Original Article

PREDICTORS OF SICKNESS ABSENCE AND JOB SATISFACTION AMONG STAFF OF A COASTAL HOSPITAL IN CALABAR, NIGERIA.

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ABSTRACT

BACKGROUND: Sickness absence can predict job satisfaction in many systems; whereas job satisfaction drives active participation in decision-making processes and is a bed-rock for effective patient care among healthcare workers.

AIM: The objectives of this study were to determine the predictors of sickness absence and job satisfaction and their relationship among staff of a hospital in Calabar, Nigeria.

METHODOLOGY: This was a cross-sectional analytic hospital-based study involving 324 healthcare workers of the University of Calabar Teaching Hospital. The study used a semi-structured pre-tested interviewer administered questionnaire, developed and standardized by the researchers. Data generated was analyzed using the Statistical Package for Social Sciences for windows version 18, descriptive and regression statistics, with the p-value set at 0.05.

RESULT: Thirty-five (10.8%) of the respondents were physicians, 42(13.0%) nurses, while non-clinician health workers constituted 55.9%. Their average age was 37.05±8.84 years with a slight preponderance of female over male (1.4:1). There were statistically significant associations between duration of sickness absence and job satisfaction (p=0.002). Following logistic regression, occupation was found as an independent predictor of job satisfaction. Participants who were non-clinician health workers, {Odds Ratio3.3; 95% Confidence interval 1.505-7.261} were significantly more likely to have job satisfaction compared with the clinicians.

CONCLUSION: The study found a high level of dis-satisfaction with the job using specific parameters in the work setting for assessment. The institution of a safety unit in the Hospital, adjustment of work schedules together with the supply of ergonomic-oriented work equipment to check discomfort at work are recommended.

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INTRODUCTION

The level of sickness absence is a ready indicator of job satisfaction in many systems, whereas job satisfaction among healthcare workers ensures optimal work management, drives active participation in decision-making processes and is a bed-rock for effective patient care. Sickness absence is a public health problem with economic consequences for individuals and the society.[1,2] It refers to all absences from work due to incapacity (illness or injury) not attributable to the work.[3,4] It might be long-termed or short-termed. Short-term sickness absence is absence from work of less than 4 weeks duration while anything more than 4weeks is termed long-term sickness absence.[5] Absence from work is recognized as a valuable predictor of disability and mortality, and a useful economic indicator for developing countries, especially in countries where employees get sick-leave allowances.[1,6]The United Kingdom National Health Services estimated that 253,206 hours was lost to sickness absence; that is, 99.[6] hours per employee in a year, while a Finnish survey found that only 80% of the theoretical working time is used for actual work.[7]In a study from South Africa, the estimated cost of sickness absence was placed at 12 billion rand per year.[8]The researcher indicated that the cost relating to absence is often under-valued, and indirect cost could surpass direct costs by as much as 200%.[8]

Sickness absence is a complex phenomenon of multi-factorial aetiology.[9]Socio-demographic factors such as: increasing age, female sex and marital status have been associated with increased sick leave.[10] Other factors like: geographical variations (such as season of the year), epidemic, inadequate health infrastructure and services, poor relationship between management and employee, have all been slated as contributing to the

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increased incidence of sickness absence.[11] Certain jobs are related to sickness absence such as employment in the health sector, educational and social sectors.[12] Health sector ranks particularly high in sickness absence in terms of both physical and psychological ill health.[9,13,14]

In Nigeria, the weak national economy in relation to the health system at this time, makes sickness absence in any sector of the economy a source of great concern.[15–19]

Researchers have also sought to understand absenteeism as an indication of psychological, medical or social adjustment to work.[20]An understanding of the process underlying sickness absence is important, since it is likely that the number of people with health conditions in the work place will rise as the days go by, for a number of reasons.[21]

With respect to the person involved, sickness absence negatively affects the individual in terms of reduced income prospects, social exclusion and reduced career opportunity.[22] It is known to be an important cause of loss in productivity and is increasingly considered to be a true measure of the health status of an employee.[23]

In examining negative working conditions as potentials for sickness absence, it has been noticed that the less satisfying a job is, the higher the sick leave frequency.[24,25] Evidence abound that a lean number of healthcare professionals / staff below a particular level would easily give rise to poor patients' management outcome.[26] The World Health Organization (WHO, 2014) indicated that there were about 60million health workers worldwide.[27] The report indicated that many of these health workers were not satisfied with their original work environments and had moved to other sites for higher pay, job satisfaction, more rewarding career opportunities, as well as for improved management qualities.[28] The massive reduction in healthcare delivery man-power in the country means therefore that the workload has increased remarkably, thus marring effectiveness and efficiency in the healthcare delivery work-force.[29]

The mental status as well as the physical and social comportment of these workers could be adversely affected by their level of job satisfaction.[30]

The main aim of this research was therefore to determine the factors that would predict job satisfaction in the University of Calabar Teaching Hospital, with the specific objectives of:

- Determining predictors of sickness absence and job satisfaction
- Determining the relationship between sickness absence and job satisfaction, and,
  Proffering intervention modalities towards the improvement of the health of the staff in this tertiary healthcare delivery institution for effective service delivery.

METHODOLOGY

This was a hospital-based cross-sectional analytic study carried out from the month of March through July 2015. The study population consisted of only our Hospital staff who access healthcare from the staff clinic. The staff clinic is domiciled in the Family Medicine out-patient clinic and offers clinical services to all staff of the University ofCalabar Teaching Hospital (UCTH), Calabar, a city located in the South-South geopolitical region of Nigeria. From the clinic register, about 150 staff are seen in the clinic every month on the average. This translates to a total of 1800 patients per annum (study population).

The study used a semi-structured pre-tested interviewer administered questionnaire, which was developed by the researchers to explore the objectives of the study. The questionnaire consisted of two sections: section A contained the socio-demographic information about the respondents, while section B contained information pertaining to sickness absence and job satisfaction.

The sample size of 317 was calculated using the single proportion formula for study population of less than 10,000; after N was gotten with the formula for population greater than 10,000 with a prevalence rate of 50%. Ten percent of the calculated sample size was added to account for attrition rate(317$\pm$31.7) totaling 348.7, which was approximated to 349. However, only 324 respondents were recruited. Some staff either declined or refused to give some salient responses in the questionnaire. The subjects were recruited by a consecutive sampling technique, where eligible subjects were registered and included in the sample frame as they present in the clinic. Subjects who were not too ill and fit into the study inclusion criteria of 18years and above and gave their consent were recruited until the sample size was reached. The study protocol was explained to each of the subjects and an informed consent was obtained from each study participant before administration of the questionnaire. Confidentiality of the study participants was assured during the study as each respondent was seen alone and the administered questionnaire was not linked to any participant.

Data generated in the course of this study was entered into the Statistical Package for Social Sciences for windows version 18 software. Logistic regression statistics was employed in testing the significance of

association between categorical variables, while other variables were summarized using descriptive statistics with the p-value set at 0.05.

Ethical approval was sought and obtained from the Health Research and Ethics Committee (HREC) of the University of Calabar Teaching Hospital, Calabar.

RESULTS

Three hundred and twenty-four (324) hospital workers participated in the study with an average age of 37.05± 8.84 years. Table 1 shows the socio-demographic profile of the participants. The ratio of junior to senior staff who participated in the study was 1:2. The South-South geo-political zone of Nigeria is predominantly Christian, hence the overwhelming representation of Christians here (309 out of 324). Non-clinician health workers (laboratory scientists, radiographers, ward orderlies and porters) constituted 55.9% of staff studied while nurses constituted 13% and doctors 10.8%. Others including staff from General administration and Personnel, constituted 20.4% of the participants. More than half (61.4%) of the study participants were married followed by 34.9% who were single. The participants were predominantly Efiks (28.7%) by tribe.

Table 1: Socio-demographic characteristics of subjects in the study

Variable	Frequency (n=324)	Percentage (100%)
Age		
21-30	86	26.5
31-40	141	43.5
41-50	72	22.2
51-60	15	4.6
61-70	10	3.2
Sex		
Male	127	39.2
Female	197	60.8
Marital Status		
Married	199	61.7
Single	113	34.9
Widowed	5	1.5
Divorced	3	0.9
Separated	4	1.0
Religion		
Christianity	309	95.4
Islam	3	0.9
Others	12	3.7
Tribe		
Efik	93	28.7
Ibibio	44	13.6
Annang	22	6.8
Qua	2	0.6
Igbo	47	14.5
Others	116	35.8
Occupation		
Non-clinical Health worker	181	55.9
Nurse	42	13.0
Physician	35	10.8
Others*	66	20.4
Designation		
Junior	108	33.3
Senior staff	216	66.7

The study found that out of the 324 participants, 61 (18.8%) had been placed on sick leave only once in the past one year, 8 (2.5%) had been on sick leave twice over the last year, 16(4.9%) had it thrice and 239 (73.8%) had not received any sick certification during the same period.

Figure 1shows the number of times the study participants were certified sick by a doctor in the past one year. Almost 60% were certified sick at least 5 times in the last one year, followed by 25.9% of participants who were certified just one time. About 1.6% were certified 4 times.

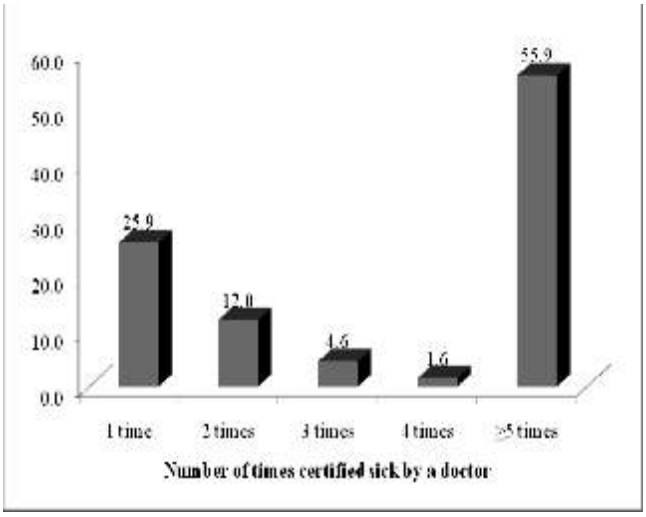

Figure 1: Number of times study participants were certified sick by a doctor in the past

Table 2 shows the relationship between sickness absence and socio-demographic characteristics of study participants. There was statistically significant relationship between sex and sickness absence. Participants who were females were significantly more likely to have sickness absence compared with those who were male (p=0.031).There was also significant relationship between tribe of respondents and sickness absence (p=0.039). However, there was no statistically significant difference between sickness absence and age group (p=0.883), occupation (p= 0.451), religion (p=0.959) and designation (p=0.153).

Table 2: Relationship between socio-demographic characteristics and sickness absence

Variable	Sickness absence		Total (n=324)	chi-square	P value
Age (years)	Yes (n=85)	No (n =239)			
21-30	21 (24.7)	65(27.3)	86(26.6)	1.170	0.883
31-40	35(41.2)	104(43.3)	139(42.7)		
41-50	22(25.9)	52(21.8)	74(22.9)		
51-60	6(7.1)	17(7.2)	23(7.2)		
	1(1.1)	1(0.4)	2(0.6)		
Sex					
Male	25(29.4)	102(42.7)	127(39.2)	4.630	0.031
Female	60(70)	137(57.3)	197(60.8)		
Occupation					
Non-clinician health worker	46(54.1)	135(56.5)	181(55.9)		
Nurse	11(12.9)	31(13.0)	42(12.9)	2.635	0.451
Physician	13(15.3)	22(9.2)	35(10.8)		
Others	15(17.3)	51(21.3)	66(20.4)		
Marital Status					
Married	57(67.1)	142 (59.5)	199(61.4)	5.750	0.219
Single	25(29.4)	88(36.8)	113(34.9)		
Widowed	0 (00)	5(2.1)	5(1.5)		
Divorces	1(1.1)	2(0.8)	3(1.0)		
Separated	2(2.4)	2(0.8)	4(1.2)		
Tribe					
Efik	27(31.8)	66(27.6)	93(28.7)	11.709	0.039
Ibibio	19(22.4)	25(10.5)	44(13.6)		
Annang	4(4.7)	18(7.5)	22(6.8)		
Efut	0(0.0)	2(0.8)	2(0.6)		
Ekoi	22(25.8)	94(39.4)	116(35.8)		
Igbo	13(15.3)	34(14.2)	47(14.5)		
Religion					
Christianity	81(95.3)	228(95.4)	309(95.4)	0.084	0.959
Islam	1(1.2)	2(0.8)	3(0.9)		
Others	3(3.5)	9(3.8)	12(3.7)		
Designation					
Junior staff	23(27.1)	85(35.6)	108(33.3)	2.041	0.153
Senior staff	62(72.9)	154(64.4)	216(66.7)		

There was no significant relationship between job satisfaction and number of times the participant was certified sick (p=0.812) and, diagnosis made by doctor (p=0.104). However, in table 3, duration of excuse duty, where applicable, was significantly related with job satisfaction (p=0.002).

Table 3: Relationship between times certified sick in past one year, diagnosis / duration of excuse duty and overall job satisfaction among participants

Variable	Job satisfaction: Satisfied	Not satisfied	Total	X^2	p-value
No of times sick					
1	54(25.2)	30(27.3)	84(26.0)	2.263	0.812
2	25(11.7)	14(12.7)	39(12.0)		
3	8(3.7)	7(6.4)	15(4.6)		
4	4(1.9)	1(0.9)	5(1.5)		
≥5	123(57.5)	58(52.7)	181(55.9)		
Diagnosis made					
Not applicable***	145(67.8)	62(56.4)	207(63.9)	9.141	0.104
Malaria	34(15.9)	18(16.4)	52(16.0)		
Hypertension	2(0.9)	5(4.6)	7(2.2)		
Low back pain	2(0.9)	1(0.9)	3(0.9)		
Others**	31(14.5)	14(21.7)	55(17.0)		
Duration of excuse					
Not applicable***	158(73.8)	81(73.7)	239(73.8)	15.293	0.002*
1day	35(16.4)	26(23.6)	61(18.8)		
2 days	5(2.3)	3(2.7)	8(2.5)		
3 days	16(7.5)	0(0.0)	16(4.9)		

*=Statistically significant;
Others** include conjunctivitis, kidney disease, diabetes mellitus
Not applicable***= Those with unconfirmed diagnosis

Table 4 shows the pattern of response to specific facets of job satisfaction together with overall satisfaction with the job. Although there appeared to have been much dis-satisfaction across all facets studied; globally, almost two-thirds of the study participants (65.4%) were satisfied with their work.

Table 4: Facets of job satisfaction among study participants

Variables	Frequency (n=324)	Percentage (%)
Work place environment		
Satisfied	123	38.0
Not satisfied	201	62.0
Work place safety		
Satisfied	84	25.9
Not satisfied	240	74.1
Salary/ allowances		
Satisfied	65	20.1
Not satisfied	259	79.9
Improving skill		
Satisfied	128	39.5
Not satisfied	196	60.5
Management/supervision		
Satisfied	152	46.6
Not satisfied	172	53.1
Work schedule		
Satisfied	251	77.5
Not satisfied	73	22.5
Overall satisfaction with job		
Satisfied	212	65.4
Not satisfied	112	34.6

In table 5, regarding the relationship of job satisfaction with socio-demographic characteristics, occupation was the only item that demonstrated statistically significant relationship with job satisfaction.

Table 5: Relationship between socio-demographic characteristics of study participants and job satisfaction

Variable	Job satisfaction: Satisfied	Not satisfied	n=324: Total	Chi -square	p-value
Sex					
Male	77(36.0)	50(45.5)	127(39.2)	2.736	0.098
Female	137(64.0)	60(54.5)	197(60.8)		
Age group/years					
21-30	58(27.1)	28(25.7)	86(26.5)	3.300	0.509
31-40	92(43.0)	46(42.2)	138(42.6)		
41-50	45(21.0)	29(26.6)	74(22.9)		
51-60	17(8.0)	6(5.5)	23(7.1)		
≥61	2(0.9)	0(0.0)	3(0.9)		
Occupation					
Non-clinician					
health worker	120(56.0)	61(55.4)	181(55.9)	13.237	0.004*
Nurse	25(11.7)	17(15.5)	42(13.0)		
Physician	16(7.5)	19(17.3)	35(10.8)		
Others**	53(24.8)	13(11.8)	66(20.3)		
Marital status					
Married	134(62.6)	65(59.1)	199(61.4)	1.329	0.856
Single	72(33.7)	41(37.3)	113(34.9)		
Widowed	4(1.9)	1(0.9)	5(1.6)		
Divorced	2(0.9)	1(0.9)	3(0.9)		
Separated	2(0.9)	2(1.8)	4(1.2)		

**others = General administration and Personnel

In table 6, logistic regression of the variables showed that health worker (non-clinical staff) was an independent predictor of job satisfaction.

Table 6: Independent Predictors of job satisfaction

Variable	Odds Ratio	95% Confidence Interval	p-value
Health worker			
Yes	3.3	1.505-7.261	0.003*
No	1		
Duration of excuse duty			
≤2 days	1.1	0.218-5.736	0.894
>2 days	1		
Having known illness			
Yes	5.9	0.000	1.000
No	1		

*=Statistically significant

The study also found (not shown in table) that being satisfied with work {Odds Ratio (OR) 0.7-1.0; 95% Confidence interval (CI) 0.376-1.325, p=0.278}, as well as, sex (OR: 0.8-1.0; 95% CI 0.453-1.520) were not independent predictors of sickness absence among study participants.

Table 7 addresses the relationship between sickness absence and job satisfaction. About two-thirds (65.9%) of the respondents who had sickness absence were not satisfied with their work environment, although this was not statistically significant (p=0.395).
The above trend was seen in almost all the other facets of the job generally, except skill improvement chances (51.2%) which differed with a statistically significant p value of p=0.048.

Table 7: Relationship between sickness absence, facets of job satisfaction and overall job satisfaction of staff at work

	Sickness Absence				
Variable n(%)	Yes(n=85) n(%)	No(n=239) N(%)	Total(N=324)	Chi -square	p-value
Satisfied with work environment?					
Yes	29(34.1)	94(39.3)	123(38.0)	0.723	0.395
No	56(65.9)	145(60.7)	201(62.0)		
Satisfied with Safety measures?					
Yes	28(32.9)	56(23.4)	84(25.9)	2.953	0.086
No	57(67.1)	183(76.6)	240(74.1)		
Satisfied with Allowance/salary?					
Yes	19(22.4)	46(19.2)	65(20.1)	0.377	0.539
No	66(77.6)	193(80.8)	259(79.9)		
Satisfied with skill improvement chances?					
Yes	41(48.8)	87(36.4)	128(39.5)	3.893	0.048*
No	44(51.2)	152(63.6)	196(60.5)		
Satisfied with issues Handling by management?					
Yes	45(52.9)	107(45.0)	152(46.9)	4.525	0.104
No	40(47.1)	132(55.0)	172(53.1)		
Satisfied with Work schedule?					
Yes	64(75.3)	187(78.2)	251(77.5)	0.312	0.576
No	21(24.7)	52(21.8)	73(22.5)		
Overall job Satisfaction?					
Yes	55(64.7)	157(65.7)	212(65.4)	2.699	0.259
No	30(35.3)	82(34.3)	112(34.6)		

*=Statistically significant

DISCUSSION

This hospital-based cross-sectional analytic research was conducted using 324 study participants to unravel the predictors of sickness absence and job satisfaction. Absenteeism has been reported to be common in the public sector in high and low resources settings.[31] Sickness absence is particularly pronounced among hospital workers probably due to the heterogeneity of work types in that system.[13] This study was carried out to obtain insight into the baseline information regarding sickness absence, job satisfaction and factors that could predict those attributes, so that preventive intervention may be recommended.

The socio-demographic characterization of the workers (table 1) showed that there were more female than male clinic attendees with a female to male ratio of 1.4:1, likely due to the known fact that women consult more frequently than men.[32]In another study, it was shown that females have better health seeking behavior than men; consequently, women are more likely to report and act on an illness than men.[33] In Nigeria, a study using self-reported absence and incorporating all hospital staff also established that women were more absent from work than men.[15] A possible explanation for this is that women seek medical help for less severe illnesses than men do and it is believed that women have different sickness culture where it is more acceptable to take sickness absence.[34]

The age range of the participants was 21-65years with an average age of 37.05± 8.84. The age bracket 31-40 years featured prominently in this study in terms of socio-demographic frequency. This age bracket appears to be the most challenging among humans in family life, being the period when young families have one firm agenda – the need to stabilize. It is certainly the age of many adventures, at which the desire to work and earn a living on a clean slate is also remarkably high. Although sickness absence is said to increase with age, younger employees had more sickness absence than older employees in this study. It is possible that older respondents who may have had chronic morbidities had their sickness absence recorded at the other specialty clinics in the Hospital and so could not be reached in this study. Younger employees are often more exposed to strenuous physical work and may have lower job control, that is, poorer working conditions, which may not allow time for them to present at the clinic when ill. However, the work by Siukula et al, did not find any relationship between age and sickness absence.[35]

There was a higher level of sickness absence among married respondents probably because of having to cope with both work and family related stress, which

may predispose them to illnesses. Besides, married employees could have been more in the study than single respondents, mainly because our Hospital Management recognizes marriage in the recruitment of stable workers.

Generally, the entire participants in the study had short-term sickness absence because the patients in the study site received treatment on out-patient basis, while those with chronic conditions requiring longer sickness absence were usually seen in the other specialty clinics where admission facilities for prolonged in-patient care were also available.

Personnel of higher cadre presented more at the clinic than junior staff, probably due to better health awareness- a recognizable attribute of higher educational attainment. That respondents of higher cadres had more sickness absences than those of junior cadres, suggests better health information and health seeking behaviour among staff of higher cadres than their junior colleagues. Administrative staff had more sickness absence certifications than clinician health workers including doctors and nurses. A possible explanation for this may be linked to the higher chances of self-medication among clinical staff of the hospital than the others.

Apart from socio-demographic characteristics, factors such as facets of job satisfaction have been found to be associated with sickness absence (table 7). This study found a significant relationship between sickness absence and satisfaction with skill improvement chances(p=0.048).In a similar study carried out in Groningen, sickness absence was found to have a significant relationship with overall job satisfaction.[28] This study also found remarkable relationship (table 7) between sickness absence and global job satisfaction (65.4%), although this was not statistically significant (p=0.259). Interestingly too, there was no significant relationship between sickness absence and many specific facets of the job. Assessing facets of job satisfaction instead of global job satisfaction might be useful in predicting workers likelihood to request for sick leave in our setting.

Furthermore, when facets of job satisfaction were explored in the current study, it was noted that more females than males subscribed to overall job satisfaction in spite of the general trend of dissatisfaction at specific levels seen in table 5. When this is taken in conjunction with the finding that the married were also more favorably disposed to admitting an overall state of job satisfaction in the midst of the apparent general apathy, it becomes more suggestive that a bio-psychosocial strut, generated possibly from a home-work commitment stand-point, may have been responsible for this development.

About two thirds (62%) of the study participants were dissatisfied with their work environment (table 4). This was different from what was obtained among public health professionals in Pakistan, where slightly less than half(49%) of the study participants were dissatisfied with their work environment.[28] Similarly, among a group of healthcare workers in Brazil, about 42.8% were not satisfied with their work environment. The commonest reason offered by them included the fact that they had small physical space.[36] Workplace environment is an important determinant of job satisfaction.[37] Many people spend a considerable part of their day in their work environment. Dissatisfaction with the work environment will therefore make the workers to feel uncomfortable and unhappy for most part of their day.

About three-quarters of the staff were dissatisfied with the safety measures at work in this study. This finding was similar to what was realized in Turkey, in which a high level of dissatisfaction with safety procedures was reported in a study of hospital workers.[38]This is not surprising as the WHO had previously shown that globally, over 59million health staff are subjected to diverse forms of health and safety hazards daily, including biological, chemical and physical hazards. Efforts geared at preventing such malady would certainly culminate in the provision of highly acceptable levels of patient care, and will, as well, engender improved staff morale and enhance productivity by mitigating time loss and absence from work.[39]

Almost eighty percent of the workers in this study were not satisfied with their remuneration in terms of salary and allowances. This was higher than what was obtained among healthcare workers in North-Eastern Nigeria, where about 50% of the staff were dissatisfied with their remuneration.[40] Similar findings were noted in a survey carried out among health workers in Uganda. In the later report, almost 90% were dissatisfied with their salaries.[41]Dissatisfaction with remuneration is a reason physicians in Nigeria are leaving for countries with better remuneration and better working conditions. It may also explain why there are incessant strikes experienced by health workers in the country.

Regarding professional development (table 4), a good percentage of the study participants (60.5%) were dissatisfied at not being given chances to improve their skills, while a smaller number (39.5%) were satisfied with chances they had in that regard. This finding was slightly lower than what was obtained in a study

among Pakistani public health professionals, where 64% of the workers were dissatisfied with their opportunities to develop their professional skills.[42] Such dissatisfaction may stem from the fact that professional development may be associated with promotion to higher ranks at work and better salaries. This facet of job satisfaction is important in our health care system as improving one's skill may mean improvement in the quality of care delivered and better health outcomes for the patients.

Dissatisfaction with the management processes in the hospital was also recorded among the participants in this study to the tune of about 53.1%. This was lower than what was obtained among health workers in Ethiopia where about 80% of the workers had varying degrees of dissatisfaction with their hospital management.[26] This level of dissatisfaction with the hospital Management may imply lack of confidence in the management of the Hospital and may affect the workers motivation to work.

A little over three-quarters of the participants (77.5%; table 4) in this study were satisfied with their work schedule. Interestingly, this was of no statistical significance as shown in table 7. Another study carried out in Pakistan among health workers, recorded on the contrary, a similar fraction but of dissatisfied workers with respect to their work schedule.[43] The work schedule on this study site was reported to be stressful because of high patient attendance with no corresponding increase in number of health workers. Also, most patients have a higher level of confidence in the Teaching Hospital where this study was carried out, hence, the high volume of patients which resulted in tight working schedule for the staff. The statistical inference at this point therefore raises a question of inconsistency.

Overall job satisfaction among study participants was 65.4% (table 4) in this study. This was similar but slightly lower than what was obtained in a hospital-based study carried out in North-East Nigeria.40 However, a lower percentage of job satisfaction was found among health care workers in Pakistan, where 41% were satisfied with their job.[43] Whereas dissatisfaction was found in almost all facets of the job, taken singly or severally in the current study; surprisingly, a higher percentage was satisfied with their jobs generally. The probable reason which hovers around home-work commitment mentioned earlier may be that these workers would not want to lose their jobs in the face of the turbulent economic terrains in our country that is associated with high rates of unemployment. Consequently, they make extra effort to accommodate their inconveniences, despite being dis-satisfied with the different facets of their job. Findings in table 5, yield credence to the need to introduce and check various parameters in the job setting, for a proper evaluation of job satisfaction. This is very important as taking a single measurement of the overall job satisfaction may produce a skewed impression of the situation.

There was an obvious relationship in the current study between sickness absence and job satisfaction, particularly considering chances of skill improvement as shown in table 7. This was in line with the study by Bernstromet al which concluded that in the presence of chances of skill acquisition and improvement, sickness absence could be related to job satisfaction.[4] Majority of the respondents in the current study who had sickness absence were not satisfied with their work environment, allowances/salary and skill improvement chances. However, these relationships was only statistically significant with skill improvement chances ($p=0.048$). Personal skill acquisition is needed for career enhancement and promotion; and so workers are always in dire need of opportunities to upgrade their skills for this reason.

The third aim of this study was to proffer intervention modalities that could be harnessed to stem the level of sickness absence and engender job satisfaction in the system studied. Doing this must take cognizance of the work environment deficiencies, inadequate safety measures, unacceptable salaries and allowances, managerial short-falls and the defective work schedules that the workers are coping with. The need to recommend the provision of ergonomic-oriented work equipment including customized chairs to check discomfort in the workplace is here therefore underlined. Creating a safety unit in the Hospital to handle matters of staff safety with the head of that unit reporting directly to the Chief Executive of the Hospital is also advised. Training and re-training of staff will make them both more competent and confident at their work, thus reducing the stress that sometimes arises from lack of technical know-how among workers. Involving every staff directly in the drawing of their work schedules, has the potential of making them feel like needed managers of their own affairs in the workplace, and so, will curtail the elements of discomfort in them regarding the appreciation of their work schedule. Management is encouraged to review the staff welfare packages, as this could boost morale and mitigate stress experienced in service, when financial rewards are difficult to optimize because of possible dwindling national fiscal returns.

LIMITATIONS OF THIS STUDY

This study was carried out among staff of the University of CalabarTeaching Hospital, Calabar,

Nigeria, that presented at the staff clinic on out-patient basis. Predictors of sickness absence with in-patients suffering from chronic illnesses with long-termed sick-leave may be different even in this Hospital, and so also could be the estimation of job satisfaction among them.

This study did not address shift work in relation to the issues taken. Shift work is a major feature of the hospital workers' health services rendering; and having to cover the 24-hour period particularly in emergencies, could be a major determinant of the pattern of sickness absence and job satisfaction among hospital workers. This is particularly important when it is recalled that humans as mammals have natural rhythmicity to many physiological functions of the body; and interruption of this circadian rhythm as occurs at the instance of loss of sleep from night duty shift and having to adjust to changes of bodily functions, tend to create chaos in the staff health status.[40] The circumstances of shift duty should admissibly have influenced sickness absence and job satisfaction if it had been studied herein.

CONCLUSION

The current study found a high level of dis-satisfaction with the job when specific parameters in the work setting were assessed. Meaningful evaluation of workers interest on the job and level of satisfaction should explore different facets of the job rather than depend on the overall or global submissions of the individual staff. Skill improvement desire among workers was found to be a very positive index of assessment of job satisfaction. Furthermore, occupation was found to be an independent predictor of job satisfaction. This finding underlines the need to accord due attention to certain occupations in terms of the provision of ergonomic-oriented tools, ambient work environments and introduction of remunerations that are tied to levels of production as well as levels of risks anticipated in such systems or units, while ensuring that needful on-the-job training and re-training of the staff is maintained.

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