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Job satisfaction and retention of midwives in rural Nigeria

A.A. Adegoke, RN, RM, BSc, MSc, PhD (Senior Technical Advisor)[a,*], F.B. Atiyaye, RN, RM, DPH (Maternal and Child Health Coordinator)[b], A.S. Abubakar, RN, RM, RNT, DPH (Formerly Midwifery Advisor)[a], A. Auta, RN, RM PHN CHO (DCH Educator, Midwifery Advisor)[a], A. Aboda, MD, MPH (Maternal Newborn and Child Health Advisor)[a]

[a] *Partnership for Reviving Routine Immunisation in Northern-Maternal Newborn and Child Health (PRRINN-MNCH), Kano, Nigeria*
[b] *Ministry of Health, Yobe State, Nigeria*

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ABSTRACT

Background: Nigeria is one of the 57 countries with a critical shortage of human resources for health, especially in remote rural areas and in northern states. The National Midwifery Service Scheme (MSS) is one approach introduced by the Government of Nigeria to address the health workforce shortage in rural areas. Since 2009, unemployed, retired and newly graduated midwives are deployed to primary health care (PHC) facilities in rural areas of Nigeria. These midwives form the mainstay of the health system at the primary health care level especially as it relates to the provision of skilled attendance at birth. This study followed up and explored the job satisfaction and retention of the MSS midwives in three Northern states of Nigeria.

Methods: this was a descriptive study. Data were collected using a mixed method approach which included a job satisfaction survey, focus group discussions (FGDs) and exit interviews to explore job satisfaction and retention factors. All 119 MSS midwives deployed by the National Primary Health Care Development Agency between 2010 and 2012 to the 51 Partnership for Reviving Routine Immunisation- Maternal and Child Health (PRRINN-MNCH) programme targeted PHC facilities were included in the study.

Results: MSS midwives were very satisfied with from the feeling of caring for women and children in the community (4.56), with the chance to help and care for others (Mean 4.50), the feeling of worthwhile accomplishment from doing the job (Mean 4.44) and the degree of respect and fair treatment they received from more senior staff and/or supervisor (Mean 4.39). MSS midwives were least satisfied with the lack of existence of a (established) career ladder (Mean 2.5), availability of promotional opportunities within the scheme (Mean 2.66), safety of accommodation (Mean 3.18), and with 'the degree to which they were fairly paid for what they contribute to the health facility' (Mean 3.41). When asked about future career plans, 38% ($n=33$) of the MSS midwives planned to leave the scheme within two years, of which 16 (18%) wanted to leave within one year. However, 39% of the midwives ($n=34$) indicated that they would be happy to continue working even after the scheme has ended. Of these 34 participants, 18 would like to continue working in the same facility where they are now whereas the remaining 16 would like to continue working in the north but not in the facility where they are working currently. Eight themes on job satisfaction and retention emerged from the FGDs conducted with current midwives, whereas six themes emerged from the exit interviews from midwives who have left the scheme.

Conclusion: the MSS programme is a short-term solution to increase SBA coverage in rural Nigeria. MSS midwives were dissatisfied with the short term contract, lack of career structure, irregular payment, poor working condition, inadequate supervision and poor accommodation being offered by the programme, which all contribute to poor retention of MSS midwives.

Implications for policy and practice: midwives' job satisfaction and retention are critical to improving the health of mothers and their newborn. Poor job satisfaction and retention therefore requires improvements in financial and non-financial incentives, health systems, supportive supervision, ensuring job security and a career structure for midwives working in rural health facilities. Initiating effective strategies to motivate and increase the retention of rural health workers is important for Nigeria to achieve the Millennium/Sustainable Development Goals.

* Corresponding author.
E-mail addresses: ade.adegoke@gmail.com (A.A. Adegoke), furerab@yahoo.com (F.B. Atiyaye), oakaisha@yahoo.com (A.S. Abubakar), amina_auta@yahoo.com (A. Auta), laditoa@gmail.com (A. Aboda).

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Background

An adequate health workforce is key to effective health services and achieving improved health outcomes (Joint Learning Initiative, 2004; Travis et al., 2004; World Health Organisation (WHO), 2006). A global estimate has indicated a shortage of at least four million health workers worldwide (Chen et al., 2004; WHO, 2006). Without significant action to address the human resource crisis in health, health systems will not be able to deliver the care required to meet the Millennium/Sustainable Development Goals (M/SDGs) by the year 2015 (Narasimhan et al., 2004). The fifth MDG (MDG 5) aims to improve maternal health and reduce maternal mortality. Progress towards the achievement of MDG 5 is monitored in part by the coverage of skilled attendance at birth.

The Skilled birth attendance strategy consists of the skilled birth attendant and the enabling environment. A skilled birth attendant (SBA) has been defined by the WHO as an accredited health professional, a midwife, nurse or doctor with midwifery skills. Midwives have however been identified as the key professional needed for the reduction of maternal mortality globally and in developing countries in particular (Chen et al., 2004; Narasimhan et al., 2004; WHO, 2006). There is however inadequate number of midwives to support the health of women and newborns with 78% of the countries facing serious shortages in the midwifery workforce that can result in avoidable maternal and newborn mortality (The State of the World's Midwifery (SoWmy), 2014). It has been noted that adequate investment in the training, deployment and retention of quality midwives could prevent more than 60% of maternal and newborn deaths (Homer et al., 2014). As a result, there has been a global call for urgent investment in high-quality midwifery to prevent maternal and newborn deaths (SoWmy, 2014).

Nigeria is one of the 57 countries experiencing critical shortage of human resources for health (WHO, 2006; Ebuehi and Campbell, 2011) and one of the 73 countries with severe shortage of midwives (SoWmy, 2014). The HRH challenge is evident by a low health provider to population ratio. In Nigeria scarce data on the availability, distribution, and trends in Human Resource for Health (HRH) has been a barrier to effective HRH planning. However, it has been established that in the Nigerian public sector there are 13 doctors, 92 nurses/midwives, and 64 community health workers per 100,000 population (Koblinsky et al., 2006). An urban Nigerian resident has a three-fold greater access to doctors and there are twice as many nurses and midwives, compared with a rural resident. Attrition rates of between 1.3% and 2.3% are highest among doctors and pharmacists, with the attrition of doctors, nurses and midwives being highest at the primary care level. This means that there are inadequate human resources for providing 24-hour health services in primary health care (PHC) facilities (Koblinsky et al., 2006). The unavailability of health workers in rural areas often leads to a delay in seeking health care and negatively impacts on service utilisation especially maternity services by women in rural areas (Koblinsky et al., 2006; Chankova et al., 2007; Uneke et al., 2008).

Maternity care in Nigeria is provided by a variety of health workers. There are total of eight different cadres of health care workers providing maternity services in Nigeria. These are: midwives, nurses, nurse–midwives, doctors, obstetricians, Community Health Officers (CHOs), Community Health Extension Workers (CHEWs) and Junior Community Health workers (JCHEWs) (Adegoke et al., 2012, 2013). The availability and retention of these cadres of health workers are therefore critical to the achievement of the SDGs.

To increase access to skilled birth attendants in rural areas, the government of Nigeria introduced the Midwifery Service Scheme (MSS) in December 2009. The aim of the MSS is to increase human resource for maternal and newborn health by deploying retired, unemployed and newly graduated midwives to PHC centres in rural Nigeria where maternal and newborn mortality and morbidity are highest (Abimbola et al., 2012). The MSS programme is implemented in collaboration with the Nursing and Midwifery Council of Nigeria (NMC), which allows newly graduated basic midwives to undertake their one year compulsory rural service as part of the scheme. The one year rural service is a compulsory programme which is a core element of the basic midwifery curriculum. To obtain midwifery licensure to practice, graduates of the three year basic midwifery programme are expected to spend one additional year in rural health facilities providing midwifery care (Adegoke et al., 2013).

MSS midwives are offered an initial two year contract with newly graduated midwives being allowed to opt out at the completion of one year mandatory NMC rural service. Other midwives (retired and unemployed) are offered initial deployment for one year renewable for the second year subject to satisfactory performance (Abimbola et al., 2012).

Since 2010, the Partnership for Reviving Routine Immunisation in Northern Nigeria–Maternal Newborn and Child Health Programme (PRRINN-MNCH) has been supporting the Nigeria government in the MSS programme through provision of induction and orientation to MSS midwives; capacity building in emergency obstetric care, focused antenatal care, postnatal care, integrated management of newborn and childhood illnesses, essential newborn care/helping babies' breath, kangaroo mother care, quality improvement and supportive supervision in three northern Nigeria states (Katsina, Yobe and Zamfara).

Although some studies have documented midwives motivation, job satisfaction and retention in developing countries (Mackintosh, 2003; Mathauer and Imhoff, 2006; Manongi et al., 2006; Manafa et al., 2009; Chhea et al., 2010; Lori et al., 2012; Mansoor et al., 2013; Wood et al., 2013), we are however unaware of any of such studies in Nigeria, despite the scarcity of midwives, particularly in northern states, and the key role midwives play in improving maternal and child survival in the country, relatively little is known about midwives' job satisfaction, retention and intention to quit.

This study therefore aimed to determine job satisfaction and identify factors that affect retention of MSS midwives deployed to rural areas of three Northern Nigeria states. This information could potentially help to formulate policies and strategies to improve midwives' retention in rural areas and improve their performance not only in Nigeria but in other countries with severe shortage of staff and low SBA availability.

Conceptual framework

Job satisfaction has been defined as a pleasurable or positive emotional state resulting from the appraisal of one's job or job experiences (Weisman and Nathanson, 1985). Job satisfaction has received a lot of research attention because of its potential effects on the behaviours and well-being of professionals (Weisman and Nathanson, 1985; Blegen, 1993). There has been considerable research on job satisfaction in nursing specifically for nurses in developed countries (Irvine and Evans, 1995; Hegney and McCarthy, 2000; Lu et al., 2005; Coomber and Barriball, 2007; Penz et al., 2008; Utriainen and Kyngas, 2009; Hayes et al., 2010; Delobelle et al., 2011) and a handful of published studies on job satisfaction among health workers in Low and Middle Income Countries (LMIC) (Bodur, 2002; Kekana et al., 2007; Kebriaei and Moteghedi, 2009; Pillay, 2009). Only a very few however have studied aspects of job satisfaction of nurses who work in PHC and in rural settings in LMIC (Manongi et al., 2006; Bester and Engelbrecht, 2009; Delobelle et al., 2011). Relatively few studies on job satisfaction and retention have focused on midwives.

Herzberg (1966) developed a 'two-factor theory' of job satisfaction. Also known as 'Herzberg's motivation-hygiene theory' and 'dual-factor theory', this theory states that there are certain factors in the work place that cause job satisfaction and another set of

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