## Appendix 1A: PARTICIPANT INFORMATION FORM



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## UNIVERSITY OF THE WESTERN CAPE

### *School of Public Health*

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### WESTERN CAPE INFORMATION SHEET

**Project Title:** Assessment of job satisfaction among health care workers in primary health centres in the Federal Capital Territory, Nigeria

#### **What is this study about?**

This is a research project being conducted by Dr. Adah-Ogoh Anne Ene, a registered MPH student at the University of the Western Cape. We are inviting you to participate in this research project because you are a member of staff at a primary health care centre in the Bwari Area Council of the Federal Capital Territory, Abuja. The purpose of this research project is to assess job satisfaction among health care workers in Primary Health care centres in the Federal Capital Territory, Nigeria.

#### **What will I be asked to do if I agree to participate?**

You will be asked to complete a self-administered questionnaire at your workplace containing information on factors affecting job satisfaction and demographic variables. This survey will take approximately 20 minutes to complete.

**Would my participation in this study be kept confidential?**

We will do our best to keep your personal information confidential. To help protect your confidentiality, the questionnaire to be filled out will be coded to protect the identity of the respondent and after respondents have completed it, they are returned to a collection box in the hall provided for collation. These are to be removed by the researcher from the venue immediately after the exercise. Only the researcher will have access to the identification key.

If we write a report or article about this research project, your identity will be protected to the maximum extent possible.

**What are the risks of this research?**

The risks of this study are minimal. These risks are similar to those you experience when disclosing work-related information to others. You may however, decline to answer any or all questions and you may terminate your involvement at any time if you choose. Your responses will be kept anonymous. Information from this research will be used solely for the purpose of this study.

**What are the benefits of this research?**

This research is not designed to help you personally, but the results may help the researcher learn more about factors affecting job satisfaction. We hope that, in the future, other people might benefit from this study through improved understanding of job satisfaction and its relationship to workforce turnover.

**Do I have to be in this research and may I stop participating at any time?**

Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalised or lose any benefits to which you otherwise qualify.

**Is any assistance available if I am negatively affected by participating in this study?**

Appropriate referrals will be made if unforeseen negative impacts arise.

**What if I have questions?**

This research is being conducted by *Dr. Adah-Ogoh Anne Ene of the School of Public Health* at the University of the Western Cape. If you have any questions about the research study itself, please contact *Dr. Adah-Ogoh Anne Ene* at: *School of Public Health* at the University of the Western Cape. E-mail address is [adahogoh@gmail.com](mailto:adahogoh@gmail.com). Telephone number is +2348173295348.

Should you have any further questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

**Director:**

Prof Helene Schneider

School of Public Health

University of the Western Cape

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[hschneider@uwc.ac.za](mailto:hschneider@uwc.ac.za)

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**Dean of the Faculty of Community and Health Sciences:**

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**This research has been approved by the University of the Western Cape's Senate Research Committee and Ethics Committee.**



**Appendix 2A: CONSENT FORM**



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**CONSENT FORM**

**Title of Research Project:** Assessment of job satisfaction among health care workers in primary health care centers in the Federal Capital Territory, Nigeria.

The study has been described to me in language that I understand and I freely and voluntarily agree to participate.

My questions about the study have been answered. I understand that my identity will not be disclosed and that I may withdraw from the study without giving a reason at any time and this will not negatively affect me in any way.

Participant's name.....

Participant's signature.....

Witness.....

Date.....



**Appendix 3: EMPLOYEE JOB SATISFACTION QUESTIONNAIRE**

**UNIVERSITY OF THE WESTERN CAPE**

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**Socio demographic data**

**Gender**

- Male
- Female



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**Age (in complete years)**

18-30 yrs	31-50yrs	51-65yrs	>65yrs

**Level of education**

WASC	Diploma	First degree	Advanced degree

**Area of specialisation**

Doctor	Nurse	Pharmacist	Laboratory



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**Number of years spent working in current health facility**

1-5yrs	6-10 yrs.	11-15yrs	16-20yrs	>20 yrs

**Factors contributing to job satisfaction**

Rate your organisation in terms of the following:

**Benefits**

	Very Satisfied (5)	Satisfied (4)	Moderate (3)	Dissatisfied (2)	Very Dissatisfied (1)
Employee salaries and wages					
Employee benefits					
Infrastructure and work environment					
Conditions of service					

**Personal Development**

	Very Satisfied (5)	Satisfied (4)	Moderate (3)	Dissatisfied (2)	Very Dissatisfied (1)
Opportunity for promotion					

Supportive supervision					
Employee development, training and skill development					
Staff recognition and appreciation					
Opportunity to demonstrate personal initiative on the job					
Feeling of accomplishment					

**Organisational Culture**

	Very Satisfied (5)	Satisfied (4)	Moderate (3)	Dissatisfied (2)	Very Dissatisfied (1)
Management support					
Team work and cooperation					
Employee appreciation					
Work load					
Freedom to use personal judgement					
Implementation of organisational policies and procedures					

**Rate your level of satisfaction with current job**

Very Satisfied (5)	Satisfied (4)	Moderate (3)	Dissatisfied (2)	Very Dissatisfied (1)
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**How likely are you to leave your current job?**

Very likely (5)	Likely (4)	Maybe (3)	Unlikely (2)	Very Unlikely (1)

