AN ASSESSMENT OF JOB SATISFACTION AMONG PRIMARY HEALTH CARE WORKERS IN RIVERS STATE, NIGERIA

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ABSTRACT

Background: Primary Health Care (PHC) is considered to be a more appropriate approach to health, and the health system, improving access to health services, as well as disease prevention. The availability and efficiency of PHC is a key determinant of the overall health and wellbeing of a people, and a useful yardstick for assessment of a nation's health system. Hence, PHC workforce are at the vanguard of essential health service delivery through direct contact with grassroots community members, within and without the health facilities, for provision of preventive, treatment, referral and follow-up health services. Poor motivation and non-retention of PHC workers weakens the health systems' ability to meet the above goals.

Aim: To assessed the job satisfaction of primary health care workers in Rivers State, Nigeria.

Methodology: The study utilized the descriptive cross-sectional design and the mixed methods of data collection. The quantitative method used semi-structured, pre-tested, self- administered questionnaires to obtain information on socio-demographic and occupational characteristics, job satisfaction, motivation, frustration, retention potentials and awareness of existing policies and incentives of respondents. The respondents which included Community Health Extension Workers (CHEW), Community Health Officers (CHO), nurses and doctors in Primary health facilities in the State, were selected using the multistage sampling method. Quantitative data was analyzed using SPSS version 20.0 software and results presented using tables and charts.

Results: A total of 378 respondents participated in the study. Nurses constituted 47.6% of the respondents, with equal proportions of CHEWs and CHOs [23.8% and 23.8% respectively] and 4.8% were doctors. The mean age of the respondents was39.8±8.1years; with 89.7% females and 10.3% males. Of all the respondents, 79.6% were married, 82% were senior cadre staff and 78.8% were Pentecostal Christians. Ikwerre, Ogoni and Kalabari had the highest distribution in ethnicity (19.3%, 14.8% and14.0% respectively). Among the respondents, 75.7% had worked for less than 7 years in their current facility while 82.9% had worked for same duration in their previous facility. Almost two third 240 (63.5%) reported that their workplace was far from their residence while 12 (3.2%) stated that it was very close. A high proportion of the respondents (78.3%) were satisfied with the general working condition in their Primary Health Care facility while 21.7% of the respondents were satisfied with the pay and promotion potentials of their work place. Notably, while 97.9% of the respondents were satisfied with their work relationships, 57.7% were satisfied with the use of their skills and abilities at their workplace and 88.1% of the respondents were satisfied with their work activities. These gave a good job satisfaction score for 88.9% of the respondents. Profession, community, distance from work and duration of work were significant factors (p < 0.05).

Conclusion: This study concluded that age, marital status, profession, and location of health facility, duration of work played vital roles in level of satisfaction of PHC workers. Hence, offering opportunities for professional advancement through training of the healthcare workers though already included in the Nigerian National Healthcare policy, should be efficiently implemented and monitored by the government and other relevant stakeholders to improve job satisfaction and in turn quality health service delivery.

Keywords: Job Satisfaction, Healthcare Workers

INTRODUCTION

Job satisfaction is a term that describes how happy or content an employee is, with his or her work.[1]It is an employee's emotional response to his/her job description, burden of work, and/or workplace conditions.[1,2]It is determined by an individual's job experience, control at work, home-work relationship, degree of work stress, and general well-being.[19]Hospice workers have been noted to perceive job satisfaction as comprising of having task significance, appropriate supervision, autonomy, routinization, non-overload, positive affectivity, good relationship with team members, distributive justice and high level of motivation to work.[3]

Primary Health Care (PHC) is considered to be a more appropriate approach to health, and the health system, improving access to health services, as well as disease prevention.[4]The availability and efficiency of PHC is a key determinant of the overall health and wellbeing of a people, and a useful yardstick for assessment of a nation's health system.[5] Like in other organizational settings where the employees constitute a key driving force, the efficiency of PHC workers(especially community health workers and midwives) is vital for the success of the globally accepted, novel philosophy and approach to health care delivery.[6]These groups of the health workforce are at the vanguard of essential

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health service delivery through direct contact with grassroots community members, within and without the health facilities, for provision of preventive, treatment, referral and follow-up health services.[5,6]

Globally, skilled health workers are in short supply with poor countries being worst hit. Many of the skilled workers often seek better opportunities in more developed countries, thus threatening the achievements of the Sustainable Development Goals (SDGs).[7] The availability of sufficient and appropriately distributed skilled health personnel especially at the PHC level, is an important determinant of the strength of a health system.[8] This is especially so in resource-poor countries, that already have weak healthcare systems with demotivated PHC workers, in the face of a high and increasing burden of communicable and non-communicable diseases.[9,10]

Primary Health Care development in Nigeria is still at its infancy. It is characterized by scarcity of human and material resources that are unevenly distributed.[11] These may lead to increased workload for the few available workers who may even be more demotivated in the face of inadequate or poor remuneration and incentives.[2] Attraction and retention of skilled staff, especially in remote PHC centres also requires understanding of the associated variables in the local setting.[12,13] The additional presence of poor workplace environment and conditions especially in rural settings with few social and other amenities, may contribute to further demotivation.[19] This contributes to poor retention of the much-needed skilled workers, with resultant brain drain, and reduced efficiency of available workers.[14] The nation's healthcare workforce therefore continues to be at risk of brain drain, with resultant weakening of the already weak health system.[9]

This study may significantly contribute to available literature, and also serve as a database for comparison with other similar and dissimilar settings. It will serve as baseline (especially in settings with paucity of data) for planning, implementation and evaluation of the requisite intervention programs and policies for improved PHC.[15] This study aimed at assessing the job satisfaction of PHC workers in Rivers State, Nigeria.

METHODOLOGY

Study Area: Rivers State is one of the six states in the south-south geopolitical region of Nigeria. From the 2006 census, the state has an estimated population of 5.18 million people consisting of about 20 distinct ethnic groups. There are four (4) largely 'urban' and nineteen (19) 'rural' local government areas spread across upland and riverine areas. Port Harcourt is the capital city and is densely populated with diverse ethnic groups. According to the Rivers state Primary Health Care Management board 2013 annual report, there are three (3) tertiary, thirty-seven (37) secondary, and about three hundred (300) PHC centres, spread across the three (3) senatorial districts of the state.[16] The over three hundred PHC centres are scattered across the twenty-three (23) local government areas (LGAs) with at least one medical officer in each PHC centre. However, with the trending regional dearth of human resources for health, the ratio of medical doctors to health centre keeps dropping due to the increasing demand for further studies, long term goals and yearning for greener pastures.[10,3] This is seen in the staff strength across the 23 LGAs which is far below the required number needed in the primary health centres (medical doctors 245, nurses 316, community health officers 138, community health extension workers 2020).[16] The study was carried out in 9 LGAs randomly selected from the 23 LGAs in the state. Thereafter, 5 Primary Health Facilities were randomly selected from each of the 9 LGAs (Obio/Akpor, Okrika, PortHarcourt city, Khana, Oyigbo, Tai,Emohua, Asari-Toru and Ogba/Egbema/ Ndoni).

Study Design: A descriptive cross-sectional design was used in conducting this study.

Study Population: All cadres of health workers in Primary Health Care facilities in Rivers state. This included doctors, nurses/midwives, Community Health Extension Workers (CHEWs), and Community Health Officers (CHOs). A minimum sample size of three hundred and seventy one(371) primary health care workers was required for the study. But a total number of **378** PHC workers were sampled for the study. The study was carried out in 9 LGAs randomly selected from the 23 LGAs in the state. Thereafter, 5 Primary Health Facilities were randomly selected from each of the 9 LGAs (Obio/Akpor, Okrika, Port Harcourt city, Khana, Oyigbo, Tai, Emohua, Asari-Toru and Ogba/Egbema / Ndoni).Written informed consent was obtained from each respondent before obtaining data from them, through self-administered questionnaires. Respondents were informed that there were no penalties or loss of benefit for refusal to participate in the study or respond to any question(s) they found uncomfortable.

Sampling Technique:
The multi-stage sampling method was used in the study. At the first stage, 3 LGAs were selected from each of the 3 senatorial districts of Rivers state (making a total of nine (9) LGAs), by simple random sampling from a frame of LGAs in each senatorial district.
In the second stage, five PHCs were selected from each of the selected LGAs (after a pre-survey mapping revealed the existing staff strength per facility), also by simple random sampling from a sampling frame of primary health centres in each of the senatorial districts, with equal allocation of the sample size amongst the forty-five (45) selected PHC facilities.

Stratified sampling proportionate to the size of the various cadres of health care workers

was then employed to select health workers from each of the selected PHCs. These cadres consisted of the CHEWs, CHOs, midwives, and doctors. Then simple random sampling was used to recruit two (2) CHEWS, two (2) CHOs, and four (4) midwives, from the nominal roll of each of the selected facilities; and two (2) doctors randomly selected by balloting from a list of 5 PHC facilities in each of the 9 LGAs. This yielded a total of ninety (90) CHEWs, ninety (90) CHOs, one hundred and eighty (180) nurses/midwives, and eighteen (18) doctors sampled from all the forty-five (45) selected facilities.

Study Instruments:
This study used the quantitative method of data collection using semi structured questionnaires.

Assessment of Level of Job Satisfaction: Job satisfaction was divided into five domains: the general working conditions, pay and promotions potentials, work relationships, use of skills and abilities and work activities. The responses were scored as follows: Very dissatisfied = 1; dissatisfied = 2; satisfied = 3; very satisfied = 4. The composite score for job satisfaction was calculated by summing the scores of the five domains. Minimum and maximum scores were calculated as 25 and 96. The scores were converted to percentages and graded as follows: scores below 50% were graded as dissatisfied while those 50.0% and above were graded as satisfied. The questions used in scoring their satisfaction were internally consistent and reliable with a Cronbach's alpha value of 0.823.

Ethical Considerations/Limitations of the Study:
Ethical approval for the study was sought for and obtained through the Institutional Ethics Committee of the University of Port Harcourt Teaching Hospital. Approval to carry out the study was obtained from the RSPHCMB. A written informed consent was obtained from each respondent before obtaining data from them.

The study may have been limited by bias of information provided by respondents who may have overestimated or underestimated their levels of job satisfaction. Cross-sectional studies are not the best for detecting causality, hence temporality cannot be assigned to the relationship between the variables. Questionnaires were simplified, good rapport was established, with confidentiality assured and enough time given to respond to questions. These were used to minimize this limitation.

RESULTS
Table 1: Socio-demographic characteristics of the respondents

Variable	Frequency (n = 378)	Percent
Age (years)		
20 – 24	8	2.1
25 – 29	26	6.9
30 – 34	65	17.2
35 – 39	91	24.1
40 – 44	92	24.3
45 – 49	47	12.4
50 – 54	42	11.1
$\geq$ 55	7	1.9
Sex		
Male	39	10.3
Female	339	89.7
Marital status		
Single	57	15.1
Married	301	79.6
Widowed	20	5.3
Religious denomination		
Pentecostal	298	78.8
Catholic	80	21.2
Ethnic group		
Ikwerre	73	19.3
Ogoni	56	14.8
Kalabari	53	14.0
Opobo	44	11.6
Okrika	42	11.1
Ogba	32	8.5
Etche	30	7.9
Engenni	24	6.4
Others*	24	6.4
Community		
Urban	157	41.5
Rural	221	58.5

Mean age = 39.8$\pm$8.1 years; Others* included Omoku, itsekiri, Ijaw, Urhobo, Ibani.
Mean age (Male) = 42.4$\pm$4.7 years; Mean age (Female) = 39.5$\pm$8.4 years
t = 3.248 (p = 0.002)

The age groups 40-44years, 35-39years and 30-34years had the highest number of respondents, as ninety two (24.3%) of the respondents were 40 – 44 years, 91 (24.1%) were 35 – 39 years while 65 (17.2%) were 30 – 34 years. The mean age was 39.8±8.1 years with an age range of 20 – 64 years.

Most of the respondents were females (89.7%) while 39 (10.3%) were males. Majority 301 (79.6%) were married and 57 (15.1%) were single. The commonest ethnic groups were Ikwerre (19.3%), Ogoni (14.8%) and Kalabari (14.0%).

Table 2: Occupational characteristics of the respondents

Variable	Frequency (n = 378)	Percent
Cadre		
Senior staff(> GL 6)	310	82.0
Junior staff (< GL 6)	68	18.0
Profession		
Nurse	180	47.6
CHEW	90	23.8
CHO	90	23.8
Doctor	18	4.8
Duration of work at current facility (years)		
1 – 6	286	75.7
7 – 12	60	15.9
13 – 18	17	4.5
19 – 24	4	1.1
25 – 30	11	2.8
Duration of work at previous facility (n = 257)		
1 – 6	213	82.8
7 – 12	36	14.0
13 – 18	4	1.6
≥ 18	4	1.6
Work experience		
≤6	159	42.1
7 – 12	136	36.0
13 – 18	60	15.9
19 – 24	8	2.1
25 – 30	4	1.1
≥ 31	11	2.8

Mean work experience = 8.7 ± 6.4 years; Mean work experience (Male) = 8.8±3.9 years
Mean work experience (Female) = 8.7±6.7 years
t = 0.151 (p = 0.881)

Most of the respondents 310 (82.0%) were in the senior staff cadre. Almost half of the respondents 180 (47.6%) were nurses, equal proportions of CHEWs and CHOs [90 (23.8%)] and 18(4.8%) were doctors. Majority 286 (75.7%) had worked for 1 - 6 years in their current facility and 60 (15.9%) had worked for 7 – 12 years. Looking at years of work at previous facilities, 213 (82.9%) had worked for 1 – 6 years while only 4 (1.6%) had worked for more than 18 years.

Almost two thirds 240 (63.5%) reported that their workplace was far from their residence while only 3.2% stated that it was very close.

Three hundred and five (80.7%) recalled that they use public transportation to get to work while 51 (13.5%) used private cars. Similarly 298 (78.8%) used public transportation to get home from work.

Level of Job Satisfaction among the Respondents

The level of job satisfaction of respondents was assessed using the general working conditions, pay and promotion potentials, and work relationships, opportunities to use their skills and work activities. Majority, 296 (78.3%) of the respondents were satisfied with the general working condition in the primary health care facility. There was a decreased tendency to be satisfied the general working condition with increase in age. Eighty two (21.7%) of the respondents were satisfied with the pay and promotion potentials of their work place. Three hundred and seventy (97.9%) of the respondents were satisfied with their work relationships.

Two hundred and eighteen (57.7%) of the respondents were satisfied with the use of their skills and abilities at their workplace. Most of the workers, 333 (88.1%) of the respondents were satisfied with their work activities.

Table 3: Mean satisfaction scores based on the different professions (ANOVA)

Variable	CHEW Mean (SD)	CHO Mean (SD)	Nurse Mean (SD)	Doctors Mean (SD)	F statistic	p value
General working environment	8.5 (2.4)	8.9 (1.3)	10.4 (1.1)	11.1 (1.3)	41.599	< 0.001*
Pay and promotion potential	7.8 (2.1)	8.1 (2.0)	9.5 (2.0)	9.4 (2.3)	18.181	< 0.001*
Work relationships	14.1 (2.1)	15.1 (2.5)	15.3 (1.0)	15.1 (0.7)	9.101	< 0.001*
Use of skills and abilities	10.8 (2.2)	11.2 (1.9)	11.4 (2.1)	9.4 (2.4)	5.341	0.001*
Work activities	12.4 (3.3)	13.4 (1.7)	13.7 (1.5)	13.3 (1.1)	7.042	< 0.001*

The differences in mean satisfaction scores between professions were statistically significant. Based on the general working conditions, doctors had the highest mean satisfaction score of 11.1 compared to the other professions. Considering satisfaction with pay and promotion potential, nurses had the highest mean score of 9.5. On the mean satisfaction score on use of skills and abilities among the professions, doctors had the least score of 9.4. Generally nurses had the highest mean job satisfaction scores.

Figure 1: Respondents Composite Job Satisfaction score
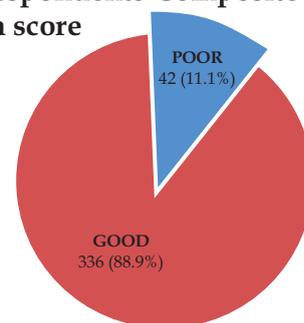
Most, 336 (88.9%) of the respondents had good job satisfaction scores while 42 (11.1%) had poor scores.

Table 4: Socio-Demographic characteristics and the job satisfaction of the respondents

Variable	Satisfaction			Test statistic	p value
	Poor n (%)	Good n (%)	Total n (%)		
Age (years)					
20 – 24	4 (50.0)	4 (50.0)	8 (100.0)	Fisher's exact =	<0.001*
25 – 29	0 (0.0)	26 (100.0)	26 (100.0)	34.355	
30 – 34	9 (13.8)	56 (86.2)	65 (100.0)		
35 – 39	17 (18.7)	74 (81.3)	91 (100.0)		
40 – 44	0 (0.0)	92 (100.0)	92 (100.0)		
45 – 49	7 (14.9)	40 (85.1)	47 (100.0)		
50 – 54	5 (11.9)	37 (88.1)	42 (100.0)		
≥ 55	0 (0.0)	7 (100.0)	7 (100.0)		
Pearson Correlation Coefficient (r) = 0.088 (p = 0.087)					
Sex					
Male	7 (17.9)	32 (82.1)	39 (100.0)	Fisher's exact =	0.175
Female	35 (10.3)	304 (89.7)	339 (100.0)	2.059	
Profession					
CHEW	28 (31.1)	62 (68.9)	90 (100.0)	$\chi^2 = 63.000$	< 0.001*
CHO	14 (15.6)	76 (84.4)	90 (100.0)		
Nurse	0 (0.0)	180 (100.0)	180 (100.0)		
Doctor	0 (0.0)	18 (100.0)	18 (100.0)		
Community					
Urban	3 (1.9)	154 (98.1)	157 (100.0)	$\chi^2 = 23.014$	< 0.001*
Rural	39 (17.6)	182 (82.4)	221 (100.0)		
Perceived distance of residence from work					
Very close	5 (41.7)	7 (58.3)	12 (100.0)	$\chi^2 = 18.152$	< 0.001*
Close	14 (18.2)	63 (81.8)	77 (100.0)		
Far	19 (7.9)	221 (92.1)	240 (100.0)		
Very far	4 (8.2)	45 (91.8)	49 (100.0)		
Work experience (years)					
≤ 6	8 (5.0)	151 (95.0)	159 (100.0)	Fisher's exact =	< 0.001*
7 – 12	12 (8.8)	124 (91.2)	136 (100.0)	49.221	
13 – 18	22 (36.7)	38 (63.3)	60 (100.0)		
19 – 24	0 (0.0)	8 (100.0)	8 (100.0)		
25 – 30	0 (0.0)	4 (100.0)	4 (100.0)		
≥ 31	0 (0.0)	11 (100.0)	11 (100.0)		
Pearson Correlation Coefficient (r) = -0.231 (p = 0.000)*					

Significant

There were significant relationships with age, cadre, perceived distance from work, place of residence and work experience ($p \leq 0.05$).

DISCUSSION

This descriptive cross-sectional study was carried out among primary health care workers in Rivers State. The study aimed to assess the level of job satisfaction among by Primary Health care workers and the associated socio-demographic and incentive factors. The study showed a high level of job dissatisfaction as more than half of the respondents were not satisfied. This is in line with the study done in Benin in which 54.0% were dissatisfied with their work.[62] Similar findings were obtained in Eastern Ethiopia[17] and South Africa,[18] Saudi Arabia[19] and India.[20] Another study done in Saudi Arabia reported a job satisfaction prevalence of 97.0%.[21] High levels of job satisfaction were also reported in Lao PDR[22] and Sweden.[23]

The present study analyzed satisfaction based on five domains as was done in the study in Saudi Arabia.[19] These domains included General working condition, Pay and promotion potentials, work relationships, use of skills and abilities and work activities. Considering working condition and satisfaction, more than three quarters of the respondents were satisfied with the general working condition in the primary health care facility. This was similar to the finding in studies done in Ethiopia[24] and Greece.[25]

The study also revealed that only a fifth of the health workers were satisfied with the pay and promotion potentials of their work places. This finding was similar to the study in Ogun state,[26] Nigeria, where 38.2% of the workers liked their job because of the pay. It was also similar to the study done in Iran[27] where majority were dissatisfied with their salary. Pay and income plays a huge role in how health workers derive pleasure from their job, as relatively low pay can cause dissatisfaction and loss of motivation. The same applies to emigration towards higher paying jobs.

The study also found that more of the nursing staff were satisfied with the pay and promotion potential of the PHC which was similar to findings from the study in Saudi Arabia[113NAHLA] among physicians and nurses. On the other hand, a significantly higher proportion of the doctors in this study (77.8%) were dissatisfied with their pay and promotion potential. This may be one of the reasons for the frequent strike actions by medical doctors.[28] It can also be worsened by the fact that job demands and workload of hospital doctors are on the increase, with no concomitant increase in pay.

Whether future changes in financial arrangements can decrease the level of dissatisfaction among physicians, or ultimately improve physician satisfaction,

will be an important area for future research. Similarly, the ongoing strike action by the CHEWs and CHOs at the time of the study could explain the high level of dissatisfaction with their pay and promotions seen in this study. This calls for the health-care systems to provide suitable salary and fringe benefits schemes to satisfy the workforce, in order to retain their loyalty. In contrast, this does not seem to be a problem in Australia, where there is a high level of satisfaction with pay among doctors.[29] This discrepancy may be due to differences in the economic status of Australian health-care systems.[29]

With regard to work relationship, almost all the respondents were satisfied with their work relationships. This attribute has the potential to lead to a higher job satisfaction, as it entails a work environment in which supervisors and subordinates consult together concerning job tasks and decisions.[30] In such practice environment where workers fulfill their expectations, and communication between them good, their retention potential is usually high.[30]

Concerning satisfaction with use of skills and abilities, many studies have shown that people are happier at work if they use the abilities they believe they possess.[24,31] This study showed that more than half of the respondents were dissatisfied with the use of their skills and abilities.

Based on work-family relationship, this study revealed that majority of the workers were satisfied with the effect of work on their family life and also their work activities. Job satisfaction is adversely affected when a worker experiences conflicting demands from his work and family situation.

Cumulatively, doctors had poor job satisfaction scores compared with the CHOs and CHEWs. This is also similar to the study done in Kano, Nigeria.[28] However, job satisfaction may increase if healthcare

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workers experienced more opportunities to advance their careers, team spirit, and better supervision. These would culminate in high retention potential among them thus ensuring a consistent healthcare workforce.

CONCLUSION

This study has shown that primary health workers in the study area had a poor level of job satisfaction. The workers' profession, cadre, sex, work experience and distance from residence were the statistically significant factors influencing it.

RECOMMENDATIONS

The following recommendations were made based on the study findings:

1. Providing local financial and non-financial incentives: attraction and retention allowance for both rural and urban communities, transportation allowance, accommodation allowance and others. Special allowances schemes (hardship allowances) should be instituted especially for doctors to remain in rural areas.

2. The positive and highly significant effect of working condition implies that primary health care managers should pay particular attention to creating enabling opportunities for career advancement of Primary Healthcare workers; provide adequate equipment for working to improve the use their skills and abilities.

3. The facility should encourage its members to attend seminars and workshops on better administrative skills, towards improving work relationships especially the senior cadre.

4. In-service training courses and attendance of scientific conferences should be intensified and encouraged for all PHC staff in order to improve their professional knowledge and skills, obtain higher levels of satisfaction and better opportunities for promotion.

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