Revue Africaine de Médecine et de Santé Publique

Article original **e-ISSN : 2617-5746** **p-ISSN: 2617-5738**

Job satisfaction among nurses in area hospitals of Djidja and Covè: Determinants and development of intervention in 2021 in Benin.

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Abstract

In Benin, nurses complain of insufficient job satisfaction. This study is the third part of a mixed research project. The aim of this article was to develop an intervention to improve nurses' job satisfaction. Participatory action research with intervention mapping was carried out in 2021. Purposive sampling was used. Interviews and panel discussions were held with 40 participants, nurses and administrative staff from the Djidja and Covè area hospitals. A number of internal factors contributed to the nurses' job satisfaction. However, external factors also militated in favor of insufficient job satisfaction among nurses. This confirms the results of quantitative evaluation of nurses' job satisfaction, in line with a number of authors. The panelists agreed on a major workshop and satisfaction improvement program. They agreed on quantified objectives, a logic model, terms of reference, a logical framework and an evaluation plan. Participants also agreed on the development of nursing work management tools. The determinants of nurses' job satisfaction are examined in depth, some of which are confirmed, also confirming a lack of job satisfaction. The workshop will focus on three interventions selected from the literature, merged and adapted by the participants. None of these interventions has been tested in sub-Saharan Africa. Intervention implementation and evaluation will be the subject of future research.

Key words: Benin; Job satisfaction; Nurses; Action research; Determinants; Intervention.

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Article reçu : 12-12-2023 **Accepté** : 15-01-2024 **Publié** : 28-01-2024

Pour citer cet article : ADOGNIBO S. Gérard et al. Job satisfaction among nurses in area hospitals of Djidja and Covè: Determinants and development of intervention in 2021 in Benin. Revue de Médecine et de Santé Publique. 2024 ; 7(1) : 301 - 313.

INTRODUCTION

In Benin, nurses' work involves several tasks that increase their workload. Improved working conditions help to reduce this workload and provide better patient care [1]. Inadequate staffing levels quickly lead to burnout, resulting in insufficient job satisfaction [1]. According to Maslach (2012), burnout is one of the consequences of low job satisfaction/motivation [2]. In recent years, the closure of a large number of private health training institutions in Benin (health reforms) has increased the workload of care providers [3]. The staffing ratio recommended by the World Health Organization (WHO) is 23 doctors, nurses and midwives per 10,000 inhabitants [4]. In Benin, this ratio is 7135 inhabitants per doctor, 2648 inhabitants per nurse and 1705 inhabitants per midwife, which does not reflect WHO standards [5]. This state of affairs has been exacerbated by the inequitable distribution of staff [6]. Overall, health worker satisfaction in Benin was 22.4% [7]. Burnout among health workers in Benin was 68.3% [8]. A review with meta-analysis [9], presented effective interventions aimed at improving nurses' job satisfaction. The authors strongly recommend the implementation of these interventions in health facilities in Sub-Saharan African (SSA) countries, even if they need to be contextualized. Indeed, several studies have addressed the issue of motivation and job satisfaction among health workers. However, none of the studies specifically addressed strategies for improving job satisfaction among nurses in Benin. No interventions were carried out, let alone with the full participation of nurses, despite the fact that addressing the problem of job satisfaction is a priority for all nurses in Benin. of insufficient resources, overload and poor working conditions for nursing staff is essential to ensure quality nursing care for the population. The participation of people affected by research is important for several reasons: to ensure the internal validity of the information and the quality of the knowledge produced, but also to promote the sustainability and appropriation of the actions carried out during interventions [10]. For this reason, we felt it necessary to work with nurses from the ZS/DAA and the HZ/CoZO in Benin to develop an intervention to improve their job satisfaction. The present study is the qualitative phase and third component of a mixed doctoral study.

I. METHOD

1.1. Population and type of study

One team consisted of nursing staff, all ZS/DAA and HZ/CoZO nurses, defined as those directly or indirectly providing nursing care (e.g., unit nurses, head nurses, specialist nurses and supervisory nurses). Another team was made up of non-clinical staff defined in our research as all ZS/DAA and HZ/CoZO administration personnel providing essential services that are required to keep the hospitals running (e.g. manager and other administrative, financial, collections and maintenance

staff). Thus, the population of the Participatory Action Research (PAR) team representing the nursing staff included 103 nurses, and that of the PAR team representing the administrative staff of the zone hospitals included 14 administrative staff. Thus, we theoretically had a population of 117 subjects. A research participatory exploratory action, with intervention mapping was carried out. Action research is justified by direct contact with the field and reality [11]. It is based on qualitative analysis (interviews, observation, focus groups, case studies) [12]. Intervention Mapping is a framework based on the ecological model, which suggests taking into account the individual and environmental determinants of health problems in order to develop effective interventions [13].

1.2. Sampling and sample

We carried out purposive sampling by maximum variation. The reasoned choice is justified by the fact that nurses are the potential actors concerned by job satisfaction and who can provide us with key information [14]. The principle of maximum variation was chosen because it allows us to take into account the greatest possible diversity of the theme addressed, and to achieve a high degree of heterogeneity in a small sample size [13 - 15]. Internal and external diversification enabled us to obtain rich information from the participants selected for the research [16, 17]. As far as external diversification is concerned, characteristics such as the participant's place of practice and function are considered. As for internal diversification, it is observed by taking into account characteristics such as age and gender. Elements of internal and external diversification are recorded on a socio-demographic sheet. The saturation effect signals the end of data collection [17]. With regard to the qualitative sample, we selected a theoretical maximum of forty (40) participants. Indeed, sample size in qualitative research varies between 12 and 60 [19, 20]. Selection of participants.

a) Inclusion criteria: To be a nurse in the ZS/DAA or HZ/CoZO; to be an administrator in one of the Djidja or Covè zone hospitals; to be present at the post at the time of the survey. All nurses from the two zone hospitals were given priority in the nurse search team. A few nurses from the health centers completed the team. In fact, the results of the quantitative study on job satisfaction revealed a lack of job satisfaction among zonal hospital nurses (37.4%). The administrative staff who agreed to take part made up the administrative research team. b) Non-inclusion criterion: Administrative staff in a peripheral health center (CS); absent from the post at the time of the survey.

1.3. Data collection techniques and tools

We used individual interviews and panel discussions. The study took place at the zone hospitals throughout the second quarter of 2021, and consisted of qualitative individual interviews and panel discussions. The individual interviews and panels took place in the zone hospitals at times

convenient to all participants. Participants were recruited from the quantitative sample of nurses for the qualitative individual interviews. Zone hospital administrators were recruited to take part in the panel discussions (the two RAP teams, administrators and nurses).

a) Individual interviews

These were conducted with nursing participants from the ZS/Djidja and the HZ/CoZO. The purpose of interviews, whether free, semi-structured or structured, is to gather data on the personal aspects of individuals in relation to given situations, as emphasized by Baribeau and Royer [20, 21]. The individual interviews took place in their respective offices at times convenient to them. The semi-directive interview guide developed was inspired by the literature, validated by peers and supervisors, and tested and re-tested on three nurses and two administrative staff at Cotonou's Bethesda Hospital. These tests enabled certain questions to be readjusted.

b) Panels

Panels are made up of nurses interviewed individually, plus area hospital administrators; the Intervention Mapping (IM) method was used. The panels are based on a synthesis of the results of individual interviews, theories and interventions drawn from the literature.

- First part of IM: The needs analysis suite

Stakeholders agree on the (theoretical) formulation of the problem, including the choice of the expected distal objectives of the intervention to be developed. Intervention mapping takes place in six stages [22]. In the PRECEDE theoretical model on which the first stage (1) is based, these determinants are categorized into predisposing, facilitating and reinforcing factors according to Fernandez (2019) [22]. In the intervention mapping (IM) protocol, these determinants are linked to key concepts in social and health psychology [23].

- Second part of MI: Intervention development

The second stage (2) of the MI consisted in formulating the quantified objectives of the expected results of the intervention to be developed. This stage brought together all the RAP teams and the facilitator to formulate the objectives of the intervention to be developed. The results of stage 1 were used to formulate these objectives. The third stage (3) of the MI is the selection of intervention theories and techniques to achieve the previously formulated change objectives. The product of this third stage is the theoretical logic model of the intervention, i.e. the mechanisms by which it is supposed to achieve its objectives. This phase of intervention development has identified the theoretical methods that correspond to the determinants (step 1) and the objectives of the

intervention (step 2). The fourth stage (4) of MI involved integrating the change techniques selected in the previous stage in the form of a program logic model [22]. The selection of relevant strategies was the subject of a strengths, weaknesses, threats and opportunities (SWOT) matrix for each of them. The RAP team of nurses synthesized the information from the previous steps to determine the intervention program. The researcher prepared all the intervention versions found in the literature for the participants. The participants analyzed these interventions in the light of the results of the previous stages and the design theories, until three of them were selected by consensus. This was followed by clarification of the intervention protocol. The fifth stage (5) of MI ensured the adoption of the intervention by the various stakeholders. It is recommended to carefully consider the context of adoption of a new intervention in order to develop a strategy appropriate to the different categories of actors in the different levels of the environment [22]. The sixth step in this work was to develop an evaluation plan.

1.4. Data analysis

Qualitative data comes from individual interviews, logbooks and panels. The individual data collected is analyzed and summarized in MasQDR. This analysis consists of finding simple frequencies of positive and negative effects that contribute to satisfaction according to the various themes proposed, and highlighting poignant speeches to illustrate these statistics. In this way, the determinants of job satisfaction are explored and confirmed. All these data, the interventions identified in the literature and the design theories were analyzed and synthesized. Discussions resulted in objectives, strategies and intervention(s) to improve job satisfaction.

1.5. Quality criteria

On the one hand, four quality criteria guided this study: credibility, reliability, confirmability and transferability [13, 21] and, on the other hand, the relational criteria developed by Guba and Lincoln [24]: balance, then authenticity.

II. Results

2.1. Distribution of participants

A total of 40 nurses and administrative staff from the two different hospitals in the Djidja and Covè zones took part in the study. A total of 25 nurses took part, including 14 from the Djidja zone hospital and 11 from the Covè zone hospital. The administrative staff totalled 15 participants, including nine from the Djidja zone hospital and six from the Covè zone hospital.

2.2. Results of individual interviews

A thematic analysis revealed a number of findings concerning the determinants and discourses conducive to nurses' job satisfaction, on the one hand, and the determinants and discourses not conducive to nurses' job satisfaction, on the other.

2.2.1. Determinants and discourses conducive to job satisfaction

Participating nurses (26 nurses) from the Djidja and Covè area hospitals felt that their superiors and peers recognized the quality of their work. "Recognition of a job well done by colleagues and superiors gives me comfort and moral satisfaction" (10/26 nurses). Participating nurses (23 nurses) also recognized that administrators describe their tasks to them. "The job description guides in the benefits and mine is well in tune with what I do for a living" (8/23 nurses). The participating nurses (26 nurses) accepted the support they received from their colleagues in carrying out their tasks. "The support that other members give to their peers is a pleasure to work with" (9/26 nurses). Participating nurses (32 nurses) also acknowledged that they had received ongoing training. "Ongoing training is important in the sense that nurses need to update their knowledge, for example, to deal with new epidemics or pandemics" (32/32 nurses). Furthermore, according to the participating nurses (37 nurses), there is a good understanding between health team members. "Good collaboration between peers puts the agent at ease, a sign of understanding within the health team" (37/37 nurses). Participating nurses (25 nurses) also declared that a good image is attached to the nurse. "The fact remains that the nurse is a savior in the eyes of satisfied customers, because of the way he or she welcomes and heals patients" (25/25 nurses).

2.2.2. Determinants and discourse not conducive to job satisfaction

The participating nurses (26 nurses), from the hospitals in the Djidja and Covè zones, did, however, associate their poor material working conditions with their lack of job satisfaction. "An uncomfortable status, a derisory salary and the scarcity of bonuses and allowances are the ills from which nurses suffer" (26/26 nurses). Participating nurses (19 nurses) also associated this with poor infrastructure. "Outdated infrastructure and equipment are detrimental to quality and satisfaction" (10/19 nurses). Participating nurses (32 nurses) also strongly associated working hours, which for them are too long. "A consensual definition of working hours is worthwhile in a context of work overload" (21/32 nurses). The participating nurses (36 nurses) confided that the work they do is enormous. "A single nurse on duty in a hospital department is very inadequate, and guarantees neither quality nor satisfaction. Sometimes when you receive three road accident victims at once in an emergency, you're lost" (7/36 nurses). According to the participating nurses (27 nurses), the job also involves a wide variety of tasks. "Sometimes, it's the nurse who consults

the patient, draws up a prescription before administering care, which is also diversiform" (27/27 nurses). Finally, the participating nurses (33 nurses), felt that they are forced to stay busy all the time doing even, some tasks they don't have the skills for. "Outside of nursing, the nurse is a doctor, an accountant and an administrator all at the same time, so there is no task-skill match" (33/33 nurses).

2.3 . Panel results.

- *First panel.*

Proposed quantified objectives for intervention results were recorded, corrected and adopted by all participants, prior to the development of a logic model for intervention to improve job satisfaction.

- *Second and third panels*

The theories making up the conceptual framework guided the various panels in understanding the objectives of the intervention to be developed: a) Van Hoye's socio-ecological theory (2020): Getting all stakeholders to adhere to the implementation of the intervention; b) Watson's Human Caring philosophy, in its transpersonal relationship: Establishing good socio-professional relations and civility; c) Herzberg's theory: Making recommendations to HZ managers on working conditions; d) The logic model for our intervention was modelled on that (from Alberta Mentoring Partnership, undated).

Insert here, the logic model for a job satisfaction improvement intervention (Table 1).

- *The fourth panel*

The first three terms of reference of this program relate to interventions in the literature: Analysis of the effect of nursing management practices [24], civility in the workplace [25], evaluation of nursing effectiveness, design of a care model and research into professional roles [26]. The last six, relating to the participants' other concerns.

Insert here the logical framework for improving job satisfaction (Table 2).

III. DISCUSSION

Interventions were merged and adapted to improve nurses' job satisfaction. Effective interventions on health workers' satisfaction were mainly educational sessions, workshops [9], idem in this study. The interventions selected and adapted had been tested favorably in the work of Forget Mathieu (2017), respectively Leiter, MP, Laschinger, HKS, Day, A., & Oore, DG (2011) then,

Allen and Vitale-Nolen (2005) [25-28]. Recognition of the quality of one's work by peers and superiors, the description given of one's task, the support provided by other team members in accomplishing one's task, and ongoing training are all determinants that integrate the nursing effectiveness assessment intervention, the adoption of a care model and the search for professional roles [25]. These determinants are congruent with Herzberg's dual factor theory in their intrinsic aspects of work on the other. There are in fact three nursing paradigms that guide nursing models [26]. In particular, the patient's history should contain "current and potential changes in needs", while the care plan should contain "nursing problems and/or nursing diagnoses". These elements seem to echo more easily nursing conceptions that are part of the school of needs and, consequently, of the integration paradigm [27]. Since a model of care is "the way of According to some authors, this contributes to affirming the singularity of the nursing profession and its gradual emancipation in both clinical and academic circles [27]. The existing understanding between members of the same care service and the image that people have of the nursing profession are all determinants that militate in favor of nurses' satisfaction. They are in line with the intervention to analyze the effect of nursing management practices [28]. They are also real causes of internal motivation, with reference to Herzberg's double factor theory [29]. The transpersonal relationship of Human Carring [30] can intervene and considerably improve the relationship between agents and each other, and between agent and supervisor, in the same way as the intervention to improve social relations and civility [29]. However, the external factors that militate for nurses' lack of job satisfaction are not real determinants of motivation [29]. That is to say, if these factors were positive, they would only satisfy for a short time, leaving nurses to fall back into a lack of satisfaction/motivation. Proposals for numerical targets for intervention results were recorded. The first could incorporate a framework for the exchange of ideas. As for objectives 2, 3 and 4, no less financial resources need to be mobilized. They recommend workshop sessions to design management tools. The entire MI section incorporates discussions between nurses and managers with a view to improving the nurses' working environment [28]. All of this takes place within an inter-active socioconstructivist approach [31].

CONCLUSION

This study identified the determinants of nurses' job satisfaction and lack of it. It confirmed a lack of job satisfaction. Finally, it developed an intervention to improve nurses' job satisfaction, which it could have implemented and evaluated. The intervention is a training and design workshop. It was inspired not only by the socio-ecological theories of Van Hoye, Watson's Human Carring and Herzberg, but also by three interventions found in the literature, adapted and then integrated during panel discussions. Future research could focus on other healthcare professional

corporations, given that we know that healthcare professionals are generally less satisfied with their work.

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