MOTIVATION, JOB SATISFACTION AND ATTITUDES OF NURSES IN THE PUBLIC HEALTH SERVICES OF BOTSWANA

A.H. HWARA

MOTIVATION, JOB SATISFACTION AND ATTITUDES OF NURSES IN THE PUBLIC HEALTH SERVICES OF BOTSWANA

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ALBERT HILLARY HWARA

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PROMOTER: PROFESSOR E.C. STRÖH

JOINT PROMOTER: PROFESSOR F.H. SMITH

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THESIS DEDICATION

This thesis is dedicated to my beloved wife Agnes and to my three children Tapiwa, Tendai and Tinashe in their descending order of birth. I owe an enormous debt of gratitude to their tolerance of the inordinate demands on their family life perpetrated by this study programme during its currency. Their unremitting support and encouragement provided a fertile source of motivation during the whole period of the peripatetic trips from home.

DECLARATION

I declare that "**Motivation, Job Satisfaction and Attitudes of Nurses in The Public Health Services of Botswana"** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

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SIGNATURE   DATE

(Mr A. H. Hwara)

SUMMARY

The aim of the study was to investigate motivation, job satisfaction and attitudes of nurses in the public health services of Botswana. The objective was to discover how nurses felt about a wide range of variables in their work environment and ultimately to distil them into what they conceived as the mainstay motivators, job satisfiers and positive attitudes. The *non pariel* (unrivalled, unique) role of the government in creating both the hardware and the software of national health services was acknowledged and recognised with a particular reference to the primacy it placed on developing the human resources in the form of nurses, in order to realize the goals of administering the public health services efficiently and effectively. It was noted that nurses were the change agents and the axis in promoting quality standards of healthcare but in partnership with the government, which must be seen to be responsive and proactive in discharging its fiduciary responsibilities, in respect of both the content and the context of nurses' occupational ambience. For the purposes of constructing a database from which both the government and the nurses can draw, the most salient thematic details of the theories of motivation, job satisfaction and attitudes were studied and examined and were used as a scaffolding for the empirical survey of nurses.

Nine hundred questionnaires were distributed to both registered and enrolled nurses with a minimum of two years work experience in the public health sector and 702 of these were returned constituting a return rate of 78%. The findings indicated that a majority of nurses enjoyed job satisfaction in certain areas of their work namely autonomy, participating in decision-making, choice of type of nursing, change of wards or departments or work units, interpersonal relationships amongst nurses themselves and between nurses and their supervisors. Nurses also perceived the hospital as an environment in which they could continually learn and they were moreover satisfied with the nursing job or the work itself.

The other end of the spectrum revealed an overwhelming majority of 92.2% of nurses who were dissatisfied with the level of pay and 88.5% who were not happy with the fringe benefits including the provision of accommodation. Working conditions were viewed as generally disliked by 67.3% of the nurses. Low pay, workload, lack of

recognition for outstanding performance and or delayed promotional chances were singled out as being particularly disliked by 67.2%, 64.9%, 42.6% and 44.4% of the nurses respectively. Interviews held with 31 nurses yielded similar results.

The research further showed that the most important motivators to nurses were dominated by competitive salary which was mentioned by 80.9% of the respondents, attractive or sufficient working conditions which were stated by 71.2% of the nurses, opportunity for continuous education which was rated by 63.8% of the nursing candidates, reduced workload which was claimed by 59.3% of the nursing cadres, opportunity for the recognition of outstanding performance and opportunity for promotion which were scored by 54.1% and 53.4% of the nurse respectively. Job satisfiers were also represented by competitive salary which received 76.1% of the nurses' votes.   Risk allowance occupied the second position with 69.1% and competitive working conditions were awarded a third ranking by 68.2% of the nurses. Those nurses who derived job satisfaction from the fact of each nursing shift being manned by an adequate number of nurses accounted for 63.1% of the sample. Competitive fringe benefits attracted 60.1% of the nurses. Opportunity to attend workshops and the need for high morale in nursing team-work were chosen as job satisfiers by 53.7% and 49.6% of the nurses respectively.

In the section on recommendations the government was exhorted to invoke corrective or remedial measures in view of the detailed exegesis of the satisfactions and dissatisfactions in the nurses' work environment and the ensuing *problematique* (doubtful, questionable) of raising the standards of health care in the public health services. Living up to these sanguine expectations should be the cherished long-term vision of the government if it is to meet and quench the soaring aspirations of its modernizing society for quality health care delivery and the escalating needs of the nurses.

KEY TERMS

Motivation

Satisfaction

Attitude

Job

Job satisfaction

Registered nurse

Enrolled nurse

Midwife

Nurse midwife

Nurse specialist

Nurse educator

Nurse administrator

Intrinsic

Extrinsic

Reward

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CHAPTER 1

INTRODUCTORY EXPLANATION OF THE THESIS

The perusal of research carried out in the health services in the Republic of Botswana (Botswana), reveals a plethora of topics dealing with the nurses' job and administrative matters in the nursing field. Undoubtedly, job satisfaction as a research topic has had a lion's share. Research studies on the attitudes of nurses on a multitude of aspects of the nursing job, have also claimed a morsel in the nursing research market. However, the topic of motivation in nursing has always been branded with job satisfaction, if not completely submerged by it, as if one cannot have job satisfaction without motivation. The task of the planned research is to reverse the traditional order by making motivation in nursing predominant over job satisfaction, and with further analysis attempt to separate one from the other and view it individually.

One of the core efforts of the study will be to trace the individual motivational process from a number of crossroads in life, such as family background, building up into adult roles, and culminating in the attitudes that individuals carry with them as psychological baggage from the past into institutional or organisational settings. The meeting point between the individual employee's motivation and the institution's goal setting will determine whether the institutional variables are acceptable to the individual. If the worker's motivational map is attracted to that of the institutional motivational system, he or she will probably stay in her or his work, and is likely to be productive.

Job satisfaction will be examined both theoretically and practically. In respect of the latter, the totality of what nurses experience in their job and the environment in which it takes place, including the various factors such as supervision, autonomy, promotion and policies that dictate the nursing content and context will form important areas of interest. A line of best fit, as it were, will then be drawn between the motivational idiosyncrasies of nurses, on the one hand, and their job satisfaction patterns on the other in order to arrive at or bring out a conducive attitude on their part towards their job in the health services.

The data collected from the interviews and the questionnaires will be the most important source of the nurses' feelings towards what the policy or decision makers in the health services should do or should not do. The research data will also be a font of information regarding whether or not the theories of motivation and job satisfaction coincide with what happens at grassroots level.

The attitudes of nurses on a number of nursing issues will be treated as an exchange point between the community, who are the consumers of the health services and the nurses themselves, as to how each party understands or perceives what the nursing job entails. The nurses will be apt to emphasise the changing nature of their job while the community will show an acceleration in their demands for better health services. The scenario of the ensuing mistrust between the two parties, forcing them to look

askance at each other, constitutes a breeding ground for conflict in the provision of health services. This study will not seek to gag the transparency in the communication between members of the public and the nursing fraternity. It will instead endeavour to show what nurses do and the constraints under which they do what they are expected to do, with the hope that the two sides will eventually share a respectable co-existence.

In view of the foregoing, therefore, this introductory chapter contains the main reason for the study. The background to the research problem traces the roots of the civil service in Botswana, of which nurses form the largest component. As the nursing profession mellowed and expanded, nestling amidst an increasingly developed and sophisticated society in relative terms, problems surrounding the interpretation of the proper role of nursing in the health services, surfaced. The community's expectations from nurses, and the nurses' failure to meet these expectations, forms the hub of the research problem. The significance of the study serves to expose to the health services policymakers the plight of nurses and their occupational handicaps, and what needs to be done to improve the quality of the health services.

As part of the effort to assist the health services decision-makers to understand the conditions under which nurses work, the aim of the study sets out to detail the nurses' job features against the chosen hypotheses and assumptions, which comprise the most important areas of concern in their work environment. As time is a finite resource, the research is limited in terms of both the geographic locality, the grades of the nursing personnel under study, and the length of the service of such nurses.

A detailed terminology is provided to explain key words and concepts whose context might be unfamiliar to the reader. The reference technique used in the study is outlined. The research methodology and the literature survey stand as the roadsign to the selected method of gathering field data, and the numerous sources of reading material, classified into two broad groups of primary and secondary data. The chapter ends with a summary of the sequence of the chapters.

1.1   BACKGROUND TO THE RESEARCH PROBLEM (OBJECTIVES OF THE STUDY OR STIMULUS)

In his inauguration speech at independence in 1996, the first president of Botswana, Sir Seretse Khama, taking cognisance of the fact that his country was poor, pledged his political efforts to reduce this poverty through a process of nation-building, characrised, amongst other things, by the creation of a vibrant civil service. Nurses comprised a large proportion of the latter, because of the government's emphasis on maintaining a healthy workforce as an integral part of its long-term human resources planning. The idea of health services became an inseparable element of nation-building, therefore, through the efforts of the nurses. This led to the emergence of a competent cadre of nurses, maturated as a result of proper government planning as the health services system gathered momentum and clarity through policy pronouncements, such as Primary Health Care (PHC), and the goal of "Health For All" (HFA) by the year 2000. It is such policy scenarios that have necessitated the

increase in the number of nurses to staff the concomitant enlarged numbers of health services facilities throughout the country.

The jobs carried out by nurses who at present account for almost two thirds or 64% of the total number of personnel employed in the health sector (Edge & Lekorwe, 1988:339; Hope & Edge, 1996:56) vary in their complexities depending on the nature of the health station, but they all share a commonality of being subjected to similar conditions of work and gradations in their remunerations. In large health centres, such as district and referral hospitals, nurses have specialised skills and training and are assigned to their areas of speciality. Those nurses, who have not acquired a special knowledge over and above their general nursing qualifications, are found in general wards and in clinics. In Botswana all these different groups of nurses are responsible for running a variety of health facilities or health units. Since 1990, the number of beds in general hospitals in Botswana has been rising. This was accompanied by an increase in the number of clinics. Similarly the proportion of nurses shot up from 18.7 to 23.1 per 10,000 population in the same period under review. These stark statistics symbolise the fact that human resources, particularly in the form of nurses, are the single most critical factor in the delivery of health services in Botswana. The foregoing figures are also illustrative of the growing health care demands of the people of Botswana, not only in respect of quantity, but also in regard to the quality of health services they receive and expect. This increasing awareness, portrayed by a newspaper on behalf of the community at large to become more sensitive and critical of the kind of care they receive from the health workers, has added a new dimension to the demands made on nurses (Republic of Botswana, 1993a: 2-3; Republic of Botswana, 1998:34).

The Minister of Health in 1993, Mr Bahiti Temane (Republic of Botswana, 1993b:5), suggested that the considerable expansion of the health services in Botswana necessitated the employment of a large number of nurses. In a similar vein, the senior Medical Officer for Palapye Primary hospital, Dr Mohammed Sherif (Republic of Botswana, 1993c:3), advocated primary health care as a mode of health service provision, and pointed out that its advantage was the full participation by the community in all its components, such as the prevention of communicable diseases. As a sequel to these pronouncements on behalf of the Botswana society and the increasing responsibilities this has created for nurses, issues of job satisfaction, motivation, and attitudes of nurses over various aspects of their jobs, have assumed prominence. For example, Rampa (1991:41-50) showed that nurses in Princess Marina Hospital were overwhelmingly dissatisfied with their levels of pay. The nurses also complained that their salaries lagged behind those of other non-nurses of similar educational qualifications, such as typists, working in industry. However, although pay *per se*, was not found by Hwara (1998:135) to be the greatest motivation and job satisfier amongst the Gaborone Private hospital nurses, its contribution emerged as a source of concern. Other factors which were identified by the two studies to impinge on nurses' job satisfaction and motivation, were lack of autonomy in decision-making, poor communication between nurses and administrative staff, organisational policies including disparities in promotion, interpersonal relationships, lack of recognition for the responsibility and accountability nurses have in their activities, too much clerical work distracting nurses' attention from patients, lack of ancillary staff such as messengers, and complaints about the job itself. This study will focus on most of the above-mentioned factors in addition to others that may surface during the course of investigation.

In the Republic of Zimbabwe (Zimbabwe), Makoni (1998:11-14, 21-22), investigated the image of nursing as a profession, following similar charges as those observed in Botswana, in the attitudes of members of the public, as promoted by the media on the one hand, and those of nurses brought about by the new developments in the profession and the new ideals, demands, and duties that this spawned on the other. Although the study concluded that both the patients, as representatives of the community at large, and the nurses, were happy with how they perceived one another, the patients produced a shopping list of unfulfilled expectations which found nurses wanting in areas such as lack of respect of patients' values and beliefs and empathy amongst others. The complaints highlighted some possible sources of job dissatisfaction in the nursing job, namely working under unrelenting pressure from both the job itself and the work environment. The conclusion was that nurses needed more than dedication to stay in their jobs.

In Botswana nurses have sought refuge in and have become clamant on the need to uplift their professional preparedness for the heightened and strident quality health care as demanded by patients through higher nursing education. Kelobang (1982:8-9) studied the attitude of registered nurses in the face of this challenge and discovered that they expressed an interest in furthering their nursing careers either by way of tertiary education or by acquiring extra qualifications from the schools of nursing. The opportunity to go for further education or training became a source of motivation. The successful completion of such an undertaking was expected to effect a change or shift in the locus of power or authority brought about by promotion and coupled with an increase in salary. The total yield of the whole chain of events was calculated to be job satisfaction.

The nurses' quest for higher education is not only a means of achieving status enhancement, but also a bulwark against being transferred to rural areas, as their advanced knowledge is more likely to be required in urban areas. In the Kingdom of Lesotho (Lesotho), for instance, Rafutho (1992:19-39), confirmed that the government faced a serious shortage of nursing staff in the health services as nurses left because of the pernicious policy of transfer into remote areas. The possible job dissatisfaction this may cause, remained unmitigated by increases in salary because the long periods of separation from family members, and the lack of better schools for the nurses' children, outweighed any progression in remuneration. Salaries that are still low throughout the health services, shortage of staff, favouritism in promotions and selection for staff development programmes, and poor nursing administration, were complaints that hindered the effective promotion of health services. The research also established nine other factors that interfered with or inhibited job satisfaction, such as poor living conditions, a lack of transport and communication, and only two factors that motivated nurses in their job, namely professional growth and social growth or public recognition. The implications of the results of this study proved that a raised salary was necessary but not sufficient on its own to retain nurses in their jobs. These parameters also constitute part of the core focus of this proposed study.

In Botswana, the health services are organised for delivery at different levels of sophistication and coverage. Thus, there are health services provided by the central government, the local government authorities, the missions, the Red Cross, the mining companies, the private hospitals, and an array of traditional practitioners (Family Health Care & Africare, 1978:43). This proliferation of health services

provision is manned by trained nurses whose work is vital to the development of the economy, society and the general wellbeing of the populace. It is with this in mind that the way nurses feel about their jobs, especially in regard to motivation and job satisfaction, should be accorded a deserved attention. Job dissatisfaction does not have implications only for recruitment and retention, but also for turnover expressed as real, or potential, efficiency, quality of care, and effectiveness (Hwara, 1998: 140 h142,188, 192). It is against the background of the indispensable role played by nurses in the health services in Botswana, that this study will examine motivation and the patterns of job satisfaction, associated with the nurses' work environment. In another way, this investigation will consider, not only the universal interest in the question of what the nurses' work does for people, but also the question of what the nurses' job does to nurses (Fox, 1976:1).

1.2   RESEARCH PROBLEM

The Botswana Guardian (1996:6) carried an article under the heading of "Nurses Ignore Patient" in which a Gaborone resident complained about the negligent attitude of nurses at the Princess Marina hospital. The same newspaper had in 1990 already chronicled a story under the title of "Gross Neglect At Hospitals" in which an elderly man had blamed the nurses for being deleterious of their duties. A month later in the same year, a member of parliament complained that there had been a deterioration in the standard of health services rendered by the nurses (Republic of Botswana, 1990:2). In Botswana, members of the public have used the media such as the newspapers, radio programmes, television, and non-governmental organisations to air their views about the health services. They have also criticised the latter through their political representatives in parliament and at audiences with the chiefs, but sometimes they have made direct approaches to the civil servants who are directly or indirectly involved with the health services.

The Botswana Minister of Health was once again irate over the alleged poor health service and admonished nurses for showing a non-caring attitude. He reminded the hospital nurses about their inefficiency and low productivity that had been impliedly brought to his notice. In order to rectify this, he appealed to nurses to attend to patients quickly and to ensure that they were seen by doctors in the shortest possible time. The Minister further pontificated that the doctors and the nurses were not trained in the medical field by mistake, and as such, the guiding feature in their routine daily work must always be sympathy to those they care for. He also warned nurses to desist from twisting the Government's arm by their alleged claim that they were underpaid, and thereby displayed an apparent reluctance to put enough effort into their work. However, as the problem of supposed poor health service continued unabated, a radio programme was arranged in Botswana in 1981, for both a representative group of members of the public and the Director of Nursing services in the Botswana Ministry of Health, to share ideas and opinions and for the nursing official to explain the origin and reasons, if not causes, of the inefficient operation of the health services (Republic of Botswana, 1981a). The director confirmed the shortage of nurses as one of the main causes affecting the proper execution of nursing duties. This revealed truth was repeated by the then acting Principal Tutor at the National Health Institute of Sciences (NHIS) in Gaborone in a Ministry of Health

circular, in which she pleaded for the forbearance of members of the public in the face of an overworked cadre of nurses who had to work under a tremendous amount of pressure exacted by the scarcity of trained staff in the public hospitals (Republic of Botswana, 1981 b; Republic of Botswana, 1993d:1).

The crusade against the nurses was revisited by the Botswana Minister of Health when he officiated at the joint meeting of the Athlone Hospital Management and the Institute of Health Sciences staff. He reiterated the concern of his government over the general public's disharmony with the way the nurses, as public servants, seemed to show a lack of interest in the discharge of their duties, basing his observation on how the ordinary man in the street had inundated various government institutions with unresolved complaints about the health service. After singling out instances of long periods of waiting at the hospitals by patients, he also excoriated the nonchalant and negative attitudes of nurses and doctors towards the proper interpretation of their roles and exhorted them to come to the ready assistance of patients without showing demure (Republic of Botswana, 1993e:2).

The number of complaints by disgruntled patients, politicians, and other members of the public, is endless. If the anecdotal evidence and the vignettes in the health service furnished above are anything to go by, they should provide food for thought to the government and to the health services managers, in respect of, not only what the nursing job does to nurses, but also the problems it causes for people. In other words, the dissatisfaction with the health services on the part of the general public, and what inhibits the nurses from carrying out their duties efficiently and effectively, foreshadows the need for the health services managers to re-examine the health services facilities in the context of the nurses who make them functional. The thrust of this research is on examining what motivates and satisfies nurses in their work. The study will emphasise the approach that the poor performance by nurses in the health service, can be ascribed to their demotivation, dissatisfaction and negative attitudes. Consequently, the research will investigate the causal factors, if any, and make suggestions, as necessary, as to how the situation can be improved. As a matter of fact the study by Hwara (1998:182) revealed that contrary to the health services decision-makers providing a satisfactory and conducive work environment for nurses, the latter found their working conditions, such as the problem of housing and transport, in Princess Marina hospital, as part of a group of factors, to be the most potent causes of job dissatisfaction. Although the actual labour turnover of nurses, as a result of this complaint, *inter alia*, was minimal, the potential labour turnover was higher than ordinarily expected. Thus, nurses were sitting on the crest of a volcano, waiting to go, if it was not for the limited visible alternative institutions to move to.

In looking at what nursing, as a job, does to nurses, the latter are not found wanting in the mud slinging game between them and members of the public. For example Tapela's (1983:19-21) survey of the Botswana nurses' attitudes towards nursing in the remote areas formed a rallying point for nurses' complaints, not only about the poor infrastructural facilities in these areas, but also about a number of other issues, such as transfers, appointments, increments and demotions, affecting nurses' job satisfaction and their motivation to stay in their jobs. These areas of dispute found their way to Parliament, where they were given a fair share of debate by the politicians who realised that if the government's policy was threatening to force the loss of nurses from the health services, it was time to listen and think about what the

nurses were saying (Republic of Botswana,1980:3). Moreover, they had been confronted by an outcry from the general public about misgivings regarding the negligent care of patients in the hospitals.

Motlhasedi (1982:11-13) noted in her study that nurses had been placed in a prolonged state of job dissatisfaction that had caused some adverse effects on their morale and consequently their ability to provide patient care whole-heartedly had been dissipated. Some nurses had become so disillusioned with the chronic absence of job satisfaction, that their motivation to soldier on had been usurped by other thoughts, not excluding the option of leaving their jobs, or sitting back pathetically, or just drifting away with the current aimlessly, or sitting on the fence waiting for better opportunities to loom somewhere. Although this survey found that there were a number of issues that piqued nurses in their jobs, working conditions were used as a summary of a myriad of factors that affected the motivational system of nurses negatively, forcing many of them to adapt the various modes of attitudes described above.

The irony of job satisfaction to nurses lies in the fact that it is not merely important for its own sake in the sense that they need to be happy, but that satisfaction and motivation underpin their effective performance, if the efficiency and the productivity of the health services are not to be mortgaged. The effectual performance of nurses depends, not only on the acquisition of skills, competencies and knowledge, but also on the individual and collective job satisfaction and motivation. Both of these two variables can be considered, to borrow a political phrase, as the *primus inter pares* (first amongst equals) of all the factors that come or are brought together to make a nurse's job. Thus, an understanding of what motivates and satisfies nurses in their jobs and work environments is crucial and mandatory in order to accomplish a positive attitude towards their work and thus improve their performance. This research will study factors that add up to satisfy and motivate nurses in the execution of their duties. It will also examine nurses' attitudes over various issues in their work environment, as well as other matters that impinge on their satisfaction and motivation.

In Botswana according to Motlhasedi (1982:1) not only was a commission of enquiry established to look into the nurses' dissatisfactions, but also the organisational structure of the nursing staff was changed three times between 1969 and 1980 to little avail. It might also be mentioned here that the health services of most African developing countries are characterised by an absence of nurses' trade unions. Botswana is no exception. The Nurses Association of Botswana (NAB), for instance, is not a trade union, but a nongovernmental organisation (NGO). As such it does not champion the nurses' cause such as the improvement of working conditions and salaries, like a trade union would, but performs a watch-dog role or oversees the maintenance of nurses' professional standards. The nurses' shortcomings, as adumbrated by members of the public, and the nurses' dissatisfactions with the lack of opportunities to experience job satisfaction, should bring home to the government the pivotal role played by nurses in the health services. The fact that nurses are the cornerstones or pillars of the health services, serves to remind the government and the health services managers that the nurses' search for job satisfaction is a bread and butter issue which deserves the concentrated efforts of both parties to fathom and thereafter look for solutions. This study will investigate the amity or affinity between job satisfaction and motivation. It will examine whether or not they are the

flipside of the same coin. The investigation will also address the question of whether or not the two concepts need to be present simultaneously in a job, or whether they can exist independently of each other, in the sense that motivation will not always lead to job satisfaction or *vice versa*. But it will also be contended that both these notions are inseparable from individual personalities, level of education, level of skill and family background. Furthermore, in studying the factors that have a bearing on nurses' job satisfaction and motivation, the controversial side of the argument of whether satisfaction and motivation are necessary or essential for performing a job will also be investigated.

It will be clear from the details given above, that there may be a continuing divergence between the Botswana society's historical conception of nursing as a calling, typified by the expected humble acceptance of a meagre wage, and a sublime compliance, and the nurses' vociferations and repudiations of such an appellation or emblematic designs. This explains the nurses' stance or posture in demanding more from the previously down-trodden nursing job, which has since undergone a technological metamorphosis, such as advances in the use of diagnostic machinery, and in the treatment of certain medical and surgical conditions in recent years. What has emerged in the studies is, therefore, a clear indication that nursing, like any other job, requires all those factors that motivate and satisfy a job occupant. To this extent, the gulf between the attitudes of members of the public, who may regard nursing as a vocation on the one hand, and the resurgent and militant aspirations of nurses, who may be determined to remove the profession from the archaic fetters or shackles of a calling on the other, is one of the relevant and topical problems that will be considered in this study.

1.3 REASONS FOR SELECTING THIS RESEARCH TOPIC (SIGNIFICANCE OF THE STUDY)

As has been illustrated above, nurses' job satisfaction and motivation have been regarded as a trifling matter, ignored and down-played, as far as the general public is concerned. Although bracketed as an essential service in Botswana, as in most other African developing countries, and protected by law against strikes or work-stoppages, the welfare of nurses and their grievances against their working conditions have not been accorded an equally serious consideration. This has left the nurses totally dependent on the whims of the government of the day, and with no trade union to vocalise their plight and to fight for them, they have been compelled to internalise their unhappy feelings, and to knuckle down and perform their duties, albeit perfunctorily. The extent of their powerlessness and their lack of job satisfaction and motivation have only made themselves obvious through the curses heaped on them by the recalcitrant, complaining and restive public. The commission of enquiry held in Botswana on nurses' job dissatisfactions, also highlighted the deteriorating nature of the nurses' work environment, and acted as a caveat to policy-makers on what to expect in the future if the situation is allowed to get out of hand.

In Botswana, as was enunciated at the time of independence, the goals of development and nation building depend on an efficient civil service, of which in the health sector and particularly the nurses playa major role. According to Gupte (1990:87), "a country's gross national product (GNP) and infant mortality rate (IMR)

tell us about the general health condition of the population". This statement underscores the oft-repeated fact that nurses are a vital cog in the development of a country. The importance of a healthy nation has significance for the leaders of industry, whose responsibility is to keep the wheels of industry turning in order to produce and accumulate capital or wealth for the nation. To facilitate the achievement of this objective efficiently, the human resources must be healthy, and this is where the health services come in, and with it, the nurses. Therefore, the problems that nurses face at work if not attended to and corrected threaten not only the viability of the health services but also that of the national economy. It has been stated earlier that in job dissatisfaction lie the seeds of disaffection, labour turnover, and apathy, while remaining in the job for the sake of survival. The public sector hospitals have been the most affected, with the loss of nurses joining the private hospitals, or going into other non-nursing jobs in the private sector, or being lured into the more lucrative West European nursing market.

In view of the above explanation, the rift between what the general public expects nurses to do for them, and what the nurses believe should be done for them in turn by their employers, in order to improve the health services, is central to this study, and forms a rendezvous of the conflict of interests. The problem of the nurses' lack of job satisfaction and the absence of motivation to stick to their job, therefore, calls for an investigation in order to understand the factors at the heart of their complaints. For this reason, this study will pull together the interest of a cross section of people at various hierarchies of decision-making in the health services, commencing with the Nurses Association of Botswana (NAB), and the Nursing and Midwifery Council of Botswana, both of which are the proteges of the nursing profession in Botswana. The underwriters of the multi-sectoral development programme at the inception of independence, include the Ministry of Health, which controls the health services bureaucracy. As such, the Ministry will take an active interest in matters involving nurses on whom it spends two thirds of its budget (Republic of Botswana,1988-2002:34), through its human resources personnel, who are responsible for the recruitment, selection, and deployment of nurses in hospitals and other designated health facilities throughout the country. The nurse managers at the different levels of seniority, running down to the supervisors in the hospitals, hospital management teams, district health management teams, and nurse training institutions, all have something to benefit from taking note of the results of this study. Moreover, the results of the research may influence policymakers and force them to adopt a self-introspection stance, if not making a *volte-face* (complete change), in their conceptions of what the nursing job entails, especially, in view of the new developments in the causation of pandemic diseases such as the immune-suppression syndrome. There are other interested observers in the health service, of course, such as the human rights and non-governmental organisations, which may scan the nurses' dissatisfactions in the face of new trends and risks in nursing, from different perspectives.

The informed members of the public will be anxious and enlightened to read about a study such as this, examining the factors of job dissatisfaction and other issues which de-motivate nurses in the way they perform their job. It is this understanding derived from researches that can spur on the general public to shift the blame from nurses on to the shoulder of the policy-makers. This will compel the latter to ameliorate the supposed poor quality of health care complained of by clients, by bringing about meaningful improvements in the nurses' working conditions and other discomforts in

the nature of their jobs. Apart from its impact on the members of the community, the study will have significant tell tale signs for the hospital managers who are faced with the majority of nursing problems and it is within the hospitals that the distinction between inept and efficient nurse management practices can be readily noticeable. These policy makers and other interested participants in the health services will be keen to maintain some kind of a "reconnoitering force" on the problematic areas affecting the nurses.

As was mooted above (pages 8 to 10), the health services are changing in step with the new attitudes of the health care consumers and as such, the managers of modern hospitals face an uphill task by having to prepare themselves for this new situation. Hospitals of today are no longer hurried centres of health care and consequently they cannot be taken for granted. Incontrovertible evidence has shown that consumers of the health services have developed high expectations of these hospitals and with the increasing literacy in the population they have become conscious of their rights. The hospital managers are entrusted with the responsibility to act as indestructible bulwarks of freedom to the access of these health facilities and the enjoyment of good quality health services therefore. Further to the problems caused by the continuous demand for improved health care, hospital managers also have to deal with the scarcity of resources including human personnel. All of these difficulties can arise either in the short or in the long run, from the lack of job satisfaction and motivation on the part of nurses. This study can act as a radar and compass In alerting hospital managers about the sources, reasons, and causes of nurses' inefficiency, ineffectiveness, lack of productivity and both real and potential labour turnover. Managers will take heed of such researches if they are alert to the need to run efficient and consumer-conscious health services.

It is imperative for modern day hospitals to use the limited resources effectively, and to maintain an acceptable and consumer-friendly level of good quality patient care. This is often an impossible task but not beyond achievability, if managers in the health services are willing to co-operate in sharing information and solutions to the common problems. This study may well provide such a forum for those managers and decision-makers, especially in the public sector who are concerned with conserving human resources in the form of nurses in Botswana. In summary, therefore, since nurse managers are involved in managing decision-making and strategic planning they must be attentive to staff job satisfaction, because of its implications for recruitment and retention. Conversely, job dissatisfaction is reflected in rising financial costs resulting from turnover, absenteeism, problems of low morale and employee conflicts in the work place (Misener, Haddock, Gleaton & Abu Ajamieh, 1996:87). The results of this investigation will provide such personnel in the vortex of the health services institutions, not only with something to ponder over, but also with the insight that the best "contraceptive" against nurses' apathy, indifference, inefficiency, and ineffectiveness, is to examine, coalesce and mobilise support for all those factors that contribute towards their job satisfaction and motivation.

In Botswana a number of studies has been done on job satisfaction and attitudes of nurses, but hardly any research has been conducted on the three themes of motivation, job satisfaction and attitudes of nurses simultaneously.

1.4   AIM OF THE STUDY

This study will investigate the employment features and job-related factors that cause job satisfaction and motivation to nurses, and the attitudes they have or bring to their job. This research will identify the possible factors which contribute to the poor quality health services and the low health services consumer satisfaction that the mass media and Parliament in Botswana have debated. It has been shown that attrition, burn out and other factors which impact negatively on nurses' productivity are related to the lack of job satisfaction. This study will examine the background causes of these problems and detail how they affect nurses' attitudes towards their work. On the other hand the study will establish those job factors which are considered to enhance job satisfaction and motivation and why and how they do so. This explanation will then be linked to how it will improve nurses' job performance, reduce absenteeism and labour turnover and foster opportunities for quality patient care. Integral to this approach, the investigation will suggest strategies that may be employed to eliminate the prohibitive job factors identified.

It is reiterated that effective performance by nurses is central to the success of health services and such performance depends, not only on the nurses' acquired skills, attitude and knowledge but also on their individual and collective job satisfaction. Therefore, an understanding of and orientation to what satisfies and motivates nurses in their work environment is required to explain their job attitudes and thus their job performance. This research will look into and will seek to discover job factors that make nurses happy and be contended with their job and motivate them to want to work and to continue to work in their nursing jobs. In the process of doing so, no doubt, the study will also unearth those factors in the work environment that have caused or precipitated poor patient care, dissatisfaction and labour turnover in order to guide nurse managers as to what factors to bring together to get the best out of nurses.

It has been stated on page 16 that high job satisfaction improves the ability of the health institution to recruit and retain nurses and this affects patient care. Herzberg (1969:94) confirmed that workers can be retained in their work if it gives them satisfaction and motivation to continue in it. As job satisfaction is derived from an individual's task, roles, responsibilities, interaction, incentives and rewards, *inter alia* (Locke,1976:1301), this research forms a perfect complement to such factors by linking them to motivation and job attitudes in order to bring out the entire picture of what happens in the nurses' work environment.

The workplace factors and the organisational aspects of the nurses' work form the couldron of most of their complaints. Kanter (1977) cited in Wilson and Laschinger (1994:40-41), proposed that an individual's effectiveness on the job is influenced largely by organisational aspects of the work environment. She identified power and opportunity as structural determinants which affect the behaviours and attitudes of employees. According to her theory, power was derived from the ability to access and mobilise support, information and resources from one's position. Opportunity refers to the expectations for growth and advancement in one's career. Kanter found that if these factors together with others were frustrated, this led to low commitment among nurses with the resultant negative performance in their work. McDaniel (1995:15-22) identified organisational culture as being critical or the kingpin of health

services and patient care outcomes. She also pointed out that there was a link between culture and morale, retention, leadership and productivity and high performance patient care units. Hastings and Waltz (1995:34) found that there were seven variables which acted as significant predictors of nurses' job satisfaction and labour turnover. These were listed not in ascending or descending order of importance as satisfaction with control or responsibility, nurse-patient ratio, satisfaction with rewards or recognition, ability to give high quality care, satisfaction with scheduling, peer support and perception of unit-level management. It is the aim of this study to explore the spectrum of factors ranging from the organisational aspects of the work environment, McDaniel's (1995:15-22) organisational culture embracing organisational policies and Hastings and Waltz's (1995:34) variables affecting job satisfaction, job dissatisfaction and the negative attitude of nurses in the Botswana's health services.

It is assumed that nurse managers and other high-profile health services administrators may have their own perceptions rightly or wrongly, of why nurses may be dissatisfied or de-motivated in the performance of their duties or in the general outlook of their professional careers. Lack of satisfaction, loss of morale, lack of professional cohesion and consequently loss of vision of where one is going in one's career will continue to chip away at what remains of nurses. This will persist until that professional lustre that attracted them in the first place as part of the smouldering aspiration from school has disappeared. With this in mind, the intention of this study's investigation is to search for reasons from the nurses themselves about what it is that motivates them or gives them satisfaction to remain in their job.

In concert with the two concepts of job satisfaction and motivation, the study will look at the nurses attitudes' over various matters impacting on their work. These matters may either be of independent origin or they may be caused by these two concepts, in which case they can either be regarded as inseparable or extrapolateable from such variables. In other words, the study argues that it is the nurses who should know where the problem lies. Accordingly, it is their views, suggestions or perceptions of what pertains to their work and its environment that can indicate to nurse managers and higher-level nurse administrators as to where in the nurses' grievances they should act in order to retain nurses and to motivate them to produce a sterling service.

This study, therefore, seeks to examine the various variables that impinge on the nurses' motivation, job satisfaction and attitudes with a particular focus on Botswana.

1.5 HYPOTHESES AND ASSUMPTIONS

A hypothesis is a supposition made as basis for reasoning, without assumption for its truth, or as a starting point for further investigation from known facts (Sykes, 1976:530). According to Auricombe (1998:7), hypotheses are tentative answers to research questions or problems, representing informed "suppositions" relating to the topic. They remain to be verified or proved wrong by means of logical testing as well as analysis of data and information. Auricombe (1998:7) further points out that hypotheses should be reasonable, consistent in terms of available facts and theories,

and should be expressed in such a way that they can be tested. They should also be formulated in such a way that they can be proven true or false. Finally, hypotheses should be stated as simply and concisely as possible (Auricombe, 1998 :7).

The following hypotheses are proposed to solicit responses on the various aspects of the nursing job which have a bearing on the nurses' motivation and job satisfaction or their converses:

(a)   Nurses' perceptions of motivation and job satisfaction influence their and attitude towards their work.

(b)   Nurses' perceptions of the various components of their working conditions, are related to their perceptions of job satisfaction, motivation and job attitudes.

(c)   Nurses' perceptions of the work requirements or the work itself, workload, rewards and inducements, are related to their perceptions of satisfaction and motivation.

(d)   Nurses' perceptions of job-related access to autonomy, nurse management practices and promotional opportunity or advancement in their job, are related to their perceptions of work commitment, professional enhancement, motivation and satisfaction.

(e)   Nurses' perceptions of supervisory practices, recognition, interpersonal relations and institutional policies or requirements, are related to their perceptions of job satisfaction, motivation and attitude.

The research is premised on the assumptions outlined below:

(a)   High morale, *esprit de corps* (loyalty to the group to which one belongs), quality patient care, efficient and effective performance in the health services, depend on nurses' job satisfaction and motivation in their work environment.

(b)   Nurses' satisfaction with various elements of their working conditions, such as pay, has a positive effect on their performance, productivity, attitude and professional standing.

(c)   Nurses' participation in decision-making concerning their work, empowers them, motivates them and gives them satisfaction in their creative knowledge.

(d)   Workload and staff shortage as job factors amongst nurses, cause both physical and psychological exhaustion, burnout or stress, negativism, poor patient care and potential labour turnover.

(e)   Nurses' satisfaction with their job motivates them and fosters their commitment to the overall goals and objectives of the health service institution.

1.6 SCOPE OF THE RESEARCH (RESTRICTIONS OR LIMITATIONS OF THE STUDY)

Botswana has a total number of 583 health facilities comprising 325 health posts, 227 clinics and 31 hospitals (Republic of Botswana, 2002:3). Included in the hospitals category is the Gaborone private hospital as well as the 4 mine hospitals which are Selebi-Phikwe; Jwaneng; Orapa; and Tati Nickel. The private and the mine hospitals make up the private health sector which lies outside the jurisdiction of the Botswana Government with respect to their day-to-day operations and management. When these private health facilities are excluded from the total hospitals population the remaining 26 hospitals and the clinics combine to form the public health services. The health posts are an integral part of the clinics save that they are of an inferior status to the latter because they are less equipped both in terms of human resources and medical equipment. They are invariably staffed by an enrolled nurse. Not included in the grand composite total number of health facilities are the 725 mobile stops (Republic of Botswana, 2002:3) which are dotted all over the remote areas with their highest concentration of 257 in the Gantsi district (Republic of Botswana, 2002:3). As they are a kind of dispensary on wheels they are operated by clinics and health posts nurses. However their efficiency and effectiveness depend on the availability of transport.

All these health care centres are distributed into 22 districts which demarcate the country. There are four possible scenarios in the provision of hospital facilities in each district. There maybe no primary or general hospital in a district such as in the case of the North East. In some districts, for instance, Gaborone and Lobatse there are two general hospitals in each area with no primary hospitals or health posts. In other districts like Bobonong there are two primary hospitals but no general hospital. The most balanced districts have either one general and one primary hospital or one general and two primary hospitals. Kweneng East and Boteti districts respectively are graced with such a mixed bag of health facilities. In the majority of cases however each district has either a general or a primary hospital. The latter is often smaller than the former with no specialist medical personnel and thus often refers medical matters of a complicated nature to the former (Republic of Botswana, 2002:3).

Clinics which are found in every district are of two different types. Some have maternity wings and others have no such provision. For obvious reasons the former tend to be larger than the latter and are staffed by more nurses. The health statistics report of 1999 showed that 84 clinics had maternity wings against 143 without (Republic of Botswana, 2002:3). Health posts are classified into those with nurses and those with none. Fortunately however the largest number of health posts is manned by a nurse (Republic of Botswana, 2002:3). In the more remote areas such as Ngamiland and Gantsi mobile stops not only supplement the over-stretched clinics but also reach out to dispersed populations distant from the established health centres.

The national number of 4992 nurses who run all the 583 health facilities in the country includes both the private and the public health sector nurses (Republic of Botswana, 2002:5). However it is cautioned that the given aggregate of nurses is only a formal establishment figure characterised by an unspecified number of unfilled vacancies in each type of health facility due to the chronic nation-wide shortage of

nurses. Against that backcloth the hospital-based nurses account for 2950 of all the nurses in the country. But this figure includes 316 non bedside public sector health services nurses who are in various managerial positions and 300 private sector health services nurses who are both excluded from the research. This leaves a qualifiable population of 2334 public health services nurses. The actual sample taken from the given total was 900, which to all intents and purposes, was representative of a third of the population.

The study covered the following health care facilities: Lobatse mental hospital and Athlone general hospital both located in Lobatse town; the Seventh Day Adventist hospital in Kanye; Thamaga hospital; Scottish Livingstone hospital; Bamalete Lutheran hospital; Deborah Retief Memorial hospital; Sekgoma Memorial hospital; Seli-Phikwe general hospital; Gaborone City Council and Francistown City Council clinics.

The questionnaire whose items include the hypotheses outlined for the study comprised the main instrument of research. In addition however a small sample of nurses from some of these institutions was interviewed to enrich the questionnaire responses in some areas.

The aforesaid health facilities are manned by different echelons of nurses. The research was conducted considering both the registered and the enrolled nurses. The title "registered nurse" was a hybrid notation embracing the various grades of registered nurses ranging from the most junior to the highest rank of matron. Within this wide spectrum the study was restricted to the level of nursing sisters in charge of wards. But unlike registered nurses enrolled nurses had only two designations, namely, senior enrolled nurse and enrolled nurse.

Registered and enrolled nurses shared the same work environment and they did the same job although at different levels of skill and knowledge. To this extent they were subjected to similar stresses in their work situation. Enrolled nurses were normally and ordinarily subordinate to all the grades of registered nurses by virtue of their lower levels of training and an almost invariably inferior level of education. The differences between these two types of nurse are described under the heading of terminology.

Furthermore a minimum of two years of practical nursing experience was used as a cut-off point for those nurses who participated in the study. This was done to ensure that all the research subjects had been sufficiently exposed to the nature of nursing work to be able to give significant answers.

1.7 TERMINOLOGY

It is advised *ab initio* (at the outset, from the beginning), that, as it is not possible to define every concept, title, phrase, unfamiliar word, or an expression in foreign language, in this section, definitions will be proffered in the course of the relevant chapters. Furthermore, for some of the concepts listed here and already defined such as job satisfaction, motivation and attitudes, which are liable to various

interpretations, although not in substance, in one aspect or another, detailed explanations will be rendered in the chapters under which they fall.

(a)   NURSE

A nurse is a person who has completed a programme of basic, generalised nursing education and passed such examinations in the practice of nursing as may be determined by the Nursing and Midwifery Council of Botswana (Republic of Botswana, 1995:A2).

(b)   REGISTERED NURSE

A registered nurse is a nurse who is registered in the register for general nurses, kept by the Nursing and Midwifery Council of Botswana (Republic of Botswana, 1995:A2, A5).

(c)   ENROLLED NURSE

An enrolled nurse is a person who has completed such period of training in practical nursing, and passed such examinations in such courses of instruction as may be determined by the Council for enrolled nurses (Republic of Botswana, 1995:A1).

(d)   MIDWIFE

A midwife is a person who has completed a programme of training and passed such examination in the practice of midwifery as may be determined by the Nursing and Midwifery Council of Botswana (Republic of Botswana, 1995:A2).

(e)   NURSE MIDWIFE

A nurse midwife is a nurse who has completed such periods of training in nursing and also in midwifery and passed such examinations as may be determined by the Council for nurses and for midwives (Republic of Botswana, 1995:A2).

(f)   NURSE SPECIALIST

A nurse specialist refers to a nurse who has also completed a programme of post-graduate training in a particular field of nursing and has passed such examinations as may be determined by the Council for nurse specialist (Republic of Botswana, 1995:A2).

(g)   NURSE ADMINISTRATOR

A nurse administrator is a title given to a nurse who has also completed a programme of training and passed such examinations in nursing administration as may be determined by the Council for nurse administrators (Republic of Botswana, 1995:A.2).

(h)   NURSE EDUCATOR

A nurse educator means a nurse who has also completed a programme of training and passed such examinations in nursing education as may be determined by the Council for nurse educators (Republic of Botswana, 1995:A.2).

(i)   TRAIT

A trait is a distinguishing feature in character, appearance, habit, or portrayal (Sykes, 1976:1230).

(j)   INSTINCT

An instinct is an innate propensity to certain seemingly rational acts performed without conscious intention, fixed pattern of behaviour especially in response to certain simple stimuli (Skyes, 1976:560).

(k)   DRIVE

A drive in psychology means energy, capacity to achieve things, inner.urge to attain a goal or satisfy a need (Sykes, 1976:316).

(l)   MOTIVE

A motive is what induces a person to act, for example, desire, fear, circumstance (Sykes, 1976:711).

(m)   STRESS

There are three models of stress, namely: stress as a demanding stimulus, stress as the result of a person's physiological and emotional responses to environmental stimuli, and stress as the interaction between the person and his or her environment.

The stimulus model of stress is based on a simple analogy with one of the laws of physics. Hooke's law of elasticity or springiness (Drake, 1996:48-49) explains the effects of weights on metals, that is, the heavier the load the greater the stress within the metal. In the same way in employment, the greater the pressure on a person, the greater the stress he or she experiences (Lazarus & Lazarus, 1994:220-221).

In contrast to the stimulus model, the response model defines stress in terms of the individual's responses to perceived stressors. Stress can be described as a non-specific bodily response to environmental demands (Lazarus & Lazarus, 1994:220). This general response is referred to as the General Adaptation Syndrome (GAS) and is divided into three phases, that is, the alarm reaction, the resistance phase and the exhaustion phase. Each stage can be characterised in terms of the person's physical and psychological states (Weiner, 1974:22).

The transactional model or the cognitive phenomenological transactional model (CPT) offers a more comprehensive view of stress and coping (Weiner, 1974:23). As its name implies it concerns the person's intellectual processes (cognitive), his or her subjective interpretations (phenomenology) and his or her interaction with his or her environment (transactions). Whereas the stimulus and the response models each

focuses on one aspect of the phenomenon, the CPT model deals with the whole process. According to this model the individual's ability to deal with problems, that is, whether stress is experienced or coping occurs, depends on the way he or she interprets or appraises his or her relationships with environmental events (Abraham & Shanley, 1992:223-226; Weiner, 1974:23-24).

(n)   ABSENTEEISM

The term "absenteeism" as used in the context of fixed weekly work schedules in factories or offices, usually refers to employee absence that occurs without suitable notification to the employer and without official sanction by medical confirmation of illness (Chadwick-Jones, Nicholson, and Brown, 1982:4).

(o)   ROLE

The concept of role is derived from the theatre where actors take on roles. Quite obviously in social situations individuals do not "act" roles; they "are" the roles. Roles are the behaviours prescribed for and expected of all persons who perform certain functions such as mother, father, doctor, nurse and patient. Role therefore informs the role-bearer of the appropriate dress, duties, talk, obligations, privileges and rights. Most individuals in society have several roles. For example, one individual can be a mother, a nurse and a local councillor (Smith, 1976:54).

(p)   STATUS

Status is closely associated with the concept of role. Status of a role tends to be higher if it has more rights and obligations than others and therefore status relates to the relative position of a role in a whole system of roles (Smith, 1976:55).

(q)   MORALE

Morale is the extent to which the members of a group identify with the aims and activities of the group. Earlier usage of the term included its application to the emotional state of individual persons divorced from a group context but current usage is in accordance with the definition given (Kempner, 1976:260).

(r)   LABOUR TURNOVER

Labour turnover can be defined as the relation between the number of those employees who leave a firm's employment voluntarily and have to be replaced and the average number of employees in employment in that firm in the same period. It will be seen, therefore, that the definition excludes those discharged by management, as well as turnover due to illness, unavoidable accidents, marriage, pregnancy, death and retirement because all these are obvious sources of departure and outside the control of management (Badger, 1966:165-166).

(s)   INTERVIEW

Interview is a meeting of persons face to face, especially for purpose of consultation and oral examination of the candidate for employment (Sykes, 1976:566). The interview is the most widely used technique for assessing human ability. Its popularity

derives from the ease with which it can be carried out, its flexibility and enormous face validity. There is no doubt that the interview is also the most widely misused technique. Interviewers are frequently untrained, inexperienced, stereotyped in their approach and unaware of the lack of validity in their conclusions.

Good interviewing demands skill, patience, careful planning and preparation and above all an appreciation of the limitations of the method. The interviewer should be quite clear about the data he or she is attempting to elicit; he or she should have a flexible, yet systematic plan of procedure; he should make the most of the opportunity to observe all aspects of the subject's behaviour; and he must have the ability of establishing swiftly the type of personal relationship which is appropriate to the particular situation (Kempner, 1976:209).

(t)   RECRUITMENT

Recruitment is the securing of a supply of possible candidates for jobs in an enterprise. It is the first stage in the process which continues with selection and ends with the placement of an individual man or woman in a job. Recruitment begins with information about and contact with the sources of supply of the different kinds of recruits required to fill vacancies in a company. In the case of young recruits these will be, for instance, schools, colleges and universities. For older people it will be employment exchanges, trade unions, private employment agencies and a variety of local groups with whom the management and the personnel department have contact. In practice existing employees may be the most useful "recruiting officers", telling the people they know and meet of possible vacancies in their own firms (Kempner, 1976:329-330).

(u)   SELECTION

Selection means choosing from a number of candidates the one most likely to be suited to a particular job. The process of selection starts with recruitment on the one hand and on the other with job analysis which enables the selectors to identify the qualities, qualifications and experience required in the post to be filled and to list these in a job specification. In practice, particularly for management positions, the selectors are also interested in the overall potential of a future employee and with the way in which he or she will contribute to and develop in the institution. In these cases the specification will be wider than that derived from the job analysis of one occupation. The task of selection is to assess the candidate against the job specification however widely conceived. In doing this information is required about the candidate's physique and health, general intelligence, special attitudes, achievements, temperament and personality (Kempner, 1976:348-349).

(v)   MOTIVATION

The motivation of individuals and groups is the process of initiating and directing behaviour (Hamilton, 1983: 15). An individual produces and sustains behaviour when he or she finds it rewarding to do so, that is, when the behaviour accomplishes an objective which satisfies a need. As far as the industrial institution is concerned, an employee will be motivated to carry out the duties assigned to him or her to the extent that to do so satisfies his or her personal needs (McClelland, 1987:i - ii, 4). Whilst it has long been recognised that individual needs are complex and unstable,

considerable reliance has been placed on financial incentives as a motivating device. Undoubtedly, financial rewards are extremely important not only for the material needs they indirectly satisfy but also for their symbolic significance as indicators of social and personal worth and status. In recent years, however, there has been an increasing disillusionment with the effectiveness of financial incentives and, following the theoretical assumptions of AH. Maslow, attention has been directed to the need to place greater emphasis on rewards intrinsic to the work itself as a necessary supplement to the traditional extrinsic rewards. Accordingly, once provision has been made for adequate earnings and satisfactory general working conditions, attempts are made to structure the work situation so as to provide opportunities for increased independence and personal accomplishment. On the whole, research data appear to support the general validity of this approach but it must be borne in mind that motivation is highly complex and that personal needs differ greatly from one person to another and within the same person over time (Kempner, 1976:261; Gellerman, 1963:83-92).

The "push" models of motivation, especially those based on the self-perception of need and the hierarchies of goals, require a reference to the knowledge of the differential directing stimuli received and inferred from the goal objective in order to account for the most efficient of behaviour (Hamilton, 1983:19-26). The study of motivation is therefore generally defined in terms of three dimensions of behaviour, that is, direction, intensity and maintenance. The processes underlying these dimensions of behaviour are inside the person where they form a bridge linking observable responses. Thus terms like "need, drive, incentive, expectancy, arousal and effect" are all common in the language of motivation and all refer to processes that go on inside the person and therefore cannot be directly observed or measured (Geen *et al*, 1984:2).

Since each of the terms used in motivation can be known only in inference, another working definition of motivation may therefore be "the operation of inferred intrapersonal processes that direct, activate and maintain behaviour" (Geen et ai, 1984:3). In practice, however, a study is made of the conditions that produce behaviour, that is, antecedent conditions and the behaviours that occur under these conditions (Geen et al, 1984:3).

From the commonsense point of view motivation refers on one hand to conscious intents or to inner thoughts such as "I want to be a doctor or a lawyer". Yet on the other hand, looking at behaviours from the outside, motivation refers to inferences about conscious intents that people make from observing behaviours. For example, if a young lady opens a piano it is inferred that she wants to play the piano (McClelland, 1987:4).

(w)   WORK

Work may be a mere source of livelihood, or the most significant part of one's inner life; it may be experienced as expiation, or an exuberant expression of self; as bounden duty, or as the development of man's universal nature. Neither love nor hatred of work is inherent in man, or inherent in any given line of work. For example, McGregor's Theory Y asserts that people do not like or dislike work inherently but rather develop an attitude toward it based on their experiences with it (Gellerman 1963:86-87). This means that attitudes to work are socially and culturally moulded.

People are taught what to expect and want from work, that is, taught by a variety of socializing agencies. What they learn to want is a social fact of great importance and there will be a variety of institutions and groups eager to do the teaching (Fox, 1976:2).

(x)   JOB

A job is a piece of work, especially one done for hire or profit. It is a transaction in which private advantage prevails over duty or public interest. A job is also a paid position of employment; anything one has to do (Skyes, 1976:582).

(y)   INCENTIVE

Incentive means tending to incite, for instance, an incitement to action or to do something. An incentive also means provocation, motive, payment or concession to stimulate greater output by workers (Skyes, 1976:544).

(z)   INTRINSIC

Intrinsic means belonging naturally, inherent, or essential (Skyes, 1976:567).

(aa)   EXTRINSIC

The word extrinsic refers to something lying outside, not belonging to, or originating or operating from without, not inherent or essential (Sykes, 1976:368).

(bb)   FATIGUE

Fatigue is a phrase used to describe an observable decrement in performance resulting from a repetition of behavioural activity, fatigue serves as a useful label to group together a wide variety of well-known phenomena. Its use as a causal explanation of these decrements is, however, questionable. It is unlikely that a single causative factor brings about the numerous observable effects which are probably due to a wide variety of mechanisms including loss of sleep, the accumulation of metabolic waste products, boredom, neural inhibition, and loss of sensory activity.

Concepts of fatigue include reference to subjective feelings of tiredness and to certain physiological states in addition to performance decrements. Experimental studies have usually failed to establish any clear relationship between these three aspects (Kempner, 1976:143).

(cc)   REWARD

Reward is the total return, tangible and intangible, which accrues to an individual as a consequence of his or her behaviour (Kempner, 1976:339). A reward may be negative, in the sense that it may consist of the avoidance of an unpleasant consequence, but more usually is positive in that it wholly or partially satisfies a need. The extent to which an individual will be motivated by a potential reward will be greatly influenced by his or her need for the reward, by his or her assessment of the likelihood that he or she will receive it, and by what he or she has to do to get it

(Weiner, 1974:43). In the industrial institution, the most obvious rewards are monetary and take the form of wages or salaries with or without additional bonuses (Kempner, 1976:239). Yet other rewards are common, for example, fringe benefits such as sick pay, pension rights, holiday pay, subsidised canteens; perquisites ('perks') such as a company car, an expense account, assistance with school fees, privileged access to company products; security of pay and employment; desirable hours and working conditions; social satisfactions including satisfactions intrinsic in the job; the approval of those whose opinions are valued; the prospects of better rewards in the future; and status (Kempner, 1976:239).

These various elements are not always consistent and to some extent more of one may compensate for less of another; security may make up for low job satisfaction or prospects compensate for immediate income (Kempner, 1976:340).

Rewards are not distributed randomly throughout an institution but are arranged in an orderly relationship known as the reward system. Generally the reward system correlates fairly closely with the status system (social position, system of rank or relative importance in society). Not only does this happen but it is widely considered to be morally right that it should happen, and where, for whatever reasons, there should develop a disjunction between the two systems, there will be dissatisfaction, particularly on the part of the individual or group whose rewards are below those implied by their status (Kempner, 1976:339-340).

(dd)   SATISFACTION

Satisfaction means satisfying or being satisfied in regard to desire or want or doubt, something that satisfies desire or gratifies feeling (Sykes, 1976:1004).

(ee)   JOB SATISFACTION

Job satisfaction may be defined as a pleasurable or positive emotional state resulting from the appraisal of one's job or job experiences (Locke, 1976: 1300).

Job satisfaction results from the attainment of values, which are compatible with one's needs. Among the most important values or conditions conducive to job satisfaction are the following: Firstly, mentally-challenging work with which the individual can cope successfully. Secondly, personal interest in the work itself. Thirdly, work which is not too physically tiring. Fourthly, rewards for performance, which are just, informative, and in line with the individual's personal aspirations. Fifthly, working conditions which are compatible with the individual's physical needs and which facilitate the accomplishment of his work goals. Sixthly, high self-steem on the part of the employee. Seventhly, agents in the workplace who help the employee to attain job values such as interesting work, pay and promotions, whose basic values are similar to his or her own and who minimize role conflict and ambiguity (Locke, 1976:1328).

(ff)   ATTITUDE

Allport defined an attitude in 1935 as

a mental and neural state of readiness, organised through experience, exerting a directive or dynamic influence upon the individual's response to all objects and situations with which it is related (Allport, 1935:798-844).

According to Halloran, Allport at the same time referred to the concept of attitude as the most distinctive and indispensable concept in the whole field of social psychology but he also admitted that the nature of the concept was still in dispute and that there was still a considerable degree of confusion surrounding it (Halloran, 1970:14). Therefore a precise definition of attitude is difficult because the concept overlaps with other kinds of psychological concepts (Halloran, 1970:14).

1.8   METHOD OF RESEARCH (RESEARCH METHODOLOGY AND LITERATURE SURVEY)

In making a decision regarding which approach is suitable for research, one has to evaluate which criteria are most significant to the study. For this research three main types of research methods are employed. The first approach to the investigation is theoretical based on theories of motivation and job satisfaction extracted from books, journals, periodicals, magazines, newspapers and other written media such as those legislated in the Botswana General Orders for civil servants supplemented by departmental sources. The information on attitudes of nurses was elicited mainly from sources such as research projects on nurses carried out in the health services and articles in the newspapers written by members of the general public, workshops held by the health personnel throughout the country and from other utterances such as those made in Parliament by politicians. The sum total of all these sources were the secondary data which were useful particularly when examined later alongside the primary information obtained from nurses by means of interviews and questionnaires which constituted the second and the third types of research approach, respectively. Questionnaires which played the principal role in gathering the data were distributed to nine hospitals and twenty-five clinics. Interviews of a small sample of nurses from clinics and hospitals provided subsidiary information.

For this study structured interviews were used for the nurses in the selected institutions. In view of the multifarious interpretations of what causes job satisfaction and dissatisfaction and what motivates nurses, the personal interview method attempted to get an across-the-board perception of the different factors that feed into these conceptions. However, because of the time constraints on the part of the researcher, it was not possible to interview a large sample of nurses. Nevertheless the interview of these qualified nurses yielded from their own experiences what problems in respect of job satisfaction and motivation they faced in the health services.

In order to gain access to as many nurses as possible the questionnaire method was more appropriate than the interview schedule. It had the advantages of being

relatively cheaper than the personal interview method. It was also quicker and easier to process and analyse data than the interview method. Unlike the personal interview which may suffer from the effects of the personal characteristics the questionnaire approach is impersonal although it suffers from a serious disadvantage of non-response.

While the personal interviews added quality to the primary data and the questionnaire method collected quantitative data, a combination of the two approaches was expected to produce a satisfactory balance of the two techniques.

The collected primary data were interpreted and treated within the framework of the job expectancy, motivation and job satisfaction theories. This conceptual framework leads to questions such as what expectations do nurses have from their work?; what motivates them in their job?; what job factors give them satisfaction?; and to what extent are their attitudes towards their work affected by styles of supervision? There is a host of other questions which can be posed to nurses to elicit their reactions to various factors in their work environment.

The use of a paradigm proposed above can be handy in, firstly, collecting data such as facts, opinions, views, responses and reactions from nurses in respect of motivation, job satisfaction and attitudinal factors in their work. Secondly, from a diagnostic point of view, the cafeteria or cocktail of ideas obtained from nurses can help determine which factors affect their motivation and job satisfaction in their daily work. Thirdly, once a fair knowledge of the problem nurses experience in their job in terms of motivation and job satisfaction factors is identified, this will form the basis for proposals to improve their work situation and also a foundation for a follow-up and a remedial action on the part of the nursing management.

1.9 REFERENCE TECHNIQUE

The reference method used in this study complies with the Harvard reference technique. The sources consulted are arranged in an alphabetical order that appears in the list of sources at the end of the thesis.

1.10 SEQUENCE OF THE CHAPTERS

Nurses form part of an expanded public service in Botswana. They play an important role in the provision of health services. But as is expected in the rendition of any service, quality is of central concern to the consumer. In the case of nurses, quality of the health services has become an area of scrutiny by both politicians and members of the general public. Nurses have become the common butt of criticism particularly in the hospital health facilities in the country. Thus, to enable them to meet the expected high standards of health services, they now need more than willingness to work harder. They require to be motivated and to be satisfied in the execution of their duties. These broad catchwords, viewed in the context of the attitude of nurses

themselves towards various matters that impinge on their work environment, comprise the composite meaning of this thesis.

Chapter 1 is an introduction containing a commentary on the choice of the subject matter. The hypotheses for the inquiry are stated and the research design and method of study are described. The aim and significance of the study are laid out, as well as the reference technique used. The chapter ends with a summary of the contents of the study.

Chapter 2 traces the evolution and subsequent development of the health services of Botswana from the time of independence to the present day and shows the milestones of their maturing process. This was guided by government policy with a conspiruous thrust on the education and training of nurses, coupled with the construction of health facilities country-wide. The need to administer efficiently and effectively such dispersed health services, ushered in a policy of decentralisation to allow adequate participation at the grassroots level by the community. Accordingly the chapter outlines a chronological development of the health services with an emphasis on the theme of primary health care which is an integral part of the decentralised health services. The chapter ends with an examination of nurses' grievances in their workplaces brought about by the exigencies of an ever-growing complex health services system.

Chapter 3 is an analysis of the nature, scope and content of a motivational system. It gives a detailed exposition of the early life experiences of an individual in a family setting focusing on the development of his or her self, his or her emotions, motives, behaviour and his or her attitudes, particularly in the sphere of employment. Relevant to this study is also the role played by mothers in the formative stages of behaviour patterns and the inculcation of certain attitudes, over and above the influences emanating from the various social contacts during the whole period of growing up. By outlining the different phases in the development of motivation through relevant theories from childhood to adult life, the picture of a potential employee is painted, in respect of all the various motives that he or she brings to work. But as the employee's motives do not exist in a vacuum, it is befitting to view them in the context of a management climate, leadership style and supervisory practices in order to discover how they interface or interact with the numerous job factors such as morale and productivity, amongst others, to affect the entire work environment and its relationships. In the end a recruitment process is scrutinised to see whether it is efficacious, in the first place, in selecting employees equipped with suitable motivational paradigms to benefit the employer.

In Chapter 4 there is an in-depth delineation of job satisfaction in its multiple aspects. The historical precedents provide a fertile ground for a subsequent debate in an area of work which has defied the application of a single theory. The chapter also chronicles a number of variables that make up the cornerstones of satisfaction at work. The Hawthorne studies and the Maslow and Herzberg theories are analysed with a reference to their application to job satisfaction. Since job satisfaction and motivation undergird each other, after analysing some models of job satisfaction, the chapter proceeds to pick out some job satisfaction components to show how they motivate an employee. But in view of the absence of a universal agreement on job satisfaction theories, let alone on the components thereof, the chapter eventually settles down for the compromise, that since there is no one way to motivate

employees, similarly, there is no one route to job satisfaction. As such the chapter, smarting under the lack of unanimity on job satisfaction, seeks refuge in the theory of work itself, and the attendant attitudes towards it.

Chapter 5 deals with a variety of nurses' encounters with many impediments in their work environment. It discusses the nurses' attitudes over important issues surrounding their working conditions. The chapter shows that at the centre of the public's misgivings about the health services, is the image of nursing. The public's expectations, fanned by politicians and the media, of what nurses ought to be doing, and what they are able to do, constitute the fig/eaf for the dissatisfactions with the health services on the part of both the community and the nurses. The criticism of nurses over patient care, is an offshoot of the discordant conception of the role of nurses in the health services by the public. The nurses' attempt to foil this adversarial attitude overshadows their own plight in the health services, bringing them back to where they started, that is, powerless to change course in their work situation. Faced with these difficulties, nurses have clamoured for further education and or training in order to arm themselves with more knowledge to enable them to be more assertive in determining how their job should be done. This is an addition to their list of dilemmas in the work-place.

Chapter 6 consists of the empirical findings. The research results are analysed not only alongside the initial hypotheses and assumptions, but also in the context of relevant theories that have featured in the previous chapters. This chapter, in essence, represents the apogee, the culmination or the *raison d'etre* (reason for thing's existence) of the whole study, in which all the preceding work in the thesis congeals or solidifies into an epitaph.

Chapter 7 provides a summary and conclusions of the thesis, as well as the recommendations, which are a by-product of the findings, while a list of the sources consulted for the study is outlined in the list of sources.

1.11   SUMMARY

The chapters are linked vertically to one another and are substantially related to the title of the thesis. This fact is amplified and made clearer by the horizontal linkages, running through the lengths and breadths of the chapters, detailing the subject matters pertinent to the study. The first chapter forms the seedbed of the planned investigation, while chapter two opens the floodgates into the playing field in which the research is conducted. Chapters three to five address the academic forum upon which the survey is mounted. The sixth chapter represents field work which gives meaning to the theory of the preceding chapters. The final chapter provides a synopsis of the whole thesis.

CHAPTER 2

STRUCTURE AND OPERATION OF HEALTH SERVICES IN BOTSWANA

2.1 INTRODUCTION

Health is influenced by an array of demographic, socio-economic, political, cultural, environmental and other factors that are constantly shifting. Urbanisation, long-term unemployment and the ageing of populations also impact and exert pressure on the health services. For these reasons most countries have sought to adopt health structures and policies that will use resources more efficiently and encourage behaviour patterns that promote health. Such reformed health systems will need health care personnel who can provide the essential elements of primary health care effectively within cost constraints. This demands the optimal and efficient use of human resources, inter-sectoral co-operation and partnership between individuals and communities (World Health Organization, 1996:2-3). Botswana is not an exception to this scenario.

On 30 September 1966 Botswana achieved its independence. Ever since the country has been one of Africa's star performers, both economically and in the development of its health services. This was the result of sound development management (Hope & Edge, 1996:53). As a consequence of Botswana's inaugural political leadership it has been natural for the country to show commitment to social progress and to consider human resources to be of capital importance in development planning. The country's leadership realized that Botswana's sustainable social progress could not take place without adequate action to promote and protect the well-being of the nation (Republic of Botswana, 1995a). This was especially evident in the government's commitment to the development of health services in the country. This awareness symbolized the fact that human resources were the single most critical factor in the delivery of health services (Republic of Botswana, 1990:70).

The National Institute of Health Sciences is the main source of supply of the health human resources in the form of nurses who are posted to the different grades of health facilities such as the health posts, the clinics and the hospitals. But in spite of the large number of trained nurses the demand for nursing manpower continues to grow in parallel with the increase in the health service facilities. However, what complicates the configuration of the health services in Botswana is that the health care demands of the people are growing in quantity as well as in quality. This should be expected in a country where incomes have been rising and life styles have become more sophisticated (Republic of Botswana, 1990:71).

Botswana is often cited as a success story in its economic management and good governance. Since the 1990's the effectiveness of its health services has been pivotal to its success, notably in reducing the infant and under-five mortality rate and in increasing life expectancy (Republic of Botswana, 2003:i). But historically it was axiomatic that a modern way of life prevailed in towns and was enjoyed by the lesser number of people compared to the larger proportion which lived in an almost permanent state of mendacity and deprivation in the countryside. As the rural

population is spread all over the country, the construction of the health service facilities has been driven by this dispersal of the populace. The physical structure, therefore, and the pattern of human settlement are factors which dominated the minds of the government health service planners.

The plan of the chapter aims at capturing the historical sequence of the health services, their evolution, their administration and the main participants in their operation. Accordingly section 2.2 gives a brief outline of the size of the country and the mode of population settlement. This is followed by section 2.3 which describes how the missionaries tried to reconcile the teachings of religion with the notion of the health services. The missionaries' myopic view of the health services is broadened in section 2.4 which ushers in the idea of a multi-sectoral philosophy to the provision of health services. The thread of this approach is introduced in sub-section 2.4.1 which traces its beginning.

Subsections 2.4.2 and 2.4.3 examine the hierarchical and decentralization structures of the health services with sub-subsections 2.4.3.1 and 2.4.3.2 considering respectively, primary health care as the model for the provision of heath services and community participation as its offshoot. Sub-subsections 2.4.3.3 to 2.4.3.6 detail various participants in the community health services. The roles of the family welfare educator and of the traditional and modern leaders in the community health services are described in sub-subsections 2.4.3.3 and 2.4.3.4. This is followed by an exposition of the part played by the development committees and other institutions in the community health services in sub-subsection 2.4.3.5. The controlling power of the district health teams in the community health services is pursued in sub-subsection 2.4.3.6. Section 2.5 scrutinizes the coordinating role of the national health policy in the health services revealing its externalities. Section 2.6 provides the summary and conclusions of the whole chapter.

2.2 PHYSICAL PROFILE OF BOTSWANA AND LOGISTICS OF HEALTH SERVICES

Botswana is a land locked country with an area of 582 000 square kilometers. It stretches 1110 kilometers from the south to the farthest north and 960 kilometers across at its widest part. Botswana's topography can be divided into two major sections, that is, a relatively narrow band running along the eastern border encompassing Lobatse, Gaborone and the Tuli Block and the vast western portion which is flat, semi-arid with scanty features save for some rocky outcrops. The former is the eastern region or the Limpopo river catchment area which straddles the north-south railway line and is characterized by a somewhat less harsh climate and more fertile soil than elsewhere. It is here that most of the Botswana live. It is estimated that more than 80% of the human settlement is found in this eastern part of the country (Selelo-Kupe, 1993: xxxi-xxxiii). However there are also human habitations in the Ghanzi ridge in the west and along the line of the Molopo River in the south. A further settlement extends from the west of the Limpopo watershed to the Nata River and westwards to the Boteti River (Republic of Botswana, 1984b:3; Republic of Botswana, 1997:49-51).

The concentration of the health facilities in regard to both the quantity and the quality has been influenced or determined by this pattern of human domicile. There are more hospitals and clinics in the eastern portion than the number of health posts found in the western part and in other thinly-populated areas of the country (Republic of Botswana, 2000:4-7). When the missionaries arrived in Botswana they took advantage of or were guided by the economies of scale in respect of human settlements to carry out their missionary word.

2.3 MISSIONARIES AND NOTION OF HEALTH SERVICES

The introduction of western health care to Botswana in 1924 was a result of contact between people of European origin either as missionaries or as colonial authorities and the local residents. These two categories of people became the principal actors or agents in the introduction of scientific health care. Western medicine was firstly meant for their own use and was secondly extended to the few Africans either as a token of kindness or in exchange for some favour either rendered or expected from the African(s) involved in the transactions. In the case of the missionaries western medicine was used primarily to entice or wheedle the African into espousing Christianity as his or her religion. This was as far as the concept of health services went as many Christian missionaries considered prayer to be more beneficial at the time of sickness than treating the patient. They believed that spreading the gospel through the evangelist and setting up schools to teach the people to read and write in order to enhance their knowledge of the Bible was more important than providing them with a health service. In their view the health of the soul seemed more important than the health of the body. Pursuant to this philosophy the majority of the missionaries believed that faith and prayer were sufficient to ensure African health (Selelo-Kupe, 1993:7-8).

Thus the evolution of missionary thinking started from a belief in healing by prayer alone. This then progressed to accepting the fact that medical science and the application of its knowledge through the medium of a trained person was correct. But the bottom line remained that this was more effective when it was combined with prayer. The medical missionary characterized by this way of thinking was therefore born. It was believed that through the healing brought by the gospel the medical missionary would be the means through which the faith or Kingdom of God could be conveyed to the unbelievers. The expectation was that when the sick recovered they would be grateful to their doctor, to the mission and, most importantly, might embrace the Christian faith. The mission doctor and nurse were thus a part of the purpose of the mission which was to bring the light to the unbelievers.

The British colonial power annexed Botswana in 1885 bringing with them western medicine for their own personal use. As the number of colonial officers increased, some rudimentary health facilities were constructed for their use but not for the use of the native Batswana. The first of such vestigial structures was a grass-roofed cottage hospital put in place in 1890 at Motloutse near Bobonong village in the eastern part of the central district for the use of pioneer soldiers. The pioneer column had a nursing contingent of nuns of the Dominican Order (Selelo-Kupe, 1993:8-9). When the early 1920s witnessed a significant deterioration of the health of the

Batwana as a result of the 1918 influenza epidemic and the impact of the First World War between 1914 and 1918 it was this worsening of the health situation which prompted the building of the first missionary hospital for the African population in 1922 by the Seventh Day Adventists in Kanye in the southern district (Selelo-Kupe, 1993:9).

The escalation of diseases in the country and the pressure from various tribal chiefs as well as the challenge posed by the Seventh Day Adventists precipitated government action and galvanized other missionary organisations into providing health facilities for the African population. In 1928 a second hospital was built in Serowe in the central district. Although it was known as a government hospital it is believed that this hospital was built largely at the initiative of the tribe that contributed a large sum of money towards its construction. It was opened by the Earl of Athlone in 1929 and was named after Chief Sekgoma of the Bamangwato. The Sekgoma Memorial Hospital had twelve beds for Blacks and four for Whites. However, the hospital only became functional in 1931 due to the lack of a water supply. It may also be noted that prior to the construction of this hospital, the only health facility in Serowe, was a small hut dispensary for the storage of medications (Selelo-Kupe, 1993:10).

In 1931, a second government hospital was opened in Lobatse in the southern part of Botswana. This hospital also had twelve beds for Blacks and four for Whites. It was named after the Earl of Athlone, and continues to bear the same name today. In the same year a German Dominican congregation of the Roman Catholic mission also opened a clinic in Khale near Gaborone in southern Botswana. The year 1932 saw the construction of yet another London Missionary Society maternity clinic in Serowe as well as the building of a twelve-bedded Dutch Reformed Church hospital in Mochudi, about thirty-two kilometres from Gaborone. The hospital was not in use for many years because of the scarcity of medical doctors (Selelo-Kupe, 1993:10).

The history of the medical services amongst the Bakgatla of Mochudi is tied up with the history of the tribe as it moved from western Transvaal to Bechuanaland. Chief Kgamanyane of the Bakgatla-baga-Kafela left the home of his tribe in western Transvaal with his people in 1870 and turned towards Bechuanaland. He finally settled in Mochundi. When chief Kgamanyane died in 1874 his son chief Linchwe1 took over the leadership of the people. Being a friend of the missionaries the new chief's attitude encouraged lady missionaries to come to Mochudi and notable among the new arrivals was Miss Deborah Retief who arrived in 1887. Her devoted service, that is, sharing many hardships and epidemics with the tribe rendered over a period of forty years resulted in the Mochudi hospital being named Deborah Retief Memorial Hospital honouring her. Organized nursing services in Mochudi started about 1924 and the first medical doctor arrived in 1927 starting a long list of doctors who have since rendered and are still giving their services to the hospital (Selelo-Kupe, 1993:16-17).

Two years after the opening of the Mochudi hospital the Roman Catholic Church built a second clinic in Ramotswa. This forced turned the Lutheran Mission which had been in Ramotswa focussing only on spiritual work for some seventy years to start a small dispensary which was credited with providing a sterling service. In 1935 the colonial government opened its third hospital in Francistown called the Jubilee Hospital. It was so named because it was built during the jubilee year of King

George V and Queen Mary. It had twelve beds for Africans and four for Europeans. The London Missionary Society opened its third maternal and child health clinic at Maun in northern Botswana in 1936. The Seventh Day Adventists opened their second hospital in Maun in 1937 which had twenty beds for Blacks and four for Whites (Selelo-Kupe, 1993:18-26).

The work for the provision of health services started by the missionaries was to continue throughout the country as the colonialists and or the missionaries settled in selected regions of the country. What daunted the settlers; however, were the diseases peculiar to the country or to the regions. For these health problems a multi pronged approach was needed in order to yield a universal solution to the country's health services in the long run (Selelo-Kupe, 1993:24-26).

2.4 MULTI-SECTORAL APPROACH TO HEALTH SERVICES

Attempts to improve the health status of the population require a multi-sectoral and intergrated approach at the community-level, and as a corollary, community involvement at all levels of the health services is a mandatory requirement. The multi-sectoral modality means that provision of education, better agricultural practices, clean water and adequate housing as well as the health services themselves must be seen as contributing to the ultimate objective of better health. The integrated approach behoves that the preventive, the promotive, the curative and the rehabilitative services must all be available as part of the health services. The irony of all these measures is that simple, but basic, changes in individual and community attitudes and practices can result in significant and lasting health improvements.

There are inter-ministerial committees which have been formed between the Ministry of Health and the other ministries to deal with health-related matters. One of the most important of these collaborative efforts is the inter-ministerial committee between the Ministry of Health and the Ministry of Local Government, Lands and Housing. Other significant inter-ministerial committees are those between the Ministry of Health and the Ministries of Home Affairs, Foreign Affairs and Agriculture (Republic of Botswana, 1984c:39).

The Ministry of Health has adopted a selective variety of intra-ministerial strategies as part of its many-sided perspectives towards improving the general health of its citizenry. For example, maternal, child health and family planning is targeted at improving the health status of mothers and children. It is maintained that the health of women of the reproductive age is crucial for both their reproductive role and for purposes of maintaining a stable and a healthy family life. In this regard the protection of the health of mothers and infants through family planning services to enable each family to be of a reasonable size corresponding to its socio-economic and health conditions, has been of primary importance. One of the main plans of action used to achieve this goal was the expanded programme of immunization which was aimed at vaccinating all eligible children. From its inception in 1990 it was directed at reducing infant morbidity and mortality which were caused by preventable diseases (Republic of Botswana, 2004:18). For this to be realisable accessibility of

the services to the communities was improved and this was done within the context of the overall development of the basic health services (Republic of Botswana, 1984b:25, 27, and 28).

A national nutrition policy is part of this broad approach to preventive basic health services. Its main objective is to develop, introduce and maintain an effective regular programme on nutrition. Some aspects of this programme include establishing a data base of the nutritional status of the various groups in the community with particular reference to identifying the causes and the effects of malnutrition. On the basis of this an analysis of the nutritional contents of the various food products is carried out leading to the propagation of information on balanced food and nutrition guidelines as well as the issuance of advice on food preservation (Republic of Botswana, 2004:ii). The treatment of some infectious diseases such as tuberculosis which is closely aligned to the nutritional status of the sufferers has been made easily accessible to all patients in the country. The specific task of the national tuberculosis programme is to identify tuberculosis cases and to monitor the defaulter and the cure rate from treatment. It operates in a similar fashion to the sexually-transmitted diseases control programme that is aimed at improving the diagnoses, contact-tracing and the treatment of those affected in the health facilities (Republic of Botswana, 2004:10). One of the most all-embracing programmes is offered by the Health Education Unit. Since its beginning in 1974 it has been strengthening its organisation to accommodate the increased demand for services at the local, the district and the national levels. The overall objective of the Unit was summarised as developing, implementing and maintaining an effective programme of health education at all levels of the health system, catering for all aspects of health services such as promotive, preventive, curative and rehabilitative (Republic of Botswana, 1984b:27,28-29).

Dental health belongs to the preventive group of health problems. The dental health service programmes have, therefore, been developed as part of an overall health care system using an integrated approach. This has called upon the services of different personnel such as nurses, family welfare educators, regional health teams and school teachers to assist the dental staff in the promotion and execution of their preventive and first-aid programmes. The underlying assumption or kingpin of a primary preventive programme is that it will produce the appropriate behaviour patterns in individuals, families and communities. In the example of dental health it will promote effective oral hygiene to prevent tooth decay and gum diseases. The restriction of sugar consumption to 13 kilogrammes per head per year to prevent tooth decay and the appropriate fluoride exposure to increase the resistance of such tooth deterioration are all part of a prophylactic (tending to prevent disease) programme. Most of the dental health service facilities were constructed in accordance with the National Dental Plan of 1982-2000 (Republic of Botswana, 1984b:29).

Oral health care plays only a small part in safeguarding the health of the people. The other safeguards comprise the provision and protection of clean water supplies, the disposal of waste and the protection of food and drink from contamination. All these variables constitute environmental health problems. With regards to water the Ministry of Health strongly supports the Department of Water Affairs to supply potable water to the villages. But it is believed that the provision of clean water supplies without adequate education on water usage and safe storage in the rural villages

would be worthless. To support this view the water hygiene campaign and the health education programme were designed to run concurrently. Attention to hygiene conditions has also been paid to food preparation and food manufacturing in order to reduce as much as possible the incidence of all factors that can cause diseases. This orientation to prevention of diseases will be accomplished by both health education and health inspection. In the field of work it is generally accepted that poor health has a debilitating effect on the workers' productivity. The other side of this view is that only when people are healthy can they be able to make the most of training or work opportunities. According to this view a national workers' health programme has been formulated to provide a comprehensive coverage to employees in all types of occupations, that is, in the traditional and modern sectors of the economy. The workers are expected to participate in the training of health personnel, in the production of educational aids on workers' health, in the health education promotion of primary health care in work places and in the activities pertaining to health surveys and investigations (Republic of Botswana,1984b:29-30).

It has been stated in the foregoing that the government expressed concern about a number of health issues such as curbing the morbidity and the mortality caused by preventable diseases. It was also worried about the need to improve the general health standards of the population. To this extent the government has made Herculean efforts to deal with the whole human environment, commencing for example, with the basic health needs such as those impinging on public health and nutrition. The end aim of all this is embedded in the belief that a healthy individual is productive. All these government initiatives could only be translated into concrete action through a properly structured health service.

2.4.1   Genesis of broad-based provision of health services

In the face of devastating and unremitting health problems facing the population, the government, after independence, decided to organize the health services within the given parameters of the location of the population and the scarcity of the health personnel (Republic of Botswana, 1984a:46). At independence in 1966 Botswana had inherited a largely curative and hospital-based health service which left the majority of the population without access to any health facilities at all (Republic of Botswana, 1984b:10). This kind of health services division found in the few available hospitals had suited the colonial masters but denied many people, particularly in the rural areas, any means of relief from various illnesses. Having inherited from the colonisers an inadequate hospital-focused health service, it was necessary to devise a wider approach to the provision of health care. Later on it dawned on the government that much of the country's population and the concomitant health problems that went with it were in the rural areas that were too dispersed to be served by the larger hospital institutions. In the face of this awareness and challenge the central government of Botswana accepted the responsibility for improving the health of its citizens through the development of a regionalised and organised health service. This was accomplished by developing smaller and widely-dispersed health service units. The other methods of improving the health services in the distant areas included increasing the education levels of the health manpower and integrating all the health care units both large and small

into a functioning whole. All these strategies were coupled with the necessary improvement of the existing hospital and health centres (Republic of Botswana, 2002:1).

As is often the case with most developing as well as developed countries, the first emphasis on creating or planning health services is curative care. Botswana was not an exception although it partly inherited what was initiated by the colonial agents and partly developed its own. Consequently it embarked on a long-term effort to establish a mixture of preventive and curative health services and to extend them into the rural areas. The government emphasized five milestones in the development of health services. The first was the need to construct clinics and health posts in all settled communities of more than 500 people. The second concern was to train and appoint health personnel to work in the rural areas. The third plan was to improve rather than to expand hospitals. The fourth need was to use hospitals as the highest level within the health care referral system. The last aim was to accelerate the training of the para-medical and auxiliary staff. The government's motto was to reach the greatest number of people possible with the broadest level of health services which it could afford (Republic of Botswana, 1988c:2-3).

The central theme of the Ministry of Health remained that of upholding the principle of providing a comprehensive health service to the various communities throughout the whole country. To do this the curative and preventive aspects of the health services were to be integrated and aimed particularly at the community or the village level. In establishing a well-balanced health service system major objectives in order of their priority were spelled out. Firstly, the strengthening of primary health services which were distributed equitably but with an emphasis on the rural and peri-urban areas was of primary importance. Secondly, the expansion and the diversification of training facilities and opportunities for medical and paramedical personnel had to follow the first goal in order to create a sound knowledge base for the effective running of the services. Thirdly, a programme aimed at the improvement of the hospitals and the health services so as to ensure adequate referrals and various specialists' services was instituted. Fourthly, the core basic objective in the process of all these priorities was enshrined in the control and the reduction of the diseases caused by an unfavourable environment by means of immunisation, surveillance and treatment. Of course as it is often argued, immunisation alone, for example, is not enough. Fifthly, the expansion and the broadening of the health education training programmes catered for the mental and the attitude preparedness of the health staff involved in teaching health education in the community. Finally, there was an increase in the Ministry of Health's administrative and planning establishment in order to manage and oversee the priority innovations (Republic of Botswana, 1984a:54).

In accordance with the principle of striking a balance in the provision of health services between rural and urban centres and between preventive and curative health care strategies the government evolved the country's stratified health system.

2.4.2   Pyramidal structure of health services

Health services in Botswana are provided by the central and local governments, the missions, the mining companies, the private and the traditional practitioners and other non-governmental and voluntary bodies such as the Red Cross. The central government represented by the Minister of Health is responsible for the general planning and supervision of the health care system and for the operation of the government hospitals and health centres. The Minister reports to the President who is both head of the Cabinet and the government. There are three health-related departments at the central government level. Firstly, the department of hospital services deals mainly with the management of hospitals. Secondly, the department of primary health care specializes in services such as community and environmental health, occupational health, rehabilitation and field inspectorate. Thirdly, health technical support services oversee the national health laboratory and the health technical equipment functions (Republic of Botswana, 2001:3-4).

At a local government level the department of social and community development within the Ministry of Local government, Lands and Housing, similarly headed by a Minister, administers local health services such as council clinics. One of the most important decentralization structures is the district health team which is supervised by a medical officer. It includes a number of other professional personnel, for example, health inspector, tuberculosis control officer, health education officer and public health nurse. As its name implies the district health team is responsible for all the health services in its region or district. The town and district councils have been apportioned responsibility for the construction, maintenance and operation of their clinics and health posts and also for the public health measures. The missions take responsibility for the operation of their hospitals and clinics although they are supported with an annual subvention by the Ministry of Health. Similarly the mines in Orapa, Juaneng and Selibe-Phikwe operate their hospitals for the benefit of their employees and dependants (Republic of Botswana, 2001:3-5).   The central government relates with the local and the district health services through a variety of inter-sectoral committees and sub-committes, for instance, the Rural Development and the Rural Extension, respectively (Republic of Botswana, 2001:5-6).

Although as far as health facilities are concerned the lowest level is the health post, there are mobile stops or units below this functional division which are operated by regional health teams. But since the regularity and the frequency of the visits by the mobile units are governed by the availability of staff and transport, the significance of the mobile stops is minimal. Health posts are staffed by family welfare educators (FWEs) who must have at least a primary school level of education. The other qualification is that a family welfare educator must be selected in the first instance by a village development committee (VDC). If the proposed candidate is approved by the regional public health nurse, who is part of the regional health team, then she or he is sent to a training centre for an eleven-week period of training before returning to the village. Any rural village which has a population of 500-1 000 people should have a health post and a family welfare educator and naturally larger villages should have a number of family welfare educators. All health posts are visited on a regular basis by supervisory personnel who are usually nurses who not only monitor, but also act as a perfect complement to the work of the family welfare educators (Republic of Botswana, 1984b:46).

The latter are also found in the clinics which provide the next level of health care in the pyramid of health services. In addition to the type of preventive and first aid services provided at the health posts, clinics cater for a wider range of health services. They collect statistics, carry out immunisations and normally have from six to ten beds for curative and maternity care. The criteria for establishing a clinic in the rural areas was that there should be a population of 4000-8000 within a radius of 15 kilometers (Republic of Botswana, 1984b:46). The government has committed itself to the "Health for All" by the year 2000 through the enhanced provision of primary health care (PHC). According to this ambition by the end of the decade every inhabitant of Botswana should have attained a level of health that allows him or her to lead an economically and socially productive life through access to essential health care. However, the availability of clinics at a government recommended distance is not uniform. For example, less than 70% of some districts in the west of the country have a clinic inside a 15 kilometer radius (Republic of Botswana, 1984a:49). In contrast in the major urban areas more than 90% of the population is within 8 kilometers of a health care facility and in Gaborone, the capital city, for instance, 100% of the residents are within the 8 kilometers–radius of a health care facility (Republic of Botswana, 2000:55).

The next level of health care is provided at the health centres. Although all health facilities in Botswana provide a combination of both curative and preventive services the main curative referral facilities are the health centres and the hospitals. The former are designed to duplicate on a small scale most of the simple curative functions which are usually provided at the hospitals as well as providing maternity and preventive health care. Health centres are usually located in remote areas with a low population such as Bobonong and Kasane. In between the health centres and the district hospitals are the primary hospitals such as Gantsi which are more advanced than the health centres but less sophisticated than the general hospitals in terms of both equipment and medical expertise. The highest levels of health care are provided at the district hospitals and at the main referral hospitals such as the Princess Marina hospital in Gaborone (Republic of Botswana, 2000:3).

The gradation of health facilities as pointed out above is based on the levels of skills obtainable at each designated health care point. Thus the referral system provides increasingly sophisticated services at successive levels. It has been said in the second paragraph of this subsection that in the very remote areas the first point of contact is the mobile stop. Then the health posts represent the primary levels of health care. The clinics develop further the functions found at the health post level. With the district health teams now transferred to the Ministry of Local Government, Lands and Housing, they play a crucial role in implementing the primary health care strategy and will continue to serve as cornerstones of the decentralised system. Local authorities are administratively responsible for these facilities with the Ministry of Health providing professional supervision and technical support services (Republic of Botswana, 2000:3-4).

The remaining levels of the referral system are the primary hospitals, district hospitals and the national referral hospitals. The responsibility for these facilities is held directly by the Ministry of Health. Its functions are to guide and implement, firstly, national health policies and strategies, secondly, health care curative services, and thirdly, health research, investigative and technical support. Fourthly, the Ministry of Health is also concerned with health manpower development and utilization. Its fifth

responsibility is health care administration (Republic of Botswana, 1988b:36-37). To ensure full coordination between the local authority and the Ministry of Health the joint primary health care coordinating committee has operated since 1976. The Ministry of Health participates in various other inter-sectoral committees including the rural extension co-ordinating committee, the town and regional planning board, the rural development council, the inter-ministerial drought committee and the inter-ministerial population committee (Republic of Botswana, 1984a:48-49). The medical missions are represented by the Association of Medical Missions in Botswana (AMMB). The missions maintain close links with the Ministry of Health and their executive co-ordinator is based in the Ministry (Republic of Botswana, 2000:3-4). The Ministry of Health's portfolio responsibility for health services is given vent by both the participants in the health scene and by the concept of health care. These two aspects lie at the heart of the government's efforts to bring health services closer to the people.

2.4.3   Decentralization of health services

Decentralization has been defined as the transfer of authority to plan, make decisions and manage public services from the national level to an agency or organization at the sub-national level which in the case of Botswana is to the district, town or city (Republic of Botswana, 1997:389). Decentralization has not been seen as an end in itself but instead it has been understood and utilized as a means to realize broader policy goals such as furthering development, progressing democracy, implementing the primary health care strategy and increasing efficiency (Republic of Botswana, 1986:324). Decentralization of health services is one of the oldest forms of health sector reform which started soon after independence and was finally approved and implemented in 1984 (Republic of Botswana, 2001:2). In the 1990s the trend towards decentralization was encouraged and spawned by the international donor organizations which made it one of the conditions for giving aid to third world governments. For example, the 1993 United Nations Development Programme (UNDP) report on human development made an elaborate case for decentralization. It argued that the participation of women, minority groups and the rural people could be enhanced by a decentralized system of health services (Molutsi, 1994:3).

Despite its critism by some pundits it is generally believed that decentralization brings services to the people and enhances communication and community involvement in health matters. It is for these reasons that the regional health teams were placed operationally under the district town councils and assumed the title of district health teams. This *modus operandi* was such that while the latter were under the executive and the administrative control of the councils, the Ministry of Health which holds the final responsibility for health in the country would continue to supervise, assist and advise the district health services so as to provide professional guidance and to ensure that the policy of the Ministry was being followed as well as to ascertain that acceptable standards of care were maintained (Republic of Botswana, 1984b:26).

Seen in this light decentralization is essentially about the structural relationships particularly and primarily between the central government and the local authorities. Specifically three interfaces or sets of relationships can be identified, that is, firstly,

between the Ministry of Health and the Ministry of Local Government, Lands and Housing. The second interface concerns the Ministry of Local government, Lands and Housing on the one hand and the subordinate local authorities on the other. The third set of relationships takes place between both the Ministry of Health, the Ministry of Local government, Lands and Housing and the local decision-makers (Republic of Botswana, 1994:5).

The Ministry of Health provides the Ministry of Local Government, Lands and Housing with an overall leadership and direction in the administration of health services with specific reference to professional standards and practices. In turn the Ministry of Local Government, Lands and Housing has a decentralized responsibility for all the health facilities that are run by the local authorities such as the city and town councils. Furthermore, the local level is an active meeting point for a mixture of both central and local government workers, as well as local decision-makers all contributing to the provision of health services. These include the chiefs, the village health committees, the councillors and the health extension workers. The first three groups are community participants who are also local decision- makers, while the last category comprises central government representatives working with local communities in health related matters (Republic of Botswana, 1994:5-6). The two Ministries further rendezvous in the administration of district health services. The Ministry of Health co-ordinates the inter-district health services at a central level. But the Ministry of Local Government, Lands and Housing supervises the day-to-day operations of the health services at the district levels, which are spear-headed by the district health teams. The latter are part of the local decision-makers working conjointly and co-operatively with the councillors, the village health committees and the chiefs (Republic of Botswana, 1994:6-7).

The decentralization of the health services has been accepted as a strategy with all these complex interactional relationships in mind. According to the World Health Organization, the decentralization of power from the national to the local authorities, is a way of putting emphasis on the integration of health care delivery (World Health Organization, 1996:1). It is needless to point out that at the end of the decentralized health services structure are the nurses. It has been noted that all the clinics and the health posts are run by the local authorities and the bulk of the health care at these facilities lie in the hands of nurses (Republic of Botswana, 1984c:74). Every level of the other types of health care facilities including the hospitals is also run and administered by nurses at least as far as nurse-related activities are concerned. Nurses participate in the shaping and the management of the health care system in Botswana. This includes making sure that the needs of the individuals, the families and the communities in general are adequately dealt with (Republic of Botswana, 1994:7-8). Nurses have to cope with the staff shortages and endure protracted bureaucratic protocols in the execution of their duties on behalf of the patients whilst at the same time trying to build and sustain a viable therapeutic team.

Nursing activities in decentralized health services environment are geared towards the promotion of inter-sectoral work in a range of settings including the community clinics, the hospitals, the schools and the workplaces. Thus, the nursing professional has an important role to play in influencing the health policies strategically whether at the local, the regional or the national levels (Republic of Botswana, 1994:9-11). This can be done through the setting of priorities, active involvement in the health programme planning and resource allocation as well as gathering, analyzing and

supplying information at all levels. All this is done against the background of the challenge facing many countries including Botswana to develop a sustainable health infrastructure which will provide health care in an integrated way. The decentralization of power from the national to the local authorities is a way of putting emphasis on the integration of the health care delivery (World Health Organization, 1996:1).

It is also indicative of the need for a structural liaison to aid the smooth functioning of the health services. In practical terms this meant the establishment of a national network of health facilities which could provide a comprehensive health service to the people throughout the country. The government was conscious of the fact that although the basic health services were to be equitably distributed, the emphasis was to be laid on the rural and the peri-urban areas (Republic of Botswana,1984b:24). To a great extent this immediate objective was achieved as evidenced by a web of health posts, clinics, health centres and hospitals which provided a reasonable access to the population in the country. Although staff constraints have limited the effectiveness of these facilities, a lot of spade work has already been accomplished by the family welfare educators playing the role of front line health workers. To capitalize upon this the Ministry of Health decided to give top priority to the concept of primary health care which demands a maximum community involvement and support for all the basic or vanguard health workers (Republic of Botswana, 1984b:25-26).

2.4.3.1 Primary health care as a prototype of health services

The health services are organized in such a way as to provide primary health care in a philosophy similar to saying that if one takes care of the pennies the pounds will look after themselves. That is, if basic health care is taken care of, this should minimize or prevent major illnesses in the community (Republic of Botswana, 1984b:25). Although the primary health care strategy has been explicitly designed as a national approach to the basic provision of health services, its particular focus is to improve the access to health care of those most in need, that is, the poor, those residing in rural areas, women and children and the young and old. The primary health care strategy emphasizes community participation in identifying health problems, setting priorities for action and in planning, organizing and managing health care. Participation is mobilized through health education and community resources which are supported by the health care system via information, training, supervision, materials and referral care. Structures such as the village health committees and the village development committees are important in ensuring community involvement (Republic of Botswana, 1984a:47-48).

The Ministry of Health has realized in its primary health care perspective that attaining good health requires adequate food, safe water, basic sanitation and maternal and child health care (Republic of Botswana, 1991:359-360). The latter includes family planning, immunization against communicable diseases, education concerning health problems and methods of preventing and controlling them as well as the appropriate treatment for common diseases and injuries. The Ministry of Health was also aware of the close links between health and poverty and

consequently an inter-sectoral approach was found necessary including both the public and the private sectors. The health services provided by the non-governmental organizations "top up" and fortify those provided by the public sector (Hope & Edge, 1996:56).

It is reiterated that during the period 1973-1978 the emphasis of health policy was the need to create a network of basic health facilities throughout the country and this goal was gradually accomplished. It also needs to be remembered that the medical missions were the harbinger of the pioneer basic health services. When the Ministry of Health later assumed the lead in the provision of health services country-wide the missions remained in existence and continued to serve the nation from basic health services to curative medicine in their hospitals. The symbiotic relationship between the medical missions, the Ministry of Health and other health services from the mining companies and non-governmental bodies, completes the panorama of the health services in Botswana. The mission dental clinic in Gaborone (now moved to the Seventh Day Adventist hospital in Kanye) in addition to the mission hospitals and six mission clinics illustrates the congenial working relationship between the Ministry of Health and the missions (Republic of Botswana, 1984a:54).

The Ministry of Health has adopted primary health care as a strategy for improving the people's health (Republic of Botswana, 1984b:26). The objective of the primary health care thrust is to integrate the preventive, the promotive, the rehabilitative and the other appropriate curative health care services through the participation of the community groups at all the levels of the national health care system (Republic of Botswana, 1987c:7). Thus primary health care has been accepted by the government of Botswana as the most suitable approach for the attainment of health for all. The central components of the primary health care technology are equity, intersectoral collaboration and community involvement. This basic health care philosophy emphasizes community participation in identifying health problems, setting priorities for actions and in planning, organizing and managing health care. Participation is mobilized through health education and community resources supported by the health care system via information, training, supervision, materials and referral care. The primary health care concept recognizes the fact that the Ministry of Health cannot single-handedly make an appreciable impact on the people's health status. Part of this awareness is the conviction that the people themselves must be fully involved as partners in their own health care. The other ministries and both the governmental and the non-governmental agencies also carry out tributary activities such as advising the less informed part of the population to change its beliefs from traditional to modern medicine. This in general contributes to a positive effect on the people's health care awareness (Republic of Botswana, 1995c:3).

The government had other aims based on the primary health care formula such as the improvement of the quality of the existing programmes, for example, strengthening the intersectional collaboration, and their use to ensure the effectiveness and the affordability of the provision of the health services. The government has also reviewed the upgrading of the health services to make them comprehensive in terms of meeting all the essential components of the primary health care modality. The strengthening of the intersectoral collaboration is based on the notion that the elements essential for attaining an acceptable state of health are many such as adequate food, shelter or housing, basic sanitation and or clean water,

maternal and child care including family planning, immunization against diseases, education concerning the prevailing health problems and the methods of preventing and controlling them, the appropriate treatment for the common diseases and injuries and finally income (Republic of Botswana, 1995a:17).

The primary health care strategy tackles the main health problems of the community with the main emphasis being focused on the prevention of disease and the promotion of healthy living habits. The government is determined to attain its health objectives through the primary health care method because it is seen as the most feasible way to improve the health of every citizen. The other advantage of this approach is that it harbours the notion that there should be an equitable distribution of whatever available health resources there are amongst the population groups. In other words essential health care should be made accessible to every one in such a way that the whole population in the country should be able to enjoy and lead a socially and or a productive life (Republic of Botswana, 1996b:2-3).

The activities for the promotion of health extend well beyond the traditional functions of health care institutions and aim at the creation of environmental conditions and human behaviour that are conducive to positive health. At the same time the preventive activities are targeted not only against communicable diseases but also against many other preventable conditions, for instance, injuries sustained at home and at the workplace. The list also includes interventions such as the provision of guards on machinery to prevent industrial injuries and a reduction in the consumption of refined sugar products. The curative activities consist of the use of drugs, surgery or other procedures to interrupt a pathological process or to reduce the harmful consequences of a disease. Rehabilitation aims at the restoration of the physical, the mental and the social functions of individuals through relevant medical procedures. To illustrate how important primary health care is in adopting a holistic approach to the community's main health problems the integration of the preventive, the promotive, the rehabilitative and the curative services through the participation of the community groups at all the levels of the national health care system has been served by the primary and district hospitals (Republic of Botswana, 1986:3).

Primary health care is community-oriented (Republic of Botswana, 1993c:3-5). It seeks to enable communities and individuals to take the necessary responsibility to take care of, and improve, their own health. As a logical consequence of this way of thinking the government decentralized a number of certain health functions, for example, the mother and child health services, with an emphasis on ante-natal and post-natal care including family planning and the care of children up to the age of five years (Republic of Botswana, 1994:7-8). This also includes immunizations against the major childhood diseases such as tuberculosis, measles, diphtheria, pertussis (whooping cough), and tetanus and polio myelitis at all the clinics with maternity wards in the country. All the country's health posts and clinics provide a certain degree of school health services whose extent and quality vary from one village to another, depending on the availability of family welfare educators. The diagnosis and the treatment of the common diseases and injuries are carried out at each peripheral health facility while the treatment for tuberculosis is available from all the health points. The health education and health promotion programmes, although difficult to quantify and measure, are very important components of primary health care. They are delegated to the local authorities and are implemented by the family welfare

educators and nurses both of whom are in the forefront of the health promotion activities (Republic of Botswana, 1994:35-36).

The health education programme is more pronounced at the district level where districts offer their support for community action through the village health committees (VHCs). The latter organize various competitions to promote good health. The health education unit at the ministerial level in conjunction with the district health teams organizes workshops for the extension workers to enable them to develop reactivation strategies (Republic of Botswana, 1997a:10-15).

Although the country is also committed to other important national goals, for example, social justice and equity, the primary health care approach underpins the national health policy. It is defined as

essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation at a cost the community and country can afford. It forms an integral part both of the country's health system of which it is the nucleus, and of the overall social and economic development of the country (Republic of Botswana, 1984c:24).

The aim of primary health care is that people will finally learn to integrate the concept of "health" in their way of life and will not equate it to, or confuse it with, medical care which is a commodity dispensed by medical personnel and institutions. The primary health care strategy recognizes that although the Ministry of Health is the overlord of the health services it cannot on its own make an appreciable significance on the people's health status. The most important aspect of the primary health care approach places emphasis on the idea of people's partnership in their own health care (Republic of Botswana, 1984b:26).

As distinct from other approaches primary health care is a neutral, conceptual and concrete model for the provision of health care. It is neither a medical, a nursing care nor an economist's model. But it is a human and social development model within which nursing can carry out its larger mission, that is, care and healing, the promotion and the maintenance of health without sacrificing its professional principles of excellence, accountability and patient advocacy. By virtue of its human and social development focus the primary health care approach, therefore, stresses community involvement and participation in the care that is planned and executed for individuals, families and communities. The approach by so doing challenges nursing to work within a multi-disciplinary health team. It also demands that the nurse should consult fully with the other members of the health team. The concept of a multi-disciplinary team requires that nursing reconsiders its definitions of nursing practice and the nature of health care provision (Republic of Botswana, 1987e:28).

According to basic assumptions of both decentralization and primary health care, local participation in health services is associated with several benefits. For example, it brings additional resources, improves service relevance, guarantees targeting and brings about a sense of local ownership such as naming institutions after names of local notables (Republic of Botswana, 1994:51-52). Other values of community participation include the democratic right of people to participate in matters affecting their lives and that participation brings about community empowerment necessary to influence and ensure the best service delivery (Republic of Botswana, 1994:53). The

conclusions from the literature on decentralization and the primary health care approach have brought community participation to the fore as one of the key development strategies of the present times (Republic of Botswana, 1994:55).

2.4.3.2   Community participation in health services

It has been mooted in the foregoing that one of the central tenets of the community participation strategy is that it guarantees both continuity and sustainability of development. Decentralized planning of which community participation forms a part is an important instrument of people's participation. It allows the disaggregation and the tailoring of development plans and programmes according to the needs of the heterogeneous geographical regions and groups within the country. Decentralized planning also increases sensitivity to local problems, needs and priorities (Republic of Botswana, 1994:54). Community participation in Botswana pays homage to the colonial era. During this time communities used to build schools, dams and constructed roads and community halls and other communal infrastructures. At independence the new government embraced community participation under the rubric of self-help or self-reliance. It was not difficult, therefore, to relate the primary health care strategy particularly its community participation aspect to the health care delivery in Botswana. Over the years the Ministry of Health has acknowledged that some of the objectives of the primary health care department are to develop and introduce measures to secure effective community participation and involvement at all levels of the health services system and in all aspects of primary health care activities. The Ministry of Health's emphasis on community participation was echoed later by the 1994 decentralization report which urged the community to participate in identifying health problems, in setting priorities for action and in planning and organizing health care programmes (Republic of Botswana, 1994:55-56).

However, it must be realized that community participation is both complex and problematic. Even under a decentralized development administration community participation may not be completely assured and when it is it is never smooth. Thus contrary to the ideal and the worldwide efforts to promote community participation this strategy remains a development problem. For many decades development workers, planners and academics have tried to find techniques of enhancing community participation but with doubtful success. The blame for the failure has often been placed squarely at the politically and administratively restrictive systems of governance (Republic of Botswana, 1994:55-56). Some of the blame has also been attributed to the bureaucratic red-tapeism which denies the communities the right to develop themselves as they wish. The other side of the story is that even when the project planners and the health staff are committed to the concept of active community participation the implementation of the approach has remained difficult. Furthermore, the lack of progress in this area has been ascribed to the fear and scepticism especially of the rural communities. Poverty, ignorance and illiteracy have also been seen as additional constraints to community participation because they create a gap between the planners and the people. In order to obviate this it has been held that with more adult education, literacy classes and collaboration with extension workers, community participation can be increased (Republic of Botswana, 1994:56).

While it may be difficult to state whether or not community participation has increased or decreased over the years, the recent concerns about the need for this strategy in developing countries suggest that more effort is required in this area. In the recent years the development workers and the researchers have made gigantic steps towards the understanding of the problems surrounding community participation when they admitted that their own ignorance, arrogance and impatience have been a stumbling block to community participation (Republic of Botswana, 1994:56). This confession triggered off a body of literature on the revised strategies of community participation in the 1980s and 1990s, for example, the rapid rural assessment (RRA) and the rapid assessment procedure (RAP) (Republic of Botswana, 1994:56-57). These and others re-introduced the belief that communities are more knowledgeable about their own environment and resources and are also clear on the hierarchy of their needs. This discovery alters the role of the development worker to that of the catalyst or the facilitator who brings in some expertise on how felt needs can be attained. In the language of the rapid assessment procedure the researcher gives responsibility to the community to direct the way (Republic of Botswana, 1994:56-57).

Still the argument rages on. While the rapid assessment procedure represents a new era in the development discourse and while it is the one that recognizes the constraints of the development worker and ceases to project the latter as the panacea to the multiple problems of the community, nevertheless it still operates at the level of utopia. This is so because the basic questions of what constitutes a community and the effects of its stratification, its power structure and its past experiences in development lack the evidence of serious treatment. Consequently the concept of the community is generally taken as given and the strategies of mobilizing it become the centre stage of the analysis (Republic of Botswana, 1994:57).

In general terms the concept of the community is regarded as synonymous with either an ethnic group or is linked to a distinguishable geographical territory like a village, a ward, a district or a region. However, the sociological meaning of the concept of the community is that of a group of people with certain common key characteristics such as language, culture, kinship and history (Republic of Botswana, 1994:57). These characteristics bring people together as a social unit with a clear identity and a collective responsibility for the retention and the defence of that identity. In addition and under normal circumstances a community develops some attachment to a particular place or territory which becomes intimately connected with its existence. For this reason communities tend to become jealous, sceptical and at times xenophobic in the way they interact with or treat non-community members. In the majority of cases the factors of common origin and kinship are linked to the existence of a revered leader in many communities (Republic of Botswana, 1987a:21-23). The leadership which in most instances is based on the powers of tradition and custom as well as beliefs and rituals usually commands a high respect and legitimacy among those who regard themselves as subjects or members of the led. In the case of Botswana it has been shown that a strong sense of community existed in many parts of the country in the past. The chief and his system of representatives operated a complex but highly organized social and political system where each person's role and status were clearly defined. For example, the organization of each community into age-sets or regiments created cohorts with a good sense of the system's hierarchy line of command and functions. The chief as head of the community operated a patriarchal structure stretching with diminishing

power from himself, the chief's advisers, the chief's representatives, the headman, the head of the ward, the head of the extended family or kinship down to the head of the family or household (Republic of Botswana, 1993c:57-58). This system limited and controlled participation by outsiders, women and children. In the 1930s and 1940s cultural history has shown that there was a strong communal ethic which was characteristic of small rural-based communities. One regiment or a hunting team, for example, could be sent to hunt a predator or alternatively be sent to go and work in the mines in order to raise funds for the construction of a school. Thus community participation took place within the framework of a structure which was guided by the adoption of strong disciplinary measures against defaulters (Republic of Botswana, 1993c:57-58).

There are three important lessons which emerge from the past community participation activities in Botswana (Republic of Botswana, 1993c:58). There was a strong leadership which commanded a large measure of respect and which was necessary and an important factor in the successful mobilization of the community. The second lesson is that community participation was ordered in age sets or regiments as well as in general divisions. The patterns of community participation, therefore, followed the wider division of labour where men were engaged in separate projects from women. The two sexes thus generally worked separately but all for the common benefits of the whole community. Finally in the past the communal ethic as opposed to the individualistic competition ethic was dominant in community participation. In other words whereas extended family members and community support was a rule in the olden days, modern society has relaxed values and beliefs in these aspects of community participation (Republic of Botswana, 1993c:58). The indicators of the weak social fabric of the resultant modern society include the use of the female-headed households and the street children, amongst others. It is also known that in the past communal activities were carried out at the household, the kinship and the community levels, for example, collective help, pooling of plough resources and gifts all in the name of supporting the poorer and the disadvantaged members of the community (Republic of Botswana, 1993c:58).

The present forms of communal participation in Botswana have undergone a drastic change over time. In the first place, men, women and children, are expected to join and work together in the construction of, for example, a school, a clinic, a health post or in any other activity for that matter. But it has been observed that only women usually shore up in large numbers albeit comparatively smaller than in the past. The second divergence from the past practice is that in addition to the traditional forms of contributing labour and cash, the present form of community participation involve committee work which proves to be more time-consuming for the individuals involved than previously. Lastly, because of the literacy requirements on the part of the committee members and in view of the generally low literacy rate of the population only a few people dominate the membership of the different committees in the community. This, naturally, affects the commitment of the rest of the members as well as the effectiveness of the committees themselves (Republic of Botswana, 1993c:58-59).

A survey carried out in 1993 on community participation in health care delivery in Botswana established a number of changes such as in the leadership, the mode, the perceptions and the content of community participation (Republic of Botswana, 1993c:59). Notable amongst these are the important fact that community

participation has been transformed into a policy matter which has to be supervised by administrators and committees and not by the chief or the headman as before. The initiative as to when and how to involve the community now lies outside the authority of the community and the chiefs. Community participation is at present initiated and articulated from outside by some administrator or an extension worker. The question "who determines the health needs of their community?" posed to the communities during the survey elicited responses which pointed in the direction of new trends in the leadership of community participation. A small percentage of 5.2% claimed that the chiefs determined the health needs of their communities. The village development committees or the village health committees were awarded 26.6%. The health workers were rated the highest with 28.6% as the emergent leaders of community participation. The councillors came third with 22.7% as the source of determination of health needs in the communities. The community members themselves contributed 16.9% in vocalizing their local desires (Republic of Botswana, 1993c:59-60).

These results indicate clearly that the chiefs are no longer regarded as part of the agenda-setting in development. The health or the extension workers in conjunction with the village development or the village health committees have been exalted to the position of "new leaders" in community participation. However, the administrators and the extension workers either pay lip service to community participation or are ambivalent about what and when to involve the community. As part of the 1993 survey referred to above many district administration and council officers, that is, the council secretary, the district commissioner, the district officer of development, the council planner, the district medical officer, the health inspectors, the matrons and nurses were also interviewed on questions relating to community participation in all the study districts. The questions required them to show who in the community they consulted, how often they did so and the subject matter of the consultation. The responses revealed that in general they did not consult and some said that they did not find it easy to consult communities about their health needs or about their health problems and about the priorities of their districts. One of the main reasons behind this negative feedback is that the chiefs' meeting at which communities are consulted have become ill-attended, because individualism as a norm has become stronger than the traditional community ethic (Republic of Botswana, 1993c:59-60).

Many respondents in the foregoing 1993 study were also not sure about the kind of activities they expected the community to take part in. Generally, however, they agreed on the need for the community to attend meetings and listen to the government policies and programmes. In the central districts, for instance, the district officer advised that council officers occasionally consulted the village development committee but could neither state the subject of the consultation nor the regularity. The other administration officer from the same district did not know whether or not the village extension teams (VETs) existed in the district. In Gantsi one senior officer reported that his council consulted the village development committee on the general development projects and problems on very few occasions. He further complained of the non-functioning status of the village development committees and also that of the other committees in the district. The general picture portrayed was that of the lack of consultation cutting across the districts, institutions and sectors. The situation ameliorated somewhat at the lower level of nurses and the family welfare educators who appeared to have less, but consistent, contact with the village health committees across the districts. These findings replicated the earlier studies which showed that

most of the village level committees were inactive partly because they lacked a clear mandate and support from above. It has become common knowledge in Botswana therefore that the village health committees are not functioning well. For example, the village health committee study of 1993 showed that only 38.3% of the health village committees were active (Republic of Botswana, 1993c:60).

The survey further made a number of observations on the problems besetting the village health committees such as the dominance of certain individuals who are more articulate, the lack of time for meetings and the lack of guidance by the local and the district leaders. This inertia on the part of the latter is due to their preoccupation with central government matters, forcing them to pay lip-service to decentralized or local issues (Republic of Botswana, 1993c:60). These were complex issues which were not likely to be resolved by the establishment of the position of a national village health committee co-coordinator or by giving more incentives as was done with the village development committees. The issues required a more comprehensive rethinking of the approach to community participation through the committees. The research also noted that the village health committees never saw it as their responsibility to question the quality of the health service provided (Republic of Botswana, 1993c:60-61). Complaints about the shortage of staff and the shortage of drugs were sent to the councillors and the members of Parliament. They were never discussed at the village health committee level. The committees and the communities were generally used as sources of labour and finance, but not as consumers of the health services and the managers who can help in dealing with the health problems in the village (Republic of Botswana, 1993c:61).

Community participation remains and is likely to remain a problem in Botswana due to a variety of factors, three of which need a thorough understanding (Republic of Botswana, 1993c:61). The first is the altered socio-political and material basis which has resulted in the changed social and family relations. The second factor is the persistent poverty and the related labour shortage at the household level. Finally, different demands from the urban and the rural population groups constitute the third vector of the community participation problems in the country. Many studies of the farming households in Botswana have shown that the household labour supply is a major constraint to the many rural families. The nuclearisation of the household where the in-laws and the extended relations play a much smaller part in the parent's household's labour supply is one cause of the lack of support for the rural family. The other bottle-neck to the household labour supply is the demand for education which has removed most of the children and teenage labour from the household for a large part of the day or the year (Republic of Botswana, 1993c:61-62). The additional point to bear in mind is that community participation is a cost to the households. The reason for this is that when they are short of labour to take care of their livestock, to plough, to weed and to harvest their crops and to do other part-time income-generating activities, households are not inclined to participate in community-related activities. It is also relevant to distinguish between the types of services for which the individual households are asked to contribute their time and money for the communal benefit. In Botswana it is more important for the communities to participate in food production and in livestock-related and water supply activities than in the social services, for instance, the construction and the management of a school, a health facility or a road infrastructure. This is explained by the simple fact that food and water relate more to their daily survival than do health and education. As a matter of

fact, in the area of health services, the community can revert to traditional medicine (Republic of Botswana, 1993c:61-62).

In essence the idea of community participation can be perceived as being both evolutionary and as a culture that changes with the social and economic aspects of people and Botswana is a case in point (Republic of Botswana, 1993c:63). Thus inputs into community participation are of both historical and modern origins.

2.4.3.3 Family welfare educators' archetypal place in community health services

The family welfare educators are the most original members of the health team in Botswana. They are the first point of contact and referrals proceed to higher levels of health care if necessary. The idea of the family welfare educators in Botswana originated in 1969 as an attempt to take the health services nearer to the people as well as to equip them to fill a gap in the motivation and support of the community in health care. The programme started as a pilot project to introduce family planning and was sponsored by the International Planned Parenthood Federation (I.P.P.F). The first six family welfare educators worked on a voluntary basis in the village of Serowe in the central district. In 1972 to 1973 the training was expanded to take in a larger number of the family welfare educators who were put on the payroll of the Ministry of Local Government and Lands. The family welfare educators are selected in the community and the system of selection works through the village development committee which is assisted by the regional health team. These basic health workers are exposed to an elementary training in maternal and child care, nutrition, environmental sanitation and health education over a period of eleven weeks at the Denman Rural Training Centre in Sebele near Gaborone (Republic of Botswana, 1988c:3-4).

Being the auxiliary personnel the family welfare educators work under the supervision of the trained nurses. This is done either on a daily basis in cases where the family welfare educator is stationed in a clinic or on periodic visits in the event of a family welfare educator being based at a health post. Most of the hospitals tap on the family welfare educators found in the nearby clinics except for the mission hospitals which employ this cadre amongst their staff. The routinised work of the family welfare educator revolves around motivating the community towards the improvement of the health of the individual families. Contact with the people they serve is their most important tool and cherished goal and this communication is made partly at the health facility and partly at the clients' homes. But at least half of the working time of the family welfare educator should be spent in the community (Motshubi, 1990:16-17).

Although it has been argued that the efforts of making the family welfare educators more community-based may be well meant they will only achieve optimal success if the issue of reactivating or of forming more viable village health committees is given more serious attention. Nevertheless, the family welfare educators should be seen as an important resource for providing a structured and a more localized training for the village health committees particularly in first aid, communication skills,

environmental health or sanitation, the causes and the methods of preventing common diseases, the care of the population at risk and home economics. However in his or her primary teaching role in the health facility the family welfare educator must motivate and educate all the individuals in attendance. His or her specific aims in this task are manifold (Republic of Botswana, 2000b:34-37). Firstly, he or she holds health education discussions on maternal nutrition, hygiene and the spacing of pregnancies with the mothers attending antenatal clinics. In the child welfare clinics the health education talks focus on child nutrition and the immunization and the rehydration of the children suffering from gastro-enteritis. The thrust of health education talks on preventive health to groups of patients is mainly centred on the good environmental practices, for example, the disposal of household waste, the disposal of faeces and making drinking water safe if it is collected from a surface source. Secondly, the family welfare educator gives demonstrations on the preparation of nutritious meals using local food with a particular emphasis on the preparation of weaning foods for babies. This is most important in the case of the babies attending "malnutrition clinics". The demonstrations also include the preparation of a solution of water, sugar and salt for the rehydration purposes. Thirdly, in situations where they are alone the family welfare educators must identify conditions for referral, render first aid treatment and care and keep records of all their activities (Republic of Botswana, 2001:5-6).

The role of the family welfare educator in the community is the most obvious of all. Firstly, he or she follows-up patients in their homes who are on long-term treatment who do not attend a health facility regularly. These include tuberculosis patients, malnourished children and the treatment defaulters from other forms of essential health care such as psychiatric patients. The home visits are carried out routinely and regularly so as to enable the family welfare educator to conduct health education and motivation talks on an individual basis. This one-to-one ratio affords him or her the opportunity to identify the problems which people may not be bringing to the health facility. Secondly, the family welfare educator collects information about the births and the deaths in the community in order to strengthen the Ministry of Health's collection of vital statistics. Thirdly, he or she also acts on behalf of the Ministry in other ways such as organizing and participating in the community meetings so as to foster a close liaison between the community and the health team. His or her other duties include advising the community on the simple measures for the hygienic disposal of refuse. Finally, in the remote areas the family welfare educator informs his or her community about the mobile health team's schedule of visits in the area (Republic of Botswana, 2001:iii).

In the schools the family welfare educator visits at the behest of the trained nurse and through a mutual arrangement with the headmaster. His or her role in the schools straddles a number of health care functions. For example, he or she educates the school children on nutrition and hygiene. He or she measures and weighs the children and detects their vaccination needs. He or she also inspects the children for contagious skin diseases and prescribes and gives treatment and where repeated applications of ointments are required, the family welfare educator involves the teachers to supervise and assist (Republic of Botswana, 2002:10-12). However in the community at large he or she is aided by the local community leadership.

2.4.3.4   Traditional and modern leaders' role in community health services

The adage in community participation is that for any community health programme to succeed it is essential for the community leaders to be involved from the beginning. Since they are legion a simile can be drawn between a big machine and community participation in which the family welfare educator is only a small cog. The chiefs are the traditional leaders who are set on a pedestal in most of the Batswana communities particularly in the large villages. They are in the majority of cases descendants of the former chiefs and by dint or virtue of their position they are respected by their respective communities and wield a great influence. The chiefs are, therefore, the first people to be approached in matters that will need community participation, for example, immunization or sanitation campaigns. The failure to go through them may result, at best, in poor attendance by the community, resulting in little or no community participation at all (Republic of Botswana, 1997:37).

In smaller villages there are headmen who are also traditional leaders in their own right but they are elected by the chiefs. They carry out certain tribal duties in their areas and like the chiefs they are very influential. They also should be approached whenever community participation is contemplated upon. In addition to the traditional authority in the communities, modern governance has also produced its own local power-heads such as the district commissioners and district officers. These officers preceded independence and they have always been regarded by the community as a link between them and the government. They work in close collaboration with the chiefs and the headmen in all the tribal affairs including community participation. The members of Parliament are also players in community participation. These are political leaders who are elected by the people. As representatives of their communities they visit facilities including health and ferret out the needs of the people and then make the government aware of the major issues in their communities by discussing them in Parliament (Republic of Botswana 1997:37-38).

The district council staff such as the councillors and the council secretaries is products of the aftermath of independence. When Botswana became independent in 1966 the district and the town councils were formed. The staff to run the new system was assigned to these councils although the chiefs' powers were preserved. The councillors are also political leaders who are elected by the people to represent them at the council meetings. These local politicians are active in promoting development projects in their respective areas and as if to strengthen this role they are *ex-officio* (by virtue of one's office) members of the village development committees. The council secretaries are the executive officers in the local government service who are responsible for the general administration of all the council staff in the area. For instance, when a community leader plans a health seminar for a particular area the process of organizing it would go through the council secretary who would then inform the appropriate people accordingly. The district council staff and the council secretaries, therefore, exude influence as members of both the post-independence leadership in the community and as active partners in community participation (Republic of Botswana, 1997:38-39). Apart from the community leadership there are committees and associated institutions that participate in community health services.

2.4.3.5 Role of development committees and other institutions in community health services

Community participation in health work has also attracted many development committees and institutions in the villages to assist both the tribal and the modern local leadership. The village development committees are found in almost every village and they are recognized by the government as the coordinators of all the development plans in all the different areas. Their members are elected by the community at the Kgotla meetings (chief's meetings). Extension workers are members of the village development committees whereas the chief and the councillors are permanent local representatives. The village development committee is a very powerful instrument for motivating people towards the self-help projects (Republic of Botswana, 1997:37). Part of its clout is shown by the fact that the selection of the family welfare educators for training is done by its members. The village extension team is a composite body comprising members from the different government departments in areas such as school teachers, family welfare educators, nurses, agricultural demonstrators and community development officers who meet regularly to discuss their activities and to share ideas on how to coordinate their efforts. They organize an annual conference to which the community leaders and the representatives of the different institutions are invited. The topics for discussion are chosen by the participants themselves. However, all the extension workers direct their activities to the upper levels through their district heads who are members of the district development committee. The Parents-Teachers Association which is found in every village is another source of influence. Its role is to encourage the parents to take an active part in matters especially concerning the health of their school children. Nurses or the family welfare educators may be present at some of the meetings to discuss an existing health problem amongst the school children (Republic of Botswana, 1997:39). But all these committees and institutions are overseen by the district health teams.

2.4.3.6 Controlling power of district health teams in community health services

One of the most important overseeing structures in community participation whose activities are not immediately visible or noticeable is the district health team previously known as the regional health team (Republic of Botswana, 1985:6-7). It is headed by a medical officer and includes in its ranks a number of professional personnel such as a health inspector who is mainly concerned with the problems of environmental sanitation, public health and the control of communicable diseases. The nursing representatives in the team include a public health nurse and a psychiatric nurse. The former is involved in public health with a special emphasis on the mother and child health care, family planning and the school programmes, amongst other duties, while the latter takes a special interest in mental health problems in the communities. A tuberculosis control officer deals with the tuberculosis problems in the district supporting and expanding the tuberculosis programme. A social welfare officer and a health education officer are also members of the district health team with the former assisting with the problems of the handicapped and the disabled people in the community and the latter educating

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people on health matters and on the basics of maintaining good health. A nutrition officer complements the health education officer's efforts by explaining the dietary items that aid and abet good health (Republic of Botswana, 2004:17).

The district health team is responsible for all the health activities in its designated area and works in close cooperation with the hospital staff in the district who represent the referral part of the integrated health system. The district health team has four main functions three of which relate to the central and the local government and the mission health facilities and the other to administration (Republic of Botswana 1982:23-24). Firstly members of the district health team are part of the central government employees who operate as an "extended arm" if not an "invisible hand" of the Ministry of Health whose main function is to liaise between the centre and the periphery. As such the team must ensure that the Ministry's formulated policies and programmes are executed in addition to maintaining adequate standards of health care throughout its district. The district medical officer aided by his health team stalwarts monitors and manages epidemics and also solves public health problems in the district.

Secondly, the district health team's biggest share of work lies with the local government. The councils have acquired a large number of health facilities over the years in the form of clinics and health posts (Republic of Botswana, 2001:5). The district health team is required to provide the professional know-how and the expertise to those expanded health services. The team, therefore, carries out a number of functions, for instance, it advises the councils on how to run or manage the health facilities and remains responsible for the quality and the standard of the health services provided. The district health team also plays the role of consultant and supervisor of the council clinics and the health posts in addition to providing curative services during the team's trips in the district. The medical officer is involved in the general planning of the rural health services, for example, the construction and the operation of the health facilities, the in-service training of the staff, the administration, community health education and various other functions relating to health in his or her district. Finally, members of the district health team also liaise between the different health and other related agencies within the district as well as between the Ministry of Health and the district.

Thirdly, in the mission health facilities, the district health team coordinates its activities especially in the implementation of its health programmes and in its preventive health activities (Republic of Botswana, 2004:6 & 12). The final function of the district health team is that of routine council administration. By virtue of being a member of the district development committee the medical officer attends its meetings and coordinates the health development planning agenda in the district. The medical officer is also a member of the health planning committee which is a working sub-committee of the district development committee. With the help of the other members of the district health team the medical officer cooperates with a number of the council personnel such as the district development officer, the council planning officer and the council senior nursing sister. The medical officer also identifies and advises on the solutions to the health-related problems in the district.

There are also informal communications between all members of the district health team, the council nursing sister and the council health administrator, on matters concerning the management and the running of the clinics and the health posts

(Molutsi, 1994:55). Furthermore, in consultation with the chief officer responsible for training in the Ministry of Health, the district health team presents regular in-service courses for the nursing staff after identifying topics which need discussion and thereafter preparing the programmes including the resource personnel. The regular in-service courses for the family welfare educators are presented separately. The district health team's contribution to community participation is clarified in its deep involvement in health education, in its efforts to identify the problems affecting the different communities, helping to present the community-oriented seminars and suggesting topics to be discussed thereat (Molutsi, 1994:60).

Community participation implies participating in a meaningful and purposeful decision-making process, regarding many development projects including the health needs of the community. It has been stated that at times the community members have to be motivated to attend the meetings at which decisions are made and government policies are announced. Part of the motivation is to arrange suitable times that are convenient to the majority of them. All this is done in order to enable people to contribute to what amounts to a bottom-up approach to planning community projects. The basic and most important ingredient identified in community participation, therefore, is motivation which begins at an individual level and it is this which needs to be understood before one looks at collective community participation in the health services. Encouragement to be part of an active and health-conscious community is guided, goaded and given impetus by an appropriate policy instrument such as motivating community members to attend community meetings and arranging suitable times for the latter (Molutsi, 1994:61-62).

2.5   COORDINATING ROLE OF NATIONAL HEALTH POLICY IN THE HEALTH SERVICES

The 1960 colonial National Health Policy was amended in 1995 to portray the values of the Botswana society with particular reference to assisting the poor and the sick by bringing health services closer to them in their homes (Republic of Botswana, 1995:2). The enjoyment of a level of health that allows every citizen to lead an economically and socially productive life is widely accepted as a human right and was the main objective of the goal of "Health for all by the year 2000" to which Botswana subscribed. The provision of inputs that facilitate the attainment of such a state of health is the joint responsibility of the individual, the community and the state. The health of its citizens is one of the most important resources needed by a nation for the pursuit of most other legitimate national objectives. Health is important among the objectives and values of most individual human beings and they expect their governments to pursue policies to attain lives of optimum duration and quality. The coordinating role of the government through the Ministry of Health as a policy-maker, a professional guide and a supervisor of health care in the whole of Botswana, therefore, assumes great importance (Republic of Botswana, 1995b:2-3).

Invested with such a fiduciary responsibility in national health matters the Ministry of Health has a number of aims in this regard (Republic of Botswana 1995:2-3). Firstly, its all-embracing aim is to promote the personal health of all its citizens. Secondly, the Ministry of Health is mindful of the contributory role played by public health in the

whole health system. Thirdly, to this extent it conceives of the need to improve environmental health within the country. Fourthly, the prevention and the control of the outbreak and the spread of communicable diseases within the country is part of the broader aim of paying attention to environmental health. Fifthly, the task of the Ministry is to provide effective treatment using appropriate technology to those affected by disease. Sixthly, as a supervisor of health services the Ministry of Health has to advise, assist and supervise local authorities in regard to matters affecting public health (Republic of Botswana, 1993a:3). The seventh objective of the Ministry is to promote and carry out research into the prevention and the treatment of the human diseases as well as the improvement of environmental health. The eighth goal is the provision of treatment and care for the physically and mentally handicapped or disabled and assistance with their rehabilitation. Finally, the Ministry of Health aims at developing health services which are commensurate with the technical and the professional human resources available (Republic of Botswana, 1995:7).

Wearing the mantle of policing the health services and in order to enhance its efficiency, the Ministry of Health re-organized its functions in 1984 into five major departments, namely, primary health care services, hospital services, health technical support services, health manpower and health administration (Republic of Botswana, 1984b:23-25). There has been no change both to the structure and the operation of the health services in Botswana since 1984. However, a review of the five departments was carried out in 2002 and a report, not available to the public, was submitted to the Botswana Cabinet. Although no official document on the expected departmental changes has been realized it is expected that there will be some alterations in their structure, but not in the operations of the subordinate health services or facilities themselves (Interview: Assitant Director: Primary Health Care. Ministry of Health. Gaborone, 21 October 2004).

The National Health Planning Unit and the National Health Research Unit provide staff services to all the departments and co-ordinate the specialist functions at the national level. It is re-stated that the Ministry of Health has a portfolio responsibility for the overall improvement of the health of the nation. Accordingly, it sets the general goals, the priorities and the direction for the operation and the development of the health services and the health-related activities in Botswana. However the running of the basic health services is entrusted to the local authorities which comprise district councils and town councils which are all elected bodies. These local authorities have a statutory responsibility to the Ministry of Health for their day to day operations of the health posts and the clinics (Republic of Botswana, 2001:10-11). But the arrangement within the central government places the same local authorities under the jurisdiction of the Ministry of Local Government and Lands for administrative matters. Such delivery of the health services at the local level was the result of an attempt to decentralize the primary health care (Republic of Botswana, 2001:9).

The above analysis has also shown how the medical missions, a number of large companies, other central government ministries and the local authorities complement the health-related activities of the Ministry of Health. The latter therefore has an important co-coordinating role to ensure that the whole health care delivery system operates efficiently and that policies are understood and implemented by all the different parties involved. As part of its superintending the health services the

Ministry undertakes to monitor regularly some designated health care curative services. This includes carrying out systematic diagnosis of the types and the causes of ill health with a special reference to the diseases affecting the rural community. It also involves carrying out effective therapeutic treatment using appropriate medical technology through the network of referral based on patient, clinical and hospitalization services. The referral system is made possible by the simple principle that the health activities and services in Botswana are delivered at different levels of sophistication. Last but not least the Ministry of Health carries out health research and investigates activities through properly established research and laboratory centres at all levels of the system. These provide a specialist service for the overall national health planning and evaluation as well as being an essential support wing for the health promotion curative services (Republic of Botswana, 2004:2-3).

The government's commitment to health development in Botswana was guided by the singularly important fact that human resources were the most critical factor in the delivery of health services. The health manpower department of the Ministry of Health working within the ambit of the national health policy mandated the National Institute of Health Sciences (NIHS) as the main source of supply of the health manpower in the form of different grades of nurses and other miscellaneous health personnel. The trained nurses were placed into the primary health care facilities in the local authorities (Republic of Botswana, 2001:14-15).

The demands for nursing manpower as one aspect of the national health services have continued to grow in parallel competition with the growth of the health care facilities in all the different components of the health services. As lifestyles became more sophisticated as a result of rising incomes the health care demands of the Botswana grew in quantity as well as in quality. The government's commitment to the goal of "Health for All by the year 2000" and to the provision of primary health care based on the advocacy for equity has directed that the training of the country's nursing manpower be aimed at satisfying these objectives. The health manpower plan which was drawn up in 1988 showing projections of the health care system up to the year 2002 was a clear reflection of the government's determination to abide by its long-term health policy (Republic of Botswana, 1990:73).

The government's one way of setting about to achieve this health policy was by developing smaller and widely dispersed health service units and by increasing the education of the health manpower in the form of nurses. The integration of all the health care units into an effective and properly functioning whole was the ultimate achievement of the government's national health policy. The latter was also designed to create not only decent conditions but also viable health services for the people living in the rural areas with the government taking the full responsibility for staffing them with nurses and maintaining them to the full benefit and advantage of these distant dwellers. The overall goal of the national health policy is to develop a healthy balance between the rural and the urban health services adequately and appropriately manned by nurses so that a patient who requires care at any point in the hierarchy of the health services can move up and down it to receive the appropriate care (Republic of Botswana, 1995:8-9).

However, the health policy tends to be oriented more towards the preventive health care at the expense of the previous curative hospital practice (Republic of Botswana,

1995:7). But in practice of course one must not underestimate the extent to which both preventive and curative medical services usually go together. It is with this in mind that the central government and the district councils have agreed on a compromise whereby the government takes charge of the overall health system responsibilities as well as a direct operational responsibility for the hospitals and the health centres, most of which have become primary hospitals, while the council has an operational responsibility for the clinics and the health posts (Republic of Botswana, 2001:15-16). One grey area in the national health policy, however, is concerned with the lack of an unequivocal policy for the other several groups of existing health providers. For example, the mission hospitals and their satellite clinics and health posts seem to suffer more from financial problems than the government health service installations although they play a vital role in the provision of health services within the general context of the national health policy (Republic of Botswana, 1995:10-12).

There also appears to be a dichotomy between the "government" and the "industrial" health services. In other words there is a lack of clear policy which defines the industrial role within the total health services of Botswana. Definitive guidelines would help to avoid a situation in which one mining hospital does not render health care to non-mine clientele, while another similar health facility welcomes both mine and non-mine patients. For example, on the one hand the Orapa and the Jwaneng mining hospitals provide health services to the general public in the same way as do district government and mission hospitals, although the government does not contribute directly to their funding. This is regarded as a contribution by Debswana, the company that owns these mines, to the public welfare through an agreement with the government. On the other hand the Selebi-Phikwe mine hospital provides health services only to its employees and their relatives to the exclusion of the general public (Republic of Botswana, 1997:381-382).

Another area of obfuscation in the national health policy is concerned with the private medical or dental practitioner. The government policy directs that the private practitioner may treat private paying patients in his or her private surgery. But he or she may not continue to do so once his or her client becomes an in-patient in a government hospital. At the same time it is also government policy to allow any health service consumer to be admitted into a "private" ward of a government hospital as a "private" patient (Republic of Botswana, 1997:382). These ambiguities in the national health policy can only be interpreted as potentially containing a considerable scope for the private general medical practitioner to play a more important future role within the broad framework of the government health policy. However, a critique of this policy as pointed out above should not be allowed to overshadow the milestones in the health services achieved by the government. In fact to all intents and purposes Botswana has become pre-occupied with improving its painstakingly centrifugal health services system (Hwara, 1998:50-57).

This is evidenced by the steps taken by the government in developing and approving the national health policy in 1995 which defined the roles and the responsibilities of the various providers of the primary health care services. In this way it strengthened the decentralization process. Thus the philosophy of the Botswana national health policy is predicated on the principles of primary health care (Republic of Botswana, 1997:380-381). Accordingly, in planning its activities the government shall be guided by priorities such as health promotion and disease prevention. It shall also observe

basic health services objectives, for instance, the access by all the citizens of Botswana to the essential health care regardless of their financial resources or place of domicile and the assurance of an equitable distribution of the health resources and the utilization of the health services. Together with the available resources the health services shall be managed in such a manner as to derive the maximum social benefit therefrom with the minimum of waste. Furthermore, government policy does not lose cognizance of the development of the private health sector which it supports and in particular favours and encourages the cooperation between the private and the public health sectors (Republic of Botswana, 1997:381). Thus the national health policy sets the tone within which the health services are perceived and operated, that is, their promises, their premises and their objectives and the best way to achieve these. But this is not devoid of pitfalls.

One of the central premises for Botswana's health care planning is that the government considers the health care services in their preventive, curative and rehabilitative aspects to be a social right to which every citizen is entitled through whatever methods of delivery can be shown to be most effective and affordable. It has been shown that the government is not confined to any one method of providing and financing the health services. A variety of approaches, for example, government medical services, missions, industrial hospitals and private practice has been used to enable people to have access to health services (Republic of Botswana, 1995:2-4).

The erstwhile emphasis placed upon the hospital-based curative health services in upgrading Botswana's health care system during the early years after independence benefited mainly the population in towns and in larger villages. Since then the government has striven to redress these imbalances by means of a better health services programme which reaches the rural as well as the urban people. The objective of this comprehensive health care development programme has been directed at making the basic health services and the provision of referral to more sophisticated health care facilities where necessary available to all the rural and the urban Batswana irrespective of their economic status. This broad-based approach to health services has necessitated improvements in the outreach facilities, in sanitation, in health education, transportation and communications, in ambulatory clinics, in maternal and child health care and in the family planning services largely in the rural areas but also in the towns (Republic of Botswana, 1988a:15-18).

The overall significance of these integrative efforts on the part of the government has been the carving out of a planning strategy for the development of a health care system which has aimed at optimizing the social and the economic benefits derived from the application of the limited resources available for the health sector (Republic of Botswana, 1995b:19). In the context of Botswana this has been achieved by developing a minimally acceptable set of basic health services. The latter are characterized by access to adequate and affordable health care including the preventive, curative and the rehabilitative components. This has also entailed the planning of a health service system which most equitably distributes the set of basic health services benefits to all the members of the population within the limits of the defined resource constraints (Republic of Botswana, 1995b:17).

However, there are caveats and imponderables in optimizing the health care services in Botswana. When health care is made available to every Motswana regardless of his or her ability to pay, it loses a market value and hence cannot be quantified as

benefits in monetary terms. Thus it has been argued that trying to look beyond the health service benefits in an attempt to put a monetary value on them is problematic. There are no guaranteed and measurable relations between the use of health care services and the improvement in the health status of an individual. It has been pointed out, for instance, that if morbidity due to an infectious disease declines this could be attributed to a number of factors such as the result of a better curative health care or the externalities of a better rural sanitation programme or of health education or the consequence of improved economic conditions which increase nutritional levels and decrease crowding. Although all these variables *inter alia* may have credible parts to play the quantitative roles of each input are indeterminate. Another argument is that even if one could definitely relate health services to improved health status one could not realistically attach a monetary value on better health. Some economists have attempted to justify the costs of anti-malaria programmes on the basis of the value of an increased agricultural production created by farmers who are no longer sick but such arguments are not hermetically sealed. The questions are basically unanswerable in monetary terms particularly if one is concerned with the health of subsistence farmers or the unemployed or that of old people and children (Republic of Botswana, 1997:43-44).

The real value of better health, therefore, is social and not financial. As such a cost benefit analysis (CBA) of a health service system in which terms or benefits must be expressed in any currency cannot describe the effectiveness of such a system. As part of the recognition that health care services must be justified primarily on the basis of non-quantifiable social values one must therefore elect to base the resource utilization planning on the cost-effectiveness principles rather than on the cost benefit analysis. In this way the effort becomes one of maximizing the distribution of a set of defined health services ensuring that at no point in the system does the level of services drop below a minimum acceptable standard while at the same time maintaining defined limits on the levels of resources utilization (Republic of Botswana, 1997:44).

Despite the debate on whether or not the benefits accruing to the recipients of the Botswana health services can be monetized, the public health system in Botswana is now established and runs smoothly. It consists of all the health facilities owned or supported by the government, as well as facilities open to the public such as private clinics and hospitals and some of the mine hospitals. It is evident that the government's inchoate role in the health services at independence has developed over the years into a mastery of a sophisticated health service system. This role has continued to manifest itself today in the expanded dimensions of administration of the health services.

2.6   SUMMARY AND CONCLUSIONS

Botswana's modern health services grew from the vestiges of the colonial health care system that had been created by and for the settlers albeit in an *ad hoc* and uncoordinated fashion. It was only after independence that monolithic efforts were made to create a health service that would not serve a minuscule population, but the whole country both urban and communal. Thus the health services were to be taken

to the people and not the reverse. The decentralized nature of the Botswana population was accentuated by the British colonialists who promoted and encouraged it because it accorded with their own policy of decentralized authority. The latter's backbone was the tribal chiefs. In decentralization lay the seeds of the development of today's health services. From the time of independence the government refurbished the then existing health services infrastructure before it resorted to the drawing board to plan and produce its own blue-print for the country's health care needs.

Botswana's development has been characterized by economic growth, coupled with social change, particularly in the health sector. Its economic growth was consistently high over a number of years without any signs of slowing down. With the increased revenues from the non-renewable resources Botswana was able to finance its mushroomed decentralized health services. The growth of the latter has been phenomenal as exemplified by the large number of the health facilities that has been constructed in the rural areas.

The decentralization of the health services has meant that they are no longer monopolized by the wealthy people living in modern towns and cities, but are accessible to every citizen regardless of the place of abode. However, the improved health services have raised the expectations of people which have continuously grown with the result that the strident demands now made on them are often beyond the capacity of the resources of the government. Nevertheless the progress towards better health services can no longer be halted. It has been hinted that the haphazard colonial health services were not the end of the road. They were there to stay and nothing could be retracted from them. When the country achieved independence it built on what it found in place and developed the prevailing health services. Its newly-founded modern health services never looked back since then.

The saying that all is good that ends well has a general application in everyday life. In the matter of the health services of Botswana the beginning was momentous, stupendous and enthusiastic, but the end may not be all moonshine and a bed of roses as the health services have been racked, dogged and permeated by staff shortages at every twist and turn. The national health policy has warned that Botswana's ability to provide staff and funds for the health care will be limited. The medical and the nursing staff limitations have and will continue to constrain the shape of the health system. Moreover the nursing and the medical personnel that are within the training and the recruitment capabilities of Botswana must be used in an integrated team which requires more staff if it is to be a showpiece of efficiency and effectiveness. Team work comprises individuals who are sustained by morale and motivation in order to be productive and above all to be retained in their jobs. The next chapter examines and analyses motivation in depth.

CHAPTER 3

DYNAMICS OF MOTIVATION

3.1　　　INTRODUCTION

Freud once observed that "if we cannot see things clearly we will at least see clearly what the obscurities are". He was alluding to the lack of a complete agreement on the content and the context of the study of the psychology of motivation. This lack of consensus is due to the existence of many branches of motivation such as Freud's psychoanalytic perspective, biological or physiological perspective and mechanistic motivation (Gross, 2005:56-67). The study at hand will however be principally concerned with motivation related to work. But since a human being is complex both inside and outside the work situation, a number of concepts in the wider field of motivation will be eked out, in order to create a broader repertoire background of knowledge. The latter will be used to analyse human behaviour in its entirety or human behaviour in its various or multi-faceted manifestations. It is hoped that this detailed approach to human psychology will prove useful, not only to the later analysis of the field work findings, but also to the whole length and breadth of the study.

Deci and Ryan (1990:62-68) elaborated that motivation is built on a set of assumptions about the nature of people and about the factors that give impetus to action. These assumptions and theories that follow from them can be viewed as falling along a descriptive continuum ranging from the mechanistic to the organismic. According to the mechanistic theories, the human organism is passive, that is, it is pushed around by the interaction between psychological drives and environmental stimuli, whereas organismic theories tend to view the organism as active, in other words, as being volitional and initiating behaviours. The latter perspective purports that organisms have intrinsic needs and physiological drives, which provide energy for the organism to act on and manage aspects of its drives and emotions rather than simply to be reactive to the environment. The active-organism view treats stimuli, not as causes of behaviour, but as opportunities that the organism can utilize in satisfying its needs. When theories are based on the assumption of an active organism, they give primacy to the structure of people's experience, and are concerned more with the psychological meaning of stimuli than with the objective characteristics of those stimuli.

Implied, if not overt in the above analysis, is the concern or focus over the behaviour of an organism and all efforts being directed towards answering the "why" questions centred around behaviour. To some writers such as Lambert (1996:40-52) psychology teaches people that needs and motivation drive behaviour. But Freud's psycholoanalytic theory offers the most general and well-known conception of the dynamics of motivation. Influenced by Darwin's 1859 writings on evolution (Gottlieb, 1984:57-65), Freud viewed individuals as striving to satisfy personal needs (McClelland, 1990:58-65). He argued that in order to meet the latter, behaviours must be undertaken that will lead to the desired goals. Freud conceded that all such goals are located in the external world. Hunger motivation provided a typical

example of how behaviour is governed by the need for food. All organisms have a biological need to ingest food. This need makes itself known to the organism by causing discomfort. After the individual engages in the efficacious activities and eats, the internal stimulation and associated pain in the form of hunger cramps, for example, that accompany food deprivation, cease. The organism thereafter feels satisfied and remains in an unmotivated state or at rest until the onset of new hunger pains. These, as before, follow a cyclical pattern again generating food-relevant behaviour.

Freud's psychological determinism implies that the behaviours of different people differ in the direction, in the intensity with which they are acted upon and in their persistence or maintenance. Put in simplified form, the difference between behaviours is one of motivation. Maslow, in the typical fashion of his theory of motivation, remarked that "motivation is a constant, never-ending, fluctuating, complex and universal characteristic of practically every organismic state of affairs" (Maslow, 1968:90-102). There are several different approaches to motivation and all these methods seek to explain human behaviour at many different levels, all the way from subtle physiological processes in the individual brain to complex social interactions.

Thorndike's (1913:254-255) law of effect is one way of studying motivation by analysing behaviour alone, without necessarily stipulating any underlying physiological processes (Katz, 1994:131-146). This law describes the common human experience that responses followed by rewards tend to be repeated, whereas those followed by punishment are inclined not to recur. Another way to explain the law of effect is to assume that rewards increase positive affect, while punishments engender negative affect. Pursuant to this view point, the law implies that human beings make responses that lead to pleasant ends, but avoid responses that produce discomfort. Such a conclusion restates the ancient doctrine of hedonism, which stated that people are motivated by the search for pleasure and the avoidance of pain. In other words, a hedonic principle of motivation is postulated to explain why people change their behaviours and thereby allow observers to say that they have learned something. About thirty years later after Thorndike's early studies, attention was rotated towards explaining the phenomenon of reinforcement in greater detail. This was a result of the earlier learning that reward facilitates an emission of a response, leading to some kind of pleasure. Therefore, the next logical thing to do was to examine the actual process that took place.

Since the idea of a drive, as formulated by investigators such as Rotter (1972:609) was regarded as a condition found in a person or an animal, arising from some biological need and manifesting itself in a high level of activity, the drive theory was resuscitated. This was bolstered up by the findings of early researchers who discovered that if a laboratory rat is not fed for several hours, it may show signs of increasing restlessness as feeding time approaches. After eating the rat is generally less active than it had been before the meal. The early advocates of the drive theory concluded that drive grows progressively stronger as deprivation of food continues and then drops off suddenly after food is taken in. Psychologists, with a particular reference to Hull (1943:54-58) perfected the drive reduction theory of reinforcement, by reasoning that drive was an unpleasant condition that the individual wished to avoid. Thus any response that reduced drive would, by definition, reduce discomfort and become more probable in the future. Hull concluded that habits were learned

through the repeated association with a reduction of unpleasant drive. Although the theory influenced thinking about motivation for many years, it lost its central place in the psychology of motivation to Bandura's "social learning theory".

One of the psychologists who did not accept the drive theory as the best explanation for reinforcement was Atkinson, who argued that people are not driven by deprivations and needs. But they are rather guided to important goals by perceptions and cognitions. He suggested that when people do something that is rewarded, they are not influenced by any real or imagined loss of drive that follows the reward, but are affected instead by the idea of being rewarded. According to Atkinson and Feather (1966:80-90), rewards themselves have value for people and the latter work to attain them. When individuals are successful, they form a mental association between the act and reward that followed it. This relationship in turn generates an expectancy that if the act is repeated, it will be rewarded again. The expectancy of being rewarded after some responses and possibly of being punished after others, forms the basis for what is called incentive. In summary this view point holds that the basis for motivation is the anticipation of the consequences of behaviour when the latter have value for the person.

Some writers in the field of motivation such as McClelland (1990:50-57), have divided the subject into two broad categories, namely internal or intrinsic and external or extrinsic motivation.   Although no hard and fast lines have been drawn with a permanent fixity, McClelland has drawn attention to the fact some individuals in society are endowed with a unique form of intrinsic motivation, which impels them to achieve while others require environmental factors to stimulate them.   In a similar fashion, McGregor (1960:35-40) also conceives motivation as emanating from within a person, as opposed to the external environment of a workplace inhabited and controlled by managers.

Since the first perspective of motivation is based on the assumption that an individual is motivated from birth, managers in employment need only concern themselves with external motivation which they can control as part of their job. For Herzberg (1993: 85-90), however, motivation is not innate. His two factor theory based on hygiene or maintenance factors such as salary and working conditions and motivators in the form of achievement and recognition, are all subject to managerial performance. When motivators are satisfied, a person derives a sense of personal growth from his or her work. This personal growth, that is, attaining an ever-increasing mastery over one's environment, is potentially the most powerful motivator of all because unlike other motives, it can never really be satiated.   In the end, therefore, internal motivation requires stimulation from external motivation factors, in order to produce desired performance in a given individual worker. Thus, the "stimulus-response" part of the performance is also an aspect of managerial function.

Another motivation theorist is Maslow (1970:61-69), who has argued that motivation does not arise from just one source, but is a result of a number of need systems. He named five basic classes of needs, which he referred to as physiological, safety, love, esteem and actualisation. The difference between the lower and higher needs forms much of Maslow's theoretical work on motivation. He claimed that when needs are satisfied, they cease to cause human beings to act.

A similar approach to motivation is the social perspective. While Maslow views human beings in terms of needs, humanist psychologists who are the proponents of the social interaction view-point, point out that people are motivated to a great extent, by the demands arising from social mixing. According to Rogers (1963:95-110), the spokesperson for humanist psychology, and Maslow, the core tendency of a person is to actualise individual potential. In this respect, there is an internal biological pressure to develop fully the capabilities and the talents that have been inherited. Maslow and Rogers make efforts to explain the field of motivation, by attempting to specify the antecedents of a particular motivational state, ranging, for example, from food deprivation to the restriction of choice. The sum total of humanist motivation is, therefore, that self-actualisation can be facilitated or impeded by the social environment, that is, the interactions and feed back from others. In Maslow's theory, however, the focus of the assumed actualising is unclear. In spite of the lack of clarity in this aspect of Maslow's theory, McKenna maintains that individuals have a higher nature, with a need for meaningful work, responsibility and an opportunity for creative expression.

The study of motivation is inundated with many different schools of thought, a few of which have been examined above. These various theories of motivation differ one from another, in terms of the constructs used to explain observable behaviour. Each theory proposes a relationship between two or more constructs, with a predictable effect on behaviour. It also stipulates rules linking the constructs to observables, through operational definitions. It, therefore, needs no explanation that theories of motivation depend partly on the viewpoints on which they are based.

Following the foregoing analysis, the approach to motivation adopted in this chapter, straddles the theories of Herzberg and Maslow on the one hand and those of McClelland and the humanists on the other. The common ground distilled from these motivation theories, rests on the argument that work performance is affected by worker motivation, work environment, the constant change in human motives and managerial style. The contents of the chapter are arranged to reflect the sequence in which motivation is analysed in the context of these factors.

Section 3.1 sets out the introduction, which gives a general flavour of different views that surround the psychology of motivation. Section 3.2 treats the concept of motivation to some depth. It details the various theories of motivation expounded by different writers on the subject. After surveying a variety of these views, a preferred working definition of motivation is chosen. Section 3.3 traces the early ideas on motivation from which motivation theories were developed. The section examines the historical precursors to the study of psychology.

Section 3.3.1 takes up the theme of intrinsic and extrinsic motivation. These two sides of motivation are a fertile field of a raging debate in psychology, in which arguments for and against defy a definitive conclusion. Their interaction in the realm of work environment and work performance explored in subsection 3.3.2 complicates further the psychology of work. Section 3.4 continues the analysis of the preceding section by examining the use of motivation to effect work performance. The controversial nature of motives and how they impact on institutional variables is analysed in subsection 3.4.1. The diversity of individual motivation is captured in the shifting behaviour of motives in relation to work environment, which is the subject of subsection 3.4.2. The main thrust of the section is to view how an individual worker's

motives change during the course of work experience. Section 3.5 is concerned with how worker self-esteem affects his or her attitude towards work. It traces the forerunners to self-esteem as developing from childhood experiences to reference group in adult social life.

Section 3.6 and its subsections ranging from 3.6.1 to 3.6.4 identify some examples of sources of motivation isolated from empirical findings. Section 3.7 shows the relationship between motivation and the recruitment process. This section reveals how the recruitment process is a meeting point for both the worker's and the manager's psychological advantages. Section 3.8 summarises and concludes the chapter by drawing together different strands from various sections.

3.2   CONCEPT OF MOTIVATION

The study of psychology which is defined in innumerable ways by different authors on the subject is the exploration of the energisation and direction of behaviour (Deci & Ryan, 1990:3). Thus, in accord with this view, psychology theories are motivational theories only in so far as they address these aspects of behaviour. Energy in motivation theory is fundamentally a matter of needs. An adequate theory of motivation must, therefore, take cognisance of both the needs that are innate to the organism, that is, those that must be satisfied for the organism to remain healthy and those that are acquired through interactions with the environment (Deci and Ryan, 1990:3-4). The direction in motivation theory is concerned with the processes and structures of the organism that give meaning to internal and external stimuli, thereby directing action toward the satisfaction of needs. In simple terms then, the field of motivation explores all aspects of an organism's needs and the processes and structures that relate those needs to behaviour. Motivation theories organize the findings of those explorations (Deci and Ryan, 1990:4-5).

Weimer (1995:11) has pointed out that the above analysis is guided by two central concepts of homeostasis and hedonism. The former refers to the tendency toward the maintenance of a relatively stable environment. This means that there is a propensity for the organism to remain in a state of internal equilibrium. The latter term is a utilitarian doctrine associated with the British philosopher Jeremy Bentham. It asserts that pleasure and happiness are the chief goals in life. In a nutshell, if homeostasis is the governing principle of behaviour, then pleasure is the result of or the by-product of being in a state of equilibrium where one's goals are gratified.

Freud further contended that all psychological work of both attaining food or just thinking about it, for example, requires the use of energy. Three psychological energy-related concepts are especially pertinent to his explanation of human behaviour (Freud, 1976:411; Ramnero & Tomeke, 2008:80-100). Firstly, conservation of energy which considers humans as close-energy systems is an idea that there is a constant amount of energy for any given individual. Freud borrowed this notion from the principle of the conservation of energy, which states that energy is neither created nor destroyed. One corollary of this law is that if energy is spent performing one function, then it is unavailable for other functions. Secondly, entropy refers to the amount of energy that is not available for doing work. Furthermore,

some energy is kinetic or bound.   Such bound energy is said to be "cathected". A cathexis, derived from the Greek word *katheko* meaning to "occupy", involves an attachment to some object that is desired but has not been attained. The third type of energy-related concept, is a distinction between kinetic and potential energy. Freud referred to his belief that thoughts and actions have causes, as psychological or psychic determinism (Freud, 1953:211; Davis, 1994: 627-640). Freud gave an example of three behaviours such as humour, slips of the tongue and dreams, as serving the same function of vicariously gratifying a forbidden impulse or an unfulfilled wish, as hidden methods of tension reduction.   According to Weimer (1995:13-14), Freud applied the principle of psychological determinism to pathological phenomena such as hysteria and obsessions and to normal actions, not by predicting events, but by post-dicting behaviour, that is, instead of prophesying the future he interpreted the past.

Freud incorporated the concepts of personality into his theory of human behaviour and motivation. He identified three components of personality, that is, the id, the ego and the super-ego which are hypothetical structures which he used to explain the typical observation of behaviours resulting from compromises involving desires, the restrictions placed by the environment and internalised moral values (Freud, 1948:304-305; Pak, 2002:70-94).   In other words, behaviours are governed by needs, rationality and ideals. The id is conceived by Freud to be the first system within a person and is intimately related to the biological inheritance of sexual and aggressive drives. The id is a reservoir of all the psychological energy or *libido* (lust) and since an individual is unaware of the existence of the inborn drive states contained in the id, the contents of the latter are primarily unconscious (Weimer, 1995:14-17).

Whilst the id is charaterised by a "primary process" thinking to aid in the service of the pleasure principle which is connected to the reflective process, for example, the sucking reflexive response of an infant to hunger pains, the ego is governed by the "reality principle". It follows the rules of a "secondary process" thought. It is an adult way of thinking typified by logic, time orientation and a distinction between reality and irreality (Freud, 1965:517; Freud, 1998:56-100).   Through its tools, memory and attention, it provides a means for delay of gratification, long-term planning and the mechanism of defence such as repression.   All these functions are primarily conscious, although the individual is not aware of the various aspects of ego operation. The last of the three structures to develop is the super-ego. This is characterised by two functions which are both based on built-in reinforcement processes. The first one is to reward individuals for acceptable behaviour. The second function of the super-ego is to punish actions that are not socially sanctioned, by creating guilt. The super-ego thus represents the internalisation of moral codes and is often called one's "conscience". It basically oppresses the expression of unacceptable impulses, rather than merely postponing them as does the ego (Freud, 1940:227; Van Wagner, 2005:60-110).

Freud's personality structures had a role to play in the dynamics of behaviour. For instance, he directly related homeostasis and hedonism to the structure of personality, by proclaiming that the energy need for behaviour resides within the id, which is directly responsive to bodily needs. The ego, however, as the "higher" structure, has the power to prevent immediate gratification. Freud analysed that if goal-attainment will lead to more pain than pleasure, the ego will establish a

"counter-cathexis", which is a force opposing goal-satisfaction and takes the form of a psychological defence mechanism, for example, repression, which banishes the threatening wish from consciousness, so that it is not directly acted upon by the individual. The existence of a conflict between an id cathexis and a counter-cathexis established by the ego is the heart of Freud's model of motivated behaviour (Freud, 1960:433; Warner, 1991:494-497). Freud viewed the person as being in a state of continuous conflict between personal desires and the demands of society (Freud, 1975:511; Davis, 1990: 185-209).

McClelland and Watson (1993:121-139) have observed that the discussion on motivation touches on the borders of psychology and other topics, as different from one another as biology, sociology and economics. The biology perspective, for example, is rooted in the scientific evolution of the seventeenth and eighteenth centuries, when great scientists such as Galileo and Newton made discoveries that led to the understanding of the universe and the physical laws that explain its functioning. It was in such atmosphere that the French philosopher, Rene Descartes, attempted to explain the behaviour of living organism, by claiming that all animals, except human beings, could be thought of as nothing more than complex machines, whose operations could be explained on the basis of purely mechanical principles (Geen, Beaty & Arkin, 1992:5-9). Later theorists perceived human behaviour as physical mechanism and it was this interpretation of human behaviour which was the beginning of modern physiological psychology and which also assumed that behaviour could be traced back to physical and chemical causes (Kelly, 1991:70-72).

This concept gathered momentum in the eighteenth and nineteenth centuries, when many early psychologists followed Descartes' lead, by thinking pf the behaviours of humans and lower animals as fundamentally different from each other. Only humans alone were thought to possess properties of reason and intelligence and lower animals were described as being guided by instincts (Gottlieb, 1994:448-456). However, Darwin (1859:70-84) rejected the simple distinctions which described lower animals as being equipped with instincts and humans as being devoid of such attributes. Although the idea that living beings evolved from lower animals to higher forms was not original with Darwin, his unique contribution was explaining evolution in terms that were purely biological. To this extent his theory had enormous consequences for the study of human behaviour. Apart from breaking down the long-cherished distinction between humans and lower animals, two conclusions resulted from this assumption. The first was that the study of animal learning was to play a major role in the development of experimental psychology (Kelly, 1989:67-90). In fact the study of comparative psychology would probably have been impossible without Darwin's theory of evolution, because the behaviour of sub-human species would have been considered irrelevant to any understanding of humans. The second conclusion drawn from Darwin's theory was that not only did the theory extend intelligence downward from humans to animals, but it also "sign-posted" instinct in the opposite direction. From that time on the existence of human instincts was considered a possibility (Kelly, 1990:130-138).

It has been noted earlier that Freud gave significance to instinct in his psycholoanalytic theory of behaviour and proposed that the origins of human action lie in deep-seated and uncouscious biological urges (Weiner, 1992:17-19). In this belief he was supported by an American group of psychologists known as functionalists, of whom William James was best known. This group emphasised the

functional value of behaviour for adaptation and survival. They accepted instincts as explanations for behaviour and thought that they accounted for most actions as appropriate innate determinants. It is well to realise that at that time a psychology of motivation did not exist and even the term motivation had not yet been coined (Watson, 1990:158-177). As such the idea of instinct served the purpose of forming a motivational construct, by giving a plausible reason why people do the things they do, such as a person working hard to earn money (McClelland, 1989:37-39). However, in modern psychology one seldom hears about human instincts any more. Nowadays psychology emphasises learning as the basis for behaviour not inborn dispositions to act in certain ways (Geen *et al.*, 1992:7-9).

Nevertheless it has been argued that any theory that defines motivation in terms of underlying mechanisms, assumes a broader approach to the subject (Gottlieb, 1994:448). Physiological explanations are those in which no specific neurological basis has been established, but in which an implicit and hypothetical cause is posited. There is also another way of studying motivation by analysing behaviour alone, without necessarily stipulating any underlying physiological processes. When using such an approach certain constructs are invented to explain behaviour, without presuming that they describe real measurable mechanisms (Steward, 1992:222-226). The behavioural perspective on motivation has grown alongside the learning theory and is closely connected to it. In the early twentieth century Thorndike (1913:255-262) proposed his law of effect as a major principle in learning. Thorndike observed that behaviours followed by satisfying rewards, are performed better and at a higher subsequent rate than unrewarded behaviour. This idea has served as a cornerstone of a model of motivation based on rewards. Thus, the impact of rewards on performance and the rate of responding, has been a central concern of the learning theory tradition, since Thorndike's classic demonstration of the law of effect.

This cognitive view of motivation owes much of its development and structure to Lewin, who expanded the principles of Gestalt psychology into the study of motivation. In brief the premise of Gestalt psychology is that human beings perceive stimuli in organised patterns (Lewin, 1951:169-170; Winston, 2002:175-190). People's perceptual systems are such that these patterns always tend to become organised in the most consistent way. It is pertinent to note the assumption of Gestalt psychologists that individuals have a natural tendency to organise their percepts into certain patterns that look and feel better than other patterns. Lewin applied this idea directly to motivation by going beyond perception as such, to propose that everything of which people are conscious at any time, that is, every thought, feeling, percept and memory falls into a pattern of consistent organisation. He called the sum total of people's consciousness the phenomenal field (Lewin, 1951:170; Freud, 2000: 120-180). Lewin's point is that people are motivated at all times to bring this field into the greatest possible consistency of organisation. Whenever anything disrupts the pattern in the field, a state of tension is set up inside the person and this tension prods or goads the person into taking action to resolve the order. Tension in the field motivates individuals to seek goals that resolve and reduce the tension. As regards which goal among many available, Lewin theorised that individuals approached the goal that has the highest reward overall payoff for them. The payoff is determined by two factors. The first is the probability that the goal will be reached. The second consideration is the value of the goal for reducing tension. Thus, Lewin's field theory of motivation assigns two important roles to cognitive processes. One engenders tension through discrepancies and

inconsistencies in the cognitive field. The other determines the goals that are most likely to be pursued. As can be noticed, this view of motivation is quite different from that of the drive theorists and other mechanists, in that it places an almost complete emphasis on the conscious and purposive nature of behaviour (Lewin, 1951:171-172; Haule, 1992:147-158).

In the same way Lewin expanded Gestalt psychology into motivation, Heider (1958:80) and Kelly (1989:191) elaborated the cognitive approach to motivation into an attribution theory of motivation. Attributions are explanations given to people for observed events including their own behaviours (Kelly, 1989:192). In motivation attributions refer to the perceived causes for the outcomes of behaviour. When applied to people's judgements for personal successes and failures, attributional concepts take an important meaning for motivation. For example, the causes imputed to past success and failure play an important role in the motivation of future behaviours. According to Kelly (1989:2-3) attributions can influence expectancies. For instance, people form stable anticipations of future outcomes when they attribute them more to their efforts than when they regard them as matters of chance. Individuals also value outcomes. For example, they value a prize more when it has been given to them gratuitously. In this way cognitive attributions form an important set of variables in any model of motivation formulated along expectancy-value lines (Kelly, 1989:3)

The cognitive emphasis in motivational theory is partly a result of the more general cognitive revolution in psychology, which gives a special significance to the role of information processing in behaviour. Another revolution is that of social psychology which has become a large and prominent sub-category within the psychology of motivation. Some of the more important human motives are the result of social interaction and social demands on the individual (Geen *et al.*, 1992:282-283). As a case in point, aggression, altruism, affiliation and other such terms, are used to describe behaviours that are animated by learned motives, functioning within specific social situations. Thus, social motives may in fact play a more important role in many aspects of everyday life than the fundamental biological ones, given the social nature of human beings (Geen *et al.*, 1992:372-406). To this extent concepts of the social perspective occupy a major niche in the psychology of human motivation (West, 1996:160-162). If to be human means to be social then the proponents of the humanist perspective, were correct in developing their theory, which Allport (1937:5) called the "third force" in psychology, after the two main movements in psychology prior to the 1960s, namely, psychoanalytic and behaviorist. This so called third force focused, not only on what a person is, but also on what he or she has the potential to become (Kimble, 1991:129-130).

The humanistic theory of motivation adopted four inter-related principles, which guided its pursuits (McKenna, 2000:237). Firstly, it argued that the experiencing person is of primary interest. The person must be examined in respect of how he or she perceives and values himself or herself. The theory views individuals as travelers in life, who must determine where they are and where they wish to go. Secondly, to the humanistic psychologists matters such as human choice, creativity and self-actualisation are the preferred topics of investigation. People are considered to have a need to push forward in life and to develop their potentialities and capabilities. These self-actualising tendencies are of particular significance (Schultz & Schultz, 1992:511-512). Thirdly, humanistic psychology argues that

psychological research has centred on methods rather than on problems. Meaningfulness must precede objectivity in the selection of research problems. The fourth parameter of the humanists is that ultimate value is placed on the dignity of the person and above all, humans are accepted as unique and noble. Individuals are believed to have a higher nature with a need for meaningful work, responsibility and an opportunity for creative expression (McKenna, 2000:238-242).

Among the prominent representatives for the humanistic motivation are Allport (1937:145-149) Maslow (1998: 40) and Rogers (1963:503-504). To these authors the central overall motivation of the individual is to grow and to enhance the self. In essence the acceptance of an actualising tendency is an axiom of humanistic psychology, which is not subject to proof or disproof (Geen *et al.*, 1992:409-411). However, rather than focusing on the strength or source of the actualisating tendency, Rogers and Maslow have given attention to what might inhibit this basic human motivation (Weiss, 1993:203-205). Rogers has been particularly concerned with what he called blockage of the tendency toward self-actualisation, which is one component of the more general actualising tendency (Rogers, 1963: 503-504). In his view one's self-concept is socially learned as the needs for positive regard and positive self-regard. If an individual, for instance, is totally accepted by others, that is, unconditional positive regard, then positive self-regard emerges. The sum total of Rogers' argument is that self actualisation can be facilitated or impeded by appropriate interactions and feedback from others. According to Kelly (1997:420-425), in the humanistic system of motivation, beliefs about oneself and attitudes toward others, are positively related. If one feels good about others, one also feels positively about oneself, while negative opinions about others are related to negative self-evaluation.

Unlike Rogers, Maslow (1998:87) does not postulate just one source of motivation, but a number of need systems. He delineated five basic categories of needs, which he defined as physiological, safety, love, esteem and actualisation (Maslow, 1998:87-92). These needs have three common characteristics. Firstly, failure to gratify the need results in a related form of dysfunction. Secondly, the restoration of the gratification remedies the dysfunction. Thirdly, in a free choice situation the gratification of one basic need will be preferred over the gratification of others (Maslow, 1964:373). The distinction between the lower and the higher needs, forms much of Maslow's (1998:90-93) theoretical work on motivation. It is generally claimed that when needs have been satisfied, they no longer impel human beings to action. Action is the result of the gap between need and goal and stops when this gap is closed. But this is true only for such basic needs such as those for food or sex. But motivation based on "higher" needs such as esteem and self-sustaining satisfaction, leads to a desire for more of the same (Maslow, 1998:95). This scenario leaves one with the impression that behaviour is essentially episodic (Frieze & Weiner, 1991:591-696)

The needs that are usually taken as the starting point for Maslow's motivation theory are the so-called physiological drives. Thus, there is a prepotency of needs with the lower needs which are physiologically-based; having the greater strength and the higher needs which are psychologically-based being relatively weaker. It is thought that physiological needs or tissue needs such as hunger are the most prepotent of all needs. Hence they must be satisfied before the higher ones seek fulfilment. This summarises what is meant by saying that the basic needs are organised into a

hierarchy of relative prepotency (Maslow, 1998:95). One main implication of their chain of events described above is that gratification becomes as important a concept as deprivation in the Maslow's motivation theory, for it releases the organism from the domination of a relatively more potent physiological need, permitting thereby the emergence of other more social goals. The physiological needs along with their partial goals when chronically gratified cease to exist as active determinants of behaviour, until they are thwarted (Maslow, 1998:95-111).

If the physiological needs are relatively well gratified, safety requirements, for example, the common preference for a job with tenure and protection, emerge as a new set of needs. These may then serve as the almost exclusive organisers of behaviour, recruiting all the capacities of the organism in their service and it becomes justified to describe the whole organism as a safety-seeking mechanism (Maslow, 1998:111-119). If both the physiological and safety needs are fairly gratified, there emerge the love, the affection and the belongingness needs and the whole cycle already described will repeat itself with this new centre. In most human societies, the thwarting of these needs results in the most commonly-found cases of personality maladjustment. This corresponds to Freud's (1940:230; Davis, 1995:320-350) work on psychoanalysis and on his development of the id and ego theoretical or hypothetical mental constructs in the development of personality. Maslow's esteem needs also correspond to Freud's ego system.

Maslow wrote that most people in all societies have a need or desire for a stable, firmly-based and usually high evaluation of themselves. They also value self - respect or self-esteem and the esteem of others (McClelland, 1990:38-39). McClelland classified these needs into two subsidiary sets. The first is the desire for strength, for achievement, for adequacy, for mastery and competence, for confidence in the face of the world and for independence and freedom. The second subsidiary set has to do with the desire for reputation or prestige, status, dominance, recognition, attention and importance or appreciation. The satisfaction of self-esteem needs leads to the feelings of self-confidence, worth, strength, capability and adequacy and of being useful and necessary in the world. The thwarting of these needs produces the feelings of inferiority, of weakness and of helplessness (McClelland, 1990:39-40).

According to Maslow even if all the foregoing needs are satisfied, it may still be expected that a new discontent and restlessness will soon develop, unless the individual is doing what he or she is fitted for. This is the desire to become more of what one is or to become everything that one is capable of developing into, or to become actualised in what one is potentially good at. In other words what a person "can be", he or she "must be" (Maslow, 1964:390). Maslow maintained that lower needs are characterised by deficits such as the lack of food and water, which push the organism to become active and to seek substances that will bring it back into a homeostatic balance. Higher needs are less urgent and pull rather than push the person toward positive goals. They develop later in life than lower needs, but they are also "instinctoid", that is, inborn in everyone (Maslow, 1998:94-100). From his study of outstanding creative individuals presumably functioning at higher levels in his hierarchy, Maslow concluded that being able to satisfy lower needs and seek self-actualisation, leads to greater biological efficiency such as sleeping better, eating better, longer life and less sickness. It also brings about many desirable human traits such as spontaneity, reality-orientation, spirituality, ability to distinguish between

means and ends, creativity, autonomy and democratic values (Maslow, 1998:52-55). However, Rotter cautioned that the simple and linear progression of one need being satisfied and another one emerging, may give a false impression that a need must be satisfied one hundred percent before the next need emerges. Yet in actual fact most normal members of society are partially satisfied in all their basic needs at the same time (Rotter, 1972:12; Hothersall, 1995:73-80).

Following Maslow's gradations of needs, McClelland (1990:40-41) lists a number of other distinctions between the higher and the lower needs. Firstly, he noted that the higher needs appeared later in the evolutionary development of mankind. All living things need food and water but only humans have a need to self-actualise and to know and understand. Secondly, higher needs appear later in the development of an individual. For example, self-actualisation may not appear until mid-life. Thirdly, higher needs are less necessary for sheer survival hence their gratification can be postponed longer. Fourthly, while they are less important for sustaining life, higher needs nevertheless contribute to survival and growth. Higher level need satisfaction produces better health, longer life and a generally-enhanced biological efficiency. It is for this reason that the higher needs are also called "growth needs". Fifthly, the difference between the higher and the lower needs, regards higher-need satisfaction as productive or beneficial, not only biologically, but physiologically as well, because it produces deeper happiness, peace of mind and fullness in one's inner life. The sixth distinction is that higher need gratification involved more preconditions and greater complexity than lower need satisfaction. The search for self-actualisation, for example, has the precondition that all the other needs have first been satisfied and it involves more complicated behaviour and goals than, for instance, the search for food. Finally, higher need gratification requires better external conditions such as social, economic and political than lower need satisfaction. For example, greater freedom of expression and opportunity are required for self-actualisation than for safety (McClelland, 1990:40-42).

Despite the fame Maslow was accused of having picked creative individuals to study, who showed the characteristics that he thought they should have. Moreover, in his theorising he tended to neglect the nature of the environmental conditions that aroused the various needs in the hierarchy. He also did not undertake the empirical investigations necessary to show that "his" needs really formed a hierarchy. But Maslow's most important contribution, in spite of some noted pitfalls in his theory, is that he gave psychologists a positive way of thinking about motives to contrast with the negative view deriving from the psychoanalysts, who learned about motives primarily from studying patients in need of therapy (Buck, 1988:2/-34).

While Maslow and McClelland shared similar views on the needs approach to motivation, Herzberg distinguished between what he called "motivation" and "hygiene factors". He defined a motivator as an influence that usually has uplifting effect on attitudes or performance. Hygiene factors produce no improvements but rather serve to "prevent losses" of morale or efficiency (Herzberg, 1993:56-58). In the field of work matters such as pay, job security and working conditions, were hygiene factors in the sense that when they were inadequate they had a significant negative effect on the workers' attitudes. But they had no important positive effect when they were properly administered. As a result of this it makes little sense, therefore, to think of motivation for workers purely in terms of paying them well and providing fringe benefits, as well as an attractive place to work. The additive effect of all these things

would not really motivate them at all. On the other hand to have deprived them of these things would have caused their motivation to deteriorate very rapidly (Herzberg, 1993:60-64).

Quite obviously motivators cannot operate in the absence of hygiene factors. The latter have a very lukewarm or tepid and unremarkable effect in the absence of motivators. This makes them both indispensable if productivity is to be maintained at a high level and if work itself is to become a source of satisfaction rather than an unavoidable drudge. It was necessary, therefore, to put the money factors in motivation in a balance so as to ensure a realistic perspective which did not emphasise any one of them at the expense of any other (Herzberg, 1993:33-45).

Herzberg, thus, in essence identified two classes of needs. Firstly, the hygiene factors formed an essential base for the second and required a fair treatment in such background factors as salary, supervision and working conditions. If these were not in proper working order or out of balance, they would constitute a severe insult to the individual's sense of worthiness. He or she would either become embittered and antagonistic to management or would be humbled beyond the point of caring about doing the kind of work he or she could be proud of. Secondly, a person could rise above such a mundane level only when the second set of needs, that is, motivators, was satisfied. In other words he or she must derive a sense of personal growth from his or her occupation. Such a feeling would exist when his or her work was not merely interesting but challenging, not merely prestigeful but significant and not merely fun but adventuresome (Herzberg *et al.*, 2004:48-62). According to Buck (1988:252-254), personal growth or self-actualisation is the ultimate goal for Maslow, McClelland and Herzberg's motivation theories.

McGregor (1964:23; Heil, Bennis & Stephens, 2000:18) presented his theory of motivation on the needs of workers in the form of Theory X and Theory Y. There are three cornerstones to Theory X. Firstly, it is assumed that most people do not like to work. Secondly, it is claimed that some kind of club has to be held over workers' heads to make sure that they do work. Thirdly, it is thought that the ordinary mortal would rather be told than have to think for himself or herself. Interpreted another way the world is supposed to be full of peons or service workers and managing them is largely a matter of vigilance, catering for their security needs with various fringe benefits and keeping the implied threat of unemployment handy in case it is needed (McGregor, 1964:25-30; Heil *et al.*, 2000:21-23).

Theory Y proclaims first of all that people do not like or dislike work inherently, but rather develop an attitude toward it based on their experience with it. The second proposition is that while authoritarian methods can get things done, they are not the only way to achieve results. There is nothing inevitable about them and their undesirable side-effects do not have to be tolerated. The third point is that people select goals for themselves if they see the possibility of some kind of reward, be it material or psychic or psychological. Once they have chosen a goal they will pursue it, at least as vigorously or with some fervour, as they would if their superiors were trying to pressure them into doing the same thing. Finally, under the right circumstances people do not shun responsibility but seek it (McGregor, 1964:27-30; Heil *et al.,* 2000:23-27).

Theory Y aims at the true integration of the individual's goals with those of the institution rather than at the subjugation of one by the other. The essential "contract" between an employer and an employee in the traditional institution, is an acceptance of external control in exchange for money and other rewards. The real task of management under Theory Y, is to make the job the principal stage on which the enlargement of competence, self-control and a sense of accomplishment can occur (McGregor, 1964:311-314; Heil *et al.*, 2000:81-90). As is well known, management can be automated but human nature cannot. People have never rearranged their motives to make themselves more convenient to administer and there is no evidence that they are about to become any more obliging (McGregor, 1964:94; Heil *et al.*, 2000:81).

Stewart (1992:35-37) has pointed out that the ambiguous term "motive" sits in a unique position between the cause of behaviour and the reason for action. The word "motive" involves both the idea "to move" and "to cause". Some of the most puzzling problems in the psychology of motivation come from mystification in the use of words. In other words, they arise from the long-standing ambiguities in the use of words like motive, cause and even the innocent-looking "idea" and "experience". Human action is not just human behaviour, because behaviour is determined by and is reducible to physical or biological events in as much as motivation can be reduced to needs and drives. Ignoring for the moment the term "motive" itself, probably the most ambiguous term is "behaviour". A motive is often thought to be a cause of behaviour. In order to have the characteristics of something that can cause a physical event like behaviour, a motive must itself be a physical event like a stimulus or a noxious sensation (Stewart, 1992:41-60). Using the logic of physicalism motivation theorists has developed all the classic paraphernalia for reducing a motive to a physical state. A motive was first a need, then a drive stimulus, then a stimulus that impelled action (Stewart, 1992:71-76).

According to McClelland (1990:590-594) a working definition of a motive is "a recurrent concern for a goal state based on a natural incentive, that is, a concern that energises, orients and selects behaviour" (McClelland, 1990:590-594). A "motive disposition" refers to thinking about a goal state frequently, that is, it denotes a "recurrent" concern (McClelland, 1990:594). If a motive is a casual agent of behaviour, Lie Bert and Spiegler (1994:310) argue further that motivation, therefore, is a term used to describe the direction, intensity and persistence of behaviour. To account for these three dimensions of action, terms that refer to processes inside the person are used. Such processes are hypothetical and are inferred from behaviour. The study of motivation therefore consists of the observation of behaviour under antecedent conditions that presumably produce the alleged internal processes (Lie Bert & Spiegler, 1994:310).

It is these antecedent conditions that form a point of departure relative to different theories of motivation (Fernald, 1997:14). The basic premise in the biological approach to motivation is that behaviour and experience are most usefully studied in terms of the underlying physical and biochemical structures from which responses emanate. Freud's psychoanalytic approach claimed that behaviour can be influenced by events that a person is no longer aware of. The motivation theory based on behaviourism maintains that only overt behaviour is a suitable topic for study in psychology. Humanistic motivation confines itself to the complexity, subjectivity and capacity for growth in human beings, which are features ignored in

other theories.   Finally, cognitive motivation concerns itself with mental processes focusing on perceiving, remembering and thinking.   It studies the mental processes by which people acquire knowledge and understanding of their world (Fernald, 1997:14-18).   It, therefore, stands in opposition to traditional behaviourism which concentrates on overt acts of behaviour rather than mental processes (Skinner, 1990:1206-1210).

Hamilton (1993:88-89) has pointed out that because motives are inferred from behaviour, the study of motivation depends to a large extent on the theory of behaviour that one follows, in deciding what inferences are to be made. A theory is basically a statement that is made about the ways in which constructs are related to each or one another and to observable events.   Thus, a good theory has two characteristics.   At the first instance it consists of two or more constructs linked together by certain rules.   By definition a construct is not directly observable but is invented to describe something that is observed.   The second characteristic is that the propositions that connect constructs in a theory are not real processes but abstractions.   To view matters simply the constructs and the statements connecting them, represent the theorist's opinion as to the way a human being functions under specified conditions (Hamilton, 1993:31-34).

In the light of diversity in the study of motivation, McClelland's (1990:594) definition is preferred for purposes of the study at hand (see preceding page), for its practical orientation particularly in the field of work.

3.3   MOTIVATIONAL ROOTS OF BEHAVIOUR

Plato was one of the early cognitive psychologists who contended that, in general, people act so as to maximise the virtue attendant upon their acts. According to him all people do what they perceive to be the right thing but their perception differs in important ways. Plato believed that peoples' ideas and thoughts are based mostly upon cognitive processing (brain selection of attitude and behaviour) (Weiner, 1974:2).   The ideas of individuals reflected prior experience although they were not caused by that experience.   A person was assumed to be rational and to process self-determination or free will but his or her rationality and will were governed by his or her often distorted perception of these ideas. Although Plato did not distinguish sharply between the motivational and the non-motivational determinants of behaviour, later writers identified them for him. For example, rationality which is the logical manipulation of ideas is clearly an associative or structural factor. The will or resolution or determination and the all-encompassing principle of seeking to maximise virtue have been seen as clearly motivational principles. The separation of structural and motivational factors, however, became more explicit with St. Augustine and other Christian philosophers who replaced Plato's optimistic virtue-seeking man with a less admirable theoretical person or a pleasure-seeking man (Hauke, 2000:37).

St. Augustine complicated Platonic man by proclaiming that man was literally torn asunder by the forces of pleasure and the forces of virtue. In this way, rather than having one optimistic principle of motivation, there were now two because man could

be motivated by good or by pleasure. It was the predominance of one kind of motivation over another that justifies people judging their fellow man or woman blaming him or her if he or she is a pleasure-seeker and praising him or her if he or she seeks to serve others or is otherwise noble. But whatever a person was, for St. Augustine this did not come entirely or even predominantly from his or her characteristic motives; it came from his or her thinking, from the kinds of perceptions and thoughts that he or she had. Like Plato, St. Augustine had a cognitive view of a person in which at least the structural characteristics of personality were cognitive (Hauke, 2000:77).

It can be seen that for the "early philosophers", the structural factors were all important and yet complicated determinants of what a person is. To these early pundits, man or woman was characterised primarily by the structural properties of his or her mind rather than by his or her motives. By contrast, the motivational principles of behaviour were quite simple, undimensional and almost monolithic in character. Motives were merely either commended or condemned. Because of the emphasis upon a person's rationality as the basic explanation of his or her behaviour the original psychology of man or woman, particularly in the American society, was necessarily cognitive. The average man in the street, regardless of what he or she may have read of Freud or Skinner still believes that he or she is rational, that his or her perceptions are unique, that his or her thoughts govern his or her acts, and that he or she is, as Socrates said, the measure of all things (Clarke, 1994:48). People can recognise other people's motives in their behaviour but this perception is subtle and they rarely talk explicitly about it. The shadow of St. Augustine still falls over people as they praise or more often blame a man or woman for his or her motives, but remain peculiarly inarticulate about personal motivations, even their own. Thus the richness of people's cognitive concepts and the poverty of their motivational concepts reflect a long historical tradition (Hauke, 2000:275).

It is not the case that there are motivated behaviours and unmotivated behaviours or the fact that behaviour arises when there is some appropriate motive for it. Such ideas smack of the old-fashioned belief in the passivity of the individual. The fact of the matter is that all of the people and all of the animals are known to be always busy doing something. The explanation of their behaviour lies not so much in seeking out the motives for what they are doing at a particular time but in explaining why they persist in doing what they are doing and why after having persisted for so long, they quit and begin doing something else (Smith, Harre & Van Langehove,1995:1-2). Behaviour is a stream or a continuity of acts. That is to say there are no structural and motivational determinants of behaviour; there is simply the on-going stream of behaviour and the task of the psychologist is to find out what modulates the stream. The modulation factors are cognitive. More specifically as the individual thinks his or her thoughts may instigate appropriate kinds of behaviour or lead to the abandonment of others (Smith *et al.*, 1995:30).

Heider assumes that individuals are motivated to see their environment as predictable and hence controllable and that they apply the same kind of logic to the prediction of social events as the prediction of physical events (Heider,1958:80; Weary & Edwards, 1994:308-318). They look for the necessary and sufficient conditions for such events to occur. Such conditions may either be situational or impersonal factors external to the person whose behaviour one is trying to predict and explain or factors regarded as internal to the person such as his or her ability or

personality. In Heider's words "Attributions in terms of impersonal and personal causes and with the latter, in terms of intent, are everyday occurrences that determine much of our understandings" (Heider, 1958:80-81; Weary & Edwards, 1994:308-310).

Heider (1958:81-82; Weary & Edwards, 1994:308-312) goes further to stress the importance of the concept of intentionality, arguing that behaviour should only be attributed to personal causes of its outcome as seen to have been intended by the actor (Heider, 1958:80-81; Weary & Edwards,1994:308-309). It is assumed that there is a kind of "trade-off" relationship between the assumed influence of personal and impersonal factors so that attributions to a person's character will not be so likely to be made if the behaviour is seen to be under the control of external constraints (McKenna, 2000:267). Personality trait descriptions are thus an attempt to explain behaviour which cannot be clearly attributed to external conditions. Even so Heider (1958:82; Weary & Edwards, 1994:312) argues that the effect of such environmental conditions may not be fully taken into account. In other words, people may be biased in explaining behaviour in terms of personal factors, i.e., a bias which may be reflected in the readiness to treat problematic behaviour as a disorder of individual personality (Whitmont, 1991:112).

On the basis of these notions Festinger (1943:226-234; Hermon-jones & Mills, 1999:196-215) proposed a model of how individuals make inferences about a person's disposition or character. Ability and knowledge are relevant in that it is assumed that the actor must be seen as knowing that his or her action could have the consequences produced and being able to produce these consequences intentionally by the action before an attribution can be made to his or her intentions. When the perceiver infers that the actor's behaviour is "in character", this is termed a "correspondent" inference (McKenna, 2000:268). For example, if the actor shows aggressive behaviour the most "correspondent" inference is that this is because of the actor's aggressiveness which also involves the assumption that the actor intended to act aggressively. At a conceptual level there are serious difficulties with this model. For example, since there may be no obvious external explanations for behaviour one concludes that unseen internal events such as motives and emotions account for them. The problem with internal events of course is that they are not directly visible and are therefore difficult to study. Alternatively one might look at the present situation or look for differences in the physiological mechanisms associated with the behaviour (Buck, 1988:8-9). At its most mechanistic level Festinger's model implies that personality causes intentions and intentions cause behaviour (Chmiel, 1998:66-67).

Further according to Festinger's (1957:20-40) theory of cognitive dissonance, any decision between alternative courses of action will lead to a state of psychological tension or "dissonance" to the extent that the net attractiveness of two alternatives is similar. This stave of dissonance moreover does not immediately dissipate once the individual has embarked on the chosen course of action. For it to do so the individual must usually engage in some "cognitive work" which will lead to a re-evaluation of the relevant cognitive elements. According to Festinger (1957:40-45; Hermon-Jones & Mills,1999:60-75), cognitive dissonance is an awareness of implicit contradiction anywhere within one's beliefs, preferences or thoughts about behaviour which should prompt attempts to change cognitions so as to restore a kind of balance. But Festinger (1957:47-50; Hermon-Jones & Mills, 1999:74-76) also spoke about the

subjective experience of dissonance being one of "discomfort". This notion was later developed into the second conceptualisation of dissonance in primarily motivational terms as a drive state involving unpleasant arousal (McKenna, 2000:269).

The above analysis has shown how important the co-ordination of cognitive theory with motivation is in understanding how cognition controls action, but it is thought that cognitive processes also have a more direct functional significance for action. It is believed that conscious thought can be a source of instigating and inhibitory forces. It is proposed that the thought of eating steak, that is, the content of that thought, for instance, instigates the action tendency for the overt activity of seeking to eat. It is also proposed that the contents of conscious thought constitute a source of instigating and inhibitory forces both for the covert activity of thinking that thought and for the overt activity referenced by that thought (Jung, 1994:190-191).

The process of thinking has intrigued attribution theorists who are concerned with perceptions of causality or the perceived reasons for a particular event's occurrence. Three general programmes of research have emerged from the analysis of perceived causality (Buck, 1984:10-12). The first deals with the perceived causes of behaviour which have been specified with particular consideration given to a distinction between internal or personal causality and external or environmental causality. The second research programme involves the general laws which have been developed that relate antecedent information and cognitive structures to causal inferences. The third programme is concerned with causal inferences associated with various indices of observed behaviour. But the most fundamental distinction is one made by Heider (1958:83-84; Weary & Edwards, 1994:308-311) that behaviour depends upon factors within the person and factors within the environment. This is manifestly similar to the Lewinian statement that behaviour is a function of the person and the environment, that is, B = f (P, E) (Buck, 1984:15-20). However, according to McKenna (2000:267-268), Heider is referring to the perceived causes of behaviour and not to the determinants of force actually acting upon the person or influencing an outcome.

The distinction between personal and environmental causes of behaviour is implicit in almost all theories of motivation. Hull (1943:9-15; Clay, 2002:201-212), for example, postulated that behaviour is in part determined by independent drive, i.e.; person and incentive, or environmental factors. Thus an instrumental action to attain food might be undertaken because the person is hungry, that is, a push motivation or because the goal object is especially attractive, that is, a pull motivation (Kantowitz, 1997:396-397). Lewin (1951:12-20) also specified that the valence of the goal is a function of the needs of the properties of the goal object. According to Atkinson and Feather's (1966:50-74; Bohart & Greening, 2001:81-82) theory of achievement motivation individuals differing in resultant achievement motivation, that is, personal factor, differentially work to achieve success at tasks varying in difficulty, that is, environmental factor. In sum both the person and the environment influence action. But Heider (1958:82) as opposed to Hull (1943:25-30), Lewin (1951:22) and Atkinson (1966:58), stresses the consequences of differential ascriptions to internal versus external factors. This dichotomy corresponds to intrinsic and extrinsic motivation which influenced the early thinking of psychologists concerned with work motivation. According to Vroom (1995:18) and McGregor (1960:23; Heil et al.,200:18), motivation is viewed as the process of initiating and directing behaviour and an individual produces and sustains behaviour when he or she finds it rewarding to do so, that is, when the behaviour accomplishes an objective which satisfies a need. The factor of

performance and all that goes with it to achieve a goal, is implied as a matter of course (West, 1996:573-574).

3.3.1   Intrinsic and extrinsic motivation

The work motivation theories first drew the distinction between intrinsic motivation and extrinsic motivation for practical reasons. White (1959:297-333; Johnson,1998:350-370) in a classic paper argued for a different kind of motivational concept, one that would complement drives and could be the basis of a motivational theory with greater explanatory power. This new motivational propensity could account for play, exploration and a variety of other behaviours that do not require reinforcement for their maintenance. White referred to this propensity as "effectance motivation" because he argued that organisms are innately motivated to be effective in dealing with their environment. According to White the feeling of effectance that follows from competent interactions with the environment is the reward for this class of behaviours and can sustain behaviours independent of any drive-based reinforcement. In psychoanalytic theory this motivational force is generally referred to as independent ego energy. The term refers to the fact that the energy of the ego which is the portion of the personality structure responsible for volitional responding, rational processes, exploration and play had originally been hypothesised to be derivative from, rather than independent of, the basic drives of the *id* (mental construct) (White, 1995:299-333). In empirical tradition, psychologists are most apt to refer to the person-drive-based motivation as "intrinsic motivation", suggesting that the energy is intrinsic to the nature of the organism (McClelland, 1990:115-116).

In Deci and Ryan's (1990:33-43) observation the human organism is inherently active and there is perhaps no place where this is more evident than in little children. They pick things up, shake them, smell them, taste them, throw them across the room and keep asking, "what's this?" They are unendingly curious and they want to see the effects of their actions. Children are intrinsically motivated to do a variety of things. They spend large amounts of time printing pictures, building furniture, playing sports, whittling wood, climbing mountains and doing countless other things for which there are no obvious or appreciable external rewards. The rewards are inherent in the activity and even though there may be secondary gains, the primary motivators are the spontaneous, internal experiences that accompany the behaviour (McClelland, 1990:591-592). Intrinsic motivation is the energy source that is central to the active nature of the organism. Its recognition highlighted the important points that not all behaviours are drive-based or a function of external controls. As human beings engage in a substantial amount of intrinsically motivated behaviour so theories of motivation must be able to explain behaviours that are motivated by "rewards that do not reduce tissue needs" such as hunger (Lindenfield, 1996:3-7). This requires an adequate conception of intrinsic motivation and general theory of motivation that includes intrinsic as well as other types of motivation. "Intrinsic motivation" is based in the innate, organismic needs for competence and self-determination. It energises a wide variety of behaviours and psychological processes for which the primary rewards are the experiences of effectance and autonomy. Intrinsic needs differ from primary drives in that they are not based in tissue deficits and they do not operate

cyclically, that is, breaking into awareness, pushing to be satisfied and then when satisfied, receding into quiescence (Lindenfield, 1996:23-27).

Intrinsic motivation is the innate, natural propensity to engage one's interests and exercise one's capacities and in so doing to seek and conquer optimal challenges. Such motivation emerges spontaneously from internal tendencies and can motivate behaviour even without the aid of extrinsic rewards or environmental controls. Intrinsic motivation is also an important motivator of the learning, adaptation and growth in competencies that characterise human development. One would think from this description that intrinsic motivation is a ubiquitous phenomenon and yet the examination of many settings suggests just the opposite. In factories and classrooms, offices and kitchens, one finds evidence of boredom, alienation and inactivity. There appears to be a strong indication that people are prone to disinterest and stagnation (Bandura, 1997:135-137).

Nonetheless, motivation is more noticeable in the field of work than in any other walk of life. Included in a list of reasons of why people work are such obvious factors as pay, fringe benefits, status and promotions, as well as interest in tasks that are challenging, self-paced and ego-involving and that permit creativity. The list can be organised in terms of extrinsic rewards, those that are part and parcel of the work itself. Notz (1995:884), stated the distinction clearly by saying that

Rewards such as pay, fringe benefits, and promotions are extrinsic, because they provide satisfaction that is independent of the actual activity itself, and because they are controlled by someone other than the employee. Intrinsic rewards, on the other hand, are those over which the employee has a high degree of self-control and that are an integral part of the work itself (Notz, 1995:884-891)*.*

A person could, therefore, be described as extrinsically motivated if he or she performed some activity solely as a means to an end. A person is described as intrinsically motivated if he or she appears to perform an activity for its own sake and appears to derive enjoyment from it. Most people complete most behaviours for some combination of these reasons (Notz, 1995:884-891). Another way to approach the definition of extrinsic and intrinsic motivation is in terms of the locus of reinforcing effects of behaviour (Deci & Ryan, 1990:4-5). The reinforcement process usually refers to tissue deficits, biological needs, or deprivations that represent aversive states and their removal. *A reinforcement process is concerned with a stimulus-response situation in which the controlling variable is not the causal antecedent but the consequence of the response* (Skinner 1990:1206-1210). Reinforcements that are caused by deprived tissue needs serve principally as an informative and motivational operation rather than as a mechanical response booster or strengthener (Gross, 2005:182-183). Hunger is an example of an extrinsic need that is based on tissue deficits. By contrast, intrinsically motivated behaviours are those "related to internally rewarding consequences which are located in the central nervous system and have no appreciable biological effect on non nervous system tissues" (Deci & Ryan, 1990:4-5). By this Deci means that the needs of the brain are somehow bound up with intrinsic motivation. Berlyne (1966:25-33; Connor, 2006:53-67) argued that certain positive consequences internal to the organism are necessary for a behaviour to be rewarding. Deci has merely added that certain behaviours are rewarding because of the experience or stimulation they provide the central nervous system. It has often been proposed that people attempt to maintain some optimal

level of stimulation. The nature of this optimal level is a major issue in defining intrinsic motivation (Deci & Ryan, 1990: 5-6).

3.3.2   Interaction between intrinsic and extrinsic motivation

The interaction of intrinsic and extrinsic motivation or the lack of it is another area of debate.   Geen, Beaty & Arkin (1992:5-7) have contributed two views to the controversy. Firstly practitioners and theorists in the field of work motivation sought to specify the relationship between intrinsic and extrinsic motivations. Initially it was assumed that the two types of motivation were independent of each other. The presence of one would not dictate either the presence or absence of the other. This assumption makes sense in that there are all manner of combinations of extrinsic and intrinsic incentives for work. Some people earn a good salary but dislike their jobs intensely whereas others enjoy their jobs immensely even though the pay is poor. Still other lucky persons can say that they gain pleasure from their work and are well paid too. Secondly a straightforward assumption was that these two types of motivation should operate additively. That is, the motivation to perform some act should be enhanced by the presence of either intrinsic or extrinsic rewards and the motivation to perform should be greater in a situation in which both intrinsic and extrinsic motives are aroused. Thus it was thought desirable to make jobs interesting and challenging, that is, intrinsically-rewarding as well as financially remunerative, i.e., extrinsically rewarding. This was the reasonable and humanitarian thing to do from the perspective of management. An employee who receives extrinsic rewards based on the performance of a job that is challenging and interesting should have the greatest motivation (Geen *et al.*, 1992:7-8; 279-290).

Some challenges to these simple and persuasive assumptions emerged in the late 1960s. It was claimed that intrinsic and extrinsic motivation do not exist in isolation or independence of each other and that they do not summate in a simple additive way. In particular it was found that one direct effect of enhancing extrinsic motivation was to diminish intrinsic motivation, demonstrating that the two forms of motivation are highly interdependent. Much of what is currently known about intrinsic motivation is a direct result of that early finding (Deci, 1992:113-120). On the interaction of both extrinsic and intrinsic motivation, De Charms (1968:63) and Geen *et al.* (1992:280) proposed that the two variables contained a basic and primary motivational power to be originators of their own behaviour rather than being pawns of external forces. People wish to experience and view themselves as causal agents and to be effective in producing changes in the environment (Geen *et al.*, 1992:280-281).

"Personal causations" are the watch words. De Charms (1968:63-70; Thomas, 2002:17-26) conceived of them as an overarching sort of motivational principle that would colour all specific motives. Because they prefer to be the origins of their own actions, people constantly struggle against the intrusion of external, coercive forces in their lives. The struggle is against being a pawn in other people's or players' games. If people view their behaviour as personally caused, see themselves as its origin, feel free in choosing to behave in some way and so forth, "they will cherish that behaviour and its results" (Notz, 1995:84).   In short, De Charms (1968:65; Thomas, 2002:39-63) conceptualised intrinsic motivation in terms of his more general distinction between origin and pawn. People who view themselves as the origin or

cause of some behaviour should be intrinsically motivated. Those who locate causality for a given behaviour in the external environment, however, feel pawn-like and consider themselves extrinsically motivated. The judgement process rests with determining the locus of causality for a given behaviour (Notz, 1995:84).

Because of the judgement process involved intrinsic motivation can be shifted to extrinsic motivation if the presence of an extrinsic reward for behaviour leads a person to conclude that the locus of causality for his or her behaviour is outside himself or herself, in the external world rather than within. This can have two effects. Firstly the introduction of extrinsic rewards can leave the overall motivation unchanged but change its basis from intrinsic to extrinsic. A person's behaviour may not change, therefore, but satisfaction derived from the activity may be greatly diminished. Secondly if the extrinsic reward is later removed a change from intrinsic to extrinsic motivation can have the after-effect of reducing the overall motivation (Deci, 1992:113-120). Both Deci (1992:115-118) and Calder & Staw (1991:76-80) also argued that being monetarily rewarded shifted the subjects' perceived locus of causality for working on an exercise such as the puzzles from "personal" to "external". As a result of this cognitive change there was also a change in the underlying motivational process from intrinsic to extrinsic motivation (Bandura, 1997:122-124).

Monetary rewards are persuasive in most present day cultures but there are many other external reasons for behaving in some way. If the cognitive process is a general sort of change in the locus of causality, the introduction of any external reason for behaving should reduce intrinsic motivation. Deci and Cascio (1972:10-20) found that avoidance of an aversive blast of noise which the subjects received through earphones if they failed to solve the puzzle was as effective in undermining intrinsic motivation as monetary rewards (Bandura, 1997:137-140). Lepper, Greene and Nisbett (1973:129-137) found a decrease in intrinsic motivation when an award was made contingent to children's use of some otherwise very desirable art materials. Several days later the children who had received the award for their artwork were less intrinsically motivated to use the art materials. In several studies, for example, Amabile, De Jong, and Lepper (1976:92-98), it was found that college students working on interesting word games became less intrinsically motivated when external deadlines were imposed on their finishing than when none were applied. Finally, children who were under surveillance from adults while working on an interesting puzzle tended to lose intrinsic motivation compared with children who were not being watched or observed (Lepper & Greene, 1995: 479-486).

Apparently virtually any external control whether positive or negative, promotive or coercive, can undermine intrinsic motivation. Despite the apparently limitless external reasons for behaviour the reduction of the latter does not invariably occur when external forces are introduced to a given situation. The external forces must be of a cervain type and be introduced in a particular way and the task must be of a certain type to produce the undermining effect. There are boundary conditions to the phenomenon (Lepper & Greene, 1995: 479-486).

The boundary conditions that determine whether or not intrinsic motivation will be undermined all seem to point to a locus-of-control judgement as the crucial factor involved (Lepper *et al.*, 1993:129-137). Firstly it appears that the extrinsic force must be apparent before the person engages in the relevant activity. For instance, Lepper

et al. (1993:129-137) gave their subjects awards for their artistic endeavours. Half the number of children who received the award was told that they could attain it before they began the activity. The remaining half was not informed about the award before they began; instead they received the award unexpectedly after they had finished drawing. The children who were told about the award before-hand lost intrinsic motivation. However, there was no loss of intrinsic motivation among the children who received a surprise award which is consistent with the locus-of-causality idea. For the children to have concluded that their artistic efforts were designed to achieve the praise, this contingency, that is, praise for good work, would have to be apparent to the children as a sort of contractual agreement before they tried the task. Consistent with this finding it has been shown that subjects' evaluations of a task increase with the amount they are paid but only when the payment is announced after the task is performed. Ironically people who begin a task knowing that they are going to be paid a lot tend to like the task less than those who are being paid little (Lepper *et al.*, 1993:129-137).

Secondly, the extrinsic force must be an obvious and salient reason for having engaged in the activity. In a study conducted by Ross (1990:245-254), the subjects were children who were to be given prizes for playing a drum. Ross had half of the subjects play while the prize was in plain view; for the remaining subjects, the prize was taken away from the laboratory before they played and was never mentioned again. The prize being in plain view had a detrimental effect on intrinsic motivation for the children in the first group. The children in the second group had forgotten about the absent prize or were engaged in the cognitive process of deciding how much they liked playing the drums (Ross, 1990:245-254). Ross goes on to conclude that it also appears that rewards that are contingent on the nature of a person's performance are more likely to undermine intrinsic motivation than rewards that are given merely for a person's willingness to do some activity. Although rewards of both types can decrease intrinsic motivation, rewards directly and explicitly associated with productivity appear to have the strongest effect. This finding is perhaps just an extension of the idea that rewards must be salient to have an undermining effect. Stated in simple terms the task must be intrinsically motivating to begin with, or it is impossible for intrinsic motivation to be undermined. This discovery concerning task characteristics raises the question of individual differences. People differ in the tasks they find enjoyable (Ross, 1990:245-254).

The results of Calder & Staw's (1991:76-80) study raise still another issue. Subjects working on the dull puzzle liked it better when they were paid than when they were not paid. This effect is congruent with all that is known about reinforcement theory. Behaviour that is rewarded increases in frequency, by definition, and generally is associated with the positive feelings that the rewards themselves produce. Therefore, the findings that rewards increase the attractiveness of dull tasks are predictable (Calder & Staw, 1991:76-80). The prototypical example of such an effect is the use of token economies in institutional settings. The effects of such "behaviour modification" practices on intrinsic motivation are minimal. Tokens are exchanged for the "good things in life" such as cigarettes, extra food, or other privileges. Firstly, behaviour modification, for instance, in the form of token economies, is ordinarily used to increase a person's performance of an inherently undesirable task that he or she would not otherwise perform. Secondly, the prime purpose of behaviour modification techniques is to raise the rate of the behaviour "in exchange for the reward". It is possible that the liking for an extrinsically motivated task will go up and

stay high after a period of enhanced reward. The worst that is likely to occur when the additional rewards are eliminated is that the behaviour will drop to its original level of undesirability (Calder & Staw, 1991:76-80).

Apart from examining the shift from intrinsic to extrinsic motivation, De Charms (1968:41-50; Thomas, 2002:6-10) has looked at the reverse process. If the locus-of-causality interpretation is correct, the perception of locus causality should be open to shifts from external to personal causation as well as the personal to external shift already presented. He anticipated this possibility and predicted that there would be a change in intrinsic motivation when extrinsic rewards are withheld. Specifically the motivation to engage in primarily extrinsic reasons might be enhanced by a sudden withdrawal of an extrinsic reward. This phenomenon would be paradoxical under normal conditions as the withdrawal of reinforcement for behaviour commonly results in the extinction of that response. However, De Charms (1968:50-62; Thomas, 2002:39-55) felt that intrinsic motivation for an activity might be liberated when coercive external controls suddenly disappear. He assumed that this would occur because the person would shift his or her perception of causality for the behaviour from external to internal. The evidence for this process is scant compared with shifts in the other direction (Walker, 1996:21-22). However, there is some evidence from Weick's (1964) research in which he invited college student subjects to participate in a study in exchange for extra credit toward their course grade. However, when they arrived to take part in the study, some of the subjects learned that they could not receive the credit they had agreed upon. On several indices of motivation, subjects who were promised the extrinsic reward of course credit but had this withdrawn before participating were more interested in the task than subjects who received their credits (Winter, 1996:596-599). It is important to note that this change in the explicit contract between Weick (1994:533) and his subjects occurred before the subjects performed the task (Winter, 1996:599-600).

Deci and Ryan (1990:33-43) have added that the withdrawal of external rewards is not necessary to foster judgements of personal causation. "In the absence of external rewards and constraints when people are free to do what they want, they should perceive the locus of causality to be internal," and their behaviour should become "governed by the intrinsic rather than the extrinsic motivational sub-system" (Deci & Ryan, 1991: 105-107). Swann and Pittman (1977:1128-1132) told some of the subjects that they could choose which games to play but because they happened to be sitting in front of the drawing game, they could begin with that. Thus these subjects were given only an illusion of choice in that they were told that they were free but were subtly induced to draw. The remaining subjects were simply told to draw. Greater intrinsic motivation was found among the subjects who had "choice" than among those who did not (Monty & Perlmutter, 1992:183-187).

If a person holds two cognitions that are incompatible he or she will experience an incompatible state called "dissonance" and will be invited to do something to reduce it (Festinger, 1957:22-27). The cognitive dissonance theory first proposed by Festinger (1957:21-39; Guzzo & Dickinson,1996:307-338) is based on the idea that people seek congruity and compatibility among their cognitions or thoughts. Clearly there is an interaction or interdependence between intrinsic and extrinsic sources of motivation. This interdependence is not always found, however. Many limiting factors and conditions necessary for interdependence have been identified. The unifying theme is the cognitive component of modulations in intrinsic versus extrinsic

motivation, that is, the attributional judgement of personal versus external causation for behaviour. Virtually every finding pointed clearly to the involvement of an attributional process (Festinger & Carlsmith, 1989:478-488). The cognitive theory proposed by Festinger (1957:47-50;Guzzo & Dickinson,1996:307-338) in his analysis of intrinsic motivation suggested that there are two dissonant or incompatible cognitions held by a person which produce an aversive state and motivate the person to restore balance or consonance. The incompatibility referred to by Festinger and Carlsmith (1989:478-488) and De Catanzaro (1999:284) is frequently between one cognition held by a person regarding his or her actual behaviour and another held about the person's attitude toward the behaviour (De Catanzaro, 1999:284-285).

In the 1960s the attribution theory provided a means of accounting for dissonance-like phenomena without the motivational construct of dissonance itself. According to Bem (1993:183-200), subjects do not "change" their attitude to reduce an unpleasant state of dissonance but merely "infer" their attitudes from watching their own behaviour just as objective observers do. Furthermore, the dissonance theory and the attributional theory make different predictions when the tables are turned and a person is paid "too much" or just enough"for an activity. The attributional theory predicts that a person who engages in an action for a large external reward would tend to view the action as caused by the reward and not by his or her own positive attitude. The dissonance theory has nothing to say about such a situation because an over-sufficient justification would produce no dissonance. On the case of over-sufficient justification the attributional theory proves correct. Because the sort of attributional judgement is the same in insufficient justification as in over-sufficient justification, there is little reason to pause a motivational state or dissonance for one but not the other. The only thing necessary in either case is the attributional judgement regarding the presence or absence and strength of personal versus external forces. This does not mean that dissonance does not exist but only that it is not a necessary condition for intrinsic motivation to be present (Weick, 1994:533-539).

This approach equates intrinsic motivation with an individual's decision that he or she is performing an act for its own sake. Ross (1990:130) pointed out that psychologists and educators tend to agree that intrinsic motivation is somehow more desirable, though the reasons for this assertion are not often elucidated. The most obvious advantage is that the intrinsically motivated person finds his or her work inherently satisfying (Ross, 1990:121-141). The micropolitics of the interaction between intrinsic and extrinsic motivation has no definite or deterministic solution in sight. As if the complex relationship between the two types of motivation is not enough, they are also intertwined with the phenomenon of work performance making the question of causality between the former and the latter even more difficult to unravel (Ross, 1990:121-141).

3.4 WORK PERFORMANCE AND MOTIVATION

The viewpoint that performance mediates the undermining of intrinsic motivation interprets losses of intrinsic motivation as an unimportant after-effect or "artifact" of performance changes (Lepper *et al.*, 1993:129-137). In particular it has been suggested that extrinsic payment for an act can make persons work harder than they would otherwise. As a result people may come to be more satiated or fatigued with the activity but not necessarily less intrinsically motivated by it. In other words people can work so hard for the extrinsic reward that they are too exhausted or bored to continue when the extrinsic reward is removed. Performance could be influenced adversely by rewards in another way also. Extrinsic rewards could have the effect of distracting persons from the activity thus lowering the pleasure they could gain from it. It seems reasonable that people working for some great pay-off might spend their time thinking about the pay and not the work. Indirectly this could cause a decline in their intrinsic motivation in the future. Two questions arise. Firstly do anticipated rewards affect task performance? Secondly do these task performance differences produce the changes in intrinsic motivation? (Geen *et al.*, 1994:290-292).

The answer to the first question seems to be a clear "yes". For instance, in one early study conducted by Lepper *et al.* (1993:129-137), it was found that children who expected rewards produced more drawings but of lower quality on several dimensions judged later than children who drew without any intrinsic incentive. However, there is a somewhat less clarity regarding the second question, that is, whether or not performance differences produce changes in intrinsic motivation. Several studies such as those of Ross (1990:135) and Calder and Staw (1991:76) have found changes in the level of intrinsic motivation with no accompanying change in the subject's performance. These findings suggest losses in intrinsic motivation that are not mediated by performance changes. Furthermore, some research found performance effects of rewards with no accompanying changes in intrinsic motivation (McGraw & McCullers, 1999:285-294).

In other studies there is at least some suggestion supporting a role for performance, for example, there is substantial evidence that factors other than rewards which promote or diminish intrinsic motivation also affect performance. Specifically a growing body of research such as that of Perlmutter and Monty (1995:759-765) shows that the illusion of control improves human performance in a variety of situations, for example, stress associated with aversive experiences is diminished if the aversive stimulation is perceived as being predictable or controllable. The reduction in stress permits increases in the motivation to perform further tasks such as working puzzles or proof reading typescript and to perform them better (Glass & Singer, 1972:39-51). In a learning context Monty and Perlmutter (1992:759-765) found that subjects who were permitted to choose their own learning materials such as paired-associate words from a set provided by the experimenters learned the materials much better than a group of "yoked" control subjects who were assigned parallel materials.

It is clear that contextual factors such as choice that affect levels of intrinsic motivation can also have a direct impact on performance. This leaves ambiguous the question of causality. Does performance influence intrinsic motivation? Do feelings of intrinsic motivation affect performance? Or is it the case that performance

and motivation change concurrently because of the changing context but do not influence each other? Regardless changes in intrinsic motivation can and do occur without changes in performance. Therefore, aspects of performance cannot account entirely for intrinsic motivation (Perlmutter & Monty, 1995:759-765).

In everyday life or at work one type of rewarding an outcome or a consequence of performing an activity is praise. It will be recalled that monetary reinforcements tend to undermine intrinsic motivation (Whyte, 1955:27-39). Deci (1991:105) proposed that just the opposite effect should occur when verbal reinforcements were used. He reasoned that verbal reinforcements convey primarily competence information but that monetary reinforcers convey that one is working for pay or being coerced by the external environment. Rather than undermining feelings of self-determination which the monetary rewards did, praise left feelings of self-determination intact and served to increase feelings of competence; subjects became more intrinsically motivated (Deci, 1991:105-115).

Verbal rewards appear to increase the intrinsic motivation of males but decrease the intrinsic motivation of females (Deci, 1992:113-120). Deci suggested that verbal praise may be perceived as more controlling by females because socialisation practices train girls to be more dependent and interpersonally focused. Boys by contrast tend to be more independent and achievement focused as a result of their socialisation. So boys and girls tend to focus on different aspects of verbal rewards naturally. However, rewards of any type have their implications and applications in one way or another. Until after the 1960s the only approach to the study of rewards was the study of theorists (Gellerman,1963:63-80). The impact of rewards on performance and the rate of responding has been a central concern of the learning theory tradition since Thorndike's (1913:255) classic demonstration of the law of effect. Thorndike's observation was that behaviours followed by satisfying rewards are performed better and at a higher subsequent rate than unrewarded behaviour. This idea has served as a cornerstone of some models of motivation. The number of settings in which rewards may be used as a social influence strategy seems limitless. The strategy is explicitly part and parcel of the relationship between supervisors and workers, teachers and students, parents and children, police and the public. Therefore, the application of research findings regarding the use of rewards carries wide-ranging implications (Farr, 1997:31-53).

In the work setting the use of extrinsic rewards, usually pay, is obvious. Commissions for sales, bonuses for outstanding performance, tenure and promotion for productivity in the academic arena, all reflect the idea that pay-as-you-go plans, forms of piece work pay, will ensure the worker efforts. This is based on Theory X of management worker relations which characterises workers as being naturally lazy and passive and thus needing to be prodded on to work. Recent theorizing in the field of management has turned to Theory Y called participative management (McGregor, 1960:23-30; Heil *et al*., 2000:21-23), which encourages workers to participate more in decision making, planning and organisation itself. Workers are thought to gain a sense of pride and accomplishment from work that is "the wheel" rather than just a "cog" in the process. This strategy should evoke more involvement in work, more commitment to one's job and better work because of enhanced feelings of self-determination. Still another approach called Theory Z has caught the attention of both management and the general public. The researchers describe Theory Z in this way:

Almost total inclusion of the employees into the work organisation so that the superior concerns himself or herself with the personal and family life of each subordinate; a collective, non-individual approach to work and responsibility; and extremely high identification of the individual with the company   (Ouchi, 1981:305-314).

Institutions that foster such an atmosphere tend to have low turnover rates, greater loyalty and morale among workers and strong worker identification with the company. One might add that all these factors augur well for job performances (Ross, 1990:245-254).

Effective performance of a job may be assessed by looking at the results, for example, do they or don't they meet the objectives of the job or at the way procedures are executed?   Some jobs are easy to assess because there are established measures and goals such as sales per month or completion of an income statement by the tenth of the month for a controller. Management or administrative jobs are assessed according to the performance of an organisational unit.   For instance monthly production of a particular item may be a measure of the plant manager's performance because it summarises the performance of the entire plant operation. For other jobs such as manager of research and development, employee relations specialist, product design engineer or scientist, there is no easy measure of performance. In these types of jobs it may be more appropriate to assess whether a person in the job is following certain procedures or processes that are important to the institution. Unfortunately, it is often easier to tell when a person's performance is not accomplishing its purpose or facilitating desired processes or results (Stewart, 1982:222-226; West, Borill & Unworth, 1998:148-156).

One of the possible explanations of performance's lack of efficacy is the hiatus between effort and performance. According to Stroh (2001:63) for employees to put effort in their work they must feel that effort will yield results in respect of performance. Once the workers are aware that effort is linked to performance they will also know that higher effort will give off better performance. But for effort to lead to performance, ability, which is one of the characteristics of each employee must be present.   Thus motivation to perform depends on a number of factors.   The performance-reward probability is one such variable which adds to the employee's motivation. Both the effort-performance and the performance-reward probability are based on the interest of the employee to reach his or her expected satisfaction. For instance, Lawler's (1969:426-435) concept of reward value or valence referred to the individual's perception of the value of the reward or outcome that might be obtained by performing effectively. For Lawler, for a given reward the reward value and the effort reward probability combine multiplicatively in order to determine an individual's motivation. Managers are therefore enjoined to establish the values of the interests of their employees and then find ways of motivating them accordingly (Ströh, 2001:64).

Part of the manager's job is setting objectives which will motivate employees. The objectives must be such that they are fair and achievable and the manager's responsibility is to direct his employees' efforts towards the key results areas of their job or the priorities amongst their tasks on which they must concentrate their efforts. This requires the manager to communicate effectively with his or her subordinates which involves, not only giving instructions but also listening to the workers and

allowing them to participate in decisions affecting their job. Feedback by the manager to his or her personnel, whether negative or positive, is an important source of motivation. The worker wants to know how he or she is doing in his or her job. Feedback is therefore the information that guides an individual worker on how to adjust his or her performance. Rewarding an employee for good performance is a visible sign of recognition by management of the effort the employee has displayed in carrying out his or her duties (Ströh, 2001:64-69).

The problem in assessing job performance is that it requires measuring several factors at the same time. Some evaluation programmes try to simplify this assessment by stating that a person's effective performance is reflected in the degree to which specific objectives are attained. Unfortunately these objectives are often short-sighted and do not incorporate a full appreciation of what performance of the particular job means. For example, a sales manager may have a goal of generating 10 million dollars in sales in a particular quarter. If the sales unit produces that amount of sales but experiences 50% turnover of staff in the same period, has the sales manager performed the job effectively? It is not clear whether or not he or she has done so (Levinson, 1990:48). It depends on how effective performance is defined. Effective performance in a job can be defined as demonstrating a system and sequence of behaviours that produce the specific results required by the job while maintaining or being consistent with policies, procedures and conditions of the institutional environment. The individual's competencies, the demands of the job and the institutional environment must intersect (Stewart, 1982:223; Mohrman, Cohen & Mohrman, 1995:180-185) as illustrated in Figure 1 below.

The Individual's

competencies

The job's demands

Effective specific

actions or behaviour

The institutional
environment
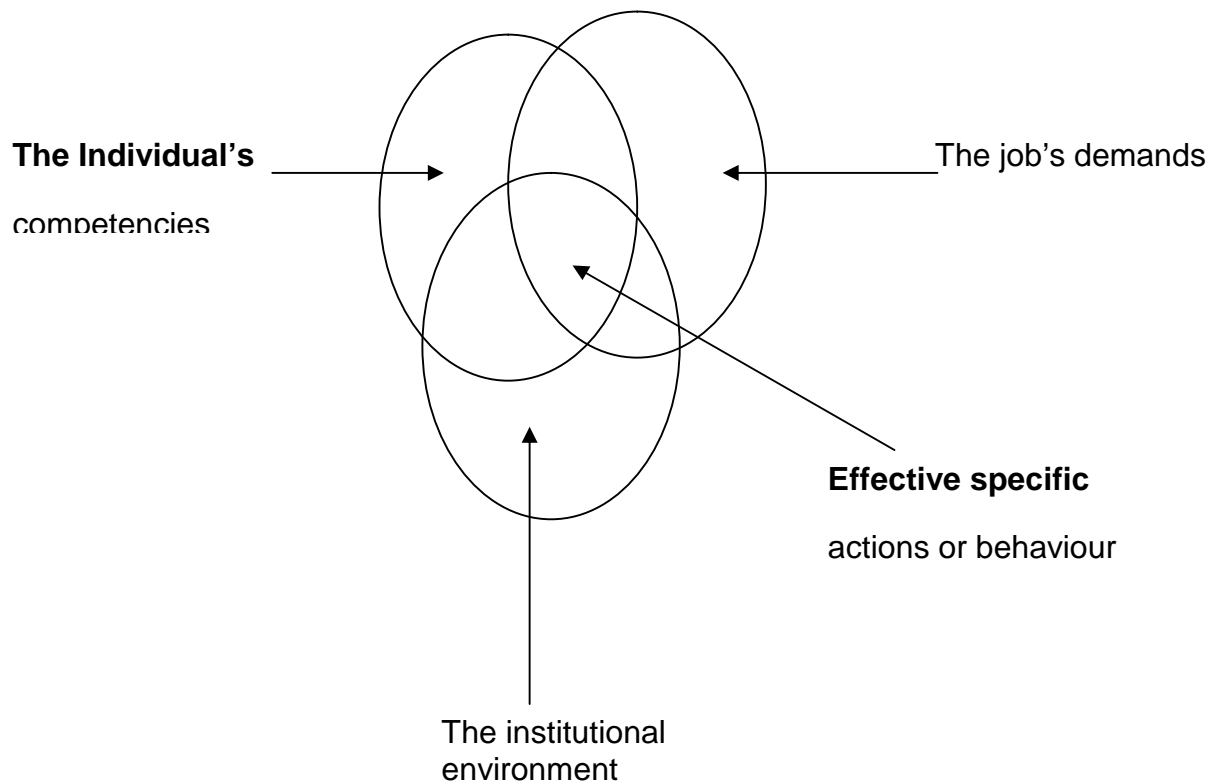
Figure 1: A model of effective job performance (Stewart, 1982:223)

Every individual has certain characteristics that can be called competencies. When individuals are asked to perform specific jobs within the context of an institution, they demonstrate some behaviour in response. If individuals' competencies lead to behaviour that would satisfy or respond to the requirements and responsibilities of the job and be consistent with the policies, procedures and conditions of the institutional environment, that behaviour will be effective. Effective behaviour of the individual occurs when all three critical components in the model are consistent or "fit". If any two are inconsistent with each other ineffective behaviour or inaction will result (Stewart, 1982:224-225).

3.4.1 Polemic nature of motives and work environment

Every institution creates and exists in an environment. Whether the environment is a suitable one in which to accomplish institutional objectives, whether all aspects of the environment are understood by members of the institution and whether these aspects of the environment are explicitly stated are all issues that determine how the institutional environment can be described in terms of a number of factors. For example, "institutional climate" has been used to describe the impact of the institution's structure, policies and procedures on its members. Whether it is used as an intermediate indicator variable or whether the actual policies, procedures and structure of an institution are used directly, the atmosphere or environment that the institution creates and transmits to its members affects their performance. For example, McClelland & Burnham (1994:100-111) reported that sales divisions within a consumer products company whose clarity about objectives and team spirit was high, achieved higher sales volume than divisions with relatively less of this variable in their climate. They showed that manufacturing plants which had greater clarity and concern about performance standards exhibited greater cost savings due to waste reduction than did plants with less of these variables in their climate. Many other researchers such as Litwin and Stringer (1968:35-59) have also demonstrated the importance of climate, structure, policies and procedures in regard to institutional performance and individuals' contribution to that performance. Other factors such as the economic, political, social and religious conditions of the culture in which the institution functions are also important aspects of the institutional environment (McClelland & Burnham, 1994:100-111).

The job itself which is carried out within the climate of the institutional environments must have certain characteristics to aid its performance. A job is usually described by a title, a list of responsibilities, the decisions that the job occupants are expected to make and the results that they are expected to produce. Every job can be said to have a set of functional requirements, that is, tasks that a person in the job should fulfill. Ideally these functional requirements and the associated output are designed to contribute to the output of people in other jobs. Taken as a whole the output of the integrated performance of the institution yields the performance of the institution with respect to its mission and objectives (Drucker, 1980:68). Any job can be described in terms of general and functional requirements.

If the job demands are aligned with aspects of the institutional environment, then the competency of the employee becomes pre-eminent. As illustrated in Figure 1, an individual's competencies are necessary but not sufficient for effective performance in a job. Stewart (1982:225-230; West, Borill & Unworth, 1998:154-158) defines a job

competency as a characteristic of a person that results in consistently effective performance. It may be a motive, trait, aspect of self-image or social role or a skill or body of knowledge that a person uses. The existence and possession of these characteristics may be an unconscious aspect of the person. Because job competencies are underlying characteristics, they can be said to be generic. A generic characteristic may be apparent in many forms of behaviour or a wide variety of different actions. Drucker (1980:68-70; Raven & Stephenson, 2001:76-80) explained that when people perform an act that has a result or several results, they also express one or more of these characteristics. Actions, their results and the characteristics being expressed do not necessarily have a one-to-one correspondence. The reason for the lack of direct correspondence is evident in Figure 1. The action or specific behaviour is the manifestation of a competency in the context of the requirements of a specific job and a particular institutional environment. Given a different job or different institutional environment, the competency may be revealed through other specific actions. In the same manner the effect of the action is related to the requirements and setting in which it occurs.

One can hardly speak of the motivational ambience without making some assumptions about the people who work in that environment and bring their own private motives into it. As a matter of fact the environment does not do all the motivating. It may be more accurate to say that it only bends the directions that the individual tends to follow naturally (McGregor, 1964:26-32; Heil *et al.*, 2000:21-24). A strongly motivated person may not be deflected from his or her goal by the environment to any great extent. On the other hand, someone whose goals are poorly defined may be so moulded by his or her environment that he or she becomes a mere passive creature of it (Preffer, 1998:31-34).

More commonly, however, people find that their jobs offer relatively little opportunity for satisfying their deeper needs and so they turn to hobbies or other non-job pursuits as channels for their enthusiasm and their best efforts. Physicians and vocational counsellors have for years given tacit recognition to the traditional bleakness of the job environment and have frequently advised frustrated people to find some "outside" avenues for their pent-up ambitions and skills. The pity or sad part of it is that an unrewarding job environment is pretty much taken for granted, especially by the middle-aged, the non-college trained and the production worker in general (Preffer, 1998:64-69).

This explains why the focus has been on management and its role as a barrier to the individual rather than on the individual and his or her own drives. The writers who have been most critical of the way in which management constructs the job environment, have freely accused it of making various kinds of assumptions about the worker. One such assumption is that people are inherently lazy and indifferent to their work rather than made that way by being over-managed. The other is that they are basically economic men or women who will react to the prospects of profit and loss precisely as a corporation would (Cava, 1990:3-11). On the other hand the critics have made assumptions of their own. Mayo for example, assumed that men had a natural tendency to form allegiances with each other and to cluster together in mutually protective groups (Cava, 1990:7-10). Likert (1967:25-37) assumes that workers feel a sense of responsibility for their work and are therefore frustrated when they can not share in the authority that controls it. Herzberg (1993:57-58), claims that the need to master one's vocational role takes precedence over other needs, at

least for people whose elementary needs are already well taken care of. There is no need, however, to confine this list of assumptions to those that the experts make because most people have their own pet theories about what makes other people tick. Indeed the decline of self-reliance is precisely what men like Argyris (1964:23-30; Cotton,1993:26-29) and McGregor (1964:26-40; Heil *et al*., 2000:24-30) are alarmed about and trying to reverse and yet beyond this misunderstanding there are deeper questions that remain to be answered. For example, the query is whether today's managerial practices actually encourage self-reliance or smother it and indeed whether management really has much of an effect on the individual's motivation at all. With these doubts it is necessary to trace the roots of motivation (Steers & Porter, 1991:3-8).

It was Freud (1976:411; Freud, 1998:215-217), who first called attention to the importance of "unconscious motivation". And of all his ideas this was undoubtedly the most important and also the hardest for laymen to understand. But he simply meant that people are not normally aware of everything that they want and that they will often have tastes, biases or attitudes which strongly influence their behaviour but for which they cannot really account. Freud's investigation convinced him that the motivations of most people were rather like an iceberg in which only a small proportion of them showed above the surface in a form the individual could recognize and be aware of, while the greater part was hidden and blocked off from consciousness by powerful forces (Steers & Porter, 1991: 9-10). These forces were not altogether bad since they made an orderly flow of thoughts possible and prevented distraction by irrelevant or disturbing notions. On the other hand if too many of a person's needs and impulses were kept out of a consciousness, tensions could accumulate which might lead to neurosis or overt mental disease in some people. But in most people, however, a certain degree of unawareness or non-recognition of motives is normal and even necessary. It is because of this normal degree of unconsciousness that most people are better able to observe the operation of Freudian mechanisms in others than in themselves (Steers & Porter, 1991:9-10).

Freud stressed the importance of the child's early experiences in developing what would later become his or her adult personality. Any person at any point in time is the product of all the events and encounters he or she has been through in the past. Since the child is relatively psychologically plastic to begin with but gradually develops a consistent style of thinking and behaving, Freud reasoned that the earliest experiences would have the greatest effect on the direction that the child would ultimately follow. As a matter of fact he concluded that by the age of five most of the broad outlines of the future personality were pretty well drawn and that the things which happened afterwards might change the details of the developing person but would not alter him or her fundamentally (Hollyforde & Whiddett, 2002:134-140). However, Freud hastened to point out that the individual was not a mere victim of his or her early environment and that he or she was not necessarily doomed at the age of five to leading a particular kind of life. The child's traffic with the environment was not a one-way street, with him or her being randomly pushed this way and pulled that way. Instead he or she was born with at least the rudiments of individuality in the form of instincts which are inborn inclinations or predispositions to behave in certain ways. While children had the same instincts, they did differ in degree so that one child might react quite vigorously while another behaved rather lethargically in the same situation. These instincts largely had to do with the preservation of life. But as the child grew older and his or her learned patterns of behaviour became available to

replace the instincts, the latter tended to persist for reasons that had little to do with survival (Hollyforde & Whiddett, 2002:253-265). Because his or her instincts worked so well in getting him or her what he or she wanted and also because unknown to him or her a number of adults had been scurrying busily at his or her wishes, the young child might reach the understandable conclusion that the world was put here for his or her convenience. He or she then had to unlearn the notion that he or she controlled his or her environment and everyone in it, which is a long difficult process. If it is completed successfully the child is said to be "civilised", and not everyone is (Steers & Porter, 1991, 61-63).

At any rate the young child's instincts and his or her environment are in constant contact gradually producing that pattern of experiences and reactions which emerges as a more or less stable personality profile. Psychologists are still wrestling with the problem of just how much of the adult personality is determined by instincts and how much is conditioned by experience, that is, the "nature-nurture" controversy (Goodman, 1995:67-73). The generally accepted view is that while the instincts and other innate characteristics set certain broad limits on what the child can and cannot become, especially with regard to intelligence, the specific paths that the child follows within those limits are strongly influenced by the early environment. This leaves a great deal of room for experience to play its part (Goodman, 1995:75-78).

The uncompleted steps in the growing-up process linger on as little flaws in the child's character right into adulthood. They can be seen in guises of petulance, self-indulgence, irresponsibility and other forms of childlike refusal to face reality. The course of growing-up is greatly expedited by a process that Freud called "identification" in which the child tries to model himself or herself after the parent of the same sex (Steers & Porter, 1991:213-216). To the extent that the father encourages this formation of a chip off the old block which he can do through attention, interest and approval, the process is reinforced and occurs more quickly. This identification which occurs to some extent in nearly all children beginning at about the age of two, provides the child with a positive incentive for growing up. It also helps to set a fundamental framework for what will later become his or her adult attitudes toward those aspects of life that are characteristically male or female concerns including attitudes toward careers, jobs and employers. However, since no one is a mere carbon copy of his or her father, the child's character is not built by a process of simple imitation but is much more complex than that. As the child grows older he or she is exposed to many other models besides his or her father and some of these may contribute something to the growing personality. Others in the family, neighbours, friends, teachers, screen stars and sports heroes, all can provide examples which the child may incorporate into his or her own growing repertoire of attitudes and mannerisms (Kagan, 1992:57-60).

There are times when the models that are available to a child are for some reason unsatisfactory to him or her so that instead of imitating them he or she actually bends over backwards to become as different from them as he or she possibly can. Freud called this a "reaction-formation", that is, the character that forms is a reaction to rather than absorption of the character of the model. Reaction-formations to the father's or mother's personality are not at all uncommon among today's crop of male or female adults. Further, these reactions seem to play an extremely important role in the development of significant job motives although they seem to be remote from the office and the factory (McNeil, 1990:16-21).

An important influence on the understanding of work motivation was also brought about by Alfred Adler who was at one time Freud's collaborator (McClelland, 1984:90-99). Unlike Freud who stressed the pleasure-seeking and the life-sustaining motives, Adler placed a great deal of emphasis on the power motive. By "power" he meant the ability to require others to behave in ways that suited one's purposes (McClelland, 1984:95-99; Levine, 2003:78-82). An infant actually has a great deal of power over others. For instance, any parent can testify that a baby can cause considerable commotion among adults within earshot with the merest yelp. According to Adler this ability to manipulate other people is inherently pleasurable. Not only does the child have a hard time unlearning it but he or she may also spend a good deal of his or her adult life trying to recapture that blissful condition of having other people do as he or she wills. Adults are the child's life line and it is a life and death matter to the child that the adults in his or her world be reliable. Therefore, the power motive acquires an urgency which it never quite loses even though it eventually becomes unnecessary. It is especially strong in an older child or in an adult who feels handicapped in some way in his or her ability to win the respect and the attention of others. Such people may go to considerable lengths to command attention thereby overcoming whatever real or imagined weakness it was that had disturbed them in the first place. In describing this process Adler introduced two well-known terms to psychology, that is, inferiority complex which refers to underlying fears of inadequacy or handicap which need not necessarily have a basis in fact and compensation, that is, the tendency to exert extreme efforts to achieve the goals which the "inferiority" would ordinarily deny (McClelland, 1990:99-105).

Further, Adler recognised that power was not the only way to solve the problem of childhood helplessness. In time the growing child realises that cooperativeness wins for him or her a more permanent assurance of safety than power ever could. If the child's development proceeds normally, and does not encounter too much tension, the power motive gradually transforms itself into a desire to perfect his or her relationships with others, that is, to make these relationships more confident, open and helpful (McClelland, 1990:99-103). Thus, the mature adult would be able to move among others freely without fear or suspicion. On the other hand if the process were stunted somewhere along the line, perhaps by too many disappointing contacts with untrustworthy adults, the power motive would not only persist but would actually become stronger. The adult who had grown-up in this way would be on guard, rarely willing to reveal very much of his or her plans or feelings and continually on the look-out for an advantage that would secure his or her position in what seemed a treacherous world (McClelland, 1990:99-105).

In conclusion, Adler, like Freud, held that the basic life style of an individual was determined quite early by the quality of the child's experiences with the adults in his or her little world. By the age of five or thereabouts the child would either have developed a flexible confidence in others, a guarded determination not to be hurt by them or as is more likely, some kind of in-between variation including both trust and power strivings to some degree. Both Freud and Adler, in their analysis of the early development of a human being, were primarily concerned with understanding psychological disorders in order to treat them more effectively. It is only recently that modern psychologists began to extend the thinking of these great classical theorists to the understanding of normal psychological development and more specifically to the adjustment of the adult to his or her career (Taylor, 2002:133-138).

3.4.2   Shuffling behaviour of motives and mastery of work environment

The works of Freud, Adler and White have attempted to locate the early roots of an individual's motivational system in a similar fashion as McClelland's (1992:36-61) work on the analysis of the beginnings of the achievement motive. What these theorists have in common is that the dynamics of motives are complex and become even more so as the individual enters the arena of employment, after touching on so many points of contacts, all of which may have a cumulative or additive effect on his or her experiences, as White (1995:331-333) pointed out. The first and most important thing to be said about motives as Gellerman (1963:20-30) noted is that everybody has a lot of them and that nobody has quite the same mixture as anyone else's. This means that there is no single strategy that will keep morale and productivity high for everyone everywhere. There are many individuals who work chiefly for money and others who work principally for security and still others who work mainly because they enjoy it. Moreover there are even those who work mostly because they would not know what to do with themselves otherwise. Therefore, the glib generalisations that are so often made about any of these motives, that is, that they are "universal" and therefore dominate everyone's reaction to his or her job, simply do not hold up under scrutiny (Sargent, 1990:3-10).

People including managers, supervisors and everyone else in charge or with authority to exercise power over others have to deal with human diversity or individual uniqueness, regardless of whether they find it administratively convenient or conceptually easy to grasp. And it is often neither. This diversity, however, arises from three basic qualities of human existence (Sargent, 1990:17-20). The first basic fact is that people grow up and live in many different kinds of environments even in one country. The second premise is that they are sensitive enough to have their attitudes towards life and toward themselves moulded to a considerable degree by the subtleties in their environments. The third basic human quality is that people's reactions to both the subtle and the conspicuous in their environments are not necessarily rational. In any sensible approach to motivation, therefore, one has to deal with people not as an engineer might have designed them but the way the good Lord did (Holbeche, 1998:13-21).

Furthermore, much of the difficulty experienced in understanding motives stems from the way they arrange themselves in any given individual. They seem to acquire a structure and to follow a dynamic all of their own. The structure has sometimes been called a hierarchy to recall Maslow's (1998:370-396) hierarchy of needs, that is, one motive will usually be more powerful and therefore more prominent in influencing the individual's behaviour than the others. Another will be the second most powerful, another the third and so on. However, this structure is not fixed, that is, a person's primary motive today may not be primary tomorrow. A reshuffling occurs whenever a motive has been so well satisfied that it sinks into the background and all the others move up a notch to replace it. As long as the "old" motive gets plenty of gratification it will remain fairly quiescent and much less likely to rouse the individual to action than one of the "newer" still unsatisfied ones (Maslow, 1998:380-396). But motives are not quite as unstable as all that. Some are harder to satiate than others. A motive can persist almost indefinitely if it represents a need that was severely

frustrated in childhood, or if each satisfaction arouses an appetite for more (Herzberg, Mausener & Snyderman, 2004:113-119).

It would seem that the kinds of motives which can be diminished when enough rewards are given are operating as "satisfiers", to use Herzberg's (1993:82-93) term. That is, they press themselves insistently upon the individual when they do not receive enough gratification but lapse into insignificance when they do. Hunger pangs, sleeplessness and even monetary desires can all be appeased and have a relatively little motivating power when they are satisfied, that is, their power is felt principally when they are not being gratified. A satisfier affects the individual more by its absence than by its presence (Herzberg, *et al.*, 2004: 13-119).

On the other hand those motives which are not susceptible to being "appeased" are operating like what Herzberg calls "motivators" (Herzberg, 1993:83-93). They can continue to play a commanding role in an individual's career for a long time despite repeated successes. As a matter of fact, repeated success is precisely what will keep them alive and a chronic lack of reward is very likely to suppress them. The dynamics of a motivator are quite the opposite of a satisfier's. When a motivator goes too long without some kind of gratifying experience to sustain it, it will drift out of prominence just as a fully rewarded satisfier does, but instead of merely dwelling placidly in the background, it is likely to acquire an alias in the form of some material need and continue to influence the individual's actions indirectly. In this manner a satisfier becomes a symbol or substitute for the motivator and is then pursued almost gluttonously. This can be seen in the so-called "symptomatic wage demands" in which salary increases are sought even though money needs are not at all severe because non-financial needs such as recognition and prestige are seemingly frustrated beyond hope of improvement. In effect the individual asks to be compensated with material rewards for having to endure a lack of psychological rewards (Hampden-Turner, 1994:20-21). Motivators are likely to be highly subjective, personalised experiences like feelings of growth, achievement and significance. In a sense they are all related to mastery of the environment as White (1995:332-333) argued and they do not become jaded because the environment, broadly conceived, is really much too big ever to be mastered (Kaplan & Norton, 1996:129-132).

The dynamics of motives operate in a rather devious fashion which makes it all the harder to understand them. Things are seldom what they seem in the motivational world. There are three important reasons for this deceptive quality, namely, masking, substitution, and maturation (Gellerman, 1963:177-178). Masking has the effect of concealing potentially important motives so well that they may not even seem to be present at all. This happens when another more urgent motive has yet to be satisfied and therefore continues to dominate an individual's actions, perhaps, even seeming to be touching on the core of his or her personality and the guiding purpose of his or her life. The motive that does the masking because it is still unsatisfied is very likely to be a desire for material things or for security, while the masked motive is more likely to be an intangible need like prestige or achievement (Gellerman, 1963:178).

The second complicating feature of motives is the capacity of one to substitute for another. The symptomatic wage demands already described are a good illustration. In fact they may even help to explain the phenomenon of "wage push" inflation (Gellerman, 1963:178-179). There are, of course, many causes for the persistent pursuit of higher wages even after monetary needs have been well-satisfied and

even when they cancel themselves out by inducing price increases. The causes are economic and political as well as psychological but it is the latter that is of interest here. Argyris (1964:28-32; Cotton, 1993:30-33), for example, believes that employees are developing a new concept of wages. They are seen less as rewards for productivity and more as management's obligation for the kind of world the workers believe management has created. Argyris (1964:29-32; Cotton,1993:30-33) goes on to explain that consequently the typical wage increases are seen more as management's fulfilling its obligation and less as a motivator or rewarder of work. However, Marxists have pointed to the workers' incurable grudge against management for its part in the exploitation of labour in the class struggle (Lambert, 1996:10-15). But historically the middle class has been absorbing the proletariat rather than clashing with it and it is a moot point who has been exploiting whom (Gellerman, 1963:179). Nevertheless the main debate on labour exploitation has been centred on the monetary payment of workers. The classical labour theorists have argued that what labour wanted was simply "more". But the other view is that what most workers want with regard to money is not "more" but "enough" (Lambert, 1996:36-39). The second opinion goes further to claim that what the workers will probably always want more of is a dignified and satisfying work life, with less tedium, less exclusion from planning and less personal significance. They would desire this more than they want a higher proportion of company earnings and they would like responsibility for a broader segment of the production process and the leeway to decide how it should be operated (Kaplan & Norton, 1996:224-230).

The third characteristic of motives which makes them difficult to understand is 'maturation" (Gellerman, 1963:177-181). Of course, it is the individual who matures but there is, however, a normal waxing and waning of motives as the individual grows older and his or her attention shifts from the problems of youth to those of adulthood, then of maturity and finally of old age. If he or she is fortunate enough to have gotten the problems of one stage pretty well solved before those of another stage come along, he or she will slip smoothly into being concerned with a newer and more appropriate set of needs. If he or she has not been so fortunate, he or she may continue to fight yesterday's battles while new ones are in effect going on all around him or her. The gradual shifting of motives due to the maturation of the individual is really a special case of the "reshuffling" principle. That is, it involves a person learning how to satisfy the needs that one phase of his or her life thrusts upon him or her and having satisfied them, he or she is no longer very strongly motivated by them. Instead he or she anticipates newer needs. This is why it is a mistake to continue appealing to workers by satisfying needs that are already satisfied. Such a programme will stimulate only the stymied or the very young, and it will leave the more accomplished individuals cold (Reck, 2001:15-26).

Thus, a person's motives may not always be the same, especially, if he or she is young and lives in a country whose economy makes it possible for him or her to work his or her way above the subsistence level while he or she is still young. At any given time he or she is likely to have a motivational potential, that is, a capacity for responding to new incentives and rewards which he or she has not yet given any hint of possessing. This potential is likely to remain masked until his or her more basic needs are attended to and will not ordinarily spring forth merely because an incentive has been flourished before him or her. As a matter of fact his or her overt pursuit of a particular goal may give a completely misleading impression of what his or her true motivation is like. Lastly time itself will gradually realign the importance of his or her

motives. Motivation is not, therefore, a particularly straightforward process which is precisely why so many straightforward schemes for motivating employees achieve such unspectacular results (Harrison, 2000:244-259).

At the risk of tautology it is reiterated that an individual cannot be abstracted from his or her motives. The needs, the motive and the whole spectrum of an individual's life *desiderata* (wants or desires) find a strong expression or outlet in his or her working life. For most people work or employment is the source of livelihood from the cradle to the grave. If any judgement or assessment or appraisal is to be made as to how a person regards himself or herself the work place is a good starting point or testing ground.

3.5   MOTIVATED SELF-CONCEPTION AND ATTITUDE TOWARDS WORK

Despite all the apparent inconsistency there is a unifying thread running through an individual's motivational history. This is provided by the set of attitudes he or she develops toward himself or herself some of which are conscious, while others are unconscious and worse still many are of that murky, ill-defined variety that is neither entirely conscious nor unconscious. Further, there is a considerable element of fiction in most people's ideas about themselves. The average individual or the man or woman in the street, or the man on the "clapham omnibus" is not particularly well aquatinted with himself or herself, so to speak, but he or she remains quite faithful if not adamant to his or her not so-accurate image of himself or herself and thereby acquires some consistency (McClelland, 1984:180). The young child reaches certain conclusions about what sort of person he or she is or more to the point he or she develops certain vague hunches from the way other people behave toward him or her. With the passage of time these hunches fit together fairly well because some are frequently reinforced by experience while others get little re-emphasis and fall away by virtue of desuetude. Throughout his or her life, he or she is motivated, that is, highly motivated by the desire to behave in a manner consistent with the symbolic role he or she has accepted as "himself" or "herself". His or her clothing, mannerisms, tastes and opinions and personality, will all tend to fit his or her notion of what his or her kind of person ought to do (McClelland, 1990:110-115).

The outlines of this self image are fairly etched in early childhood (McClelland, 1984:182-183; Hothersall, 1995:191-195). This is why biographical research is so revealing, for example, the achievement motivated adult may always have regarded himself or herself as "destined" to accomplish great things. In selecting his or her goals and persevering toward them he or she is only doing what he or she feels is appropriate for someone like himself or herself. In a similar manner, a security-oriented person may always have regarded himself or herself as a more or less helpless audience to the events that shape his or her fate. His or her passivity and reluctance to accept change are traits that a person in his or her predicament "ought" to have. Thus the unfolding of motives that goes on throughout individuals' lives is in many ways a continuing exploration of these roles (West, 1997:1-20). The underlying pattern of consistency in motivation is undeniable despite the masking, the substitution and the changes of maturation. The individual does not deviate very far and because he or she wants to be a particular kind of person, he or she tailors

his or her actions and even his or her thoughts to what he or she thinks is appropriate for that kind of person. There is, of course, a certain amount of illusion in all this role playing. For instance, if a person is immature or unsure of his or her status, what he or she is often matters less to him or her than what other people seem to think he or she is. This under girds the reason why courtesy and face-saving can be so important in international relations or diplomacy (McClelland, 1984:184). It has been known that few experiences are so devastating as having one's pet illusions about oneself being openly flouted. In a work situation the main defect of supervisory relations is not that production-centred supervision is necessarily inferior to other styles, but rather that it is applied indiscriminately (Rose, 2001:681-688).

In childhood a sense of self-worth is not achieved but conferred by the attitudes of other people, especially his or her parents who tell the child how much of an intrinsic claim he or she has on the attention and indulgence of others. The degree to which a child is made to feel welcome or unwelcome, valued or worthless has a great deal to do with what kind of reception he or she learns to expect from others. It therefore colours his or her willingness to try to do things well, quite apart from his or her ability to do them well. Thus a highly capable individual may attempt very little because he or she feels unworthy of the rewards that come with achievement, while a person of modest talents may successfully undertake a great deal because he or she feels he or she deserves all the rewards he or she can get. In other words, the sense of competence and the sense of self-worth will be consistent with each other (White, 1995:298-330). The self-concept that individuals bring to their job is, therefore an amalgam of many things, that is, the reception his or her parents gave him or her, the roles he or she has learned to play convincingly with his or her peers, his or her record of past successes and failures, and his or her notion of what rewards he or she deserves. His or her conduct at work will reflect this self-concept and his or her morale, that is to say, his or her attitude toward his or her job, will be heavily influenced by whether the job lets him or her be the kind of person he or she thinks he or she is (White, 1995:297-333).

One status barometer par excellence of an individual's attitude towards rewards is income (Gellerman, 1963:188). Income certainly does not reflect how nice people are or necessarily how hard they work or what they deserve. It only reflects the rewards they want to get. But despite its imperfections it is the primary measurement by which most people rate their own and everyone else's status. There are at least three reasons for this, that is, firstly nearly everyone receives some kind of income so it is a standard that can be applied to practically anybody. Secondly most other status indicators particularly the kind that can be consumed conspicuously have to be purchased anyway, and thirdly money comes in precise denominations and can be measured right down to the penny (Gellerman, 1963:187-189). It is completely unambiguous, that is, there can be no doubt as to whether income is increasing or decreasing. Thus whether or not income is a measure of anything relevant, it can be measured accurately itself. People view their incomes from the standpoint of someone who can buy all that he or she needs but not necessarily all that he or she wants. A person may compare his or her income with what he or she thinks is being earned by certain other groups. These "reference groups" are usually chosen because clues to their incomes are readily available, for example, neighbours, friends or people with "published" incomes such as union members or government employees, or they represent a status level which he or she feels he or she should equal or exceed. He or she selects his or her reference groups either because he or

she cannot help comparing himself or herself with them or because his or her self-concept compels him or her to compare himself or herself with them. In both cases, he or she is seeking a feedback for the all-important question of whether the world agrees with his or her own estimate of himself or herself (Brockner, Bierman ,Machan, Thomas, Weiss, Winters & Mitchell,1993:199-209).

In effect this imaginary person conducts a highly informal salary survey which differs from a true survey in some three important respects (Gellerman, 1963:189). For instance, his or her "data" are frequently irrelevant because they may not reflect the going market price for his or her services, but rather a price that can be commanded by better-situated workers with whom he or she would like to equate himself or herself. Secondly his or her data are often inaccurate because they are based on rumour, indirect evidence or sheer guesswork all of which usually have an inflationary effect. Finally his or her conclusions will be biased by a rather generous weighting of his or her own importance in comparison with other people's. All this points to the fact that some degree of dissatisfaction with income is almost inevitable even in someone who is being fairly paid relative to the market (Rose 2001:380-389).

The market price for a person's services, therefore, lags behind the "ego price" (Porter, Bigley & Steers, 2003:7). But in an important sense the ego price has already changed the character of the wage markets; for very few people are in a truly free market in which the price of their services is determined exclusively by supply and demand. A free market price for a person's services would be the minimum cost of replacing him or her but custom, contracts and the law itself effectively prevent so vigorous a market from operating. This was not always true however. In the early industrial economy described by Adam Smith (1776:160-180) competition between workers held their wages very close to the "dry crust" level of subsistence. Since then many forces have contributed to the change not the least of which is the tolerable position in which a free-wage market puts the ego and even people who subsist on dry crusts. The degradation of having to live in a world that contradicts one's self-concept is certainly no less painful than a nearly empty stomach. Very few people will ever be paid their full "ego price" for their work, but very few people are paid the free-market price any longer, either. The wage market has been made to conform to the way in which self-concepts function rather than vice versa (Porter *et al.*, 2003: 494-506).

Although the self-concept comes from the "inner fibres" of the individual's motivational system, it is often impacted upon by the environment. This is why current approaches to understanding organisational behaviour are dominated by situationists. The situationist perspective according to Brockner (1988: ix; Gilbert & Malone, 995:21-38) focuses attention on features of the work environment as determinants of job attitudes and behaviours. It has been learned that the ways in which goals are set, performance is appraised and feedback, rewards are administrated and the like, are predictive of how people think, feel and act at work. In all this, however, it seems that the individual has lost his or her identity as an active agent with a personality. The classical theorists "biographied" that during his or her earliest months a child begins to sense that the universe is not entirely under his or her control, and that there may be a big world out there which is not merely an extension of himself or herself (Gellerman, 1963:106-107). This realisation continues to grow throughout life and "the world out there" is likely to affect him or her. To understand the individual, therefore, his or her "environment" has to be defined

subjectively and it consists of anything he or she is aware of or thinks he or she is aware of that can have an effect on him or her. Whether that environment has any substance of its own does not really matter. People always behave as if the world is as they presume it is, but since they differ vastly among themselves as to what the world is really like; their actions often seem incomprehensible to each other. The phenomenon was summarised rather neatly more than forty years ago by saying that

what each man does is based not on direct and certain knowledge, but on pictures made by himself or given to him. The way in which the world is imagined determines at any particular moment what men will do. It does not determine what they will achieve. It determines their effort, their feelings, their hopes, not their accomplishments or results (Gellerman 1963:190).

Yet the important point is that the worker behaves as if his or her environment is real and not as if management's or anyone else's environment is real. At the same time management behaves as if its environment is real and so on *ad infinitum* (without end). Thus much labour-management conflict, as well as political conflict results from a failure to realise that the other fellow may live in a very different kind of world and accordingly that his or her fundamental outlook on what is good and bad, possible and impossible, is likely to be very different from one's own. Given that there is in this sense many different "environments" within a single organisation, they are likely to have at least one common feature, that is, that the individual's position is clearly defensible in terms of the way he or she understands his or her environment. His or her preconceptions about his or her environment have a great deal to do with whether he or she will be, for example, optimistic or pessimistic, vocal or impassive, for no matter what kind of world he or she thinks he or she is living in, he or she always tries to behave consistently with his or her view of it. In fact, his or her ideas about himself or herself are in many ways the obverse of his or her ideas about his or her environment, i.e., they are like two sides of a coin, each reflecting the individual's experience and his or her attempt to explain that experience in a way that provides a reasonable comfort to his or her ego (Bartol & Martin, 1994: 398-400).

Like his or her self-concept, the individual's implicit ideas about what kind of environment he or she is living in are seldom articulated or even conscious. But insofar as they affect his or her working behaviour and attitudes, the "pictures" that the individual forms of his or her environment have two important aspects (Brockner, 1988:5-6; Morrison & Phelps, 1999:403-419). The first one is the power aspect which is whether the environment is seen as omnipotent or as controllable to some degree. The second involves the reward aspect, that is, whether the environment is seen as benevolent or harsh. There is, of course, any number of possible combinations of environmental perceptions. For instance, with regards to power, the individual, if he or she is fortunate, gradually acquires the ability to influence events in his or her environment. If he or she comes to believe that he or she can manipulate events in his or her environment so that they turn out the way he or she wants them most of the time, then the most appropriate role for him or her to play in such a world is that of the manager. He or she will develop the habit of managing and will expect to control any situation in which he or she finds himself or herself, largely because the world as he or she sees it is so thoroughly manageable. On the other hand if the proportions are reversed, the individual finds himself or herself in a less fortunate situation in which he or she learns that events will take their own course with him or her whether he or she tries to cope with them or not. In this case his or her

environment will be his or her master, and his or her most appropriate role will be to comply with whatever happens to come along. Instead of seeking opportunities he or she will seek instructions. Because his or her fate is largely out of his or her hands, he or she is not likely to take his or her career or income very seriously (Bartol & Martin, 1994:376-378).

The reward aspect of the environment is in general largely determined by the economic level of the society in which the individual was raised, although the spending habits of his or her family are also pertinent. But in any event either through his or her own experience or through a vicarious knowledge of rewards that others receive, a person comes to regard his or her environment as having a certain capability for providing him or her with things he or she may want. He or she is likely to be sceptical of promises that exceed what he or she has learned to expect and he or she is also likely to be rather outraged at rewards that fall short of his or her expectations. Such expectations of reward work hand in hand with concepts of power to produce an underlying notion of what the environment is like, which in turn has ramifications in motives and behaviour. The interaction of these two aspects of the psychological environment (Gellerman, 1963) can be illustrated with caricatures of the following four possible combinations of extreme cases (Baird *et al.*, 1990:154-158).

The first combination considers someone who has learned to have both high expectations of reward and a high sense of power to influence his or her environment. This person's dominant motive will probably be an achievement drive and will feel that he or she can get whatever he or she wants if he or she puts his or her mind to it. It is this optimism that will make him or her take life for granted and maintains a calm, unsurprised attitude toward his or her successes. The second example is of a person who also has high reward expectations but who feels that he or she has only a low degree of influence on the happenings in his or her environment. Since bettering his or her position seems unlikely or at any rate out of his or her hands, this individual concentrates on protecting what he or she has. As his or her life will be a rather privileged life, much of his or her thinking will revolve around attempts to justify and preserve these privileges. His or her station in life will usually have been won for him or her by his or her forebears and what is left for him or her is to be conscious of his or her heritage and fearful that he or she may not be equal to it. But in a sense what has been labelled "conspicuous consumption" (Brockner, 1988:6-7; Rothman, Salovey, Turvey & Fishkin, 1993:39-47) is this person's way of proving that he or she has the taste and breeding to qualify for wealth and he or she shows this by his or her sophisticated way of spending money. He or she is also likely to be the pampered product of a well to-do background, who is not likely to be very sympathetic toward others, largely because he or she is too absorbed in his or her own problems to be particularly aware of other peoples'. He or she is likely to be proud, gay and carefree or insouciant when all is well but easily alarmed by bad news (Baird *et al.*, 1990:308-310).

The case of someone who has low reward expectations but feels a high degree of power over his or her environment is the third illustration. Because he or she believes that the environment can be reshaped to become more rewarding if he or she works hard at it, he or she is likely to be primarily money-motivated and to pursue wealth with a relentless vigour and with a possibility of being a little unscrupulous at times. Life will be a mixture of successes and failures but the game will be eminently

worth the candle. His or her approach toward life will be full of determination, grit and a stubborn unwillingness to quit. This is the strategy that will be most likely to pay off for him or her. He or she will nevertheless feel a certain guarded optimism, never sure enough of success to become complacent, but never really doubting that he or she can win in the long run (McClelland, 1994:107-109).

Finally life for a person who has low reward expectations and also feels a low degree of power over his or her environment will be a vale of tears. His or her primary motive will be to secure at least a bare subsistence for himself or herself and his or her family. If he or she ever succeeds in insuring even a meagre income for pension, he or she may regard himself or herself as fortunate. He or she may acquire a peasant's wisdom that enables him or her to appreciate simple things but the indifference of the world will seldom be far from his or her thoughts. He or she more or less expects to fail in projects undertaken at his or her own initiative. He or she is passive and pessimistic. Such resigned and ineffectual people have made up the majority of mankind until a few hundred years ago and in countries which have not yet been industrialised, they are probably still in majority. What Mayo called anomie is precisely the reaction of people with little hope to a bewildering, overpowering environment (Weihrich & Koontz, 1993:41-42).

The commonality running through these four fictitious sketches and through the millions of portraits that could be drawn of real people and their perceived environments, is that the individual is always following a sensible strategy for getting along in the kind of world he or she thinks he or she lives in. He or she is always seeking his or her maximum advantage. But it is now clear that "advantage" had to be defined psychologically rather than economically. Although the discredited ideas about people behaving like "economic men" were not so far from the truth after all, they failed the test of experience largely because they interpreted advantage too narrowly, in an exclusive financial sense. Thus the monetary theories of motivation have lost some of their credibility because they tried to generalize the entrepreneur's perception of his or her world to the employee's perception of his or hers, that is, they failed to recognise that in a psychological sense there are many different worlds on this planet even many worlds in one company or institution as illustrated by workers' interests (Weihrich & Koontz, 1993:151-155). One such world for prospective employers is to heed the myriad experiences that underpin workers' motivation as revealed in relevant research.

3.6 EXAMPLES OF INDENTIFIED SOURCES OF MOTIVATION IN EMPIRICAL FINDINGS

While motivation, job satisfaction and attitude can, in theory, be subjected to definitional isolation, in reality these variables are so interconnected that trying to speak of one without touching on the substance, or at least the fringes of the other(s), is at best an exercise in splitting hairs. The present study's empirical results have highlighted these factors in different or variable degrees of emphasis or proximity. This section gives some examples of the sources of motivation that emerged from the empirical findings.

3.6.1   Autonomy in choice over type of nursing as a source of motivation

Stamps and Piedmonte (1986:45; Lawler, 1994:3-15) have defined autonomy as the ability and freedom of the employee to determine or influence the scheduling or exercise of choice in respect of his or her work. In the case of the public health services nurses, this involved deciding on the field of nursing.   It also entailed exercising autonomy over nursing procedures and prioritising over their sequence or the sequence of their execution.   The majority of nurses confirmed that they had freedom in choosing the type of nursing they were interested in (see chapter 6: table 7).   Modern trends in nursing provide a wide variety of nursing specialisms such as urological and oncological nursing.   From the beginning of their nursing careers, these nurses had taken important decisions regarding their professional areas of interests which formed strong foundations of their motivational systems.   The significance of their decisions bore implications on the job contents of their chosen nursing pursuits, such as the skills required and expected, the anticipated job variety and the task identity components. These composite job elements were integral roots of motivation, which anchored the nurses' elective nursing choices, during the developmental stages of their careers.   For example, task specialisation or job variety, which is associated with alleviating the boredom that comes from performing routine jobs, is positively correlated with aspects of motivation such as self-esteem, feelings of personal growth and prestige (Gruneberg, 1979:43; Latham, 2007:38).

Participation in the choice of type of nursing has also other motivational advantages such as job status.   The overall importance felt about a job at the personal level, as well as its importance to the institution and to the community, are part of job status (Stamps & Piedmonte, 1986:18; Lawler,1994:3-15).   For the public health services nurses, therefore, selecting the type of nursing they preferred was a boost to their perception of the professional status that they accorded to nursing.   It was a reinforcement of their self image and self-esteem which motivated their behaviour and performance in the workplace (Strasen, 1992:18) (see chapter 5: section 5.3). The positive relationship between job status and the freedom to choose the type of nursing, not only raised the nurses' morale, but also emphasised the significance of their work role in the community.   It greatly influenced the way in which other people responded to them outside the work situation. The esteem in which the nurses were held, created a motivational base for them and put a spotlight on the image of nursing.   These were the byproducts of their able performance within their chosen nursing specialties.   The nurses' motivated job performance that resulted from their choice of nursing area, enhanced the understanding on the part of members of the community about what the nursing job entailed and the role played by nurses.   The appreciation of the nurses' work by the community would eventually bridge the gap between the nurses' desire to be seen in better light and the community's awareness of the nurses' contribution to its health needs. These expectations were a product of the nurses' motivated performance, which was derived from their choice of type of nursing. In other words, because the nurses were placed in nursing area of their own choice, they were motivated to prove to themselves that they had made a professional decision that they felt bound to honour. These parameters, emanating from the exercise of choice over the type of nursing, were the cornerstones of a motivational system, which enabled nurses to weather difficult nursing work

environments, such as working under pressure from the work itself (see chapter 6: table 11). The knowledge and satisfaction regarded by nurses, in having chosen their fields of nursing, acted as reservoirs of motivation. This was shown, not only in their job performance, but also against many other nursing problems that they encountered, including adverse working conditions, such as shortage of staff (see chapter 6: tables 21 and 23 respectively).

Once the nurses had made their choices in the type of nursing to practice, that predilection provided sound reasons for purposeful involvement and motivation in their jobs. The autonomous power to choose brought three related motivator variables together, that is, recognition, achievement and responsibility (Gruneburg, 1979:48; Latham, 2007:41), to give the nurses the motivation to make a career out of their voluntary nursing choices. This implied that whatever problems they face in their jobs, they could not complain that they had been coerced into any type of nursing. Their choices gave them the professional motivational preparation to work towards recognition and promotion, which were brought about by motivated performance in their preferred areas of nursing. The nurses' motivation to achieve was based on the challenge and the commitment to the goals that they had set for themselves, by indicating their chosen area of nursing practice. The nurses' motivation and higher-order need to achieve, were founded and strengthened by the personal responsibility that they had placed upon themselves, by deciding on their nursing choices. As Mowday, Steers and Porter (1979:224) have noted, it is the actions and outcomes for which one takes personal responsibility and which involve one's ego, which produce greater motivational effect. Likewise the nurses' autonomous act of choosing their preferred nursing areas of practice, generated commitment and personal motivation to steer them through their respective career progressions.

3.6.2   Motivation from use of initiative or discretion in the way nurses work

Commenting on the desire for autonomy as a motive, Likert (1961:97-104; Parker,1998:335-352) stated that a person who feels incapable of making for herself or himself decisions, which are reserved for her or his superiors is, in effect, prevented from being herself or himself at work. She or he is constrained to play a more dependent and less competent role than she or he feels is necessary. In the employee's eyes, this is a wasteful misuse of her or his talents. The public health services nurses were not stripped of the autonomous prerogatives of deciding on how to do their work. The majority of them were able to use initiative or discretion in the way they worked (see chapter 6: table 9). The use of initiative involved, for instance, the freedom to make decisions such as those regarding patients' care and treatment, ward meetings and agendas, matters concerning continuous education and duty rota. The use of discretion created in nurses the feeling of being in charge and in control of their nursing affairs. It gave them a sense of responsibility for their decisions and a mental challenge to become interested, motivated and involved in their job. The motivation arising from the nurses' upward appraisal of their skills and self-esteem as a result of the use of the initiative in determining how they worked raised their morale and productivity. The morale-raising use of initiative or discretion created positive expectations from the nurses' jobs such as future promotions, which

in turn motivated them to perform better. They saw their use of initiative as an extension of their self-concepts and psychological advantage. For the nurses the use of discretion represented a real-life role, which corresponded to their favourite ideas about themselves, as being responsible for their actions and confirmed their image of the enabling status of the nursing profession.

This sense of pride motivated them to play more active roles in the way they worked such as making collaborative decisions concerning the allocation of staff leave and seasonal holidays. A natural consequence of the nurses' use of initiative or discretion in the way they worked was that the majority of them confirmed that they had an input in the way they carried out their duties (see chapter 6: table 8). Their motivation from their participation in making decisions about their job, was strengthened by the fact that it involved the immediate group of nurses which worked as a team of nurses in the wards or clinics. This team of nurses decided, for instance, on what jobs needed to be done first before visiting time or before the ward round. In the clinical area, for example, nurses suggested which patients should be referred to the physiotherapy department, based on their observations. The nurses' use of initiative and discretion meant that they did not wait for decisions that were within their ambit to be made by medical doctors or their nursing supervisors. In the clinics, nurses made referrals to hospitals of patients whose medical conditions were observed not to be improving. Active participation in decision-making related to their use of initiative and discretion, therefore, drew nurses into a motivated professional involvement in their work. They had cause to perform better on their jobs driven by the sheer sense of ownership of the decisions they had made and the goals they had set for themselves. The motivating effects integral to the use of initiative and discretion in the way nurses worked were evident in the way nurses absorbed or tolerated the adverse effects from their work environment such as inadequate pay. It could also be argued that the use of initiative and discretion in their jobs motivated and increased the nurses' expectancy of success in a number of achievement-related activities such as expected opportunity to further their education and or training in the relevant job areas they were doing.

The nurses' "need" for achievement (Murray, 1938:43; Rotundo & Sackett, 2002:66-80), buttressed up by the motivation derived from the use of initiative or discretion in the way they worked, encouraged them to like the kind of work they did (see chapter 6: table 13). This was in spite of the fact that they blamed the job itself for the pressure under which they worked (see chapter 6: table 12). The nurses' use of initiative and discretion was extended to their ability to change the way they organised their work duties (see chapter 6: table 10). For example, nurses could organise their patients' birthdays in such a way they were not celebrated on days on which ward rounds were conducted. Nurses could also use their initiative or discretion to re-organise ward duties to prepare their patients attending specialist consultant clinics, such as surgical and orthopaedic. The recognition of being independent, autonomous, contributory and participative in the professional areas of their work, motivated nurses to converses knowledgeably in seminars, workshops and continuous education fora. These were the benefits of the nurses' motivation obtained from the use of initiative and discretion, which they were permitted to employ by their supervisors in a planned structure of personal and professional development.

The need for self-actualisation (Maslow, 1998:91-92) (see chapter 4: section 4.4.1.1) or to do more and more of what nurses are trained to do, could not have been expressed better than by the use of their initiative and discretion from their professional capacity. This brought about intrinsic motivation, self-esteem and self-concept and the image of nursing into the focus of Strasen's (1992:1) self-esteem-performance cycle to produce a dedicated and motivated cadre of nurses. The choice of field of nursing that the nurses had made, coupled by the participative supervisory practices, which allowed them to use their own initiative in the conduct of their duties, gave the nurses the positive vision of what nursing could be under a motivating work environment. The nurses' autonomous use of attributes such as the use of discretion, ability to change the way they organised their work and their participation in decisions concerning their job motivated them to be masters in their chosen areas of nursing.

This autonomy also developed their abilities and competences to be professionally proactive and independent in taking decisions that would lead to their experienced maturity in their chosen nursing practices. The nurses' competencies that stemmed from their use of initiative and, discretion in the way they managed their work, were motives (McClelland, 1990:325-329) that used a body of professional knowledge to perform their functions. For example, the nurses were motivated by using specialised knowledge about nursing and the medical systems on which they were operating. In their competency, for instance, in changing the way they organised their work, the nurses improved on the conventional, rigid and routinised approach to nursing, which demanded the making of beds in a military fashion. They were also competing against a standard of nursing excellence, which they had brought with them from their modern nurse training colleges. Thus, what began as the use of initiative and discretion in the way nurses worked, opened wider professional nursing dimensions which imbued nurses with an achievement-oriented motive. The latter nested amidst other needs and motives, such as the desire to dominate their work environment and to seek the approval of others and recognition (Maslow, 1998:91) (see chapter 4: section 4.4.1.1), all of which are necessary for team effort such as that required for working in the hospital wards and clinics.

Once the achievement motive was stimulated by the use of initiative and participative decision-making related to their job, the nurses' motivated thoughts were directed to select a motivated behaviour (McClellard, 1992:333) to engage in activities that improved their performance further. The nurses' self-esteem which was initially ignited by the liberty to choose the type of nursing, having input in the way they worked, ability to change the organisation of their work and the use of initiative or discretion in the way they worked, created the foundation of a motivational system characterised by Strasen's (1992:18) configuration of high self-esteem-high performance cycle (see chapter 5: section 5.3). However, the motivation that underpinned the cycle was weakened, if not annulled, by inequities in pay.

3.6.3   Pay as a source of motivation

An overwhelming majority of nurses was emphatically dissatisfied with pay (see chapter 6: table 14). The majority of nurses also mentioned a good salary as their

leading motivator (see chapter 6: table 41). Either way pay was, therefore, directly or indirectly a source of motivation to the public health services nurses. The empirical findings established unequivocally that the most leading concern on the part of nurses was to do with pay. For example, the majority of nurses further elaborated on their worry about pay by pointing out that their level of remuneration was not related to the amount of work they did (see chapter 6: table 15). To make clearer what was abundantly obvious, the nurses further suggested that they desired a salary increase of more than 40% (see chapter 6: table 17). These statements were all implied if not overt, indications that money or pay (used interchangeably in this section) was the greatest source of motivation to nurses. Dubin (1976:304), once argued that even in a moderately complex economy, money wages and salaries are developed as a means for valuing and rewarding the work and contributions of those who produce goods and services. The public health nurses complained that the health care services they provided, were not sufficiently remunerated or rewarded and by implication, therefore, not valued. They protested that the pay they received was not related to the amount of work they produced. Nurses in the rural clinics, for example, were liable to attend to medical emergencies outside working hours, without consideration of paying them for unsocial hours.

In fact the relatives of a patient involved in a medical emergency, could call at the nurses' residence at any time of night. These duties were an addition to the daily workload at the clinic during normal working hours. Some nurses were rostered for on-call duties throughout the night, without additional pay compensation to their normal salary. Regardless of whether they were called at night or not, they were still expected to be on duty the following day without either rest or pay allowance. Over and above these absurdities, nurses received meagre salaries for their normal daily duties without any recognition of their daily workload. The upshot of the argument is that if the nurses had been paid adequately for all the work or services they provided, they would have been motivated. Clearly there was a significant message, issued by the nurses from their statements and replies to the relevant questionnaire items, that pay was a strong or potent source of motivation.

To understand why nurses considered pay as a source of motivation and why it should be measured against the amount of work done, it is necessary to analyse its economic dimension. A salary, wage or pay is the payment made to workers for placing their ability and energy at the disposal of an employer (Lupton & Bowey, 1974:50; Altonsi & Williams,1998:233-276). Furthermore, pay has a number of rules and procedures which relate effort to reward (Lupton & Bowey, 1974:50-51). It could be argued on behalf of the public health services nurses, that they had more than complied or satisfied the requirements of a wage, by even taking or accepting more duties, as well as absorbing the stress resultant there from (see chapter 6: table 12). The nurses' dedication to their effort over their job, took three main forms (Lupton & Bowey, 1974:51-52; Bingley & Walker,1997:1375-1390). Firstly, it involved time effort which relates pay solely to the amount of time worked or attended at the place of work. The public health services nurses would be motivated, if pay was related to the time effort, with particular reference to the out of hours duties they sometimes endured. Secondly, nurses would be motivated if their energy effort, which is measured by the amount of output against a rating scale, was related to pay. Nurses complained that they generated more output than they were paid for. The converse of this is that if their remuneration was related to the amount of output they produced, they would be motivated (see chapter 6: table 15). Thirdly, another source of

motivation for nurses related to pay, was their competency effort. If this was related to pay, the latter would take into account the acquired skills from their training, the amount of time they spent on their jobs including their productivity, and other abilities and competences.

Behavioural scientists have proposed a number of models which seek to explain the relationship between pay and work and the role money plays as a motivating force. With a 92% majority of the public health services nurses registering a strong protest against their pay levels (see chapter 6: table 14), there can be no shadow of a doubt that these nurses rated the importance of money highly, compared to other factors such as intrinsic rewards, for instance, recognition. If Taylor's (1947:28) principles of "scientific management" (whose essence includes time input into work, training for the worker, incentives for good performance and paying the worker more money) were correct, it appears that the only reward that the nurses sought and that would motivate their calculated effort was money. McGregor's (1964:32-35; Heil *et al.,* 2000:22-26) Theory X and Theory Y would support a scientific management approach in the sense that the nurses were thought to prefer security in the form of money above everything else. The Hawthorne studies (Roethlisberger, 1973:54-67), although surrounded by a maze of confusion, suggesting that motivation and productivity were a result of complex behaviour patterns, influenced by a range of variables such as personality and cultural background, failed to refute the money incentive. Maslow's (1998: 370-396) (see chapter 4: section 4.4.1.1) need hierarchy theory implied that an adequate income is a prerequisite for survival. Thus, scientific management, the Hawthorne and the need-hierarchy studies would justify the public health services nurses' strong motivational attachment to money.

Vroom's (1995: 173-196) conception of money as a motivator, is that money is used to achieve desired outcomes and it acquires a higher valence or degree of importance according to the number of needs that the individual thinks it will satisfy. The nurses required money, not only for their own survival, but also for the welfare of their children, the majority of whom was over ten years of age (see chapter 6: table 5) and going to school with the obvious school needs such as the cost of uniform. Their treatment of pay from work as a source of motivation was, therefore, not difficult to appreciate. Following Goldthorpe and Lockwood's (1969:59-72) study of car workers in which they found that money was rated higher than such factors as recognition, acceptance by peers and appreciation of supervisors, similar findings in the study of public health services nurses, also revealed that money, as a motivator, was at the top of their motivational agenda, higher than all the other factors such as promotion and communication in their work environment.

To the extent that money is patently related to Maslow's (1998:282) need-hierarchy theory, it plays identified roles in nurses' lives. For example, it could be argued that pay in the form of money to the nurses, acted as a generalised reinforcer, incentive, anxiety-reducer, motivator of behaviour and a motivational instrument for gaining desired outcomes (Opsahl & Dunnette, 1966:94-118; Blundell, 2001:128-132) such as catering for the needs of their families and purchasing goods and services. According to Vroom's (1964: 59-70) cognitive model of motivation, the "force" that impelled nurses towards demanding a higher pay, was the perceived expectancy that it would lead to the attainment of their desired portfolio of needs and outcomes. The other interesting notion about money, was that it was interpreted as a projective device (Gellerman, 1963:160-169) propping the nurses' self-concepts and self-

images in the community and the image of professional nursing that must be seen as being well paid. The motivational properties of money were, therefore, directed towards raising the status of nurses in society. Whyte's (1955:185-186) analysis would argue that the public health services nurses' reaction to money as a source of motivation, could be summarised by their biographies to-date. This was denoted by their early economic environment dominated by either parental upbringing or by a social reference group or both, that transmitted the motivation for money to them. The nurses' psychological advantage, born out of these sources of pecuniary propensities, goaded nurses into nursing and rooted itself as a motivational force. According to this view, the nurses' demand for higher pay was, therefore, the most evident indication that money to them was a supreme source of motivation.

As a source of motivation to nurses, money can represent achievement, prestige, power and security, or can take on the role of the cynic's only trustworthy companion or the idealist's devil (Gillerman, 1963:160). But it is only when it becomes a credible vehicle for achieving any of these factors that it can begin to symbolise them. Furthermore, it is only when money symbolises them that it begins to acquire a significant motivating power (Gellerman, 1963:160-161). Thus, although the popular quip might say "money" is not everything, it is "way ahead of whatever is in second place" Gellerman, 1963:161). However, the potency and significance of money motivation tends to change, that is, to become less acute or less all-consuming, as affluence increases (Gellerman, 1963:161-169). But the public health services nurses' financial environment, has not yet reached the latter level, to make money irrational or to reduce its primary role.

While money formed one type or source of motivation with the nurses, another came from their positive interactions with their supervisors and amongst themselves.

3.6.4 Supervisory practices as a source of motivation

The nurses' work environment and their ability to use their skills and competences, as well as their discretion to determine their goals, was aided by insightful supervisory practices. The good working relationships with their supervisors, were a major source of inspiration and motivation for the nurses. Elton Mayo's human relations theory, had long stressed the determining influence of work environment, by pointing out that the basic difficulty that faced workers, was in their work situation and not in their personal problems (Gellerman, 1963:31). The supervisors can create a work situation in which workers can become demotivated, under motivated or a motivated and in which low productivity reigns or becomes he norm (Gellerman, 1963:29-30). The public health services nurses were fortunate in having supervisors, whose supervisory policies motivated them, through good working relationships (see chapter 6: table 27). The supervisors' participative style of supervision, motivated nurses by shifting the responsibility for making decisions concerning patients to nurses themselves (see chapter 6: table 28). This was made easier than it would have been otherwise, by the fact the majority of nurses found it easy to talk to their supervisors and other higher authorities (see chapter 6: table 29). The nurses' good working relationships with the supervisors, working in tandem with the autonomy extended to them by the latter and the open lines of communication between them

and the latter motivated the nurses to maximise their professional potential. The conducive working environment created motivated performance standards to which most nurses adhered. The nurses' awareness that they belonged to a wider network of friendly and supportive supervisors, who did not subject them to a passive acceptance of method of working or regulated them to a level of puppetry or treated them as a horde of soulless automatons, lifted their morale and motivated them to levels of self-actualisation.

Since the nurses had a chance to make their own decisions about their job, they did not feel that they were made to surrender to a meaningless, insecure, docile and degrading way of practicing their nursing knowledge. The dignity and the fellowship that they enjoyed with their nursing peers and their supervisors generated a continuous stream of motivation which enabled them to give a serious attention to their patients and their work in general. The participatory system of supervision made the nurses feel that their supervisors' motivations were geared less towards the latter's satisfactions in controlling them, than they were directed towards the benefits of facilitating high nursing standards. This provided the nurses with a source of pride and motivation that their efforts to maintain the professional image of nursing were positively supported by their supervisors. As the Michigan group studies (Gellerman, 1963:31-32) argued, the supervisors' attitudes and behaviour affected the motivation and performance of employees. Likewise in the case of nurses, the supervisors' participatory supervisory practices and their friendly inter-personal relationships with nurses, built a baseline of motivation on the part of nurses, based on their empowerment to make decisions and use discretions over the conduct of their jobs.

Although according to McGregor (1964:23-30;Heil *et al.*, 2000:21-26), there seems to be no right or wrong way of supervising people, as far as motivation of subordinates is concerned, he has argued, however, that what is no longer in doubt is that styles of supervision have a demonstrable effect on the individual worker's productivity or performance. The nurse supervisor's behaviour was the most immediate and visible indication of how the institutions for which the public health services nurses worked regarded them. It can be regarded as the heart of the nurses' motivation in their work environment. The nurse supervisors supervised from the wings, as it were, leaving the nurses themselves to decide over their work areas, without someone peering over their shoulders. It was this degree of trust bestowed on the nurses that created a deep sense of pride and motivation in them. There can be no doubt that as a consequence of the mixing of supervisors and junior nurses, and of the good working relationships between nurse supervisors and nurses, based on the nurses' needs for attention and self-esteem, the nurses' motivation developed. Out of all this, however, the chief or true motivator (Herzberg, 1996:86-90) emanating from supervisory practices, was the nurses' control of their work situations, which came from the chance to make own work decisions.

The public health services nurses may have been fortunate in enjoying motivation in certain areas of their job. But at the point of entry into nursing like other job-hunters, they straddled the blind-alleys of an unpredictable recruitment procedure.

3.7   MOTIVATION AND RECRUITMENT PROCESS

Broadly speaking, a job-seeker may look for employment in a particular institution for any of the understated three reasons (Gellerman, 1963:235). He or she may choose to do so deliberately because he or she thinks that it best suits his or her advantage. The second reason is that he or she may do so because he or she has no real notion of where his or her advantage lies and finds this institution about as attractive as any other. Finally, he or she may have no real alternative because of limitations of his or her marketability. The deliberate choice probably occurs most frequently among fairly well-educated people of middle and upper-middle class origins who can opt for one of the many specialised kinds of jobs in large institutions and for whose services these institutions compete. When a job-seeker is allowed a free choice, his or her search is usually a thinly-disguised form of psychological-advantage seeking. He or she seeks a job in a company and an industry which as far as he or she can tell, provides the kind of environment which is most compatible with his or her psychological advantage. Thus the security-oriented individual will be attracted to the solidly established firm with a reputation for paternalism, while the socially-ambitious man or woman will seek a firm which he or she thinks is likely to advance him or her rapidly to a position of prestige or at least to reflect a little of its corporate glory onto him or her (Koontz & Weihrich, 1990:13-31).

The woman or man who feels capable enough or lucky enough to outwit the law of averages, will be attracted to the job that pays a piece rate or a commission and the man or woman who dreads the effects of unpredictable dips in his or her income, will seek a steady salary. However, the individual's impression of the environment offered by a given job or company is seldom very accurate, especially if he or she has not had much first hand experience with it. In the absence of facts, not many people are willing to suspend judgement about the nature of careers or companies. The all-too-human tendency is to accept certain recurring myths or to concoct a stereotype of one's own on the basis of very limited evidence. This is how "images", that is, the popular unexamined and as a rule grossly over-generalised ideas of outsiders about what something they do not know very well at all is "really like", are born. A company's image as a prospective employer results from the more or less random accumulation by individuals of four kinds of information which they tie together with a good deal of guesswork to form a loose web of impressions (Vroom, 1990:80-84). The chief sources are the prevailing folklore about the company, suggestive evidence, direct contact with the company's personnel or products and exposure to the formal recruiting process. Of these, folklore is by far the most important since it effectively precludes many people from seriously considering the company as a potential employer at all (Vroom, 1978:80-84).

Motivation is notoriously difficult to measure with paper and pencil tests, and it is largely for this reason that even the best testing programmes are limited to a statistical rather than on individual validity, that is, when a group of tests is valid, it will give an accurate forecast of job performance more often than not, but one never knows in advance whether the tests will forecast accurately for any given individual. Most testing programmes are built around individual measurements such as aptitude or intelligence tests, because most jobs require at least a minimum degree of aptitude if they are to be handled successfully at all. There is, in other words, a certain intellectual "threshold" for most jobs below which it is most unlikely that a

person could cope with a job adequately. The reason why some people with high aptitude scores fall short of success, is simply that aptitude scores do not measure the energy and persistence with which a man or woman characteristically uses his or her capacities. They merely measure his or her capacities and indicate whether he or she could deal effectively with the job at all (Koontz & Weihrich, 1990:4-19).

There are, of course, many tests which attempt to measure interests, attitudes, values, personality traits, and other more or less stable products of an individual's underlying motivation (Gellerman, 1963:237). Many were designed for clinical purposes, that is, to detect signs of psychological malfunction. Others were designed for vocational guidance, and some of these, especially vocational interest tests, have amassed a very respectable statistical record in their own right. The projective type of test attempts to analyse the unconscious forces that sometimes reflect themselves deviously in the products of an individual's fantasy. Aside from the difficulty of plumbing anyone's emotional depths during a comparatively brief period, all of these testing methods share the common handicap of artificiality. In other words, they are hardly likely to reproduce the social environment in which the testee would be living on the job, and therefore they often fail to sample his or her way of interpreting his or her psychological advantage in that environment. In effect, these tests provide a portrait of the individual which, even if accurate, is often irrelevant. Tests are, however, by no means the only selection method available and they are seldom the most important (Argyris, 1999:31). The key factor in the hiring decision generally is somebody's "intuition". More precisely the decision depends on whether one person manages to create a subjective impression that corresponds to another person's preconceived notions of what a desirable employee looks like. The unpredictable effects of preconceptions about hiring occur when the hirer's ideas are only partially valid or not valid at all, and when the applicant succeeds in deceiving the hirer into believing that he or she has the desired qualities or both. The hiring is really a random choice even though both parties may think otherwise. The results which can ultimately be achieved by the employee are quite difficult to predict. This has led many hirers whose "intuition" consists largely of unfounded biases, to conclude that human motivation is essentially unfathomable and that attempting to predict how an applicant will perform on the job is merely an exercise in speculation (Argyris, 1999:236-237).

3.8   SUMMARY AND CONCLUSIONS

In identifying the kinds of needs people posses, the kinds of goals they seek only tells the interested observer part of the story. Specifically, one may assume that the person who has needs or desires or goals, is motivated to engage in some kind of behaviour. But one does not know for certain what form of behaviour he or she is likely to exhibit. The motivational process refers to the mechanics which get the person concerned from the motivated state to some specific form of behaviour. In this sense, a motivational process refers to the direction of behaviour. It may be contrasted with needs or outcomes which are more applicable to the intensity of motivated behaviour, although the two aspects of motivation cannot clearly be separated in real life settings. To study the motivational process is very difficult, because one can concretely examine only the outcome of motivation, that is, the

actual behaviour chosen, but the process of arriving at that behaviour is largely internal to the individual engaged in behaving. It is, therefore, not surprising that a variety of theories has been formulated in an attempt to explain the motivational process.

The employee's performance at work is affected by various factors and job characteristics are one of them. These aspects pertaining to the work itself have to combine in order to motivate the employee. It has been suggested that these job characteristics perhaps must have the effect of a shotgun blast with the whole charge to bring the beast down. The question is whether they should combine in the multiplicative or in the additive manner. In the former model the interaction effects between the various characteristics are large *vis-à-vis* (in relation to) the effects of single characteristics. On the latter paradigm the effects of single characteristics are larger than the effects of the various characteristics in interaction. The job characteristics such as control over means and job difficulty, operating independently, had an overwhelmingly greater influence on the job behaviour in the Herzberg and the Michigan studies. This suggests that increases in one job characteristic can induce increases in employee motivation, even when other characteristics remain unchanged. Skill discretion is the characteristic most likely to produce achievement feelings, while the influence of means discretion is especially marked in job commitment. Goal clarity and difficulty are the characteristics most directly related to performance. Contribution adds meaning to one's job activities and thereby enhances feelings of worthwhile accomplishment. Contributions to some end product or service, derive their motivational value from the fact that they effect changes within the total structure of the task; the greater the contribution to the total task, the greater its power to motivate. Of course, the effects of contributions must be unequivocally perceived by the performer in order to maximise their motivational value. Maximum motivation seems likely only when all four characteristics, i.e. control, skill discretion, goal clarity and contribution to end product are amply represented in the job.

The job aspects ordinarily have meaning in the context of the environment, particularly, managerial, in which they are performed. The management theories advanced by renowned authorities, such as McGregor, Likert, Argyris and others, have argued for a liberal participative, and a "dignified" approach to management that "respects" and treats the employee as a human being with feelings, who should be given his or her head over most of his or her work activities, so as to promote productivity. The pros and cons of different management perspectives were explored, and at the end, it emerged that there was no "best way" to manage, but an assortment of different methods to suit various work environments was possibly the best way to proceed. Both the manager and the employee brought to the work process their psychological advantages, their personalities, their early experiences dating back to their early childhood and the experiences they gathered on their way to adulthood. In other words, motives form the basic cornerstones of how people become what they are.

Research results have indicated that many traditional ideas about motivation are either too simple, or too pessimistic, or both. Motivation as the term is commonly used refers to the speculation about someone's purpose in doing something, and this purpose may be shown in some obvious goal, such as money, security, prestige or promotion. Later it may turn out that the particular goals that people appear to be

striving for, are conduits for attaining other fundamental goals. Thus, in a way, wealth, safety, status and all the other types of goals that are thought to "cause" behaviour, are only the "golden road" to attaining the ultimate purpose of any individual, which is to himself or herself. In the final analysis, as has to been detailed above, the ultimate motivation is to make the self-concept real, that is, to live in a manner that befits one's preferred role, to be treated in a way that approximates one's chosen or preferred rank or position or station in life, and to be rewarded in a manner that reflects one's estimated abilities. Thus, both the manager and the employee are all in perpetual pursuit of whatever they regard as their deserved role, trying to convert their subjective ideas about themselves into objective truths. The manager's management or leadership style will be affected by this "portfolio" of ideas about himself or herself. The employee will similarly perform his or her subordinate role "wrapped up" in this portrait of himself or herself. If they both perceive their psychological advantages in a negative way productivity in the workplace will be "dented". However, when their experiences are positive and seem to be confirming those ideas about themselves, they are likely to feel that life is good and the world itself is just, and they are more likely to be productive.

If there is one universal human characteristic, it is probably that everyone tries in his or her own fumbling imperfect way to follow the advice of Polonius to his son in Greek mythology: "This above all, to thine own self be true". But there are many ways of being true and many kinds of selves to be true to, and this variety results in such a large number of motives and outlooks on life that it hardly seems possible that they are all the result of the same fundamental process, and yet they are. One's experiences nearly always confirm his or her belief that his or her basic attitudes must be right, partly because these attitudes were moulded by the realities of his or her own particular environment, and partly because he or she makes sense out of his or her experiences by managing to fit them into his or her system of beliefs. In the same way, other people's experiences also confirm the rightness of their basic attitudes to him or her. The meeting point of both sets of attitudes becomes a melting pot in which the challenge lies, first of all, in accepting the difficult responsibility of understanding, rather than dismissing the attitudes of people with whom one must deal regardless of whether one agrees with their viewpoints. The challenge also lies in recognising that managers are much more capable of changing their own habits and ideas than of changing those of the people who work for them, and that accordingly, they should concentrate more on improving their own effectiveness than on persuading employees to improve theirs. In other words the manager's psychological advantage is capable of being plastic compared to that of the employee. The other challenges to the manager lie in his or her re-examining the necessary and usefulness of out-moded and ossified practices which have never been seriously questioned because they were presumably considered to be indispensable especially with regard to organisation of work, supervisory methods and compensation. The manager also faces challenges in discovering practical ways of realising the energy and the creativity that has been suppressed in apparently many apathetic and alienated employees. Finally and perhaps most importantly, the manager must learn to prevent himself or herself from preventing employees from being themselves.

In the end one has to ask if there are any good reasons why management should concern itself with making work a more satisfying experience for its employees. The answer is a resounding "yes" for three main reasons. Firstly, making work more

satisfying may very well lead to a more profitable operation, or at the very least, lead to a greater flexibility in adapting to changes that will enhance profitability, if not, productivity at the same time. Secondly, making work a more satisfying experience is the best possible preventive measure for resistance to change, restriction of output, and strikes. Finally, the third reason for management making work a more satisfying experience is perhaps the most potent one of all, that is, the effective use of human resources, which is the central problem of management. Therefore, good managers, who are true to their own self-concepts, will not shrink from its challenge. So, one can conclude the exploration of work motivation on a hopeful note, with faith in the likelihood that the best motives of working people and their managers, will ultimately prevail against the worst.   This will enable both parties to put a foot in the door of job satisfaction, motivation and productive attitudes.

While managers face the task of harnessing the motives of their employees in order to make them more productive, they are also confronted with the further challenge of making them satisfied with their job. Both motivation and job satisfaction are arguably pivotal in increasing productivity or enhancing job performance. Managers have to grapple with the need to create a work environment that meets the requirements of both of these variables. Chapter four directs its attention towards the intricacies of job satisfaction.

CHAPTER 4

LABYRINTHS OF JOB SATISFACTION

4.1   INTRODUCTION

Job satisfaction is one of the main factors in overall life satisfactions, although attempts to clarify the direction of causation between job satisfaction and life satisfaction have not been completely successful. However, some bold claims have been made that it is job satisfaction which influences life satisfaction. Another possibility is that areas of work and non-work have a lot in common, such as friendship, status and similar styles of behaviour, and that they jointly affect satisfaction with life as a whole. It was stated in the introductory part to chapter 1 that job satisfaction has been studied extensively in the health services of Botswana. Internationally job satisfaction is one of the most researched topics in psychology. The reason for the popularity of the subject is not hard to explain. Most individuals spend a large part of their working lives at work, so that an understanding of factors involved in job satisfaction is relevant to improving the well-being of most of them. Another valid reason for investigating job satisfaction is the belief that increasing job satisfaction will increase productivity, particularly in the private sector but not least of all in the public sector as well, however it may be measured in the latter.

Being happy coupled with improving one's performance could not be clearer or more evident than in "group professions" such as nursing. Because nurses work in cooperative situations job satisfaction creates a psychological symbiosis. This is a process by which people supplement one another's psychological capabilities and resources to maintain the level of mental functioning deemed appropriate for the group to which they belong. The human relations which evolved from the Hawthorne studies demonstrated that job satisfaction resulting from the cooperation and comradeship among workers increased production. The emergence of a group spirit based on meeting the expectations of others and gaining their affections was not only responsible for the upsurge in job satisfaction but also fostered morale. The latter was integral to the employee's psychological advantage. Thus, Elton Mayo's Hawthorne investigations concluded that job satisfaction, nestling amidst team spirit and morale, was both central to human relations at work and to productivity. Similarly Herzberg's research found that job satisfaction raised the morale of workers, reduced absenteeism and had consequences on high productivity.

The value of studying job satisfaction viewed against the foregoing background would seem plausible enough for any aspiring social scientist. But as if to spurn common sense, questions have been asked as to whether wishing to increase the stock of human happiness in the world through improved job satisfaction is a sensible goal. Pursuant to this negative approach to job satisfaction, it has been argued that job dissatisfaction, if considered to be the opposite of job satisfaction for the purposes of the study at hand, can be creative and may lead to constructive changes such as exploring and discovering one's latent talents or skills in other areas of working life. In support of such a thesis it has been pointed out that a human being is

capable of creativity and personal psychological growth in boundless opportunities of life.

A further criticism of the value of studying job satisfaction comes from people who see such research as providing little of worth. The fundamental issue raised by such critics is that the extraordinary emphasis on job satisfaction published in the current and professional press appeared to be adding confusion and apprehension. This was done at the expense of clarifying the basic question of whether job satisfaction would change the means by which society gets its work done. This dissatisfaction is further compounded by the fact that relationships between measures of job satisfaction and factors of economic importance such as productivity have failed to materialise. Furthermore, dissatisfaction has also been expressed because it has often been felt that the study of job satisfaction was only a study of minimal satisfaction possible under deprived conditions such as poor managerial leadership.

Even though, however, these objections to job satisfaction studies might have some validity, it can nevertheless be argued that in such a complex area confusion is expected to abound. It is unarguable that only a considerable study would help reduce this confusion. It is inescapable, for instance, that a complex relationship such as that which is thought to exist between job satisfaction and productivity would require a detailed and subtle analysis. To this extent, therefore, whatever the defect of the present day jobs, the present-day realities of job satisfaction are worth investigating and the benefits of so doing outweigh the criticisms, at least in the eyes of enlightened managers.

The sequence of the contents of the chapter reflects the many-sided views of job satisfaction evidenced in the various theories. Empirical findings are incorporated into the end of the chapter to show the practical application of job satisfaction factors in Botswana health services.

Section 4.1 introduces the topic under discussion outlining the case for and criticism against studying it as an academic subject. Section 4.2 looks at the concept of job satisfaction putting forward different views of how it is conceived by different writers in the arena of work. It is from these origins that its deeper understanding is derived. Section 4.3 traces a historical background of job satisfaction scrutinising the past to show how, for example, tasks were arranged during the industrial revolution. The way in which human labour was perceived during these early times by the early practising managers left no room for job satisfaction. Feeble attempts to study job satisfaction in the early part of the twentieth century were not welcomed. The Hawthorne studies, however, made a breakthrough in studying job satisfaction with an emphasis on human relations at work. Subsequent studies such as those by Hoppock and Herzberg consolidated the academic roots of job satisfaction as an area of concern.

Section 4.4 gives an overview of job satisfaction theories drawing on the work of many interested parties in the field such as managers, psychologists, philosophers, social scientists and novelists. It is from these varied approaches that the main theories of job satisfaction were developed.

Content theories are the first group of these theories which are examined in section 4.4.1. Maslow's and Herzberg's theories described in subsections 4.4.1.1 and

4.4.1.3 respectively are the main representatives of this approach to job satisfaction. Criticisms of both theories are noted in subsections 4.4.1.2 and 4.4.1.4, respectively. Content theories stress the fact that certain needs must be satisfied before a person can attain job satisfaction.

Process theories which comprise the second major group of job satisfaction theories are detailed in section 4.4.2. These theories extend the views of content theories by adding the aspect of expectations that individuals must have in relation to their job. The social reference group theory, outlined in subsection 4.4.2.1, is one of the process theories. It is based on the comparison of one's job situation with that of others. It may be used as a frame of reference, for example, in deciding on a reasonable pay. Its criticism is exposed in subsection 4.4.2.2. The need fulfillment theory, described in subsection 4.4.2.3, is the other member of the process theories. Its main dimension of analysis is examining the extent to which employees' personal needs are satisfied in a job context. Subsections 4.4.2.3.1 and 4.4.2.3.2 are the discrepancy and multiplicative models of the need fulfillment theory giving meaning to the different facets of the main theory. Their combined criticism is contained in subsection 4.4.2.3.3.

Section 4.4.3 argues that the dynamics of job satisfaction are not static. Considerable differences in job aspects that produce job satisfaction have been found over time. In professional jobs, for instance, long-term changes in the levels of job satisfaction have been observed. Section 4.4.4 brings together job satisfaction theories and contrasts their strengths and weaknesses. It has been suggested that it is the latter that thwart efforts to arrive at a universal theory of job satisfaction.

Section 4.4.5 summarises the job satisfaction theories exposing their usefulness or the lack of it in the field of work. In so doing some theories have been adjudged to be more beneficial than others. Section 4.4.6 and its subsections 4.4.6.1 to 4.4.6.5 survey identified sources of job satisfaction extracted from the empirical findings of the study. Summaries of the main threads of the work contained in the chapter are presented in section 4.5 and conclusions are drawn.

4.2   CONCEPT OF JOB SATISFACTION

The most solid ground on which to view job satisfaction is that there is no one agreed definition. In appreciation of this difficulty a list of nine different operational definitions has been drawn up with each based on a different theoretical orientation and with each resulting in different measures. It has been established that the major difference between definitions is in terms of the different ways in which aspects of job satisfaction are combined. Further when the relationship between job satisfaction for different aspects of the job and overall job satisfaction is analysed, it has been found that considerable differences in the extent of the correlation are found. It has been concluded that there is no optimal way to measure satisfaction. The best measure therefore depends on what variable overall satisfaction is related to (Gruneberg, 1979:3; Latham, 2007:12).

Despite the diversity of measures, however, the Cornell Job Descriptive Index (JDI) is regarded by many workers as the most effective instrument for measuring job satisfaction. It employs a scale consisting of five sub-scales for pay, promotion, people, supervision and work, and each scale has a number of items. The use of questionnaires of any kind to measure attitudes is another way of measuring job satisfaction. But this method is problematic for a number of reasons. For example, it is well established that people often give socially acceptable rather than "real" responses to questions. They also tend to expend little time and effort in filling them in addition to being often influenced by the way the questions are phrased (Oakley, 1993:3-4).

The diversity and the lack of consensus on the definition of job satisfaction has not deterred some writers nonetheless from attempting to express ideas in this nebulous area. For instance, Locke (1976) in Slocum, Susman and Sheridan (1992:338-343) has defined job satisfaction as a pleasurable or positive emotional state resulting from the appraisal of one's job or job experiences. In other words job satisfaction results from the perception that one's job fulfills or allows the fulfillment of one's important job values, providing and to the degree that those values are congruent with one's needs. An expanded version of this definition details that job satisfaction results from the appraisal of one's job as attaining or allowing the attainment of one's important job values, providing these values are congruent with or help to fulfil one's basic needs. These needs are of two separable but interdependent types, that is, bodily or physical needs and psychological needs, especially the need for growth. Growth is made possible mainly by the nature of the work itself (Slocum *et al.*,1992:338-343).

The terms job satisfaction and job attitudes are typically used interchangeably. Both refer to affective orientations on the part of individuals toward work roles which they are presently occupying. In this regard positive attitudes toward the job are conceptually equivalent to job satisfaction and negative attitudes toward the job are equivalent to job dissatisfaction (Mueller & McClosky, 1990:113-117). The term "morale" has been given a variety of meanings, some of which correspond quite closely to the concepts of attitude and satisfaction. For example, job morale has been defined as an individual's "mental attitude toward all features of his or her work and toward all of the people with whom he or she works" (Vroom, 1995:89-100). Morale has also been defined as the extent to which the individual's needs are satisfied and "the extent to which the individual perceives that satisfaction as stemming from his or her total job situation" (Mueller & McClosky, 1990:117).

The concept of job satisfaction is not only beset by definitional problems, but is also inter-twined with other related concepts such as morale. Since satisfaction is an emotional response, the meaning of the concept can only be discovered and grasped by a process of introspection, that is, an act of conceptual identification directed to one's mental contents and processes (Longest, 1991:46-52). Although both morale and satisfaction refer to positive emotional states which may be experienced by employees, the concept of job satisfaction is related to, but distinguishable from, the concepts of morale and job involvement (Longest, 1991:46-52). Most writers in distinguishing between job satisfaction and job morale view the latter as referring to a group-well-being, whereas job satisfaction refers to the individual's emotional reactions to a particular job (Seybolt, 1993:193-202).

This definition brings out two differences in emphasis from the concept of satisfaction. Firstly, morale is more future-oriented, while satisfaction is more present and past-oriented. Secondly, morale often has a group referent based on a sense of common purpose and the belief that group goals can be attained and are compatible with individual goals. Satisfaction on the other hand typically refers to the appraisal made by a single individual of his or her job situation. However, one could perceive morale as being caused, in part, by job satisfaction, in that a person, who achieves his or her job goals or is making progress toward them, should feel more confident about the future than one who is not so successful (McCloskey, 1990:140-143).

Job satisfaction must also be distinguished from job involvement. To involve means to "pre-occupy or absorb fully". An individual who is involved in his or her job is one who takes it seriously, for whom important values are at stake in the job, whose moods and feelings are significantly affected by his or her job experiences and who is mentally pre-occupied with his or her job. Thus, a person who is highly involved in his or her job should be more likely to feel extremely satisfied or extremely dissatisfied with it, depending on his or her degree of success. The other side of the coin depicts an uninvolved person who would have less extreme emotional reactions to the same or analogous job experiences (McDaniel, 1995:15-22). Because a job is described as involving an emotional state, the definition of job satisfaction given by Slocum *et al.* (1992:338-343) (see penultimate page to preceding page) is preferred for this study.

Since job experiences that satisfy have both a present and a past, the elusive nature and populist view of job satisfaction as a field of research imply that the subject has a history behind it. It is its historical antecedents that will help clarify why it has taken its toll on researchers or why it has engaged their interest for so long.

4.3. HISTORICAL ANCHORS OF JOB SATISFACTION

The concern with the fragmented and meaningless nature of tasks has been expressed since the industrial revolution when human labour or craftsmanship was replaced by machinery. Karl Marx was among the early critics of the fragmented nature of work which resulted in a lack of fulfillment and gave rise to feelings of misery rather than enjoyment. Surprisingly the initial concern of psychologists in industry was not basically with the psychological welfare of the individual but with improvements in productivity as a result of changes in the physical environment. Foremost in this tradition was Frederick Taylor (1911) whose famous study at the Bethlehem steelworks involved redesigning equipment and selecting the right workers for the job with a resultant increase in production (Gruneberg, 1979:4-5; Latham, 2007:9-12).

Thus, although systematic attempts to study the nature and causes of job satisfaction did not start until the 1930s, the important role played by a worker's "attitudes" in determining his or her actions in the job situation was recognised long before. Commenting on his scientific management in 1912, Taylor faithfully claimed that the great revolution that took place in the mental attitude of management and workers under scientific management, was that both parties ignored the idea of sharing profits

as the all-important matter. Instead they together turned their attention toward increasing the size of the surplus until the latter became so large that it was unnecessary to quarrel over how it should be divided (McClelland, 1990:12-15).

But by "attitude" Taylor meant much more than just feelings. He meant the workers' philosophy concerning their cooperation with management and their view of their own self-interest in the work-place. Taylor implicitly assumed that a worker who accepted the scientific management philosophy and who received the highest possible earnings with the least amount of fatigue would be satisfied and productive. This was, of course, an erroneous view as later revealed by the British researchers such as Wyatt, Fraser and Stock in 1929. These investigators were responsible for some of the earliest studies of industrial boredom and autonomy. Among the organisational antidotes to the occupational "hazards" such as boredom suggested by the British writers were piece rate incentives, smaller lot or batch sizes, rest pauses, increased work variety that is, horizontal enlargement and social interaction (Knutsen, 1992:15-20).

The next development of historical significance or importance was that of the Hawthorne studies which began in the 1920s at the Hawthorne plant of the Western Electric company under the direction of Elton Mayo. These researches initiated by Mayo and his colleagues began as a study of the effects of such factors as rest pauses and incentives on productivity. But the emphasis soon shifted to the study of "attitudes" when the employees failed to react in a mechanistic manner to these changes. In short the Hawthorne researchers "discovered" what Taylor had observed decades before, that is, that workers had minds and that the appraisals they made of the work situation affected their reactions to it. In the footsteps of Taylor, the term attitude, as the Hawthorne researchers used it, referred to more than just job satisfaction. It included the employee's view of management, of the economic situation at the time, their hypotheses or thoughts about the purpose of the studies and their moods among others (Knutsen, 1992:22).

The interpretations of the Hawthorne studies stressed the role of the informal group and supervisory practices in shaping employee attitudes and performance. Meanwhile the role of economic incentives was downgraded or down-played on the grounds that workers were more interested in social relationships than money and were in any case too irrational and or unintelligent to make meaningful economic calculations. It should be noted undoubtedly, however, that there is good reason to question the validity of the Hawthorne researchers' conclusions concerning the role of money in employee motivation (Frey, 1997:30-32).

The Hawthorne studies began very much in the Taylor tradition and apart from employees' attitudes the investigations focused on productivity. In this respect the research commenced by examining ways in which alterations in physical conditions would affect production. The first studies involved changes in the levels of illumination, and yielded the surprising result that changes in lighting resulted in changes in productivity, regardless of the direction of the change in illumination. For instance, in one experiment, illumination was reduced to the level of moonlight and yet productivity increased (Friedlander & Margulies, 1991:246-250).

This finding has been attributed to the individuals' awareness of being in an experimental situation. It has been suggested that they acted in this way because

they felt that experimenters were taking an interest in them. Whatever the reason, thenceforth when subjects in experiments improve performance because of the experimental situation, this is now known as the "Hawthorne" effect. The results of the studies on illumination led the Hawthorne investigators to set up other studies designed to examine why productivity should increase despite deteriorating physical conditions (Heinrichs, 1990:479).

The first of these new studies was the relay assembly test room which involved a small group of girls who were all friendly or well disposed toward one another. The research manipulated a number of variables such as rest pauses, hours of work, payment systems, heating and temperature which were all varied. After a two-year period it was observed that output had increased by 30%. It was clear that in varying so many factors it was difficult to establish precisely what had caused the increase in productivity, although the Hawthorne investigators considered that it was mainly due to human associations at work. They predicated this conclusion on the fact that the work was carried out in a friendly atmosphere (Lawler & Porter, 1991:426-435).

The role of friendly supervision as a factor in increased productivity was unfortunately found to be of dubious validity. As was noted at the beginning of the preceding paragraph the first relay test room study began with girls who were friendly towards one another. However talking became such a problem that two of the girls had to be dismissed. This incident was a red warning light to the belief that satisfaction with work and productivity were necessarily related. When two replacement girls came in, output increased immediately mainly due to the efforts of an Italian girl whose mother had died leaving her the sole breadwinner. She was motivated by this sad patch in her life and immediately took a leadership role and led the way with increased productivity. Therefore, productivity was certainly influenced by factors other than friendly supervision. Indeed if anything, friendly supervision came after an increase in productivity rather than before (Lipietz, 1991:18-20).

Nevertheless, following the relay test room experiment, other experiments were designed with the aim of clarifying the role of friendly supervision in increasing productivity. For a variety of reasons, however, they failed to demonstrate that social factors were critical in improving productivity. And yet the experiment itself was of considerable historical importance in that it led directly to the "Human Relations" school of thought in organisational psychology which made the assumption that job satisfaction leads to increased productivity and that human relationships in organisations are the key to job satisfaction. Concomitantly such relationships involve both leadership and supervisory behaviour as well as informal social groups within organisations (Misener, Haddock & Gleaton, 1996:87).

The Hawthorne research spawned other subsequent studies in the same field. For example, two years after Mayo's preliminary report on the Hawthorne investigations appeared, Hoppock published the first intensive study of job satisfaction in 1935. This is regarded as the first major work to use survey methods and attitudes scales in an examination of the problem of job satisfaction. Hoppock used samples which included most employed adults in one small town and 500 school teachers from several dozen communities. His work and orientation was not toward any particular management philosophy but was typical of many studies which have taken place since, where job satisfaction is seen to consist of a multiplicity of factors. His results and interpretations emphasised the existence of a number of variables that could

affect job satisfaction including both factors that had been studied previously, that is, fatigue, monotony, working conditions and supervision and those which were only to be stressed later such as achievement. Hoppock's method typifies what has been termed the traditional approach to job satisfaction, in that he assumes that "if the presence of a variable in the work situation leads to satisfaction, then its absence will lead to job dissatisfaction, and *vice versa*" (Misener *et al.*, 1996:87-88).

One of Hoppock's (1935:35-50; Boucher, 2004:22-27) studies involved analysing the responses of 500 teachers to a questionnaire on different aspects of their job. He examined the differences between the 100 most and the 100 least satisfied. One factor which was found to discriminate most was emotional maladjustment. He found that 21% of the least satisfied teachers had parents with unhappy marriages, compared with 6% of the most satisfied teachers. Such findings are very much in agreement with more recent work on the relationship between job satisfaction and life satisfaction. The results do suggest further that to some extent individual factors will determine whether someone will be job satisfied or not (Misener *et al.*, 1996:88).

Hoppock concluded that perhaps people were not too easily satisfied in a job. He went on to suggest that it was possible that individuals who stayed in a job came to adapt to it. However, Hoppock saw as a hopeful sign the fact that many people report themselves satisfied even in dull-routine jobs. He prognosticated further that

the effects of dissatisfaction, whatever they may be, are not the inevitable results of technological progress and the accompanying factory system (Misener *et al.*, 1996:88-90).

One of the main catalysts of job satisfaction is the role of the supervisor. For instance, the outgrowth of the Hawthorne studies together with the researches of leadership stimulated by the needs of the armed forces in the Second World War was the "Human Relations" movement which stressed the central importance of the supervisor and the work group in determining employee satisfaction and productivity. The leaders of this movement in the past war years were industrial psychologists of different orientations or descriptions such as Whyte (1955) and Likert (1961) quoted in Locke (1976:1299). Likert was one of the foremost advocates of participatory management.

The Human Relations Movement reached its peak of influence in the late 1950s or early 1960s. The publication of Herzberg, Mausner and Snyderman's monograph in 1959 signaled the beginning of a new trend which was to refocus attention on the work itself, a factor which had been ignored or de-emphasised by nearly everyone except the Industrial Health Research Board. This time, however, the emphasis was on vertical rather than horizontal job enlargement. The new emphasis suggested that the real satisfaction with the job could only be provided by allowing individuals enough responsibility and discretion to enable them to grow mentally or psychologically. Thus, the method of improving employee morale and performance through the redesign of the work itself has gained or grown rapidly in popularity (Locke, 1976:1299; Spector, 1997:94).

Herzberg's 1959 new dimension on the work itself was mixed with his major attack on the earlier views of job satisfaction such as those of Hoppock. He also excoriated both the Human Relations view that "human relationships" were of critical importance

in job satisfaction and the traditional view that job satisfaction and dissatisfaction lay along a single continuum. After dismissing these ideas Herzberg then put forward his famous two-factor theory of job satisfaction in which he argued that the causes of satisfaction and dissatisfaction were separate and distinct. He explained that factors associated with the individual's needs for psychological growth contribute to job satisfaction. Such factors include the nature of the job and achievement. On the other hand, factors associated with the job context such as pay and supervision lead to job dissatisfaction if they are defective. Herzberg further contended that the emphasis on attaining job satisfaction through the work itself is perhaps the major interest of contemporary workers in the field of job satisfaction. However, this claim was made in the wake of a considerable criticism of Herzberg's work itself (Tumulty, 1995:61-63).

It has been argued that few present day writers would be willing to adhere to any of the historical schools of thought on job satisfaction. As an extension of this broad perspective, it is generally appreciated that the physical design of jobs can affect job satisfaction as can social relationships, payment and supervisory systems and a myriad of other variables. It has also been pointed out that generalisations cannot be made without taking individuals' differences into account (Tumulty, 1995:62).

As a result of a multiplicity of factors that impact on job satisfaction, three major schools of thought can be identified. These historical trends concern the variables believed to be most conducive to employee job satisfaction. Firstly, the physical-economic school emphasised the role of the physical arrangement of the work, physical working conditions and pay. Its major proponents were Taylor and the British Industrial Health Research Board and most American researchers of the 1920s. Secondly, the social human relations school which began in the 1930s. Its philosophy emphasised the role of good supervision, cohesive work groups and friendly employee-management relations. Its exponents were the Hawthorne investigators and more recently the industrial sociologists and the Michigan and Ohio state leadership researchers. Thirdly, the contemporary work itself or growth school which emphasizes the attainment of satisfaction through growth in skill, efficacy and responsibility made possible by mentally challenging work. The authors of this approach include Herzberg and his colleagues (Locke, 1976:1299-1300; Spector, 1997:98) amongst others. These historical schools of thought not only compartmentalize the various views on job satisfaction but also provide a comprehensive background on which to base relevant theories on the subject (Tumulty, 1995:62-65).

4.4   JOB SATISFACTION THEORIES

A starting point for practical theories about job satisfaction is Frederick Taylor's monumental work called *The Principles of Scientific Management* published in 1911, which presented research which linked job satisfaction with a variety of both individual and organisational variables. Taylor's theories were based on the assumption that individuals would be motivated to do their work well if rewards were directly related to their performance of carefully planned tasks. Later, however, managers often fragmented and skewed Taylor's concepts in their favour and used

them inappropriately for productivity rather than for worker satisfaction purposes which produced a dramatic difference in focus. Nevertheless, significant research evolved from these early attempts at improving satisfaction in the work-place. Mayo's studies in the 1930s resulted in the development of the human relations movement with its concern for worker satisfaction and emphasis on leadership and personal relations (Wickens, 1995:23-24).

American psychologists quickly incorporated the idea of motivation of employees into their research. For example, Maslow in 1943 suggested that human needs form a five-level hierarchy, from basic physiological needs to higher-order needs of safety, belongingness, love, esteem and self-actualisation. He argued that most normal individuals are both partially satisfied and dissatisfied in all these basic needs at the same time. Maslow's work formed the basis for the development of ideas about job enrichment by Herzberg and others in the heydays of the 1960s (Wickens, 1995:24-26).

Unsurprisingly concern with the level of satisfaction at work has almost been entirely relegated to the academic rather than the practical domain. Occupational sociologists and industrial psychologists have focused most of their efforts upon employees in non-professional lower level jobs. This has had the effect of defining both the type and the content of investigation and of people's perceptions about their jobs. The major motivation for studying job satisfaction, even amongst the academics, has been to create a link between productivity and satisfaction. Investigations towards this goal have provided varied and contrasting results. For instance, job satisfaction has been directly related to problems in turnover, accident rates, tardiness and absenteeism. Further, attendance records reveal that motivated and satisfied employees have fewer days off, have fewer physical complaints and progressively take on more difficult objectives within the constraints of their jobs. However, these results are not verified by all the studies. All of these factors are costly to management and become especially crucial in a medical setting where patients' health is concerned. It is a paradox that the inability to document the relationships between the above factors and job satisfaction consistently has not led to a diminution of interest in job satisfaction. Instead interest has increased in recent years (Argyris, 1999:349-357).

In addition to the intuitive relationship between productivity and job satisfaction, a second major focus is more humanistic. This thrust examines the role of work in individuals' lives in relation to their overall quality of life. Indeed the role of work cannot be ignored in any consideration of quality of life. This humanitarian emphasis has strong, albeit not necessarily entirely altruistic antecedents in the American society. Humanists often note that increasing job satisfaction may also increase productivity. This statement has a considerable political appeal in modern economics. In the health industry where labour costs are the biggest part of the budget, this link takes on an even greater significance (Stranks, 2001:99-108).

The relationship between woman or man and her or his work has long attracted the attention of philosophers, scientists and novelists. The interest of psychologists in this problem dates back to the early part of the twentieth century. Much of the early work in these fields dealt with the measurement of aptitudes and abilities and with the utilisation of these measurements in improving the selection of persons by institutions. This emphasis on the "fit" between the abilities of persons and the

demands of their jobs made an important contribution to both institutional functioning and individual adjustment. It did not however assist much on the basic processes affecting the behaviour of people in work situations. The concepts of aptitude and ability have always been difficult to deal with in any formal or theoretical perspective and to this day have not played an important role in systematic theories of behaviour and job satisfaction (Ward, 1999:28-29).

A somewhat different kind of thinking on the problem of motivation and job satisfaction emerged from the writings of Elton Mayo and his followers amongst others. It was due to these incipient problems that prompted Stamps and Piedmonte (1986:30-34) to point out that many of the difficulties in the development of job satisfaction studies involve the lack of a formally-organized and a formally-accepted framework that could define parameters for the applied efforts in carving out theoretical orientations (March, 1990:3-8).

The present-day theories of job satisfaction have been divided into two broad categories, namely content theories and process theories (Gruneberg, 1979:9; Latham, 2007:15).Content theories give an account of the factors which influence job satisfaction. Maslow's (1943) needs hierarchy theory and its development by Herzberg into a two factor theory of job satisfaction is one important example of content theories. Process theories on the other hand try to explain the process by which variables such as expectations, needs and values interact with the characteristics of a job to produce job satisfaction. Equity theory, for example, argues that job satisfaction occurs when one compares that what he or she puts into a job and the rewards that he or she receives with those of others and finds that he or she is equitably treated. The theory involves taking into account the expectations of individuals in relation to their job satisfaction. The reference group theory considers the way in which one refers to other individuals in deciding what is equitable. The need and value fulfilment theories account for job satisfaction in terms of the discrepancy between the individual's needs and values and what the job has to offer (Gruneberg, 1979:9-10; Latham, 2007:7).

However, any theoretical orientation is dogged by the phenomenon that job satisfaction is not a single variable but rather a complex set of variables. For example, workers can be found who report that they are very satisfied with their supervisors, indifferent toward company policies and very dissatisfied with their wages. The question is which one or combination of these represents their level of job satisfaction? Alternatively is it not both theoretically and practically useful to consider specific referents for satisfaction within the work role?(Armstrong, 1990:107-109).

Moreover, the meaning typically accorded to the term satisfaction comes very close to what is meant by valence. If one describes a person as satisfied with an object, one means that the object has positive valence for him or her. But satisfaction has a much more restricted usage. In common parlance one refers to a person's satisfaction only with reference to the objects which he or she possesses. Thus, one might speak of a person's satisfaction with his or her present job but not with jobs that he or she never performed. No such restriction, however, has been placed on the concept of valence (Vroom & Deci, 1992:100).

If one considers job satisfaction as the valence of a work role to its occupant, it becomes clear that there could be different valences with different properties of work roles. The general valence of the work role might be of most value in predictive behaviour in relation to the work role as a whole, that is, actions which lead a person towards or away from it. The other view is that the valence of particular sets of properties of the work role, that is, task content, promotional possibilities and so forth, might be of value in predicting how individuals would respond to changes in work roles, as well as the degree to which they might seek to initiate changes on their own (Posner & Randolph, 1990:237-244).

If it is decided, for instance, that job satisfaction is best treated as a set of dimensions rather than as a single dimension, one is immediately confronted with the problem of specifying these dimensions. One can hazard a guess as to how the characteristics of work roles can be divided in order to arrive at useful dimensions of job satisfaction. It has also been suggested that in discussing choice of work role, a distinction can be made between choices among occupations and choices among institutions. This difference is necessitated by the fact that for most persons occupational and institutional choices are temporally separated. A parallel distinction can be made for job satisfaction insofar as one can determine the extent to which a worker is attracted to his or her occupation and its associated activities, as well as the extent to which he or she is attracted to his or her employing institution (Pruijt, 1997:35-42).

The early Survey Research Centre studies used four dimensions of morale in their investigation of job satisfaction. These were intrinsic job satisfaction, company involvement, financial and job satisfaction, and pride in group performance. Measures of each of these four dimensions were obtained in a study of white collar workers. It was found that each of the measures was significantly correlated with the others, with the exception of pride in group performance which was not meaningfully related to any of the other three dimensions (Argyle, 1993:55-62).

The apparent positive correlation on most of the dimensions studied poses serious theoretical and methodological difficulties in the study of job satisfaction. There are at least four possible explanations of the fact that different measures of satisfaction are positively correlated. Firstly, it is possible that there are characteristics of individuals which similarly condition their reactions to the objectively different aspects of the work situation. One such possibility is that persons have developed different adaptation levels or standards of judgement as a result of differences in the amount or kind of experience in work situations. As a result of these differences, some people might be "easily satisfied", reporting satisfaction if the work situation meets certain minimal requirements whereas others have much higher thresholds (Annadale-steiner, 1991:34-36).

Secondly, it is also possible that the positive inter-relationships among measures of satisfaction are due to response sets. On many satisfaction measures, a tendency to choose the first alternative or to choose the "yes" or agree response, results in high scores indicating a high-level of satisfaction. There is conclusive evidence that people vary in the extent to which they will agree with a statement regardless of its content. This lends support to the idea that acquiescence, as it has been called, might be the basis for a generalised satisfaction with the job. However, another form of response set, that is, social desirability, cannot be easily handled. For example, in many situations, reporting a high level of job satisfaction may be construed as a

socially desirable response. Therefore it is possible that individual differences in the tendency to give such responses may be the basis for associations between specific satisfaction measures (Argyris, 1993:141-167).

A third possibility is that work situations providing one type of reward tend also to offer other types of rewards. For example, jobs which are highly paid also tend to provide a greater variety of stimulation, higher status and many other frequently-mentioned sources of rewards. The positive correlations between persons' satisfaction with these different aspects of the work role may be due to the fact that situational conditions which determine these attitudes are associated with one another. Finally, it is possible that the measures of satisfaction with different aspects of work roles are associated because they are functionally interdependent. Changes in satisfaction with one aspect, for example, supervision, may result in changed satisfaction with another aspect such as the content of the work and *vice versa*. Similarly the effects of job satisfaction of many other aspects, namely the work group, wages and promotional opportunities can be considered (Baker & Hanson, 1992:79-91). These complex theoretical considerations provide scaffolding for the detailed analysis of each theory and sub-theory.

4.4.1   Content theories

One of the most popular accounts of job satisfaction is that the latter involves fulfilling the individual's needs. Content theories attempt to specify the particular needs that must be satisfied or the values that must be attained for an individual to be satisfied with his or her job. Two major theories have dominated the contemporary scene, that is, Maslow's needs hierarchy theory and Herzberg's two-factor theory or the motivator-hygiene theory (Locke, 1976:1307; Spector, 1997:99).

4.4.1.1   Maslow's theory

One of the first needs theories is that of Maslow who postulated that there was a needs hierarchy with the needs divided into those of a lower order and those of a higher order. He asserted that a person has five basic categories of needs. The first group comprises basic physiological needs such as food, water, air and others. The second category was composed of safety and security needs including freedom from physical threats and harm as well as economic security. The third division of needs is the social or affection needs or the belongingness and love needs. The fourth order of needs is the esteem needs which are of two types, that is, the need for mastery and achievement and the need for the recognition and approval of others. The final hierarchy of needs is the need for self-actualisation which is defined as "the desire to become more and more what one is, to become everything that one is capable of becoming" (Maslow, 1970:91-92). The theory argues further that these needs are arranged in a hierarchy of "pre-potency" or dominance. The first three are lower-order needs while the fourth and the fifth belong to the higher-order hierarchy. According to Maslow the less pre-potent needs are neither desired nor sought until the more pre-potent needs are satisfied or fulfilled (Katz, 1994:131-146).

Maslow argues that only after the lower-order needs are satisfied is a person capable of being concerned with fulfilling higher-order needs. He gave as an example of the application of the theory a man shipwrecked on a desert island. First he must find food and water to survive. Thereafter follows a search for shelter and a means of establishing some defence for same. After this he will establish whether the island is inhabited with a view to securing his own position and with the aim of making social contact. Only after the basic needs are fulfilled is it possible to pay attention to the higher-order needs of self-fulfillment and establishing his individual worth as a human being. In the job situation the theory would predict that only after the lower-order needs for security and pay have been satisfied will the employee seek satisfaction and achievement from the work itself (Aldrich, 1998:20-24).

It has been admitted that there is evidence that Maslow's theory has been found applicable in respect of both occupational level and job satisfaction. For example, using this theory it was found that those employees in lower level occupations are likely to be motivated by lower-order needs such as pay and security, whereas those in higher level occupations who have these basic needs fulfilled are more interested in fulfilling higher-order needs. It must be accepted, however, that other explanations are possible such as the different expectations of individuals from different levels of society or education as to what a job should offer (Hackman & Lawler, 1991:259-286).

Setting aside these interpretations of Maslow's theory, it has been further argued that Maslow did not, in fact, devise his theory in order to account for job satisfaction, although a number of theorists has used it in this way (Gruneberg, 1979:10; Latham, 2007:17). Gruneberg did not even develop a specific theory of work motivation, although the implications of his theory for the design of incentive systems by management are obvious. The optimal job environment for a given employee would be the one which corresponds most closely to his position on the need hierarchy (Mintzberg, 1990:59-63). Notwithstanding this inadvertent mistake on the part of theorists a number of criticisms has been leveled against Maslow's theoretical approach to job satisfaction.

4.4.1.2. Criticism of Maslow's theory

Whilst Maslow's theory has a great intuitive appeal as Locke (1976:1308) points out, it has some major drawbacks. First and foremost there is no evidence for this hierarchy of needs. Furthermore, it is in the nature of things that a person's needs, even at the lowest levels, are not satisfied by one consumatory act. In any case there are always physical needs to be satisfied. Indeed there is some evidence that the satisfying of certain needs leads to a strengthening of those needs rather than the reverse (Gruneberg, 1979:10; Latham, 2007:7).

Maslow offers no proof that the list of needs which he proposes is, in fact, needs. While the existence of the physiological needs is well established enough not to require further proof the same is not true of the remainder of the list. For example, it has been asked on what grounds Maslow claims that a person has a need for self-esteem. It is also virtually impossible to find an intelligible definition of the concept of

self-actualization in Maslow's writings. For instance, to "become more and more what one is" is self-contradictory. To become "everything that one is capable of becoming" is impossible if taken literally, since every person is metaphysically capable of becoming an almost unlimited number of things (Locke, 1976:1308; Spector, 1997:99).

Further, Maslow seems to be caught in the horns of the dilemma when he appears to recognize the distinction between needs and values, but implies that it is irrelevant since he believes that "most often under good conditions, what man wants is what he needs, that is, what is good for him in order to avoid sickness" (Maslow, 1970:125). This means that there is a near perfect correspondence between needs and values. This is simply not true. While needs by definition are innate and universal one can observe that men or women differ enormously in what they value both within and between cultures (Locke, 1976:1308;Spector,1997:99). Maslow goes further to claim that needs can "disappear permanently" (Maslow, 1970:147). While values can disappear, that is, changed or be replaced, needs cannot, since they are part of an organism's nature. Needs can therefore be fulfilled or frustrated. Maslow's other claims are that "The organism tells us what it needs and therefore what it values by sickening when deprived of these values" (Maslow, 1970:152-153). This is precisely what the organism does not do. Instead the experience of pain, discomfort or suffering does serve as a signal to the organism that some need has been frustrated. But the experience of suffering as such does not automatically endow an individual with knowledge as to what need has been frustrated. It also does not tell him or her once the need has been identified how specifically to go about satisfying it (Warr, 1997:67-70).

To cite an obvious example, thousands of children used to die of, or be crippled by, polio (short for poliomyelitis, meaning infectious viral inflammation of the spinal cord nerve cells causing paralysis). The existence of this disease or illness, however, did not tell Jonas Salk how to develop his vaccine and it did not identify the nature of the organism causing polio. All of this had to be discovered by years of painstaking research, methodological experimentation and excruciating mental effort. The nature of a person's needs, both physical and mental, and how to satisfy them must be discovered by his or her mind (Wilson & Laschinger, 1994:39-47).

All people have a hierarchy of values but this order differs with each person, and a given ordering may or may not correspond to the individual's needs. Maslow is additionally blamed for confusing actions with desires. He is somewhat inconsistent about what his theory is a theory of. At one point he claims that it is a theory of action, that is, that more pre-potent needs will always be fulfilled or satisfied than the less pre-potent ones (Maslow, 1954:100-101). On the other hand, however, he claims that the theory postulates only felt desires to act (Maslow, 1954:99) and admits that these felt desires may not be expressed in action. These two views obviously have different implications for predicting and explaining actions and attitudes (Godfrey, 1995:89-104).

It must not be forgotten that the basis for Maslow's theory is the premise that "a satisfied need is not a motivator" (Maslow, 1954:105). Strictly speaking while this may be true, it is also true that no human need is ever permanently satisfied as the result of a single act or a series of actions. It is in the nature of needs that they must be continually and repeatedly fulfilled if the organism is to survive. Furthermore,

Maslow admits that behaviour tends to be determined by several or all the basic needs simultaneously rather than by only one of them. This would seem to contradict the idea of need satisfaction occurring in a fixed hierarchical order (Wagner, Loesch & Anderson, 1977, 120-130; Stride, 2007:76-86).

It can be concluded that despite the "intuitive" appeal of Maslow's need hierarchy theory there is little firm support for its major thesis of a fixed hierarchy of needs which automatically governs action. It is not necessarily what a person needs but what he or she values most strongly that determines his or her thoughts and actions. Furthermore, the individual's value hierarchy may put known physical needs first or it may not. A teenager who takes drugs which he or she knows to be dangerous solely in order to "belong" to his or her peer group provides an example (Locke, 1976:1309; Spector, 1997:99). However it has been aptly observed that it has proved easy to interpret situations by Maslow's model, but rather more elusive to actually test it out. If Maslow's theory is deemed to be practically test-defiant one surmises if Herzberg's motivator-hygiene theory is any better as a content theory (Porter & Lawler, 1993:70-75).

4.4.1.3   Herzberg's theory

Related to Maslow's needs hierarchy theory is Herzberg's famous two factor theory of job satisfaction. The original basis for the motivator hygiene or two factor theory was a study of some 200 engineers and accountants who were asked to describe a time when they felt especially satisfied and a time when they felt especially dissatisfied with their job. These "critical incidents" were then classified by grouping those together that "seemed to go together" and recording the frequency with which each category was mentioned. Incidents classified as involving the work itself, achievement, promotion, recognition and responsibility were frequently mentioned as sources of satisfaction. This group of factors was labelled "motivators" and was asserted to involve mainly aspects of the work itself (Deci, 1992:113-120).

Incidents classified as involving supervision, inter-personal relations, working conditions, company policies and salary were frequently mentioned as causes of job dissatisfaction but less often as causes of satisfaction. This group of categories was labeled "hygienes" and was claimed to refer primarily to the context in which the work was performed. Thus the theory argues that job satisfaction and dissatisfaction result from different causes, that is, satisfaction depends on motivators while dissatisfaction is the result of hygiene factors (Morse & Weiss, 1992:115-129).

Herzberg (1968:50-64; Rowan, 2007:43-56) later expanded his theory by applying these findings to a specific view of the nature of man. Firstly, he gave an example of physiological needs whose root is a person's possession of a reasoning mind. Secondly, the need to use one's mind which Herzberg calls psychological growth is satisfied by such actions as increasing one's knowledge, making abstract integrations, creative activity, being effective in ambiguity and developing individuality. If the concept of self-actualisation were to be made intelligible, the above criteria might be a more promising approach than those suggested by Maslow (Brayfield & Crockett, 1991: 396-424).

Herzberg further argued that the physiological needs motivate action according to the pain-avoidance or tension-reduction principle. When frustrated they produce discomfort, when fulfilled they produce a relief from discomfort but no positive pleasure. In contrast the physiological growth needs motivate action only in a positive sense. Attaining growth brings pleasure but failure to grow does not bring displeasure. The two-factor theory of job satisfaction parallels this dual theory of a person's needs. The hygiene factors operate only to frustrate or fulfil a person's physical needs while the motivators serve to fulfil or frustrate a person's growth needs (Morse & Reimer, 1956:120-129).

Herzberg (1968:50-64; Rowan, 2007:43-56), therefore, distinguishes two classes of factors involved in job satisfaction. The first group are motivators which if present in the working situation lead to satisfaction, but whose absence does not lead to dissatisfaction. Such factors include achievement, recognition and the intrinsic interest of the work itself. These variables correspond to the higher levels of "self autonomy" and "self-actualization" in Maslow's hierarchy of needs. These higher-order factors are separate and distinct from the second group of hygiene factors which when inadequate lead to job dissatisfaction, but which when adequate do not lead to job satisfaction. Among the hygiene factors are pay, security and physical working conditions which correspond to the lower-order needs in Maslow's hierarchy (Porter, 1991:1-12).

In splitting the factors involved in job satisfaction in this way, Herzberg argues that the causes of job satisfaction and job dissatisfaction are separate and distinct. Drawing an analogy with the concepts of pain and pleasure, the mere absence of pain in the normal healthy individual is not pleasurable of itself although over the short term it might be that the relief of pain is considered enjoyable. Similarly, hygiene factors such as working conditions do not normally lead to the feelings of satisfaction when they are newly introduced. On the other hand when they are bad they do lead to job dissatisfaction (Seybolt, Pavett & Walker, 1994:4-9).

The thrust of Herzberg's argument is that such factors as pay and working conditions are context factors which have little to do with deriving satisfaction from the job. They are necessary conditions for, but do not of themselves produce, job satisfaction. On the other hand job satisfaction is produced by the job itself, allowing the individual to "grow" psychologically, that is, to achieve recognition for his or her efforts and so on, so that he or she can regard himself or herself as a worthwhile individual. Herzberg argues that the absence of such motivators on the job does not in itself lead to dissatisfaction but merely to a failure to achieve satisfaction (Weisman, Alexander & Chase, 1980:341-364).

Herzberg likens the concept of job satisfaction with the concept of mental health and argues that like job satisfaction and dissatisfaction, mental illness is not the obverse of mental health. The causes of mental illness are to be found in the strain imposed by the environment, whereas mental health involves a reaction to the factors involved in psychological growth. The mentally healthy individual will seek psychological growth from his or her job and Herzberg (1966:54) implies that those who seek satisfaction from hygiene factors have characteristics which add up to neurotic personalities. It was due to some of these claims that laid Herzberg's research and his empirical findings open to criticism (Aiken, 1991:324-330).

4.4.1.4　Critique of Herzberg's theory

Herzberg and others' (1959) basic study investigated engineers and accountants using a basic method known as "the critical incident technique" in which workers were asked to think of a time when they felt exceptionally good or exceptionally bad about their present job or any other job they had had. These incidents were then classified. At the outset one criticism of Herzberg has been that his conclusions are based on far too narrow a sample of the working population (Gruneberg, 1979:12; Latham, 2007:9).

According to Locke (1976:1310; Spector, 1997:98-99) Herzberg's view of man's nature reveals a profound and unwarranted mind-body dichotomy. Herzberg argues that man has a "dual nature" with each part operating according to the opposite principles and unrelated to the other, that is, "to use one's brains is a need system of itself, divorced from any connection with, or dependence on, the basic biological stresses" (Herzberg, 1968:51). In fact man's mind has a great deal to do with his physical needs. "It is by means of his mind that he discovers the nature of his physical as well as his psychological needs and how to satisfy them" (Locke, 1976:1310;Spector,1997:99). The reason that he needs to use his mind productively is ultimately a biological one, that is, his mind is his means of survival (Locke, 1976:1310; Spector, 1997:99-100).

Herzberg has also been criticised for what he thought was a unidirectional operation of needs. It has been argued that there is little justification for the view that either psychological or physical needs cause affect only in one direction. The tension - reduction view of motivation has been thoroughly discredited even for animals. Furthermore such acts as eating and drinking in man involve much more than simply the avoidance of hunger or thirst pangs, for example, the pleasure of taste itself is involved (Locke, 1976:1310-1311; Spector, 1997:99-100).

Herzberg's critics have further pointed to the lack of parallel between man's needs and the motivator and hygiene factors. Herzberg's attempt to draw a parallel between man's animal or physical needs and the hygiene factors on the one hand, and his growth needs and motivators on the other, does not hold up under close scrutiny. For example, hygiene factors such as managerial decisions and supervisory actions may have direct consequences for the individual's interest in his or her work, his or her success, advancement and responsibility. Herzberg himself found that the two main second-level factors causing job dissatisfaction were unfairness and lack of growth, both of which have more to do with psychological than with physical needs. On the other hand, motivator factors may involve physical as well as psychological needs. For instance, a person may dislike his or her work because it is too physically demanding or dangerous or dirty (Peiperl, Arthur & Anand, 2002:56-59).

The incident classification system used by Herzberg has been another target of battering. There are numerous logical inconsistencies in Herzberg's incident classification system. For example, if an employee reports that the work is too easy or too hard, it is classified in the "work itself" category, but if there is too much or too little work, it is classified as "working conditions". Similarly, if the worker is praised or criticised for his or her work, it is classified as "recognition", but if credit is given or

withheld, it is classified as "supervision or interpersonal". Further, if the employee reports being given new responsibility, it is classified as "responsibility, but if the supervisor will not delegate responsibility, it is called "supervision or technical", and if the company does not allow him enough responsibility, it is called "company policy" (Peiperl, Arthur, Goffee & Morris, 2000:316-318).

It has also been observed that these inconsistencies are caused or made possible by the fundamental confusion in Herzberg's classification system. This confusion is between the event or condition that causes the employee to feel satisfied or dissatisfied and the agent that could be a person, institution or thing, which caused this event or condition to come about. Herzberg's system includes a random mixture of both, with all of motivator factors turning out to be events or conditions such as work, achievement, advancement, responsibility and recognition, while the major hygiene factors are agents, for example, company, supervisor and co-workers. Frequency comparisons between event and agent categories are meaningless, since they involve different levels of analysis. Every event logically implies at least one agent, and every agent implies at least one event or condition brought about by that agent (Herriot, 1992:2-12).

Another charge levelled against Herzberg is centred around the fact that it has been observed that his results might be an artifact of defensiveness on the part of the employees. Thus, to avoid any threat to their self-image they took credit for the satisfying events that occurred while blaming others for dissatisfying occurrences. Defensiveness is such a well known phenomenon that some serious attempt to answer this criticism is clearly needed. Herzberg (1968:62; Rowan, 2007:53) made an attempt to answer it but his answer only consisted solely of logical fallacies, that is, question-begging and diverting the issue (Herriot, 1992:167-168).

Herzberg's use of frequency data attracted further questions. Herzberg's results were based entirely on frequency data. He compared the relative frequency with which the various categories were mentioned as sources of affect. If one is to infer a theory of human nature from such data, one assumption that must be made is that the responses are caused mainly by the attributes of the persons answering, that is, their needs and values. However, as Herzberg himself acknowledged, the reports of satisfying and dissatisfying incidents gathered with this method were also determined by the actual nature of the jobs held by the employees (Mowday, Steers & Porter, 1979:224-247). Thus, while one reason that failure is not mentioned as a source of dissatisfaction may be that it does not cause displeasure when it occurs, another reason may be that it simply does not occur very often since most people are fairly well matched to their jobs and thus are able to perform them successfully. One way to avoid such difficulties in interpretation is to use an intensity approach, that is, to ask employees to think of a time when they succeeded, failed, were recognised and were criticised, and to have them indicate the degree to which the event affected their attitude toward their job (Nord, 1993:557-578).

Herzberg is criticised for consistently having minimised or denied the existence of individual differences among employees as to the reported sources of satisfaction and dissatisfaction. While it is defensible to argue that all persons have the same needs, by the very nature of needs, it is not defensible to argue that all persons have the same needs, by the very nature of needs, it is not defensible to argue that they all have the same values. Yet it is the individual's values that are the most direct

determinants of his or her emotional reasons to the job. It has been argued that all employees do not value jobs which allow them the opportunity for psychological growth. Similarly, it has been acknowledged that all workers do not respond positively to job enrichment programmes (Reardon, Lenz, Sampson & Peterson, 2000:221-223).

Herzberg tried to answer this criticism however by arguing that employees who do not value or attempt to attain psychological growth in their work will not attain the same quality or quantity or duration of satisfaction from their work as those who do value and seek it. The reason is that these workers' values conflict with their needs. Although Herzberg has a point and one would tend to agree with him, the whole issue however suggests the need for further research to test the hypothesis systematically. But one problem involved in testing Herzberg's theory is that the theory itself has not been consistently stated by Herzberg (Locke, 1976:134; Spector, 1997:76).

It is undoubtedly true that much of the controversy surrounding Herzberg's theory arises because of Herzberg's own ambiguity in interpreting the results. For example, he states that "when the factors involved in the job dissatisfaction events are coded, an entirely different set of factors evolved. These factors were similar to the satisfiers in their undimensional effect. This time however, they served only to bring about job dissatisfaction and were rarely involved in events that led to positive job attitudes. Even a look at the term "rarely" in this context is highly suspect. "Salary", for example, extends considerably into "satisfiers" and "recognition" extends measurably into "dissatisfiers" (Gruneberg, 1979:13-14; Latham, 2007:9-11).

Further, reviews of the work undertaken on Herzberg's theory, confirm the ambiguous way in which Herzberg states his theoretical position. Five possible interpretations of the theory have been observed. For example, the "strong" theory views motivators as contributing only to satisfaction and hygienes only to dissatisfaction. The "weak" theory states that motivators contribute more to satisfaction than do hygienes and *vice versa* for dissatisfaction (Locke, 1979:14).

In fact Herzberg does indicate that he allows for the possibility that some individuals do gain satisfaction from hygiene factors. Those individuals are regarded by Herzberg as being unfortunates who "have not reached the stage of personality development at which self-actualising needs are active". From this point of view they are fixated at a less mature level of personal adjustment. Again "a hygiene seeker is not merely a victim of circumstances, but is motivated in the direction of temporary satisfaction" (Neumann, 1992:165-176).

Two comments are in order at this point. Firstly, even in Herzberg's own work, hygiene factors are sometimes reported as leading actual satisfaction. The general statement therefore that only motivators satisfy must be qualified. Secondly, Herzberg equates hygiene-seekers with poor adjustment, but there is ample evidence that poor working conditions can also lead to bad adjustment. Indeed it could well be argued that in the many situations where psychological growth is not possible in the job because it is dull and routine, a search for hygiene factors, such as money is a healthy adjustment. Furthermore, many studies have shown that it is not only the individual but the culture from which the individual comes which determines what he or she will seek from his or her job, and for some groups money

is seen as the most important aspect of the job. To take account of one's social relationship is not normally considered poor adjustment (Arthur & Rousseau, 1996:169-170).

One of the most serious charges is that, Herzberg's theory is method bound, that is, when using his method, the critical incident technique, the results tend to confirm the weak form of his theory at least. Using other methods, however, there have been consistent failures to confirm Herzberg's theory. The main argument against the critical incident technique is that it may induce respondents to blame unsatisfactory events on others, for example, their supervisor, who is a hygiene factor, whilst taking credit themselves for the good things that happen, for instance, claiming responsibility, which is a motivator. Herzberg denies this by arguing that in fact when employees wish to make themselves look good, they do sometimes blame motivators, saying that they have no responsibility and the work is uninteresting. Herzberg's central argument is that the incidence of this kind of response is much less than is the response of dissatisfaction caused by hygiene factors. Actually this argument of Herzberg's can be turned round and used to disprove the "strong" theory of the two-factor model, which claims that only hygiene factors contribute to job dissatisfaction (Stephen & Bailley, 1990:26-32).

Another problem with the critical incident technique is that bad motivators may not occur as critical incidents. Being bored with one's job, for example, is not something that necessarily occurs at a critical point in time but daily. There is often, in other words, no incident which makes the job boring but merely the repetition of hidden aspects of bad motivators which cause dissatisfaction. If this latent artifact cannot be captured by the critical incident technique, then other methods of establishing Herzberg's theory are required. However, attempts to verify Herzberg's theory using other techniques have met with universal failure (Strilaef, 1992:28-31).

Be that as it may, it must be pointed out that Herzberg was well aware of the possibility of methodological criticism of the critical incident technique. His reason for using the technique in the first place nevertheless was the mistrust shown by a large number of the psychologists of job satisfaction questionnaires. Unfortunately the fact that there are problems with other techniques does not necessarily lessen the problems of Herzberg's own technique. An important point concerning Herzberg's theory is that he does not say how the motivators and the hygienes will be weighted together to give an overall assessment of job satisfaction. In essence, he claims only that motivators contribute to job satisfaction, and hygienes to dissatisfaction. An analogy again might be drawn between pleasure and pain. Herzberg's argument is that the kind of things which cause pleasure, such as falling in love, are separate and distinct from the kind of things which cause pain such as breaking one's leg. How a person who has fallen in love and has fractured a leg in the same week would feel if he or she were asked whether or not he or she was happy, cannot be deduced from the theory (Bartol, 1991:55-67).

Thus, it can be argued that studies which have sought to disprove Herzberg's theories by relating motivators and hygiene factors to the overall job satisfaction can be seen to be irrelevant to the argument. Of course, exactly how individuals weigh up what is satisfying and what is dissatisfying in coming to a decision about the overall job satisfaction is a very important issue. Indeed it might be regarded as "the" issue in measuring the degree to which an individual is or is not satisfied with his or

her job. To the extent that Herzberg plays down this problem, his theory is weak in giving an account of the nature of job satisfaction. A second point of major importance in considering Herzberg's theory is the distinction between being "satisfied with" and "deriving satisfaction from "one's job. Herzberg's theory is clearly concerned with the latter, yet questionnaires which ask respondents to rate on a scale from "satisfied" to "dissatisfied" with various aspects of their job, are asking for the former (Gruneberg, 1979:16-17; Latham, 2007:11-13).

To point out that a hygiene factor does not motivate must be regarded as a refutation of the considerable evidence that for some individuals hygiene factors, such as pay, are a source of satisfaction. Even Herzberg's own data indicate this and various other studies such as that of Locke (1976) support the view that certain hygiene factors can contribute to job satisfaction and more importantly certain motivators can contribute to dissatisfaction. Furthermore some studies such as that of Warr (1977:45) would seem to indicate that motivators are more important factors in both job satisfaction and job dissatisfaction than are hygiene factors (Vroom & Deci,1992:102-103).

Whilst few people, therefore, appear to allow that Herzberg has provided evidence which unambiguously supports his theory, there is little doubt that his emphasis on the importance of motivators rather than hygiene factors cs contributing to job satisfaction is justified and has wide acceptance from authorities such as Locke (1976:38-42;Spector,1997:24-36). Furthermore, Herzberg's argument that those who do gain satisfaction from hygiene rather than motivator factors are missing out on life, is readily accepted by researchers, such as Locke (1976:42-44;Spector,1997:33-35) again, who see such individuals as having values which conflict with their needs. But one might argue however, that in reality the present opportunities for psychological growth on the job are so limited and confined to so few people that it is perhaps fortunate that so many seek only hygiene satisfaction from the job (Vroom & Deci,1992:105).

In conclusion, in one respect Herzberg has made a major contribution to the human knowledge and understanding of the nature of job satisfaction. This contribution stems from his stress on the importance of psychological growth as a precondition of job satisfaction and his assertion that such growth comes from the work itself. This has led to many fruitful suggestions concerning how jobs might be redesigned to allow for greater psychological growth. While Herzberg was not the first theorist to posit the existence of such needs, his work has served to focus attention on the importance of psychological growth and its relation to work and has been a major impetus to applied research. On the other hand Herzberg's insistence on the idea of unipolar continua, that is, one pertaining only to dissatisfaction and involving hygienes and the other applying only to satisfaction and involving motivators, seems indefensible both logically and empirically. Furthermore, it has been pointed out that the adherence to this view is really unnecessary from the point of view of emphasising the importance of work in facilitating psychological growth. For example, the experiments on job enrichment conducted by the advocates of Herzberg's theory do not in fact presuppose the validity of the unipolar continuum aspect of Herzberg's theory (Arthur, Hall & Lawrence, 1996:66-70).

Finally, Herzberg's treatment of the supervisory practices as hygiene elements is entirely spurious and ultimately contrary to the implicit assumptions of his theory and

even to some of his own statements made, for example, in Herzberg, Mausner and Snyderman, (2004:135). While Herzberg's official theory makes the supervisor out to be an environmental appendage, who can only cause or not cause dissatisfaction, when the theory is applied to industry, the supervisor is given an important new role, one that is not implied in any of the "Human Relations" theories, that is, the role of a redesigner of the work itself. The supervisor is in effect regarded as an agent whose job is to help increase opportunities for psychological growth. The job of the supervisor in this view is to help his subordinates to gain values, especially task values (Arthur *et al.*, 1996:332-334).

It must not be thought that Herzberg regards the adequate provision of hygiene factors as unimportant. The prevention of pain as it were is as important in its own way as the provision of pleasure. Thus in its own way ensuring adequate hygiene factors is as essential for the well-being at work as providing motivators. Indeed Herzberg argues that it is only when hygiene factors, such as pay are adequate that one can begin to structure a job so that motivators come to play a part in the individual's satisfaction with his or her job (Opsahl & Dunnette, 1994:94-118).

Herzberg's emphasis on the intrinsic aspects of the job is in part a healthy reaction to the "Human Relations" school, which saw human relationships at work as the central area of concern for organisational psychology. Whatever the defects of Herzberg's theory, he must be thanked, for no one will ever again be able to ignore the importance of analysing the characteristics of the work itself in coming to an understanding of job satisfaction (Arthur, Inkson & Pringle,1999:165-177).

Another way of looking at job satisfaction is through three theoretical orientations, namely the need fulfillment theory, the social reference group theory and the two-factor theory which have been bracketed under "process theories" (Stamps & Piedmonte, 1986:18-20).

4.4.2   Process theories

The theories of Maslow and Herzberg have been described as content theories of job satisfaction since they are basically interested in identifying the factors which make for job satisfaction and dissatisfaction. In contrast there are a number of theories called process theories which aim to describe the interaction between variables in their relationship to job satisfaction. Process theorists see job satisfaction as being determined, not only by the nature of the job and its context, but by the needs, values and expectations that individuals have in relation to their job. Process theories no less than Herzberg's theory of job satisfaction thus attack the view that increases in job satisfaction simply arise by giving individuals more of a variable that normally leads to satisfaction, for example, more money (Gruneberg, 1979:18-20; Latham, 2007:12-15). For ease of analysis process theories will be examined individually.

4.4.2.1   Social reference group theory

It is well known to everyone that expectations about one's environment affect how one behaves. One important aspect of expectations is that they give to the individual a frame of reference by which he or she judges the world about him or her. If events in the world do not fit his or her frame of reference, he or she is often unhappy and sometimes changes his or her interpretation of the world in order to accommodate awkward facts. In a job one uses frames of reference when deciding, for example, what a reasonable pay is. One relates what he or she is getting to what others are getting, and if one finds himself or herself getting too little, he or she becomes dissatisfied. This is the central notion of equity theory which argues that one has a concept of what a just reward is for his or her efforts. There is, as it were, a psychological contract between an employer and employee that for a given amount of effort, there should be a given amount of reward. This is established by the individual comparing the efforts and the rewards he or she receives with those of others. Only where the rewards and efforts are seen as reasonable in terms of the rewards of other people is there satisfaction (McCloskey, 1991:239-247).

It is obvious why the social reference group theory is sometimes known as the equity theory. An essential aspect of the equity theory is that the individual compares his or her inputs and outputs from a job with those of others, such as his friends, his work mates and people in his or her industry before deciding whether or not he or she is equitably treated. It has been argued therefore that an appreciation of the groups, that is, a reference group, to whom the individual relates, is of critical importance in understanding job satisfaction (McClelland, 1991:321-333).

Gruneberg (1979:34; Latham, 2007:17) further demonstrates the importance of reference groups by citing an example of the effect of the expectation between college-educated and non-college-educated managers. The former were found to be less satisfied with their pay than the latter. The college-educated managers had higher expectations of pay because of their education and that they related their salary to a different reference group, namely a highly-educated and highly-paid group, compared to those of non-college-educated managers who compared their salaries with other non-college-educated managers and lower-paid individuals (Barker, 1993:159-170).

The social reference group theory arises from the criticisms of the need fulfillment theory. It holds that job satisfaction is a function of or is at least positively related to the characteristics of the job that meet the desires of those groups to which a worker looks for guidance in evaluating his or her own reality. The social reference group theory significantly departs from the need fulfillment theory because it stresses the importance of what other people do in shaping the individual's stated needs. Philosophically, the theory means that persons can only measure their satisfaction when compared to their peer group (Everly & Falcione, 1990:346-348).

It has been argued (Stamps & Piedmonte,1986:22-25) that job satisfaction is determined by the perceived ratio of what a person receives from his or her job relative to what a person puts into his or her job. This ratio which is computed internally is dependent on how a person judges the satisfaction that others in the same or similar job situations are experiencing. Thus, this theory sees satisfaction as

a function of the magnitude of the discrepancy between the real and the expected outcomes. It is like the multiplicative model (see subsection 4.4.2.3.2) except that it adds two notions of how this process works. Firstly, the expected outcomes are determined by comparing one's work and rewards to others doing a similar job. Secondly, it recognises that dissatisfaction may be caused both by over-rewarding and under rewarding. Over-rewarding may lead to feelings of unfair treatment. This theory makes a step forward in trying to state how a worker evaluates his or her situation as satisfying or dissatisfying and also reveals some of the complexities of the notion of job satisfaction (Vroom & Deci, 1992:106-108).

However, for all it is worth the social reference group theory has been accused of leaving many questions unanswered.

4.4.2.2   Criticism of the social reference group theory

A number of questions have been put forward such as: how do individuals choose which reference group to relate to? Why do reference groups have the expectations they do? What constitutes a reference group? It has been observed that clearly individuals differ in the reference group they choose because of their own individual personalities. On the hand it has been suggested that those most influenced by their reference groups are those with a low self-esteem. Those with a high self-esteem can afford to ignore the reference group to a large extent and "do their own thing". At present the argument tenable is that the only certainty is that the reference group theory is at best a partial explanation of how individuals regard the inputs and the rewards of the job as equitable (Ross & Zander, 1990:327-338).

Further questions have been raised, for example, on whether expectations and their relationship to what the job actually gives, have any relevance to understanding job satisfaction. It has been argued that when expectations and reality are different the reaction is not dissatisfaction but surprise. Satisfaction or dissatisfaction will depend upon the value which a person places on his or her reward. Thus, the importance of values rather than expectations has been emphasised. Furthermore, there has been an indication that giving individuals a more realistic idea or rather more realistic expectations of, for example, the institution they join and the role they will be playing, has a positive effect on job satisfaction. It has been reported that ambiguity of role is one factor which causes job dissatisfaction (Henry, 1998:6-10).

Expectations are also likely to affect job satisfaction where they affect self-esteem. For instance, a junior manager who fails to gain the post of managing director of General Electric company, may well be less dissatisfied with his failure than a failure to obtain a junior management job elsewhere. Thus expectations rather than values would determine job satisfaction in this situation. A further important aspect of expectation noted by the equity theory is that certain expectations have intrinsic value for the individual. The expectations that people have about situations are valuable to the individual in giving stability to his or her environment. The act of undermining people's expectations, therefore, can be dissatisfying (Rose, 1993:48-54).

Clearly the problem of expectations in relation to job satisfaction is complex. In some situations, changes in expectations appear to lead to changes in job satisfaction, in others not. It may be that changes in expectations lead only to changes in job satisfaction where there are accompanying shifts in values expected, or it may be that the fulfillment of certain expectations has a value in its own right. What is quite clear is that knowledge of the expectations of individuals in relation to their job is of considerable significance in an understanding of how people behave in their jobs (Rose, 1993:60-64).

Individuals differ in what they value in a job and this, too, is likely to affect the degree to which they are satisfied. For example, a study conducted on the job satisfaction of school teachers, found that male teachers wanted far more from their jobs than their female counterparts. The discrepancy between what men wanted from the job and what they got was related more to the overall job satisfaction than was the discrepancy for women for whom the job was not such an important aspect of life satisfaction. However, each individual clearly differs in what he or she wants from a job, and the aim of need discrepancy theorists is to examine the way such differences operate in relation to job satisfaction. Thus, a number of theorists has argued that it is the degree to which the job fulfils needs that determines job satisfaction (Baird, Post & Mahon, 1990:387-391).

4.4.2.3   Need fulfilment theory

Need fulfilment is a broad theoretical perspective under which several models of job satisfaction can be grouped. Job satisfaction from this stance is a function of or at least is positively related to the degree to which personal needs are met in the work situation. The greater the need the more satisfied the individual will be when it is fulfilled. Likewise the more dissatisfied the person will be if a great need is left unfulfilled. This theory permits a straightforward methodology for measurement. All the researcher will need is to assess how much satisfaction the worker is currently receiving, then identifies whether this is a lower-level need or a higher-level need. There are two sub-types which should be separated within the need fulfilment theory, that is, the discrepancy or the subtractive model and the multiplicative model (Baird *et al.*, 1990:391).

4.4.2.3.1 Discrepancy model

Although this model is sometimes called a theory and is often referred to independently, it may more accurately be termed the subtractive model of the need fulfillment theory. This modifies the ideas represented by need fulfilment by noting that job satisfaction represents the difference between what an individual needs and the extent to which the work environment fulfills these needs. From this job satisfaction is viewed as the difference between the actual amount of outcome, with the latter being some aspect of work, such as pay or autonomy and the desired amount of outcome divided by the desired amount. The assumption is that the more workers want a particular outcome, the more dissatisfied they are with the increasing

discrepancy between the desired and the actual amounts of that outcome. Another suggestion notes that satisfaction is a function of the perceived rather than the actual difference between what one wants and what one perceives the job offers. Other views argue this point noting that satisfaction is the difference between what the workers expect to receive and what they actually get (Stamps & Piedmonte, 1986:2).

Vroom (1995:43-105) has also examined these two forms of need fulfilment. According to him the subtractive model argues that job satisfaction is negatively-related to the degree of discrepancy between what the individual needs and the extent to which the job supplies these needs. The greater the total discrepancy, counting all needs, the less the satisfaction. The greater the congruence the greater the satisfaction. One problem with this theory is that it ignores the importance of a particular need. A view of job satisfaction which does not take into account the relative importance of needs is misleading. Some needs are more important to individuals than others so that a fulfilment of such needs can well be set off, against minor failures to fulfil lesser important needs. On the other hand, a failure to fulfil important needs may well not be set off by satisfaction with a whole host of minor needs. Since individual differences affect the importance of needs and need fulfilment on the job, it would appear that the subtractive model is at best only a partial answer (Gruneberg, 1979:25-26; Latham, 2007:17-19).

The discrepancy or subtractive model is further unable to distinguish adequately between the various nuances of job satisfaction. It does not consider the value placed on these expectations. Thus, although the discrepancy theory takes account of these expectations it does not attempt to weight them differentially (Stamps & Piedmonte, 1986:2).

In view of the shortcomings of the subtractive model outlined above, Vroom (1995:43-105), therefore, argues for a second model.

4.4.2.3.2 Multiplicative model

An alternative to the discrepancy model is the multiplicative model, which is a variation on the need fulfilment theory developed by Vroom (1995:126-130). This hypothesises that an individual's job satisfaction is a product of the relative importance or weightings of various work-related and personal needs. Therefore, the degree to which the current job fulfills those needs is a measurement of satisfaction and the sum of these products is a measure of the level of job satisfaction. This approach makes the important modification that job satisfaction cannot be taken as a totally separate factor from personal contributors to satisfaction. Although this model assigns weights for components of job satisfaction, it neglects the perceptions of satisfaction of other workers in similar situations. The importance of this comparison with peer groups becomes clear in the social reference group theory (Gross & Brown, 1995:73-92).

According to Vroom (1995:43-105) in this form of need fulfillment theory, need importance is taken into account by multiplying the perceived amount of need fulfillment offered by the job, by the importance to the individual of that need. The

products for each need are then added together to give a total measure of job satisfaction. Suppose, for example, that a person receives 5 units of achievement from his or her job and thinks that it has 7 units of importance, then the 5 is multiplied by 7 to give 35 units. All the other need fulfilments on the job are calculated in the same way and are all added together to give a total sum. So if an individual, for the sake of argument, has 80 units, he will be more satisfied with his or her job than someone with 60 units. Vroom found support for this type of model from studies in which only individuals who liked to take part in decision-making were affected in their job satisfaction by whether or not their supervisor was participative (Vroom & Deci, 1992:109-111).

4.4.2.3.3 Criticism of multiplicative and discrepancy models

It has been pointed out that even the multiplicative model of job satisfaction has its problems. It fails to distinguish between how much one wants something or its importance and how much of something one wants. For example, one might want a salary of $12,000 per month, but being realistic might not want it very much. Alternatively, one may wish very much to serve on the university senate, but only for a short period of time. It has been argued that in measuring discrepancy people may be influenced by value, and in measuring value people may be influenced by the discrepancy between what they want and what the job offers. It would, therefore, be highly desirable if the amount of a value wanted and how much a person wants a value could be distinguished (Mass & Jacobs, 1993:50-58).

Although need fulfilment models of job satisfaction have an intuitive appeal, some writers such as Locke (1976) in Slocum *et al.* (1992:338-343) are unhappy with the term "needs" and prefer to argue that it is what people value that is important. After all people often value things which they do not need or which are indeed positively harmful to them, such as drugs. Thus, for most theorists the terms "need" and "value" are used more or less synonymously (Vroom & Deci, 1992:111-112). However these words may assume different meanings over time.

4.4.3 Time changes in job satisfaction

One criticism of the job satisfaction studies is that the latter tend to be static, taking a picture of job satisfaction at one point in time rather than examining how job satisfaction is regarded by some theorists as a constant adaptation to changing situations and changing values. For example, what might constitute a factor of psychological growth, a motivator, at one point in time might merely become a hygiene factor at another point in time. The new bride might be regarded as a motivator who stimulates the young man in a positive way. After fifteen years of marriage the positive stimulation may be lacking, but the stability, care and love provided give pleasurable feelings of security, so that threats to the relationship still have unhappy consequences. In other words, the wife has become a hygiene factor. Similarly a job might involve a number of factors, some of which start out as exciting but soon become a matter of routine. The university teacher or lecturer initially

enjoys reading essays. After a few years however rarely does it fill him or her with pleasurable anticipation (Drucker, 1980:37-46).

In a study of four occupational groups, namely, administrative, professional, clerical and maintenance workers, Gruneberg (1979:25-27) examined the dynamics of job changes overtime in three distinct areas, that is, institutional policies such as pay and working conditions, the interpersonal context of the job and the job itself. The first two groups of workers had career structures while the last two had none.

The major finding of the research was of considerable differences between jobs in their reported satisfaction with different aspects over time. The administrators, for example, displayed a sharp increase in satisfaction with company and policy decision after ten years, a pattern which was absent in other groups. Not only does this indicate that changes in job satisfaction do not necessarily occur only shortly after joining an institution, but can take place a considerable time after. It also indicates the dangers in generalising from one group to another. However, it has been pointed out that the finding of increased satisfaction with company policy after a period of ten years is perhaps not surprising as administrators will be increasingly involved in these company policies as time goes on. It may also well be, as Katz (1994:131-146) pointed out, that the administrators were only fulfilling their institutional behavioural requirements. Three basic types of behaviour are essential for a functioning institution. The first one is that people must be induced to enter and remain within the system. Secondly, they must carry out their role assignments in a dependable fashion. Lastly, there must be innovative and spontaneous activity in achieving institutional objectives which go beyond the role specifications (Katz, 1994:131-146).

Barnard (1938) and Simon (1947) quoted in Vroom (1992:200-208) have provided a language for the identification and analysis of conditions under which an institution can induce persons to participate in its activities. The inducements-contributions theory as it is called, views each member or participant in the institution as receiving inducements for his or her participation. In the case of employees such inducements may include, for instance, pay, recognition and prestige. The employee's contributions to the institution encompass the opportunity cost to him or her with respect to the participating effort. Therefore, the individual's decision to participate in the system is determined by the relative magnitude of inducements and contributions when both are measured in terms of the participant's values and motives.

As far as other job properties are concerned, the administrators' satisfaction with interaction falls after a year or so, getting back to its initial level only after about twenty years. Perhaps this too is not surprising since administrators have to make decisions which affect other people's lives and often lead to interpersonal conflict. The actual job itself grows rapidly in terms of satisfaction for the first year or two, then stays at this higher level. Presumably getting to know and mastering the job leads to a higher level of satisfaction. Generally, however, the actual overall level of satisfaction falls below that of satisfaction with the job itself, indicating possibly the importance of context or hygiene factors in the assessment of the overall job satisfaction of administrators (Gruneberg, 1979:27-28; Latham, 2007:19-21).

As with administrators professional employees show long-term changes in the levels of job satisfaction. In particular there appears to be a decrease in satisfaction with the job itself after a period of above fifteen years, accompanied by a sharp drop in the overall satisfaction which recovers after about twenty years. Satisfaction with interaction with employees after decreasing for the first two years steadily increases over time, whilst satisfaction with company policies after decreasing increases after about ten years. The overall satisfaction of professionals appears a little better after twenty-five years than after two. This is contrary to the pattern for clerical and maintenance workers which is characterised by a constant climb in the overall job satisfaction with time, despite the fact that the occupations have no career stages (Gruneberg, 1979:28; Latham, 2007:22).

The puzzling aspect of these findings is that the overall job satisfaction is consistently higher than is satisfaction with any of the components, for example, satisfaction with job itself, interaction with others, or institutional policies. These start at a lower level and then decline further after about fifteen years in the case of the clerical workers. Such findings, if they really do reflect the actual situation, tend to suggest an increasing adjustment to the work situation despite the perceived difficulties with the job, for clerical workers (Gruneberg, 1979:28-29; Latham, 2007:22-23).

Whilst the study reported above involved a survey of some 4,400 individuals, it must be stressed that the findings are of limited value, as they surveyed individuals at different stages of tenure in occupations at one point in time, rather than examining the individual's progress in his or her career at different points in time. The study is, therefore, at best a guideline of very limited scope, but nevertheless in pointing out the possibilities of important findings using a longitudinal approach, it is undoubtedly important. The basic assumptions about job design and career structure may at best be inadequate and at worst wrong. How people's job satisfaction interacts with their personality development and life and family situation over time is unknown yet it is likely to be of crucial importance. How jobs which start off interesting, with motivators become routine, how their interest can be sustained and who is likely to benefit in the long term from job design changes, are all problems in urgent need of examination. Without an understanding of this dimension of job satisfaction, theories of job satisfaction are incomplete (Kashka, 1997:29).

The efficacy of the theories of job satisfaction remains a nebulous area. But agreeably some theories are rated higher than others, although none of them is beyond reproach.

4.4.4   Comparative insights into theories of job satisfaction

Most investigators agree that the two strongest theoretical approaches to the understanding of job satisfaction lie in the subtractive or the discrepancy model of the need fulfilment theory and the social reference group theory. The social reference group theory is obviously, important in that it includes the perceptions of one's peer group. The subtractive model of the need fulfilment theory emphasises the importance of differing values or weights people place on the components of their work. Herzberg's theory represents the complexity of measuring levels of job

satisfaction. One factor may be a satisfier for one person and not for another. The difference may in fact rest partly on the importance an individual places on the rewards given to a peer group (Stamps & Piedmonte, 1986:3-5).

The theories provide a direction for most of the current research and practical application. They provide useful information about the expressed needs and concerns of workers. All share some important weaknesses, however. As classic theories they do not reflect the most recent developments that have arisen in considering worker alienation and the redesign of the workplace. It should also be noted that all these theories contain a certain ideological perspective that should be recognized. Attempts at measuring job satisfaction primarily reflect productivity concerns. The larger problem of the degradation of work in the workers' failure to adjust to the system in which they work is the emphasis. This is a sort of "blame the victim" orientation toward job satisfaction (Stamps & Piedmonte, 1986:3-5).

Nord (1993:557-578) has further criticised the job satisfaction paradigm built on these theories for its failure to recognize the hierarchical power system in which most work in most societies, particularly in developed countries, is rooted. This criticism is most important in considering the application of this theoretical approach to the various health agencies and institutions, especially hospitals. An understanding of institutional factors that influence job satisfaction is not always recognized in any of these theories. As a result these theories are all based upon a theoretical assumption about the expression of human needs and job satisfaction's relation to them. There are at least seven models or theories of human needs ranging from Darwin's instincts and drives to Maslow's comprehensive theory that individuals strive to become all they are capable of becoming. Maslow's highest level of the human need drive that is self-actualisation, exists in and of itself and cannot be linked to the primary drives for food, shelter and safety. Self-actualisation as the pinnacle of needs, presumes people's basic dissatisfaction in the sense that after one need is satisfied, another emerges (Baird *et al.*, 1990:384-385).

Therefore dissatisfaction is a motivator of behaviour, but satisfaction is not. Human needs are also arranged in a hierarchy from the lowest physiological needs up to the safety needs, such as love and esteem and the self-actualisation needs. This hierarchy attempts to understand, not only what needs are, but also the process by which they become important. It is largely Maslow's research that has amplified the conflict between work as a means of production versus a means for self-actualisation. This conflict remains a major current issue (Baird *et al.*, 1990:407-412).

Definitive theories of job satisfaction have been elusive because the complexity of determining what makes workers happy or unhappy. The early studies concentrated upon the individuals' physiological needs while the behavioural outcomes were given insufficient attention. Those studies that focused on productivity were the exception. Most of these attempts to link job satisfaction with productivity were neither consistent nor conclusive. Brayfield and Crockett (1991:396-424), for example, show no relationship between satisfaction and job performance in their review of the literature. Vroom and Deci (1992:191-203), analysing the data from twenty studies, found only a modest correlation between job satisfaction and performance. The recent studies are much less likely even to include productivity measures. In fact they are far more likely to view satisfaction as the outcome of rewards rather than as

a concept that precedes or causes some kind of effort. A stronger relationship is found between dissatisfaction and absenteeism, turnover rate and accidents, all of which are more likely to be included in the recent studies as behavioural outcomes. Both absenteeism and turnover rate reduce institutional effectiveness and although both are related to satisfaction, the direction and the nature of the relationship is not always clear (Misener, Haddock, Gleaton & Abu Ajamieh, 1996:87-90).

It is now thought that the wrong questions have been raised regarding the issue of job satisfaction. It has been suggested that frustration not dissatisfaction, causes lower levels of performance. The conditions under which negative behaviours occur may depend upon both personal and group characteristics. Much of the current research has examined the role of the institutional factors in determining satisfaction. This emphasis represents a significant shift. However, this research is not anymore conclusive than the earlier lines of investigation. Bartol (1991:55-67) conducted research to determine if the individual or the institutional factors were more predictive of job satisfaction and turnover than other variables among professionals. She found that individual factors were more important among professionals than institutional variables, in predicting satisfaction with the work itself, but individual variables often played a larger role in satisfaction with the contextual aspects of the job. Institutional factors seemed to be significant predictors of turnover (Bartol, 1991:67-68).

Baker and Hanson (1992:79-91) noted that the small changes in job designs that are so often implemented were not sufficient to affect worker satisfaction and that matching employees' work orientation with the nature of their jobs would improve worker satisfaction more. They noted that modest differences in the structure of jobs were not systematically related to job satisfaction.

The review of literature confirms that occupational sociologists have raised many issues but have resolved few of them. As might be expected, when people in the health field, for example, started examining job satisfaction, they turned to these academic studies for guidance. As a result the same factors have been studied in the health field, that is, moving from the earlier studies of psychological variables and productivity to the later studies of absenteeism and turnover rates. Most recently a few studies have even included institutional variables. The most commonly studied group has been the nurses, which is not surprising, since nurses are the most numerous group within the health field. However, this selection is also indicative of the many professional status conflicts that occur both within nursing and between the nursing profession and other direct medical care providers. It is interesting to note that the theoretical framework most often used is the one that is most controversial, that is, the Herzberg's two-factor theory (Stamps & Piedmonte, 1986:4-5).

However, it has been pointed out that each theoretical approach to job satisfaction has its utility but is marred at the same time by its weak and strong points which bedevil the efforts to arrive at a single unifying theory.

4.4.5　Critical summation of theories of job satisfaction

There are basically two classes of theory of job satisfaction. Firstly, there are those theories which attempt to give an account of what needs, values or expectations are important to individuals in determining their degree of job satisfaction. These are the content theories. Secondly, the process theories are those which in general terms try to give an account of how the individual's needs, values and expectations interact with the job to provide job satisfaction and dissatisfaction (Gruneberg, 1979:30; Latham, 2007:18).

An analysis of the content theories of Maslow and Herzberg reveals many major methodological and conceptual problems. No real evidence exists to support the Maslow theory although it might have an intuitive appeal. Herzberg's theory which postulates that the causes of satisfaction and dissatisfaction are separate and distinct can be related to Maslow's needs hierarchy theory. Thus, those factors which cause dissatisfaction when not satisfied are the lower-level needs of Maslow's hierarchy. Those factors which cause satisfaction when satisfied involve the higher-order needs. Again as with Maslow the major problem with Herzberg's theory is that the evidence, apart from that obtained by means of the critical incident technique, does not support the theory. The critical incident technique is clearly suspect and studies using other techniques strongly support the view that motivators are important both in satisfaction and dissatisfaction. The evidence on dissatisfaction is perhaps not so clear-cut, although here too, it does appear that some individuals derive satisfaction from hygiene factors such as pay, whether it is "good" for them or not (Gruneberg, 1979:30; Latham, 2007:18).

Whatever the merits or otherwise of Herzberg's theory, it is undoubtedly of great historical importance in shifting the emphasis of interest in job satisfaction away from the "human relations" school's concern with human contacts at work, to the importance of the job itself as crucial to an understanding of job satisfaction. Herzberg has been a prime instigator of the movement to redesign jobs in order to allow individuals to have possibilities of psychological growth (Pruijt, 1997:37-42).

One of the major criticisms of Herzberg, however, is that he plays down the importance of individual differences in coming to an understanding of job satisfaction. It is here that the process theories of job satisfaction have an important contribution to make. They claim that it is interaction between the individual's expectations, needs and values, and what the job offers which gives rise to satisfaction and dissatisfaction. Merely looking at the job itself, therefore, in terms of opportunities for psychological growth, without looking at the individual who is to fill the job and who will vary in terms of the values he or she wishes fulfilled in the job, is a mistake (Collin & Young, 2000:64-65).

Exactly how the individual interacts with the job is, however, the subject of dispute. Some theorists argue that it is the matching of an individual's expectations to what the job offers which determines job satisfaction. Whilst this kind of theory has support when the job does not come up to expectations, it does not seem to be supported when the job exceeds expectations. Equity theory which is an extension of this kind of theorising, argues that job satisfaction arises when the individual

compares what he or she puts into the job and what he or she gets out of it (Argyris, 1990:42-56).

How the individual comes to compare himself or herself with others is the concern of the reference group theorists. They point to the importance of peer groups in determining what the individual regards as reasonable to expect from his or her job in terms of reward and what is reasonable to give in terms of effort. Yet as has been pointed out, the reference group theory is as yet unable to specify why some individuals choose one reference group whereas other apparently similar individuals choose another. Personality factors must, therefore, be an important aspect of understanding the kind of rewards and efforts that an individual seeks and expects on a job. Again, as Locke (1976) points out the expectations that individuals have do not necessarily determine job satisfaction (Vroom & Deci, 1992:108-110).

Process theorists such as Vroom have tried to account for job satisfaction in terms of matching individual needs to what the job provides. Two models are considered, that is, the subtractive and the multiplicative, but both have their limitations. As far as the subtractive model is concerned, it fails to take account of the importance of different needs. As far as the multiplicative model is concerned, it fails to distinguish how much a need is wanted and how much of the need is wanted. Finally in considering any theory of job satisfaction, the changing values and adaptations that individuals make over time must be taken into account. Job satisfaction research has largely given a picture of job satisfaction as something static, but it has been shown that job satisfaction involves a dynamic interaction between the individual and his or her environment (Treiman, 1991:69-73).

Whatever the differences and limitations of using one approach, it seems clear that job satisfaction involves the matching of the individual's needs, values and expectations to what the job offers. In such a complex field as job behaviour, it is likely that no single theory accounts for all the phenomena all the time. Sometimes expectations and sometimes values will be the main focus of interest. At other times examining the individual's personality and examining his or her cultural background will be the most fruitful approach. But certainly at present it has to be unhappily admitted that the field of job satisfaction is far from a generally acceptable overall theory (Locke, 1996:7-17).

4.4.6 Selected sources of job satisfaction isolated from empirical results

Mueller and McCloskey (1990:113-117) have pointed out that there was a lack of a universally acceptable theory of job satisfaction in nursing. As a result of very little standardization either in methodology, questions asked, or the theoretical framework used, there has been a "copious opinion but meager research on what satisfies and dissatisfies nurses" (Stamps & Piedmonte, 1986:6). Despite this, factors differentiating satisfied and dissatisfied nurses have been found to include interest in their work, their relationships with superiors and family and broader social relationships, as well as rewards and incentives (McCloskey,1991:239). The latter were divided into three groupings, that is, firstly, the psychological needs including educational opportunities; job responsibility; recognition of work; career advancement

and participation and research. The second group in order of importance comprised the safety awards that encompassed salary, vacation time, schedule concerns and insurance programmes. The third grouping was the social rewards and incentives including relationships with co-workers and supervisors (McCloskey, 1991:239-247).

This section analyses examples of McCloskey's (1991:239) job satisfaction factors identified from the results of the empirical investigation done for this thesis.

4.4.6.1 Decision-making in the nursing arena as source of job satisfaction

The Hawthorne studies acknowledged that the basic difficulty facing workers was in their work situation (Gellerman, 1963:31; Baldoni, 2005:23). In the Botswana study of public health nurses, participation in decision-making and control, choice, discretion and the ability to change the organisation of work were the first group of variables to be examined in the context of job satisfaction. A distinction has been made between participation which is immediate and which involves one's own immediate work group and distant participation which involves participation in wider company policies. It has been noted that there is correlation evidence to support the view that the degree of immediate perceived participation is related to employee satisfaction (Gruneberg, 1979:75-76; Latham, 2007:52). The Botswana nurses expressed job satisfaction in their being able to decide on which type of nursing they preferred to practise (see chapter 6: table 6). This was a practical example of immediate perceived participation in decision-making. Although the majority of nurses chose medical and surgical nursing the preferences were fairly spread across nursing fields. The freedom of choice was intended not only to enable nurses to enjoy their job but also to provide a future avenue of specialisation. This further ensured that when nurses experienced problems in their branches of nursing, boredom would not be one of them. As discerned from chapter 6 (table 7) some nurses elected not to answer the question related to nursing choice but those who did were in the majority. Nurses were, therefore, satisfied with their ability to choose the type of nursing they wished to follow.

An even higher rate of job satisfaction was shown in the manner in which nurses managed their nursing tasks (see chapter 6: table 9). Judging from this evident satisfaction it appears that the Botswana public health nurses contributed a significant amount of initiative and discretion into the way they targeted their nursing goals (see chapter 6: table 8). The job satisfaction displayed in the nurses' input into the way they worked and the exercise of initiative and discretion in the execution of their duties were reinforced by the liberty they enjoyed in organising their duties (see chapter 6: table 10). One of the advantages of choice, initiative or discretion and autonomy in the conduct of one's job, is a major aspect of job satisfaction (Gruneberg, 1979:47-48; Latham, 2007:37). However, it has been debated that it is quite conceivable for a person to be very involved in his or her job and yet be very frustrated because it is not going well in other aspects. Thus, it is possible that the greater the job involvement the greater will be either job satisfaction or job dissatisfaction. Therefore, job involvement by no means guarantees job satisfaction (Gruneberg, 1979:48-49; Latham, 2007:35-36).

Autonomy which has been defined as the amount work-related independence, initiative and freedom, either permitted or required in daily work activities, generates more job involvement and hence more job satisfaction (Stamps & Piedmonte, 1986:17). According to Gruneberg (1979:45; Latham, 2007:32) this applies in particular to people with higher order needs who are known to require a greater amount of autonomy. It has been argued that the degree to which one has freedom to make decisions about one's job does depend on the amount of skill which one can apply. It will be recalled that the Botswana study was based on post-qualification nurses with a minimum of two years working experience. The responsibility for making decisions concerning their job was therefore a prerequisite of applying a skill. It is reasonably assumed that only a job which allows the individual to apply a skill can be expected to allow possibilities of growth in self-esteem due to a successful completion of the task. Arguably if the skill aspect is removed then any successful performance is someone else's success (Osipow, 1993:57-59).

In spite of the experienced skill levels and autonomy in their work schedules, the public health nurses in Botswana were overwhelmed by their job. They worked under pressure, which was a source of job dissatisfaction for the majority of them (see chapter 6: table 11). Most of the stress originated from the work itself (see chapter 6: table 12). It is known that the majority of nurses were dissatisfied with the staff shortages on their wards, units or health facilities (see chapter 6: table 23). But whether or not there were other factors in the organisation or execution of nurses' duties, that augmented the pressure from the workload resulting from shortages of staff, was beyond the scope of the investigation. Having discounted the unknown variables, a strong relationship has been found between task variety and autonomy which has suggested that both factors enhance the meaningfulness or satisfaction of a job. In another way it might indeed well be that increasing job variety without increasing autonomy could lead to increased job dissatisfaction. It has also been pointed out that increased job variety reduces the individual's chance of escaping or slipping from the job into activities such as day dreaming (Paul & Robertson, 1990:68-75). However, since the parameters of the present investigation were limited to establishing whether nurses experienced pressure in their work and where the latter came from, it was not easy to discover the interface between work pressure, autonomy, workload and other factors such as initiative and discretion.

4.4.6.2   Interpersonal roles and relationships as sources of job satisfaction

In their study of registered nurses, Weisman *et al.* (1990:350-364) found that autonomy was one of the strongest predictors of job satisfaction although this needed to be conceived in the context of team work with other nurses. These "social aspects of the job" refer to all "on the job" contacts made by the worker with other workers especially those at the same or nearly the same level within the institution (Herzberg *et al.*, 2004:52-67). The complexity of the relationship between social motivation and work becomes apparent when one attempts to specify the kinds of social outcomes which provide satisfaction. Clearly it is not social interaction in any general sense that is satisfying to a given person but specific kinds of socially derived outcomes such as having influence over other people, being liked by other people and being cared for by other people (Herzberg *et al.*, 2004:56-67). The interpersonal

relationships between different nursing strata in the Botswana public health nurses' study provided a sound basis for job satisfaction. More than half of the nurses reported that both the senior and the junior nurses mixed well with one another at work (see chapter 6: table 20). When it came to whether nursing supervisors related well with junior nurses the responses of the majority of nurses were equally divided between "yes" and "sometimes" (see chapter 6 : table 19). But there was no doubt that the public health nurses enjoyed intrinsic job satisfaction from their work (see chapter 6: table 13). This was fostered by the fact that the majority of junior nurses themselves liked one another which promoted team spirit and acted as a catalyst for job satisfaction (see chapter 6: table 18).

However, the yawning gulf between the subjective amount of work done and the level of pay created a great source of job dissatisfaction. A high percentage of nurses was not happy with pay (see chapter 6: table 14). Almost the same number of high responses was recorded for the nurses who complained that the level of remuneration was not related to the amount of work done (see chapter 6: table 15). Contrary to the findings of the Botswana study, in respect of pay, Elton Mayo's work in the Western Electric Company emphasised worker relations, not pay, as a source job satisfaction and productivity (Gellerman, 1963:22-31; Baldoni, 2005:24). According to Maslow's hierarchy of needs, pay is only one of the basic needs to be satisfied before a person can attain higher personal growth (Maslow, 1970: 380-384). Herzberg's theory also regarded pay as one of the hygiene factors, not a motivator, which when absent could cause job dissatisfaction (Morse & Weiss, 1992:16). All these theories underplay the role of pay as a job satisfier yet among the public health services nurses in Botswana this factor alone occupied one of the highest prominences in their minds.

Under the shadow of such high degree of job dissatisfaction with pay, it was obvious that the nurses were desirous of pay awards. The highest number of nurses pitched their requests for pay hikes of up to 43%. This high percentage of pay increase was hypothetically calculated to consummate the extent to which the nurses were flexible in exercising independence, choice, autonomy and participation in decision-making in their jobs. Vroom and Deci (1992:33) have pointed out that if a person shows qualities of independence and is not particularly awed, threatened or frightened by people who wield positions of authority, he or she is likely to have a say in decision affecting his or her job. The job satisfaction derived from participation in decision-making by the public health services nurses was a response to a participative type of nursing leadership. The latter did not only give latitude to nurses to show authority over decisions concerning their job but also nurtured good working relationships with them (see chapter 6: tables 27, 28 and 29). The same nursing management, however, was criticised by a majority of nurses for delayed promotions (see chapter 6: table 22) which were a cause of job dissatisfaction. But as Gellerman has pointed out, there is no supervisory panacea which can bring out the best in all workers or solve every employee's problem under all conditions (Gellerman, 1963:46-47; Baldoni, 2005:33).

4.4.6.3 Working conditions as sources of job satisfaction

Some of the nurses' job dissatisfactions were part of a broad group of Herzberg's hygiene factors which he referred to as working conditions. There are far too many aspects of working conditions to make any thorough summary possible (Herzberg *et al.*, 2004:69-74). Some of the relevant working conditions in the Botswana public health services which adversely affected the nurses include the relocation system, provision of nurses' accommodation, transport, children's facilities and social amenities. The majority of nurses were not satisfied with both the whole package of working conditions as well as with individual variables such as pay, shortage of staff and the lack of opportunity for further nursing education (see chapter 6 : tables 21, 22 and 23). The discrepancy theory argues that job satisfaction is representative of the difference between what a person needs and the degree to which the work environment affords these desires (Vroom, 1995:44-47). As a consequence of the job dissatisfaction expressed by the Botswana public health services nurses against working conditions, it is not unexpected that the majority of them thought either actively or sometimes of leaving their jobs (see chapter 6: table 24). However it was noted that most of the nurses had an untapped reservoir of job satisfaction to sustain them in the public health services if terms and conditions were improved (see chapter 6: table 26). The alternative to this would be too ghastly to contemplate for the Botswana Government as more than half of the nurses would not remain in the public health services until retiral age (see chapter 6: table 25).

It has been stated that the majority of the nurses were subjected to an occupational stress which defied supervisory interventions (see chapter 6: tables 11 and 12). One of the factors integral to the nurses' working conditions that could be used as a rallying point is the nursing supervisors. In the same way that nurses desire a cooperative co-existence with the other members of a multidisciplinary team such as the medical doctors, they also yearn for the same thing from their supervisors (Stamps & Piedmonte, 1986:18). As Herzberg discovered, supervisory practices or supervisor-nurse interactional relationships are an important source of job satisfaction (Herzberg *et al.*, 2004:68-72). Since the majority of nurses were satisfied with their nursing leadership (see chapter 6: table 27) but were dissatisfied with how the supervisors handled their promotions (see chapter 6: table 22), it could be argued that if the latter improved on their supervisory defects this could muster or enhance support of most of the nurses. Such an effort would reduce some of the negative signals such as intention to leave nursing, on the part of the nurses in the public health services (see chapter 6: table 25).

Autonomy was one of the strongest job areas over which the public health services nurses expressed satisfaction with their supervisors (see chapter 6: tables 7, 8, 9 and 10). Traditionally autonomy in the field of nursing has been viewed from the perspective of the relationship between nurse supervisor and junior nurse. It has been pointed out that the leadership of nurse supervisors contributed greatly to nurses' job satisfaction (Tasto & Colligan, 1993:77-79). According to Likert (1961:97), if a worker is not directed on matters falling within his or her bailiwick he or she is likely to become ego-involved in his or her work. Judging from the positive response of the public services nurses, the Botswana nursing supervisors for their part provided a particular kind of leadership that was not only interested in its nurses but was also supportive and non-intrusive. It was not an instrumental leadership that

was devoted primarily to getting things done. An extension of this view is that an institution's investment in its employees is not adequately protected if the employees are all well-paid but poorly led (Likert, 1961:97-104).

The Botswana public health services nurses were, therefore, fortunate in having democratic nursing supervisors who took their views into account. However the nurses' job satisfaction with supervisory practices was jettisoned by deficits in the institutional requirements. The latter are the main source of satisfaction or dissatisfaction, as all the functional activities that are applicable to supervisors and employees point towards the institution as a whole (Wandelt, 1980:62-70). The institution can determine the nature of the individual's work tasks; his or her workload; his or her degree of responsibility; his or her promotional opportunities; his or her rate of pay and the physical conditions of work. In fact the institution has more ultimate control over these factors and many more than the employee's immediate supervisor (Locke, 1979:1327-1328; Spector, 1997:111).

4.4.6.4 Communication system as source of job satisfaction

The nurses in the Botswana study worked under a poor institutional environment such as the communication system (see chapter 6: tables 30 and 31). The communication system referred to written modalities of expression originating from the matron's office as well as from higher offices such as the Ministry of Health. Only 25% and 11.3% of the nurses thought that communication was good in the workplace and from higher authorities, respectively (see chapter 6: tables 30 and 31). The level of job dissatisfaction in respect of institutional communication was therefore significant. The effects of inadequate communication permeated the supervisory structures to affect the nurses' task requirements. For example, there were still some unacceptable levels of nursing job aspects such as interacting with patients which nurses could not give as much time as they would have wished to (see chapter 6 : tables 32 and 33). However these areas of job dissatisfaction were mediated by the majority of nurses who stated that they were satisfied with the fact that they could still learn from their present posts (see chapter 6: table 34). This was the case despite their dissatisfaction arising from the little opportunity provided by their employers to learn from attending seminars and workshops (see chapter 6: table 35).

Task requirements are those things that must be done as a regular part of the job such as bed making and sluicing which change with time as nursing technology changes (Stamps & Piedmonte, 1986:17-18). Studies of task requirements have been found to be inconclusive in general largely because a few of them take the time discriminate among the various levels of nursing. Of all the components of job satisfaction this differentiation is probably the most important in task requirements (Locke, 1976:1310; Spector, 1997:99). Herzberg (1968:56-57) contended that work content is only crucial in the determination of job satisfaction but not dissatisfaction. But according to Wandelt (1980:62-64) the fact remains that task requirements are important segments of the presence or absence of job satisfaction among nurses.

Task requirements underpin rewards and it is the latter in the form of praise and acknowledgement for one's achievement that leads to psychological growth and job

satisfaction. For many individuals achievement sooner or later requires external validation or recognition if it is to be sustained. For instance, Locke (1979:38-45; Spector, 1997:27-35) maintains that virtually all employees value being praised for their good job performance. He found recognition to be one of the single most frequently mentioned job satisfiers and the fourth frequently mentioned job dissatisfiers especially among blue-collar workers (Locke, 1979:1324; Spector, 1997:115).

The starting point for the Botswana public health services nurses' recognition of achievement was information collated on an appraisal form. Only an insignificant 4.1% of the nurses rated the appraisal system in their workplace as good (see chapter 6: table 36). Even the number of those nurses who measured their recognition by means of inward self-appraisal accounted for only 24.6% of the nurses (see chapter 6: table 37). The majority of nurses (34%) further confirmed that they almost never received recognition for their nursing accomplishments (see chapter 6: table 38). The nurses' dissatisfaction with nursing management was made further apparent by the 44% majority of nurses who thought that they would be better off in private nursing than in the public health services (see chapter 6: table 39). Moreover compared to other non-nursing workers with similar educational levels, the majority of the Botswana nurses in the public health services regarded themselves as worse off. Perceived low levels of pay for the 38% majority of nurses were therefore a potent source of job dissatisfaction (see chapter 6: table 40). In summary the most salient sources of job dissatisfaction stated by the majority of the Botswana public health services nurses hovered around pay, working conditions in general, certain aspects of the working conditions such as risk pay, staffing levels, fringe benefits such as housing and opportunity to attend workshops and seminars as part of personal professional development (see chapter 6: table 42).

4.4.6.5   Recognition as an adjunctive factor of job satisfaction

If job dissatisfaction forms one aspect of task requirements, the other side is occupied by job satisfaction of which recognition is an additive and inherent element. It is known that another function of recognition for one's good work performance is that it provides feedback concerning one's competence. Thus praise as part of verbal recognition indicates that one has done a job correctly according to the standards of one's superiors, while criticism shows that one has not met his or her standards (Locke, 1979:1323-1324; Spector, 1997:114). The desire for recognition is typically attributed to the need for self-esteem or a positive self-concept. However this view takes for granted the validity of the theory that genuine self-esteem comes from the approval of others. Nevertheless it is clear that many people do in fact attempt to gain self-esteem by gaining the approval of significant others (Locke, 1979:1324-1325). As expected there are individual differences in the value placed upon the effect of recognition or its absence on people (McClelland, 1994:102-110). For example, individuals with low self-esteem have been found to be most dependent on recognition and most emotionally affected by it positively or negatively (McClelland, 1994:110). Furthermore there is evidence that females are more sensitive than males to the interpersonal job factors of this type, although the ultimate causes are probably cultural rather than biological (Herzberg, 2004:35-58). The Botswana study did not show gender differences in this respect. According to Locke

(1979:1324-1325; Spector, 1997:116) one of the elements of recognition that has not received sufficient emphasis is the desire for justice. Another is the desire for knowledge which in turn helps one to become more efficacious in one's job and attract promotion.

Promotion has been shown to be part of recognition (Locke, 1979:1323-1326; Spector, 1997:116-118). In the Botswana study, over half of the sample of public health services nurses interviewed expressed job dissatisfaction with promotions. They vowed that the latter took too long to come. They also further challenged the criteria on which they were based. For instance, junior nurses holding degree qualifications were favoured over non-graduate senior nurses with many years of practical experience in the field such as midwifery (see chapter 6: table 22). Although this finding was based on a limited population of nurses and cannot be generalised, it tends to fit in well with the general job dissatisfaction with rewards and inducements which affected the majority of nurses.

However, Gruneberg (1979:36-37; Latham, 2007:27) has warned that promotion is fraught with problems. Firstly, there is the difficulty of making an objective assessment of an individual's worth. This is notoriously difficult, for example, in situations in which a supervisor must make a subjective report on a subordinate. Obvious difficulties involved in interpersonal relationship may colour judgements. Even the so-called objective procedures have their problems (Gruneberg, 1979:37-38; Latham, 2007:27). The Botswana public health services nurses' Appraisal Form did not contain details of work activities or functions for each branch of nursing, such as surgical, medical and psychiatric. It outlined general aspects of work applicable to all civil servants, for instance, punctuality and the speed with which a work activity was carried out. The problem was the weight placed on such a limited number of activities, many of the latter did not apply to nursing functions. Thus, when promotion was considered based on data contained in the Appraisal Form, certain aspects relevant to nursing such as quality of care and patient satisfaction were relatively ignored.

Secondly, a problem with promotion concerns the suggestion of the inadequacy of those not promoted (Gruneberg, 1979:38-39; Latham, 2007:28). It is probable, for example, that in the Botswana study nurses' complaints about the weight given to graduate nurses or to punctuality or interpersonal relationships in promotion procedures, were merely symptomatic of a basic dissatisfaction with a system in which some people were rewarded and others not, when the difference in ability between them was difficult to determine (Gruneberg, 1979:38; Latham, 2007:27-28). In fact, the weight accorded to a limited number of nursing factors in the Appraisal Form, if used as information for promotion or the lack of it, may be detrimental to furthering professional nursing interests. Gruneberg (1979:38-39; Latham,2007:27-28) has suggested that to promote some individuals and not others in such a situation is to imply that the promoted individuals are somehow "better" than the non-promoted persons in indeterminate ways. Otherwise the latter would have been promoted.

It is common knowledge that of course as far as the individual is concerned, promotion involves more than the recognition of achievement. It can also involve increases in financial rewards and status. In this situation, however, salary cannot be regarded purely as a hygiene factor (Likert, 1967:42-47). It too, is intuitively related to

status and recognition. The more one is financially rewarded the greater is the recognition for services in an institution (McClelland, 1980:60-65). Money can act as an incentive because it affects the respect in which the individual is held by others. It is little wonder therefore that a financial reward can sometimes be measured as a satisfier in job satisfaction (Gruneberg, 1979:39; Latham, 2007:27). Satisfaction with promotion can be viewed in the same way as satisfaction with pay. It is a function of the frequency of promotion and its importance in relation to what the individual desires (Gruneberg, 1979:39-42; Latham, 2007:33).

The equity concept provides some content for this model although employees do not agree on what constitutes equity. As Locke (1979:1323; Spector,1997:115) argues, public institutions are more likely than private ones to stress, for example, seniority, that is, the number of years on the job or in an institution, as a basis for promotion. Thus while equity is one factor that influences a person's value standard concerning the desired number of promotions, it is not the only factor. It is easily conceivable that an employee could appraise the promotion system in his or her institution as fair and yet still be dissatisfied with his or her chances for promotion because there were none, depending on his or her personal ambitions and career aspirations (Locke, 1979:1325-1326; Spector, 1997:116-117).

Alternatively an individual might view the promotion system in his or her institution as unfair and still be personally satisfied with it, because he or she does not desire to be promoted (Locke, 1979:1322-1323; Spector, 1997:114). Since promotion ordinarily entails an increase in responsibility and work difficulty, an individual who does not feel up to such a challenge, for instance, one who has a low self-esteem or who is at the limit of his or her ability, will not desire to be promoted or will at least be in conflict with the prospect. Promotions which require moving, for example, the Botswana Government transfer policy which involves moving with or without promotion, may also be unattractive to some employees (Locke, 1979:1324; Spector, 1997:115). The majority of nurses in the Botswana study disliked the government's transfer system (see chapter 6: table 46). The roots of the desire for promotion would include the need for psychological growth made possible by the greater responsibility; the desire for justice if one has earned the promotion; the desire for higher earnings and desire for social status for those who base self-image on what others think of them (Locke, 1979:1324-1325; Spector, 1997:115-116).

It has been pointed out that not everyone desires promotion to the same degree. However, it has also been argued that one would expect that self-esteem and self-confidence would affect the desire for promotion at all occupational levels, although this issue has not been frequently researched (Locke, 1979:1325-1327; Spector, 1997:118). What is known better, however, is that role occupants may remain in the same role throughout their institutional membership or they may be "promoted" to a role involving greater wages, power and status. The opportunities for promotion afforded to institution members are highly variable and are often assumed to have a marked effect on job satisfaction (Vroom, 1995:152-153).

Institutional membership is nourished and sustained not only by conducive supervisory ethos and promotional opportunities, but also by the membership itself comprising workers and the way they relate to one another on the job which have consequences for the satisfaction they derive from work (Vroom, 1995:153-154). In the matter of interpersonal relationships nurses in the Botswana study were satisfied

(see chapter 6: tables 15-20). The public health services nurses also showed job satisfaction in the intra-institutional transfers (see chapter 6: tables 43-45) from one department to another, which facilitated their learning, especially in the hospital settings. However the infamous government transfer policy caused job dissatisfaction for most nurses (see chapter 6: table 46). As Locke (1979:1325-1327; Spector, 1997:118) pointed out most employees value a location close to home. The basic principles underlying the employee's preference for a permanent locality are the desire for working conditions which facilitate or do not block the attainment of his or her work goals (Locke, 1979:1327; Spector, 1997:118). The Botswana public health services nurses complained that their family ties were disrupted or broken and other relationships such as friendship were also dislocated as a result of the transfers.

Nurses on a transfer notice had to leave their permanent homes to go to areas which were less developed and with fewer social facilities and amenities such as shops, accommodation and schools for their children. Both Herzberg (1993:56-60) and Whyte (1955:70-80) have pointed out that complaints about physical working conditions sometimes cause deeper frustrations such as anxiety, personal problems and distrust of management, which are related to other work-related factors such as occupational stress, which soon disappear when these problems are resolved. Herzberg (2004:50-57) further argued that women tend to consider working conditions to be more important than men. The same is also true of working hours. The majority of the Botswana public health services nurses who endured the transfer separations were women by virtue of the greater number of women than men in nursing.

4.5   SUMMARY AND CONCLUSIONS

Work or job are two words that are used synonymously and however they are defined, they form an integral part of satisfaction in the world of work. Thus job satisfaction presents itself as two phenomena telescoped or intussuscepted into one. As a field of study the phenomenon of job satisfaction has concerned researchers for two main reasons. Firstly, it can be viewed as an end in itself since happiness after all is the goal of life. Secondly, it can be studied because it contributes to other attitudes and outcomes. While there is evidence that job satisfaction does have effects research findings must be interpreted with great caution.

Since one's job is part of one's life it is logical, to expect job satisfaction to influence life satisfaction. Writers such as Kornhauser have found significant correlations between attitudes toward the job and those toward life. An individual's job attitudes can also affect his or her view of himself or herself. Herzberg, for example, found that satisfying job experiences such as achievement and recognition often increased the individual's self-confidence. One would expect an equal and opposite effect as a result of dissatisfying experiences, although Herzberg did not find this.

The experience of dissatisfaction itself is an unpleasant psychological state. Furthermore the existence of this state implies conflict since it means that the employee is holding a job that he or she would prefer to avoid, at least in some respects. This suggests the possibility of a relationship between satisfaction and mental health. The most systematic study of the relationship between job

satisfaction and mental health was conducted by Kornhauser. He developed an index of mental health from six component indices involving anxiety and tension, self-esteem, hostility, sociability, life satisfaction and personal morale as opposed to despair and anomie. Kornhauser found consistent relationships between satisfaction and the total mental health index.

The view that job satisfaction was one of the causal factors in job behaviour, especially the level of performance or output was an outgrowth of the Hawthorne studies. This is ironic in the sense that firstly, previous work had indicated that there was no necessary relationship between satisfaction and productivity, and secondly, the Hawthorne findings themselves proved no such relationship. On the first point, longitudinal laboratory studies by Thorndike and others had both shown that performance could remain constant or even improve while the individual's feelings of fatigue or dissatisfaction were increasing. On the second point what the Hawthorne researchers actually found was that when certain changes were made in the work, such as incentive system, type and degree of supervision, both performance and morale improved. In no case did they show that satisfaction as such led to higher output. Nevertheless one school of thought believes that feelings of satisfaction have their roots in emotions.

It has been argued by authors such as Locke that emotions are the form in which one experiences value judgements, the causal sequence being: an object situation leads to perception or cognition, which causes appraisal value judgement and is finally followed by emotion. If the individual appraises the perceived object as furthering his or her experience or well-being, by the standard of his or her values, he or she will experience a positive emotion. Locke has argued that emotions involve, as part of the experience of emotion itself, action tendencies, that is, felt urges to action. The two basic urges were asserted to be approach and avoidance of the valued or disvalued object or situation. Such action tendencies, however, do not necessarily lead to overt-action. There are numerous action alternatives open to a person in the face of an emotion.

Thus in order to know how an individual will act in response to an emotion, one would have to know which action alternative(s) he or she will select. This will be affected by such factors as his or her values, beliefs and methods of thinking, the constraints and opportunities offered or presented by the situation and the specific object which is perceived as beneficial or harmful to the individual.

Since the basic tendencies following job satisfaction and dissatisfaction are approach and avoidance, the most obvious behavioural prediction would be a relation between job dissatisfaction and such actions as absences, termination and lateness. While reported correlations between amount of satisfaction and absenteeism or turnover have been consistent and significant, they have not been especially high, being usually less than 0.40. The reason is that most employees do not act solely on the basis of their feelings.

In summary job satisfaction itself or in combination with the conditions both in the individual and in the job environment which bring it about, has a variety of consequences for the individual. It can affect his or her attitude toward life, toward his or her family and toward himself or herself. Thus, it can in total affect an individual's physical or psychological health. It may be related indirectly to mental

health and adjustment and plays a causal role in absenteeism and turnover. Under certain conditions it may affect other types of on-the-job behaviour as well such as stress. However, the relationship between job satisfaction and productivity has been found to be tenuous.

Nevertheless some investigators of institutional behaviour have doubted the value of the concept of job satisfaction. For example, Deci considered that the current emphasis on job satisfaction is leading to confusion, whilst writers such as Argyris saw the concept as limited in usefulness because so many different factors can be responsible for job satisfaction. Given the many contradictory findings in the field and the lack of a generally accepted theory of job satisfaction the reader can be forgiven for agreeing with critics that the field of job satisfaction is vague, contradictory and perhaps for the most part common sense.

Such a pessimistic view, however, is not fully justified. For example, one can consider the argument that findings on job satisfaction are no more than "common sense". One must distinguish between a common sense explanation and a reasonable explanation. Explanations given after the event are invariably seen as reasonable. It is reasonable to account for the fact that there is no relationship between job satisfaction and productivity, for example, by pointing out that people often derive satisfaction in work from aspects of the job that have little to do with productivity such as from social interactions. Notwithstanding this, if people are asked what they think is the likely relationship between satisfaction and productivity, before they examine the actual relationship, the great majority will hypothesise that the greater the satisfaction the greater is the productivity. The "common sense" approach is clearly at variance with what actually happens.

Of course it is true that a number of studies in the field of job satisfaction are unsatisfactory in design and interpretation. It must be remembered, however, that one is dealing with complex human behaviour in social, institutional and technological situations which vary subtly from study to study. One study is not likely therefore to give an answer to any particular problem. Where contradictory results do emerge such as in the field of sex differences, then further research has often thrown light on why such inconsistencies are occurring.

As a consequence of the various contexts in which job satisfaction has been studied, it has not shown any consistent linearity in its historical background. Since the industrial revolution, Karl Marx criticised the unstructured nature of work which caused misery, meaninglessness and lack of fulfillment in the lives of many workers. His critique was an indirect attack on the absence of a coherent approach to the study of job satisfaction. But in spite of his observation few writers were willing to adhere to any of the prevailing historical schools of thought on job satisfaction. When Frederick Taylor's research in the early twentieth century linked job satisfaction to a variety of both individual and social organisational factors, this marked the beginning of a more concerted and meaningful effort towards the study of job satisfaction.

Subsequent authors such as Happock, however, instead of pursuing a more practical approach towards the level of satisfaction at work, relegated their concern to the academic domain. It was not until more than half way into the twentieth century that the study of job satisfaction was revived, this time dominated by two main groups of

theories. Firstly, content theories focus on the particular needs and values that must be satisfied for an individual to be happy with his or her job. The two dominant theorists in this group are Herzberg and Maslow. Secondly, process theories describe the relationship between job satisfaction and its environment, as well as the needs, values and the expectations that people have in relation to job satisfaction.

However, all these theories cannot be regarded as static as they have to adapt to the changing values and expectations that form part of mainstream societal changes. A case in point is that of the Botswana study of public health services nurses in which pay was found to be both a job motivator and a job satisfier. Earlier studies such as that of Herzberg had not treated monetary rewards as central to job satisfaction. The Botswana study further demonstrated another aspect of time changes in job satisfaction in respect of autonomy. The public health services nurses made their own decisions regarding how they organised their duties. This level of decision-making was in contrast to Taylor's era of carrot and stick in superior-subordinate job relationships. However, the questions of what makes some workers happy and others not still rages on. But definitive theories of job satisfaction have been formulated, although they are elusive because of the difficulty of determining what goes on in each worker's mind and what attitude he or she is likely to have towards his or her job let alone towards himself or herself.

It has been noted that an individual's attitude can have an effect on his or her view of himself or herself. This is one of the most unresearched subjects in the area of job attitudes in which various job experiences and conditions affect performance. The following chapter explores attitudes and nurses' perception of certain aspects of their profession.

CHAPTER 5

ATTITUDES AND PRACTICAL NURSING EXAMPLES

5.1   INTRODUCTION

At a superficial level attitudes need little introduction because everyone has them. Most people are able to articulate their attitudes towards other individuals, towards events and towards ideas and institutions, which make up their social world. People, for instance, hold attitudes towards the welfare state, towards smoking, homosexuals and pornography.   Thus, according to Jonas, Eagly and Stroebe (1995:59-70) holding an attitude may help a person to fulfill different kinds of psychological needs thereby forming the basis of the complex inter-relationship between attitudes and behaviour.

Attitudes, beliefs and values share several common attributes. Principally they are all psychological constructs, that is, they cannot be observed directly by another individual, but must be inferred from the individual's introspective reports and to a lesser degree from observations of his or her behaviour. Each set of constructs involves the individual's orientation to the external world, which is often the social world, even though the constructs themselves are internally based, and to some extent self-oriented. Their common rendezvous is their effects on behaviour (Hogg & Vaughan, 1995:40-52).

Beliefs are assumptions about the probability that an object exists and that it possesses certain characteristics or that it is related to other objects in certain ways. The most important role of beliefs is to serve as guides for action or as signposts indicating which lines of behaviour are possible and which would be improbable if not impossible.   It is common knowledge that virtually every move that an individual makes depends to a large extent on his or her beliefs about aspects of the world that he or she cannot immediately perceive. For example, "I believe in God" or "there is no God". Beliefs are therefore largely cognitive in the sense that they are concerned with knowledge or what the individual considers or assumes to be knowledge. This is opposed to being affective or being concerned with emotion or being conative, that is, involving will or behavioural intentions. In the terminology of learning theorists, beliefs possess cue properties which help to guide the individual toward his or her goals rather than motivational properties which urge him or her to seek a particular goal.   However, the pure cognitive form of beliefs is considered rare.   Moreover people often confuse themselves and others about what they really believe because of the human tendency to express desires as beliefs (Abelson, 1982:45-47).

Whereas a person's beliefs indicate what he or she thinks is true or at least what is probably true, his or her values show what he or she desires to be true. This entails a movement from Plato's cognitive faculty to the affective domain, or in other words from knowledge to emotion or from cue properties to motivational properties. When Thomas and Znaniecki (1927:27-32) introduced the term "value" into the social-scientific literature they defined values as "the objective cultural elements of social life" in contrast to attitudes which they saw as "the subjective characteristics of the

members of the social group". That is, they conceived a value as an object with some social meaning, for example, food desired by members of a culture. This use of the term "value" to refer to objects external to the individual was also employed by Ehrlich (1969:29-34).

In practical terms belief, value and attitude are useful categories for differentiating certain aspects of human psychological functioning. But they have no independent existence outside human thought and feeling. The human brain does not work as a precision production tool in their manufacture. In real life situations beliefs are often heavily influenced by values which in turn are dependent in part on beliefs about what is at least possible, and attitudes are directly dependent upon both beliefs and values. It is not surprising then that the demarcation lines between these variables become hazy at some points of interface and disappear altogether at others. However, the three categories should be used only when they can facilitate the understanding of human psychological processes, but should not bar the way to comprehending such phenomena when they become more complex than a tripartite categorisation can handle (Keisler, Nisbett & Zanna, 1969: 321-327).

It is clear therefore that in addition to an individual's criteria for judging the worth of things, that is, values and his or her assumptions about the state of things, that is beliefs, he or she will also have positive and negative feelings about many, though not all, of the things in whose existence he or she believes. These positive and negative feelings about the objects in his or her psychological world are his or her attitudes (Allport, 1935:37). Many writers such as Heider (1946:107-112) have argued that people come to hold positive attitudes toward anything that helps them to attain their goals, and negative attitudes toward whatever blocks goal attainment. In the final analysis an attitude may be seen as a blend of belief and value, that is, a feeling about a particular object in terms of its assumed relationship to one's values. In Plato's terminology, attitudes combine cognitive, that is belief, and affective, that is value components (Eiser, 1986:16-18). The plan of the chapter is intended to bring out these two attitudinal milestones in their various dimensions.

Section 5.1 lays the foundation of the chapter by preparing the ground for further development in the subsequent sections of the study. Section 5.2 ekes out the academic forum within which pundits on the topic have analysed and expanded the horizons relevant to the subject. Section 5.3 examines the everyday uses of attitudes and how they manifest themselves through behaviour in everyday life experiences. Section 5.4 provides the theoretical framework within which to analyse the connection between attitudes and behaviour. Subsection 5.4.1 is an extension of this approach which posits that attitudes and behaviour are derived from learning. Sub-subsection 5.4.1.1 and 5.4.1.2 are two offshoots of the learning mode of analysis.

Subsection 5.4.2 and sub subsections 5.4.2.1 and 5.4.2.2 embody other perspectives of conceiving attitudes and behaviour. For instance, an expectancy-value theory believes that people behave in such a way that they show preference to alternatives that yield the most favourable outcomes. The balance theory in sub subsection 5.4.2.1 basically refers to equilibrium between two states of mind over a given matter. In sub subsection 5.4.2.2 cognitive dissonance deals with inconsistencies between beliefs.

Sections 5.5 and 5.6 consider two areas which are thought to affect nurses' attitudes. The image of nursing in section 5.5 critiques the acceptant perceptions of nurses about their marginalised role in nursing. Section 5.6 traces the nurses' lack of empowerment to the traditional pattern of bringing up a female child in a family. This approach to rearing girls is blamed for preparing them to expect or accept as given a lesser place or role in employment than men.

The female gender is singled out because nursing is a female-dominated profession. Section 5.7 samples some areas of nurses' activity that have been studied to show how nurses feel about certain aspects of their job. Subsections 5.7.1 to 5.7.6 denote some practical examples of nurses' attitudes over a limited number of work-related factors. Section 5.8 and its subsections 5.8.1 to 5.8.7 deal with examples of nurses' attitudes over selected aspects of their job, identified in the present study's empirical findings. Section 5.9 brings together the main themes in the contents of the chapter and concludes on the observation noted.

5.2   CONCEPT OF ATTITUDE

Fleming (1967:287-365; Dinaver & Fink, 2003:9-50) traced the usage of the concept of attitude from the art industry in which it was used to describe body position in a painting. Its initial spread throughout the art world included the adoption of the concept for the drama equivalent of body position and calculated pose. In this sense the word implied phoniness symbolic of actors and actresses pretending to be something other than their "real" selves. The word "attitude" first appeared in the English language around the year 1700. Darwin (1872:27-34) introduced "attitude" into the literature of science. Darwin did away with both the pretend and the theatrical aspect of the concept and replaced them with a concept implying a behavioural reality. For Darwin "attitude" now referred to stereotypic motoric responses associated with the expression of an emotion in the sense of the posture of the entire body.

Sherrington (1906:45-51; Bullock & Howe, 1991:7-17) continued the Darwinian concept of "attitude" but viewed it as a continuous state not as an occasional outburst. In other words whereas Darwin viewed the attitude as evidence of being upset, for Sherrington attitudes indicated normal pose. They reflected the stable nature of body position. Quite independently in the German language psychology, a concept very similar to the idea of attitude was developed by proponents of the Wurzburg school of psychology. The term *aufgabe* usually translated "mind-set" rather than "attitude" but implying something quite similar to the word attitude as it is used to-day, was seen in Wurzburg writings. In spite of the translation difference an attempt was made to integrate Sherrington's concept of attitude with the concept of *aufgabe.* This development helped to establish one element of the eventual concept of attitude (Kahle, 1984:2).

A second element of the evolving concept of attitude came from Goldstein's phenomenological critique of Sherrington's thinking. Goldstein criticised Sherrington's attitude concept and its failure to consider imagination, creative thinking and the ability of humans to be concerned with the possibilities of life. He

hinted that the concept of attitude should include what Piaget called formal operational abilities, that is, the idea that formal operational thought should be included in any adequate concept of attitude (Flavell, 1963:28-37; McLeod, 2004:50-67).

The thought of the origin of thought was left unexplained. Geneticists filled the void by suggesting that inherited factors played a role in the evolution of attitudes. For instance, Jung in 1934 (Eiser, 1986: 29) proposed the existence of archetypes, that is, unconscious predispositions toward certain patterns of thought and behaviour upon which conscious attitudes may be based. His evidence, however, was scientifically questionable. Eysenck (1954:42-55; Roid & Fitts, 1991:70-86) on the other hand hypothesised that inherited differences in conditionability lead to a tough-minded or tender-minded personality dimension which in turn predisposes people to adopt certain kinds of political attitudes. But his evidence was also at best indirect. McGuire (1969:136-314) reviewed several other possible ways in which genetic factors could influence attitudes as being very loosely related to genetic influences. For example, a person may be more prone to aggressive attitudes if he or she inherits in some way a lower tolerance threshold for frustration or a higher level of generalised aggressiveness. But it has been argued that such an inheritance or innate acquisition would in no way determine the particular objects toward which the person develops aggressive attitudes (Shavitt, 1990:124-128).

A more probable process of attitude acquisition, however, resembles an evolutionary natural selection, although it occurs through learning and experience during the individual's lifetime rather than as a result of genetic and environmental variation during the history of a species (Triandis, 1971:18-22). As an example, the human infant begins life with a clean attitudinal slate or *tabula rasa* (white sheet of paper on which nothing has so far been written). By the time he or she is old enough to recognise attitudes in himself or herself or to express them to others; he or she will at least have formed tentatively a number of attitudes through the direct conditioning of responses such as repeatedly feeling good after milk delivery in his or her mouth through a nipple (Eagly & Chaiken, 1993:403-412). He or she will also have developed attitudes through conscious experience in meeting his or her needs or gratifying his or her desires, for example, by finding that one kind of behaviour leads to his or her mother giving him or her sweets while other kinds do not. He or she may further acquire attitudes by observational learning, for instance, watching his or her father exchanging money for sweets. Sometimes attitudes can be learned through a primitive form of rational deduction, for example, by reasoning that if small toys are fun, big toys must generate more fun. The child may then begin to act upon the basis of these attitudes or to express them to others (La Pierre, 1934:230-237; Barnes, 2002:207-225).

The tentative or inchoate or incipient attitudes that serve the individual's interests by leading to the achievement of desired goals are likely to be retained while those that do not are likely to be discarded. Those that survive for very long periods may undergo a progressive elaboration and modification. Again those that survive the modifications may lead to psychological or material rewards. Furthermore, the surviving attitudes may also limit or guide the individual's perceptions and behaviours in ways that strengthen the existing attitudes and make the development of new ones less likely. In other words attitudes may, like biological species, modify their environment in self-perpetuating ways. Under normal circumstances however,

attitudes do not restrict the individual's perceptions and interpretations of new information in such a way as to exclude all possibility of change (Baron & Byrne, 1991:30-45).

It was noted that the mutation of attitudes within the social environment was a consequence of the changing or fluid nature of the social world. It was this view that linked affect and cognition in the attitude concept and conveyed the notion that attitudes had implications for behaviour (Warren & Jahoda, 1973:24-25). In the social science classic, Thomas and Znaniecki had elaborated the concept of attitude by asserting that "By attitude we understand a process of individual consciousness which determines real or possible activities of the individual in the social world" (Thomas & Znaniecki, 1927:15-22; Vaisey, 2006:835-864).

The two authors formulated a vision of the attitude concept that more or less persists to-day. But without empirical observation the scientific usefulness of an attitude was questioned. To correct this a number of social scientists hurried to the scene most notable of whom was Thurstone (1928:529; Raven, 2001:625-670) who stated that attitudes could be measured. Henceforth many definitions of attitude became operational rather than strictly conceptual in that they defined an attitude as what attitude scales measured. Even when authors do not overtly identify their concept of attitude as operational one should be wary of conceptual definitions that radically diverge from operational definitions. A further problem is that in some cases what a particular researcher claims to measure and what he or she in fact measures, that is, the operational definition, may not always conform (Kahle, 1984:3).

Osgood, Suci and Tannenbaum (1957:35-40; Doyle & Harris, 1992:45-64) conducted a number of factor analytic studies in which they discovered three components of attitudes, that is, the affective or evaluative dimension, for example, good-bad and like-dislike. The other two dimensions are the activity or behavioural dimension such as active-passive, and the potency dimension, for instance, strong-weak (Osgood *et al.*, 1957:43-67). However, many contemporary writers prefer to define a different third dimension namely a cognitive, knowledge or belief dimension. Most attempts to measure attitudes today directly assess only the affective or evaluative dimension. In other words attitudes are operationally-defined as preferences. For example, Bem's definition simply points out that "attitudes are likes and dislikes" (Bem, 1970:14-15). This is probably a good rough and ready definition. Most researchers assume, however, that the evaluative information provides insight into probable behaviours and into the social knowledge that a person holds (Bem, 1992:14-15).

Contemporary trends in the definition of attitudes also include the drift toward more theoretically based definitions and the drift toward emphasising social cognition (Fiske & Taylor, 1991:39-50). The former trend involves authors who define the attitude concept to fit more clearly a specific theoretical position. For instance, some proponents of self-perception theory have defined attitudes as what can be inferred from behaviours. The other trend has developed from the ascendancy of the cognitive aspect of attitudes. Cognition has become an increasingly important force in contemporary psychology and some writers have implied that it may be the long-desired unifying theoretical force across all of psychology (Kruglanski, 1979:1447-1457).

Many definitions of "attitude" include as a defining component the notion that an attitude is a "predisposition to respond" in a certain way (Kahle, 1984:4), although such conceptual definitions have not always corresponded well with the results of empirical research based on more operational definitions of attitude. The other view is that some writers such as Deutscher (1966:235-254; Berli, 2000:128-132) believe that attitudes hardly ever lead to behavioural responses. Others, for example, Bem (1972:17-26; Zoerink & Lavener, 1991:19-28) cite evidence that in some cases attitudes as predispositions to evaluate are actually predispositions derived from responding rather than predispositions to respond. But if one assumes that a cognition that fails to lead to behaviour is by definition not an attitude then the "predisposition to respond" definition clearly fails to encompass a number of important empirical manifestations of "predispositions to evaluate" (Weisz & Zigler, 1979:831-857). This unresolved debate has led to the suggestion that a more adequate conceptualisation of "attitude" should therefore specify more precisely the functional relationship between attitudes and behaviours. This would be done in such a manner that it would be possible to incorporate the insights of self-perception theory, evidence that sometimes behaviours and attitudes appear not to be related and other more classic views of attitudes (Wicker, 1969:41-78; Dryovage & Seidman, 1992:12-21).

One possible starting point for the framing of a more encompassing conceptualisation of "attitude" would be to recognise that social cognitions such as attitudes are indeed cognitions and that much of the existing theory and research on other types of cognitions may therefore also be applicable to attitudes (Kahle, 1984:4). Thus people use attitudes to help them know about their social worlds. One of the best known theories of cognition that has only recently received much attention in areas of social cognition other than moral development is that of Piaget. In the latter's view a function of cognition is to facilitate the process of adaptation to one's environment. He goes on:

There is adaptation when the organism is transformed by the environment and when this variation results in an increase in the interchanges between the environment and itself which are favourable to preservation (Kahle, 1984:5).

In addition to adaptation, a second function of cognition is abstraction. But it has often been asked how attitudes fit in this view of cognition. Although it has been pointed out that attitudes differ from other cognitions, what many authors have failed to recognise, however, is what attitudes have in common with other cognitions which are not formed as predispositions to evaluate. A primary function of attitudes as of other cognitions is to facilitate the process of adaptation to the environment. Attitudes may then be defined as adaptation abstractions or generalisations about functioning in the environment, especially the social environment, which are expressed as predispositions to evaluate an object, concept or symbol. This abstraction process emerges continuously from the assimilation, accommodation and organisation of environmental information by individuals, in order to promote interchanges between the individual and the environment that from the individual's perspective are favourable to preservation and optimal functioning (Kahle, 1984:5).

A plethora of other definitions has dominated the concept of attitude. For example, Allport defined an attitude as

a mental and neural state of readiness, organised through experience, exerting a directive or dynamic influence upon the individual's response to all objects and situations with which it is related (Allport, 1935:14).

At the same time, Allport referred to the concept of attitude as the most distinctive and indispensable concept in the whole field of social psychology, but he also reminded his students and readers that the nature of the concept was still in dispute and that there was still a considerable degree of confusion surrounding it (Allport, 1935:14-15; Doyle, 2002:25-27).

There were three important aspects that arose from Allport's definition of attitude. Firstly, an attitude is a state of readiness leading the individual to perceive things and people around him or her in certain ways, that is, to be more ready with certain categories and interpretations than with others. Secondly, attitudes are not innate, that is, they are learned, they develop and they are organised through experience. A third aspect of Allport's definition follows from this and that is that attitudes are dynamic. They are not merely latent states of preparedness awaiting the presentation of an appropriate object for their activation. They have motivational qualities and can lead a person to seek or avoid the objects about which they are organised. "An attitude is a product of experience, but it enters into subsequent experience as a directive factor" (Halloran, 1990:14). Halloran points out however that a precise definition of attitude is difficult because the concept overlaps with other kinds of psychological concepts.

According to Reece and Brandt (1984:70) most psychologists define an "attitude" as any belief that has an emotional component. It is a state of mind backed up by feelings. They state that one acquires many attitudes throughout one's life and may stay with a number of them for a long time. Attitudes developed in childhood are usually difficult to change and may persist against all evidence to the contrary. Kagan has pointed out that there are five ways of acquiring attitudes. Firstly, people acquire attitudes by looking and listening during early childhood. Secondly, individuals develop attitudes through the experience of reward and punishment. Thirdly, attitudes can be attained through a process of identification. Fourthly, cultural influence can lead to the development of attitudes. Fifthly, seeking attitude consistency leads to the acquisition of attitudes as one generally experiences considerable anxiety if he or she cannot maintain a consistent set of attitudes (Reece & Brandt, 1994:71-73).

Eiser (1986:19-25) adopts the commonsense approach that people have a rough idea of what attitudes are. To say that people have a certain attitude towards something or someone is a shorthand way of saying that they have feelings or thoughts of like or dislike, approval or disapproval, attraction or repulsion and trust or distrust. Such feelings will tend to be reflected in what they say and do and in how they react to what others say and do. Some of the main assumptions implicit in the use of the term "attitude" are that firstly, attitudes are subjective experiences. Secondly, they are experiences of some issue or object. Thirdly, attitudes are experiences of some issue or object in terms of an evaluative dimension. The fourth and fifth assumptions respectively are that attitudes involve evaluative judgements

and they may be expressed through language. Sixthly, expressions of attitude are in principle intelligible. The seventh and eighth assumptions assert that different individuals can agree and disagree in their attitudes. Lastly, people who hold different attitudes towards an object will differ in what they believe is true or false about that object (Eiser, 1986:11-13).

An attitude is a subjective experience involving an evaluation of something or somebody. That something or somebody is represented within the experience but also has a "public" experience, that is public in the sense that if one expresses his or her attitudes, another person should in principle be able to identify the something or somebody to which one's evaluation refers (Eiser, 1986:13). Attitude statements are distinguished from other kinds of descriptive statements primarily because they imply a value judgement of some kind, not because they describe different kinds of phenomena. This point is of central importance for the conception of attitudes since it suggests a picture of individuals actively perceiving, interpreting and evaluating their external world. It is only because attitudes have a public reference that they can be described as consistent or inconsistent, stable or changeable, normative or deviant and related or unrelated to non-verbal behaviours (Eiser, 1986:13-14).

This picture of the individual as an active perceiver and interpreter of events is fundamental to one of the central concepts of social psychology, that is, the notion of "cognitive consistency". The basic idea is that people are predisposed to organise their attitudes and beliefs into internally consistent structures. Although defined in slightly different ways by later writers, the essential features of this idea are best introduced by considering Heider's theory of cognitive balance. Heider defines balance as "a harmonious state, one in which the entities comprising the situations and the feelings about them fit together without stress" (in Eiser, 1986:14).

Perhaps the major source of conceptual ambiguity concerns the notion of response consistency. At least three types of consistency can be distinguished. Firstly, a person may be observed to consistently perform the same response or set of responses in the presence of a given stimulus object. This stimulus-response consistency may be taken as reflecting an attitude toward the object. A definition of this type, however, fails to distinguish attitude from other concepts such as habit, trait, drive or motive. One can alleviate this problem in part by requiring that each response express some degree of favourableness or unfavourableness toward the object in question (Fishbein & Ajzen, 1975:6; Oskamp & Schultz, 2004:23).

A second interpretation involves the degree of consistency between different responses with respect to the same object. Instead of the requirement that the same responses be made with respect to an object, the requirement in this case is that whatever the responses are that are elicited by the object; they should be consistent with one another. This response-response consistency has also been taken as indicative of an attitude toward the object. Although it is not clear what is meant by consistency in this context, consistency of a person's behaviours must be judged along some dimension. Two behaviours are considered to be consistent if both are located on the same side of the dimension. For example, Tom enjoys fishing and he likes to eat fish. They are inconsistent if they are located on opposite sides (Fishbein & Ajzen, 1975:6-7; Oskamp & Schultz, 2004:22-23).

Like stimulus-response consistency the notion of response-response consistency fails to discriminate between attitude, trait, motive and various other concepts. At this point it is remembered that the proposed definition of attitude which will follow refers to behaviours that are consistently favourable or unfavourable. That is response consistency should be judged with reference to an evaluative or affective dimension. Two or more behaviours are considered consistent in this sense when both are located on either the positive or the negative side of the evaluative dimension. Observed consistencies of this type are taken as evidence for the existence of favourable or unfavourable attitudes (Fishbein & Ajzen, 1975:7; Oskamp & Schultz, 2004:23).

The third type of response consistency is related to multiple behaviours at different points in time. Even in the absence of a stimulus-response or a response-response consistency, a set of behaviours may exhibit evaluative consistency over time. That is, on different occasions a person may perform different behaviours with respect to an object. The overall favourability expressed by these behaviours, however, may remain relatively constant and in this sense they may be defined as consistent (Fishbein & Ajzen, 1975:7; Oskamp & Schultz, 2004:23).

However as pointed out by Keisler *et al.* (1969) "all too often, social psychologists have tried to make their definition of attitude both a conceptual definition and a theory of the concept" (Keisler *et al.*, 1969:321-327). For example, most investigators would probably agree that an attitude can be described as "a learned predisposition to respond in a consistently favourable or unfavourable manner with respect to a given object" (Fishbein & Ajzen, 1975:6; Oskamp & Schultz, 2004:23). Consensus on this description of attitude, however, does not eliminate the existing disagreements among attitude researchers. It merely serves to obscure the disagreements by providing a description with multiple interpretations. A closer examination of the description reveals some of the underlying ambiguity. There are three basic features, that is, the notion that attitude is learned, that it predisposes action and that such actions are consistently favourable or unfavourable toward the object (Fishbein & Ajzen, 1975:6; Oskamp & Schultz, 2004:22).

On a simpler plane, Chapman (1997:3) notes that attitude is the way a person communicates his or her mood to others. When one is optimistic and anticipates successful encounters one transmits a positive attitude and other people usually respond favourably. When one is pessimistic on the other hand and expects the worst, his or her attitude is often negative. Inside one's head where it all starts attitude is a mind-set. It is the way one looks at things mentally. Attitude is never static. It is an on-going, dynamic, sensitive and perceptual process. The changeability of attitudes is reflective of the functions they serve for an individual (Chapman, 1997:3-4).

The common denominator uniting all the diverse theories on attitude is the mental state. From this, various attributes of attitudes such as emotions, feelings, beliefs, thoughts or cognitions, likes or dislikes, trust or distrust, favourable or unfavourable and approval or disapproval are derived. The other important ingredient in the concept of attitude implicit or explicit in these theoretical formations is that an attitude is acquired through learning and experience in a given environmental context. More relevant and preferred in the interests of the present study is Allport's (1935:14-15; Doyle, 2002:19-21) elaborated definition of attitude because of its comprehensive

approach. Firstly, Allport's analysis of attitude begins from the premise of a mental state. Secondly, his theory refers to the perception of things or people in commerce with the environment. Thirdly, he points out that attitudes are not inborn but are learned through life experiences. Fourthly, his theory acknowledges that attitudes change overtime. Fifthly, Allport makes the important point that attitudes have motivational qualities leading or causing a person to behave in certain ways.

5.3 FUNCTIONS OF ATTITUDES AND THEIR CONNECTION TO BEHAVIOUR

Allport (1935:59; Doyle, 2002:70) considered attitude to be the most distinctive and indispensable concept in contemporary American social psychology, being characterised by an embarrassing degree of ambiguity and confusion. This is partly due to its use as an explanatory concept in diverse areas of investigation. For example, under the general rubric of attitude research, attempts to explain discriminatory behaviours have typically made reference to attitudes, stereotype, prejudice and ethnocentrism. Likewise, research on performance, absenteeism and turnover in industry has frequently invoked concepts like attitude, job satisfaction and morale. Finally, as Fishbein and Ajzen (1975:1; Oskamp & Schultz, 2004:15-17) have pointed out, concepts such as attitude, attraction, attribution of dispositions, liking and behavioural intentions have been used to account for a wide variety of interpersonal behaviours. All these concepts, as well as many others, have been assumed under or incorporated within the general label "attitude". This has undoubtedly led to some confusion and ambiguity surrounding the attitude concept and it is hardly surprising that few investigators agree on an explicit definition of attitude. In view of the diversity of attitude definitions and the lack of consensus or justification for one definition as opposed to others, most investigators have intuitively selected a particular measurement procedure that seems to fit the purpose of their study (Stainton, Stainton, Stenner & Gleesen, 1995:32-50).

Smith (1976:50-56) states that any individual's attitudes help him or her to deal with material reality through the object-appraisal function, with social reality through the social-adjustment function and with his or her inner psychological reality through the externalisation function. Since a single attitude may function simultaneously at all three levels or may operate largely at one, Smith emphasises the usefulness of considering all three functions by pointing out the inadequacies of stressing a single attitudinal function. Although Smith's (1976:52-56) functional categories may appear eminently reasonable and indeed they have been incorporated into many psychological discussions of attitudes, they are not the only way of dividing or carving up the attitudinal pie. A categorisation used just as widely is that of Katz (1960:103-204).

Katz (1960:103-204; Kruglanski, 2007:90-170) divides the figurative pie into four parts. Firstly, the adjustment or the instrumental or utilitarian function which is concerned with the utility of attitudes in helping the individual to obtain rewards and to avoid punishment in the outer world. It also refers to development of positive attitudes toward rewarding objects and of negative attitudes toward punitive objects such as affective associations based upon experiences in attaining motive

satisfaction. This function inclines individuals toward interacting more often with those objects which are most likely to continue satisfying them. Therefore in terms of attitudes helping the individual to cope with the real world of reward and punishment, the adjustment function overlaps with a substantial part of Smith's object-appraisal function and with most, if not all, of his social-adjustment function (Terry & Hogg, 2000:43-49).

Secondly, the ego-defensive function refers to the ways in which individuals' attitudes defend their self-image. For example, when people fail to admit to themselves that they have deep feelings of inferiority, they may project those feelings onto some convenient minority group and bolster up their egos by attitudes of superiority toward this underprivileged class of people (Terry & Hogg, 2000:44).

Thirdly, the value-expressive function is one in which the individual derives satisfactions from expressing attitudes appropriate to his or her personal values and to his or her concept of himself or herself. Whereas Katz's first two functions assume only that the individual has a range of outer and inner-oriented needs that attitudes can help satisfy, this functional category considers the existence of one quite specific need that any individual feels for giving positive expression to his or her central values and to the type of person he or she conceives himself or herself to be. For instance, the teenager who by dress and speech establishes his or her identity as similar to his or her own peer group may appear to the outsider a weakling and a craven conformer. Yet to himself or herself he or she is asserting his or her independence of the adult world to which he or she has rendered child-like subservience and conformity all his or her life. However, the existence of a need for self-expression is not accepted by all psychologists, but for some such need is a prominent feature of several theories of personality, including those usually described as ego psychology. For example, the need to establish and to assert an individual identity as described by Erikson (1968:31-50) and humanistic psychology, for instance, the need for self actualisation as described by Maslow (1968:372) are cases in point.

Finally, Katz proposes the knowledge function of attitudes which assumes that each individual has a need to give adequate structure to his or her universe, and that attitudes can help to serve that need. People may not be avid-seekers after knowledge as may be desired by the educator or social reformer. But they do want to understand the events, which impinge directly on their own life. Moreover many of the attitudes they may have already acquired give them a sufficient basis for interpreting much of what they perceive to be important for them. But here again some psychologists would dispute the existence of such a need or would demand more proof of its importance (Fiske & Taylor, 1991:45-56).

The controversy surrounding the functions of attitudes is coextensive with doubts that have permeated the correlation between attitudes and behaviour. For example, Abelson (1982:49-52) wrote a paper querying the necessity of attitudes. The instant response would be that attitudes are obviously necessary to enable individuals to efficiently organise their emotional responses to the material world, identify with or differentiate themselves from other people and cope with their inner psychological problems in addition to playing a major role in the individuals' personality paradigms (Zimbardo & Leippe, 1991:30-50). The importance of attitudes on these grounds is hard to deny, and indeed few people have criticised the attitude concept with regard

to these largely internal functions. Attitudes go beyond organising individuals' internal psychological economy because they also initiate behaviour. Paradoxically, however, the major attack on the attitude concept has come from challenging the existence of a firm relationship between attitudes and behaviour. These attacks were often inspired by La Pierre's (1934:230-237) study on the attitude-behaviour relationship. La Pierre had obtained two kinds of data on the responses of American hotel and restaurant personnel toward a racial minority, that is, private answers to a simple questionnaire, and overt public behaviour toward minority group members. He found substantial discrepancies between these two kinds of data.

La Pierre's study spawned a large number of comparisons between observations of humans behaving in actual social situations and their verbal statements of attitudes. As in La Pierre's investigation, the relationship between behaviour and attitude has often been low in these later studies. Not long after La Pierre's study was published, Corey (1937:271-280) gave college students a carefully prepared questionnaire on attitudes toward cheating. He then compared their stated attitudes with their actual level of cheating on a series of course examinations. The correlation between cheating behaviour and attitudes toward cheating was 0.02, indicating almost no relationship at all. However, Corey later found that a much better predictor of cheating behaviour was the student's temptation to cheat. In other words if a student knew the material poorly he or she was much more likely to cheat than a student who knew the material well, regardless of either student's attitude toward cheating (Corey, 1937:271-280).

Wicker (1969:41-51) summarised a number of empirical studies on attitude-behaviour relationships in which he found conflicting results. His first conclusion on the studies of attitude behaviour relationships he compared in tabular form suggested that it was considerably more likely that attitudes would be unrelated or only slightly related to overt behaviours than that they would be closely related to actions. Yet or on the other hand approximately half the studies listed by Wicker showed at least some attitude-behaviour correlations of more than 0.40 or at least a 40% proportion of subjects whose attitudes and behaviours were in agreement. There was little indication of strong negative correlations between attitudes and behaviour. In view of the large sample studied a correlation of 0.40 was statistically significant, that is, indicative of a *bona fide* (sincere or genuine) relationship between the two variables being correlated (Wicker, 1969:51-78).

One might still wonder why the relationships were not perfect or why about half the studies cited by Wicker showed only weak or non-existent relationships between attitudes and behaviour. Wicker's second conclusion was that the relationships were poor because attitudes in the traditional behaviour-influencing sense may not exist. At the same time a substantial portion of his paper was devoted to summarising factors which can be used to support the traditional position in favour of attitudes. That is, reasons why even though attitudes may influence the individual toward particular kinds of behaviour, they are not expressed in behaviour clearly congruent with the attitudes (Wicker, 1969:190). People who believe in attitudes have accused Wicker of holding an anti-attitudinal attitude. In essence it can be said that Wicker has behaved inconsistently with regard to attitudes (Hogg & Vaughan, 1995:52-57).

Many social scientists such as Corey (1937:271-280) who wrote about attitudes and behaviour hold very different assumptions about the relationship than Wicker did.

They assume that not only do attitudes exist as latent predispositions within each individual, but also that if no other influences were at work, an individual's attitudes would be expressed in appropriate behaviour. The failure of attitudes to account completely for the occurrence of specified behaviours is partly explained in Wicker's discussion. But this failure may be easier to understand and accept without rejecting the usefulness of attitudes completely. Basically researchers have often been disappointed in their search for attitude-behaviour consistencies because firstly, they have used inappropriate measures of attitudes, behaviours or both. Secondly, researchers have held inappropriate expectations about the expression of attitudes in particular behaviours. Finally, researchers have been disappointed in their search for the relationship between attitude and behaviour because they have held inappropriate expectations about the solitary influence of particular attitudes on certain kinds of behaviour (Ajzen, 1988:39-52).

If one wants to study the relationship between attitudes and behaviour, one of the first questions one might ask oneself is whether one is really measuring attitudes on the one hand and behaviour on the other. Behaviours are reasonably easy to identify as behaviours, although the accuracy of most behavioural measures may be questionable at best. But attitudes are not directly observable, and since they can be only assessed through behavioural expressions one may find oneself in serious doubt as to whether he or she is correlating an attitude with a behaviour or one behaviour with another behaviour. For example, the "attitude" measure used by La Pierre (1934:230-237) in a questionnaire asking hotel and restaurant proprietors whether they would be willing to accept members of the Chinese race as customers, reflected nothing about the proprietor's own personal attitudes, and indeed the questionnaire asked nothing about them. In summary therefore if a study provides data on only one concept in a two-concept relational statement, then it should not be counted as evidence for or against the relationship that is asserted. Thus, because only one kind of concept was measured in these studies, that is behaviour, the evidence may have little if any bearing on attitude-behaviour relationships (Ajzen, 1988:54-57).

A number of other questions may be asked in respect of this problem. For instance, one might ask whether one's measure of attitudes and behaviour is at the same level of difficulty. This question involves the level of specificity of attitudes and behaviour. A final question one should ask him or her with regard to the measurement of attitude-behaviour relationships is whether his or her measurement techniques accurately measure what he or she would want them to measure (Ajzen, 1988:55).

The connection between attitude and behaviour is one thing, the learning of attitude-behaviour is another. People often fail to learn behaviours which would appropriately express their attitudes. The large number of social institutions and techniques, which exist chiefly for the purpose of teaching people such behaviours, bears testimony to this. Ehlrich (1969:29-34) has pointed out that "learning how to behave in a manner consistent with one's attitudes is a primary objective of socialisation at all stages of the life cycle". Schools spend a good deal of time improving the general coping abilities of students so that the latter can realize their ambitions and lead a more rewarding life. Books and courses on "social skills" teach young people how to interact effectively with other young people of the opposite sex (Ajzen, 1988:56-59).

Without access to appropriate behaviours, attitudes may exist for long periods without any noticeable behavioural expression. For instance, a thirteen year old schoolboy who took a school shop course in letterpress printing developed a positive attitude toward the art and craft of setting type and printing publications by hand. If he had not gone to university to study psychology instead, he might well have pursued a career in printing. But once involved in another career he had no necessary tools to engage in letter-press printing as a hobby. Had he been given an attitude scale that mentioned printing he would have indicated a very positive attitude toward printing. It was only after some fifteen years that he found information on amateur printing that he began to engage in substantial overt behaviour that expressed his positive attitude toward letterpress printing. Therefore one could detect considerable consistency between his attitude and his behaviour with regard to printing. This sums up the argument that researchers often hold inappropriate expectations about the expression of attitudes in particular behaviours, where such attitudes lack the necessary means or "tools" to galvanize them into the activity of causing or reactivating a particular behaviour (Ajzen, 1991:27-29).

As with a certain type of behaviour it has been argued that if one seeks attitude-behaviour consistency by looking only at one attitude at a time in relation to behaviour toward a particular kind of object, one may also be restricting one's attitude measurement. As Warren and Jahoda (1993:181) observe, a person may have many attitudes relevant to a single real world object, and a focus on just one of those attitudes may lead to a conclusion of attitude-behaviour inconsistency even though behaviour toward the object may be quite consistent with the person's other unmeasured attitudes. When, for example, the hotel desk clerk confronted La Pierre's Chinese friends his response was probably determined not only by the fact that these people were Chinese in particular rather than Chinese in general, but also by his possession of attitudes toward young people, toward neatly dressed individuals, toward people who spoke good English and toward a myriad of other possibilities. These probabilities are sufficient to indicate that a single attitude seldom stands alone in determining behaviour (Ajzen, 1991:29-33).

The social scientists who believe in the importance of attitudes and who write the definitions often seem to assume that their readers will realize for themselves that a single attitude's influence will always be modified or diluted by other attitudes and other non-attitudinal factors. Critics of the attitude concept, however, typically interpret attitude definitions as implying a powerful one-to one relationship of a single attitude to a single response, and then point to all the studies that have found a much more ambiguous relationship. Therefore the attitude-behaviour controversy is generated at least in part by mutual miscomprehension (Ajzen, 1991:34).

Wicker (1969:181-188) mentions several other factors besides additional attitudes that may affect the attitude-behaviour relationship. These are such things as values, competing motives and social norms. Of these the latter have received the greatest attention. In part this is because of the sociologists' theoretical interest in the attitude-behaviour controversy. The emphasis may also involve more than that, however. The practical importance of social norms has been demonstrated in research on public and private expressions of attitude-related behaviour. One such study is that of Minard on coal miners, in which perceptions of the potential difficulties that might arise from a violation of social norms apparently overwhelmed moderately favourable attitudes toward socializing with blacks among some whites. However, measures of

the miners' attitudes were not obtained so that this explanation of their behaviour is somewhat speculative (Wicker, 1969:80-92).

Although Wicker (1969:41-78) mentions only one personality characteristic or activity level that can affect attitude-behaviour consistency there are probably many others. For instance, an extrovert may be more likely to translate any attitude into publicly observable behaviour than an introvert. An authoritarian individual may await commands from above before he or she feels to express his or her own attitude behaviourally. A manic-depressive person may show a cyclical pattern in which he or she expresses an attitude in many different behavioural forms on some days and hardly in any on other days. Alternatively, he or she may be particularly prone to the behavioural expression of his or her optimistic or anxiety-denying attitudes during his or her manic phase, and of his or her pessimistic, anxiety-acknowledging attitudes during the depressive phase (Wicker, 1969:67-79).

In addition to relatively broad personality characteristics, the individual may have acquired specific habit patterns that interfere with the direct behavioural expression of attitudes on some occasions. Habit is defined by Triandis (1971:27-33) as a pattern of learned behaviour with no pronounced emotional component. The typical desk clerk in the La Pierre 1934 study, for instance, probably had developed a set of habits associated with performance of his job, that is, smiling at each potential customer, presenting the hotel register for the customer's signature and calling a bell-boy to carry the guest's luggage. All of a sudden confronted with La Pierre's young Chinese friends, the desk clerk probably would find it much easier to resort to this well-practised set of habits regardless of his own personal attitudes than to devise a new set of behaviours on the spur of the moment (Triandis, 1971:35-42).

Finally, a behavioural expression of attitudes may be limited by environmental constraints. This refers to the actual circumstances of an individual's environment, which may prevent him or her from behaving appropriately. If for instance, the letter-press printing enthusiast finally learns of sources where he or she may purchase printing equipment but discovers that he or she has too little money to buy the essentials, his or her lack of printing behaviour should be chalked up or ascribed to environmental constraints rather than to an inconsistency between attitudes and behaviour (Ajzen, 1991:27-29).

Sample and Warland (1971:292-304) have identified a common characteristic of attitudes which is both expressed in consistent behaviour and held with a relatively high degree of certainty. They measured students' voting behaviour and their attitudes toward candidates in a student government election. The certainty with which they held these attitudes that might influence voting behaviour, for example, friend's voting behaviour and personal acquaintance with candidates was noteworthy. Among students whose attitudinal certainty was low, the relationship between attitudes and voting behaviour was correspondingly greater. But high attitudinal certainty was associated with substantially stronger attitude-behaviour consistency, and under these circumstances the influence of other variables on voting behaviour was inconsistent (Sample & Warland, 1971:304).

It would be easy to conclude from Sample and Warland's results that in all previous studies showing attitude-behaviour discrepancies, the attitudes were simply held with a high degree of uncertainty. But the data available so far do not permit a strong

case to be made for or against that position. However, the certainty variable appears to be more than just another useful addition to the wide array of variables already known to influence the attitude-behaviour relationship. It offers to the interested readers and students at least a tentative way to predict when these other variables are most likely to weaken the link between attitude and behaviour (Ajzen, 1988:58-59).

On the other hand as if to strengthen the connection between attitude and behaviour, the argument that attitudes are poor predictors of behaviour can easily be reversed. Attitudes may remain an important part of the individual's vital inner core although they are reflected only palely and inaccurately by his or her external behaviour. The most powerful attitudes are likely to find a path to expression, though the search may take a longer time than most social scientists are willing to wait. But in many instances behaviours may reveal little of interest about a person's attitudes. The behaviours may instead be revealing the person's perception of social norms, incentives, environmental constraints and other important influences on overt behaviour. If one wants to know about an individual's attitudes and their importance to him or her, one may have to turn away from his or her gross behaviour patterns and simply ask him or her to tell him or her what his or her attitudes are. This would be congruent with the observation that people's behaviours do not closely fit their attitudes (Ajzen, 1988:60-62).

The thoughts of the individual are of primary importance in any understanding of the directions of attitudes. Whether a person accurately perceives the world or not, the perceptions the individual possesses and the relationships among them dictate what attitudes will be manifested (Kahle, 1984:9). Theories of attitudes like theories in other fields of study such as economics are designed to organise the multitude of variables that constitute the many faces of attitudes into a systemic or conceptual whole (Kahle, 1984:10).

5.4 THEORIES OF ATTITUDE

The field of attitudes abounds with numerous theories. Since it would not be necessary or practicable to go through them all, only relevant paradigms will be analysed briefly for the purpose of the study at hand. Most contemporary attitude theories have their origins in two major schools of thought that have shaped theory and research in social psychology. Whereas the various learning theories of attitude are based on the stimulus-response approach of behaviour theory, most theories of cognitive consistency are influenced by the cognitive approach of field theory. A distinction is therefore usually made between behaviour theories of attitude and cognitive consistency theories. This classification into behaviour-versus consistency theories, however, blurs the distinction between a theory's theoretical origin and the phenomena it deals with. For example, Osgood and Tannenbaum's (1957) congruity principle, quoted in (Olson & Zanna, 1993:233-346), is typically viewed as a consistency theory since it deals with attitudinal consistency or congruity, although it originated within the behaviour-theory tradition. For this reason it has been suggested that the distinction between behaviour and consistency theories be de-emphasised in favour of a more unified presentation (Olson & Zanna, 1993:233-346).

5.4.1 Learning theories

Several investigators have used principles taken from the learning theories of Hull (1951:62-70) and Tolman (1948:189-208) to study the acquisition of beliefs and attitudes. Generally speaking these learning theories are concerned with the processes whereby a given response becomes associated with or is conditioned to a given stimulus. Most learning is explained in terms of two basic conditioning paradigms, that is, classical conditioning and operant or instrumental conditioning (Fishbein & Ajzen, 1975:22; Oskamp & Schultz, 2004:29).

5.4.1.1 Classical conditioning

The principles of conditioning involve an unconditioned stimulus (ucs) which elicits automatically without prior learning one or more overt unconditioned responses (ucr). For example, an unexpected loud noise produces a startled response, and a painful stimulus or electric shock leads to various withdrawal responses. The classical conditioning paradigm starts with an unconditioned stimulus that is always followed by some characteristic unconditioned response. When a conditioned stimulus (cs) which does not initially elicit the unconditioned response is consistently paired with the unconditioned stimulus, it ultimately comes to elicit some of the response characteristics previously produced only by the unconditioned stimulus. That is, the conditioned stimulus (cs) by itself now elicits the unconditioned response (ucr). When an initially neutral stimulus, that is, the conditioned stimulus (cs), acquires the ability to elicit a response, that is, the unconditioned response (ucr) originally elicited only in the presence of another stimulus, that is, the conditioned stimulus (ucs), learning is said to have occurred (Fishbein & Ajzen, 1975:22; Oskamp & Schultz, 2004:29).

An example of classical conditioning is a child who always cries, that is, unconditioned response (ucr) or who cries at the sight of a spider, that is, unconditioned stimulus (ucs). Classical conditioning occurs when the child hears the word "spider", that is, conditioned stimulus (cs), being uttered consistently in the presence of the spider. After several such conditioned stimulus-unconditioned stimulus (cs-ucs) pairings the child starts to cry whenever he or she hears the word "spider", even when no spider is actually present. In classical conditioning, then, the response to be learned is initially elicited by the unconditioned stimulus (Fishbein & Ajzen, 1975:23; Oskamp & Schultz, 2004:29).

Classical conditioning theory, which is also known as respondent or Pavlovian conditioning, was introduced by a Russian physiologist Pavlov. The theory holds that repeatedly pairing an eliciting or unconditioned stimulus, which is capable of producing some desired response, with an originally neutral stimulus, which cannot initially produce the desired response, eventually leads to the originally neutral stimulus becoming a conditioned stimulus which is capable of producing the desired response. For example, Pavlov paired a bell, that is, neutral stimulus, with meat powder, that is, unconditioned stimulus, when eliciting saliva from his dogs, that is, desired response. Eventually the bell, now conditioned stimulus, elicited salivation, even in the absence of meat powder (Kahle, 1984:21).

In one of the first applications of learning theory to the attitude area, Leonard Doob (1948) in (Kahle 1984:24) defined attitude as a learned implicit anticipatory response. That is, he viewed attitude as an unobservable response to an object that occurs prior to or in the absence of any overt response. Osgood, May and Miron (1975:67-72) argued that the implicit mediating response represents the "meaning" of the object, and they suggested that attitude refers only to the evaluative part of the total meaning response. Osgood and others' view of attitude as a mediating evaluative response has met with general acceptance by theorists working within the behaviour-theory tradition. For example, Staats and Staats (1957:74-80) have proposed a theory of attitude acquisition and change that applies the principles of classical conditioning to social psychology (Kahle 1984:25).

Most learning theories of attitude are concerned with the ways in which attitudes are acquired, that is, how implicit or evaluative responses become associated with a given stimulus object. For example, the stimulation involved in a child who has frequently eaten M & M candies produces for instance overt responses such as suckling, salivating and swallowing. In addition, an implicit response with a positive evaluative component has occurred prior to or in conjunction with the overt responses. According to the mediational conditioning principle, there will be a tendency for this implicit response to become associated with the candies themselves, that is, the child develops a favourable attitude toward M & M candies. Further, once this association has been learned, any other stimulus frequently paired with the M & M candies will also tend to elicit the positive mediating response. Thus, according to the principle of higher order conditioning, if the M & M's are always dispensed by the child's uncle, a positive attitude toward the uncle should develop (Fishbein & Ajzen, 1975:24-25).

5.4.1.2   Operant conditioning

In contrast to classical conditioning, operant conditioning or trial and error learning involves a situation in which the organism initially emits a variety of different responses. One of these responses is reinforced, that is, the response is instrumental to obtaining some reward or avoiding some punishment. The probability of the recurrence of the reinforced response increases with each reinforced trial, and the response is said to be learned when it occurs with high probability. As an example of instrumental conditioning, a mother gives her child a piece of chocolate every time he or she picks up his or her toys but not when he or she cries, demands chocolate or throws objects at his or her mother. The reinforcer (chocolate) will thus strengthen the response and the child will learn to pick up his or her toys. Factors that have been found to influence instrumental conditioning include frequency of reinforcement, that is, in a number of times the response is followed by reward, temporal relation between the response and the reinforcement schedules of reinforcement and magnitude of reinforcer (Fishbein & Ajzen, 1975:23).

When a given response reduces the drive state by leading to appropriate reward or by enabling the organism to avoid punishment, the response is said to be reinforced, and the reward is known as a reinforcer. A distinction is made between primary and secondary or learned reinforcers. Primary reinforcers are rewards that are unlearned

reducers of drive states such as food, chocolate and water. Secondary reinforcers which were previously neutral stimuli acquired reinforcement properties because they have been associated with primary reinforcers. That is, just as a conditioned stimulus (cs) comes to elicit unconditioned response (ucr), a stimulus that is consistently paired with a reward will take on some of the reinforcing properties of the reward itself (Fishbein & Ajzen, 1975:24).

Operant, instrumental or Skinnerian conditioning is a more free-form theory than classical conditioning. In operant conditioning the experimenter waits until a targeted response is freely or randomly emitted by the subject and then either reinforces the response if an increase in response frequency is desired or punishes the behaviour, if a decrease in response frequency is preferred. The subject's behaviour is eventually shaped to the point that he or she learns to behave appropriately, although it has been doubted whether the shaping involves attitudes (Kahle, 1984:23). It has also been noted that according to a behaviour-theory approach, belief formation should follow the laws of learning. Furthermore, a person's attitude toward some object is a function of his or her beliefs about the object (Kahle, 1984:26).

5.4.2   Expectancy – value theories

According to Tolman (1948:189-208) people learn "expectations", that is, beliefs that a given response will be followed by some event. Since these "events" could be either positive or negative "reinforcers", that is, could have positive or negative valence, his argument essentially was that people would learn to perform or increase their probability of performing behaviour particularly in the light of positively valenced events (Fishbein & Ajzen, 1975:29). The best known expectancy-value model is the subjective expected utility (seu) model of behavioural decision theory. According to this theory when a person has to make a behavioural choice, he or she will select that alternative which has the highest subjective expected utility, that is, the alternative which is likely to lead to the most favourable outcomes (Fishbein & Ajzen, 1975:30).

Rosenberg in Fishbein and Ajzen (1975:3) was the first to introduce an explicit expectancy-value model in the attitude area. He defined attitude as a "relatively stable affective response to an object" (Fishbein & Ajzen, 1975:31). According to Rosenberg the more a given "object", that is, an action or policy was instrumental to obtaining positively - valued goals or consequences and to blocking or preventing negatively valued goals, the more favourable the person's attitude toward the object (Fishbein & Ajzen, 1975;31).

According to Katz's (1960:103-204) functional approach to attitudes, the latter are necessary because they permit the individual to achieve certain goals or values, for instance, they allow him or her to organise knowledge, to maintain his or her self-esteem and to express his or her views. Katz's initial formulation can be viewed as being concerned with the extent to which an object facilitates or hinders the attainment of such valued goals (Fishbein & Ajzen, 1975:31).

Rosenberg expanded Katz's definition of attitude by including beliefs within the attitude concept. This expansion was accompanied by an explicit statement of affective-cognitive consistency. Specifically, he argued that "humans have a need to achieve and maintain affective-cognitive consistency" (Rosenberg, 1965:123-124). Rosenberg's theory of cognitive–affective consistency is one of a number of theories dealing with the effects of inconsistency among beliefs, attitudes, intentions and behaviours. The origin of these consistency theories can in large part be traced to Heider's principle of balance (in Fishbein & Ajzen, 1975:31-32).

5.4.2.1   Balance theory

Heider's (1958:47-59) concern with balanced configurations grew out of his interest in the factors that influence causal attribution of an event to a person. Many factors may influence causal attributions. One conclusion arrived at by Heider is that if the attitudes toward a person and event are similar, the event is easily ascribed to the person. He further argued that "a balanced configuration exists if the attitudes toward the parts of a causal unit are similar" (Fishbein & Ajzen, 1975:31-32). That is, a balanced state exists when the two entities composing a unit have the same "dynamic character". In other words, equilibrium obtains when the person's attitudes or sentiments *vis-a-vis* the two entities are either positive or negative. For example, in relation to the United States of America, a person may attribute responsibility to the President for the fact that his or her son was drafted. A balanced state exists when the person likes the President and approves of the fact. When he or she has a positive attitude toward one element, for example, the President, but a negative attitude toward the other, for instance, the drafting of his or her son, a state of imbalance is said to exist (Fishbein & Ajzen, 1975:32).

According to Heider's model balance also exists if the person holds different attitudes toward the two elements and perceives that one element has not been caused by the other. Thus, if in the above example the person liked the President, disapproved of the fact that his or her son was drafted, but perceived that the President was not directly responsible for the drafting of his or her son, a balanced state would exist (Fishbein & Ajzen, 1975:32).

It will be noted that in balance theory inconsistency may exist between two beliefs, two attitudes, or a belief and an attitude. In contrast the consistency theory that has attracted most attention, that is, dissonance theory may be viewed as dealing only with inconsistency between beliefs.

5.4.2.2   Theory of cognitive dissonance

The most important consistency theory of all, in respect of its influence on research and on subsequent theoretical discussions, was not limited to attitudinal consistency or even to attitude – behaviour consistency. It was called "cognitive dissonance theory" (Rosenberg, 1965:123-124). In its original form it proposed that human beings will strive to maintain consistency or consonance among any cognition that

they perceive to be related to each other in anyway. Cognitions in this sense refer to the things a person knows about himself or herself, about his or her behaviour, and about his or her surroundings. Thus a person is assumed to seek consistency between his or her knowledge that he or she holds an attitude toward an object and his or her knowledge that he or she is behaving in a particular way toward the object. Consistency prevails between his or her knowledge that the object possesses certain characteristics, and his or her knowledge that in terms of his or her value system these characteristics are good or bad, and ultimately there is consistency among an immense number of other bits of knowledge (Rosenberg 1965:123-124).

Rosenberg's consistency theory resembled Festinger's earlier writings on the subject. Festinger made four important original propositions (Festinger, 1957:226-234). Firstly, he stated that inconsistencies between cognitions generate in the individual a feeling of dissonance. The individual does not merely acknowledge a discovered inconsistency as a neutral bit of information and then go on with other business, but also experiences a particular kind of feeling as a result of having perceived such an inconsistency. That feeling or psychological state is what Festinger called dissonance (Festinger, 1957:228-230). Secondly, the individual experiences dissonance as unpleasant and he or she is therefore motivated to reduce or to avoid it. Festinger compares cognitive dissonance with hunger or other states of physical tension and assumes that the individual responds to dissonance as he or she would ordinarily do to hunger by seeking to terminate the state. Festinger did not see other possibilities to an individual's response to dissonance such as seeking an optimal state somewhere between maximum and minimum arousal. He assumes instead that the individual wishes to cleanse himself or herself of dissonance as much as possible (Festinger, 1957:229-230).

Thirdly, the intensity of the motive to reduce dissonance is dependent upon the total amount of dissonance experienced, which is in turn dependent upon various quantitative relationships between cognitions. For any two inconsistent cognitions considered together, the amount of dissonance generated will depend upon the importance of the cognitions. That is, the more important they both are, the greater the dissonance. If one cognition is very important and the other very trivial, for instance, the dissonance will presumably be small or can easily be resolved. But the total amount of dissonance an individual experiences at any one time will be dependent upon the number of dissonant relations he or she feels in proportion to the number of consonant or consistent relations he or she perceives (Festinger, 1957:230-231). Fourthly, when dissonance is present, in addition to trying to reduce it, the person will actively avoid situations and information, which would be likely to increase the dissonance. This hypothesis was soon broadened to assert that the person will seek information consonant with his or her attitudes and other cognitions as well as avoid dissonant information (Festinger, 1957:231-234).

Festinger's (1957:226-234) theory of cognitive dissonance begins with a consideration of the relations between two cognitive elements. The latter refer firstly to the things a person knows about himself or herself, about his or her behaviour, and secondly about his or her surroundings. The terms "dissonance", "consonance", and "irrelevance" are used to describe three kinds of relations that may exist between any two cognitive elements. Two elements are in a dissonant relation if, considering these two alone, the obverse of one element would follow from the other. For example, the one element "I know I smoke" would not follow from the element "I know

smoking causes cancer", and hence these two cognitive elements are dissonant. If, considering a pair of elements either one does follow from the other, then the relation between them is consonant. For instance, since the element "I know I smoke" follows from the element "I know I enjoy smoking", this pair of cognitive elements is in a consonant relation. Finally, where one cognitive element implies nothing at all concerning some other element, these two elements are irrelevant to one another. An irrelevant relation is exemplified by the two elements 'I know I smoke" and "I know that George is my brother" (Festinger, 1957:226-234).

Festinger (1957:226-234) described four basic situations that give rise to cognitive dissonance, that is, decision-making, forced compliance, voluntary and involuntary exposure to dissonant information, and disagreement with other persons. For example, whenever a person makes a choice between two or more alternatives, dissonance is assumed to exist. That is, his or her knowledge that the unchosen alternative has unfavourable aspects are both dissonant with his or her knowledge of his or her choice. In this situation, the theory predicts that increasing one's evaluation of the chosen alternative and or decreasing one's evaluation of the unchosen alternatives may reduce dissonance. The amount of change will be related to the magnitude of dissonance involved. The magnitude of post-decision dissonance is an increasing function of the general importance of the decision and of the degree to which chosen and unchosen alternatives are similar in attractiveness. In the forced-compliance situation, an individual is induced to perform a behaviour that is inconsistent with his or her beliefs or attitudes. For example, a prisoner of war who believes that communism is a repressive system might be induced, through threat of punishment or promise of reward, to state publicly that communism is not a repressive system (Fishbein, 1975:41).

Festinger's (1957:226-234) theory has to do with the organisation and dynamics of the cognitive system. This system is "empty" at birth but progressively develops as new elements of contagion add to the previously acquired ones. Any knowledge, opinion or belief about the environment, about oneself or about one's behaviour can be defined as a cognitive element. This adding of new elements to the cognitive system however, is not to be seen as a simple accumulation but rather as an integration of cognitions. Each new cognitive element is said to establish a dynamic relation with some elements of the pre-existing system. The dynamic relation, if any, between two cognitive elements is said to be either consonant or dissonant. The relation is dissonant if,

disregarding the other cognitive elements the one element does not or would not be expected to follow from the other (Nuttin, 1974:5).

The basic propositions of Festinger's theory states that

the existence of dissonance, being psychologically uncomfortable, will motivate the person to try to reduce the dissonance and achieve consonance. The existence of non-fitting relations among cognitions is a motivating factor in its own right and will lead to activity oriented toward dissonance reduction just as hunger leads to activity oriented toward hunger reduction (Festinger, 1957:226-234).

The second proposition linked to the former stipulates that the strength of the pressure to reduce the dissonance is a direct function of the magnitude or intensity of

the dissonance (Festinger, 1957:227). From the above definitions of dissonant and consonant relations, it follows that dissonance reduction ultimately depends on a change in the cognitive system. Whatever overt or covert activity the subject undertakes to reduce his or her dissonance, this more consonant state can only be achieved through a change in the cognitive clusters under consideration (Nuttin, 1974:7-8).

Theorists such as Freedman (1965:145-155) who believe in the utility of dissonant information proclaim that there is a tendency to prefer consonant information although there is little indication that people make an effort to avoid dissonant information. Some studies such as that of Sears (1968:50-57) even indicate a preference for dissonant information when it might be useful in coping with reality, for instance, a desire to find out the location of a dentist's surgery. Dissonance theorists acknowledge that dissonant knowledge may sometimes be useful and may therefore be sought rather than avoided. As Festinger (1957:226-234) himself points out, since the existence of dissonance is, after all, only one among many determinants of behaviour, it is not surprising that once in a while these other factors override the effects of pressure to reduce dissonance.

However, dissonance theory has steadily diminished in scope from its original form in which all kinds of inconsistency were considered to be motivating and the theory was applied to a broader range of human behaviour than to its current versions in which numerous criteria must be met before dissonance is considered likely to occur. But at every stage of the theory's evolution or devolution, several alternative theories have been advanced as accounting more adequately for the same or similar phenomena. The main thrust of the attitude theories of which dissonance theory is part is to expose the variety of nuances in the concept of attitude. The measurement of attitudes is a further mileage not only in quantifying attitudes toward a given object but also in lending cogency and credence to the notion of attitude itself. Although attempts at measuring attitudes have not been perfected to the degree of precision found in natural sciences, accurate scales of measurement have been developed to practical and useful proportions. For example, the most widely used techniques of attitude measurement such as the Thurstone method, the Likert scaling and the Semantic differential have attracted a large share of attention (Ajzen, 1991:179-211).

In most uses of the Thurstone and Likert techniques, measurement of an attitude's affective aspects is stressed, though cognitive and conative qualities are often intermingled with the affective judgement. The semantic differential largely separates out the affective aspects in terms of the evaluative dimension of meaning and separately measures two important aspects of belief through the potency and activity dimensions, leaving the conative aspects for other kinds of measurement. The affective features of attitudes have usually been of greatest interest to researchers, as well as to the average individual who first wants to know whether something is good or bad before he or she has anything else to do with it. But the individual's beliefs about an object's potency, activity, and at times other less important dimensions of meaning, may also be crucial to his or her overall attitude, determining whether his or her behaviour toward an object is similar to or very different from the behaviour of other individuals whose evaluative ratings resemble his or her own (Ajzen, 1991:179-211).

Attitude measurement in the nursing field would serve many purposes, particularly in assessing attitude orientations of nurses towards job satisfaction, placement in remote areas, level of pay, labour turnover, participation in decision-making in their jobs and supervisory practices, amongst many other job factors. The manner in which nurses perceive nursing as a profession has roots originating from school guidance, family tradition, peer pressure, comparison with others who may have joined the profession before them as well as other sources of information which may persuade an individual to join nursing. All these variables congeal into nurses' attitude-formation which reveals itself in the many aspects in which nurses play their role in the nursing career.

The image of nursing is one of the most important of the nurses' attitude-sets as it translates itself into the way nurses apprise the whole concept of nursing. But nurses are not alone in shaping the image of nursing. They are assisted by patients and members of the public amongst other agencies. However, it is the different interpretations placed on the image of nursing by the nurses themselves and the community they serve that fosters conflict between the former and the latter.

5.5 IMAGE OF NURSING

The image of nursing is an issue that has concerned the profession for decades. Brown and Stones made recommendations to improve the standing of nursing. Their suggestions included that firstly, the media needs to portray nursing in a more positive light. The second recommendation exhorted physicians to treat nurses in a better way. To this extent hospitals were urged to develop formal programmes designed to improve the physician-nurse relationships. The third area of concern was centred on the hospitals, which were reminded of the need to evaluate and improve nurses' salaries and compensation packages. Finally, hospital institutions were tasked with the responsibility of initiating statewide professional image recruitment campaigns (Brown & Stones, 1971:32-45).

However, some of the blame for the impoverished image of nursing has been apportioned to the nurses themselves. Mackay has confirmed that nurses are a problem. They are a problem for their patients, for their managers and for their government. Nurses cause problems for their patients because there are often not enough of them to do the work. For managers in the health services the problem is that they are often hard-pressed to keep the services going because of a shortage of nurses. Lastly, nurses present the government with another problem of voting with their feet and leaving the health services because they are not well paid (Mackay, 1990:1-3).

The level of pay in either direction is an inseparable element of both the image of the nursing profession and of the nurses' self-image. According to the self-image model a person's thoughts and beliefs determine that person's self-image. The latter determines actions, performance and achievements. Each nurse's actions and achievements in turn affect the collective image of professional nursing. The image of the latter then supports or alters the individual nurse's self-image.

Graphically these relationships can be outlined as follows:

A	B	C	D
Thoughts and beliefs of nurse	Self-image of nurse	Actions, performances and achievements of nurse	Image of nursing profession
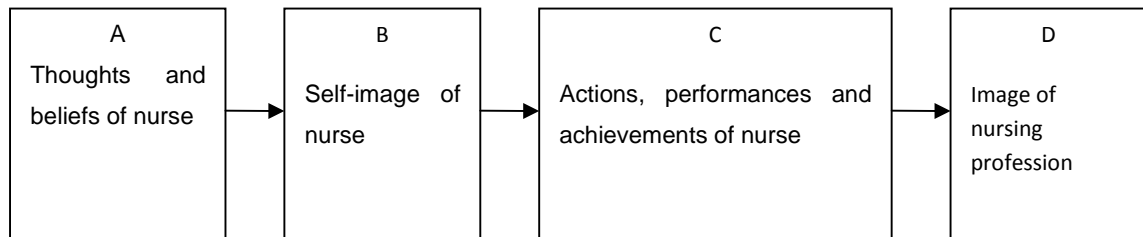
Figure 2.   Self-image model for the nursing professional (Strasen, 1992: viii).

Most of the efforts to improve the image of nursing have been aimed at point D in the model, that is, on the already established professional image of nursing. The focus does not appear to have been effective and little change has been evident because it is difficult to develop a concrete, effective plan of action to change the image of such a large group of people. Hence it has been suggested that the thrust should be exerted on point A in the model. Changing the thoughts and beliefs of individual nurses will in turn determine their self-image and subsequently their actions and performance (Strasen, 1992:viii-ix).

The self-image itself influences behaviour and performance in the workplace by affecting how one thinks, acts and uses one's work to enhance, preserve or develop one's self-esteem.   Since self-image is related to performance-satisfaction relationship (Brockner, 1988:22-24), it can be used as a predictor of one's occupational choices. Research on the difference between persons with high self-esteem and those with low self-esteem has shown tjat people with high self-esteem are more apt to work harder in response to negative feedback. Such people are less likely to be affected by acute sources of stress in the work environment. They are further less negatively affected by chronic stressors such as role ambiguity and conflict in their work. Another finding of the research was that high self-esteem is directly correlated with high job performance (Brockner, 1988:24-26). Figures 3 and 4 show the self-esteem and performance relationships.

High self-esteem

High performance

Low self-esteem
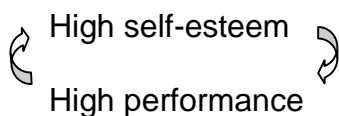
Low performance

Figure 3   High self-esteem

Performance cycle

(Strasen, 1992:18)
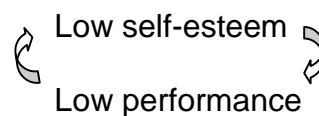
Figure 4   Low self-esteem

Performance cycle

(Strasen, 1992:19)

From such background variables impacting on work attitudes arose two apparently conflicting images of nursing. The first is the image of the humanitarian and altruistic person who is more or less competent and endowed with sympathy, compassion and exceptional capacities for establishing rapport with patients. The second is the image of the professional, well trained, technically-efficient and cool-headed individual who can be relied upon for able performance within his or her specialty and who is relatively independent of the feeling components. Whereas the above description could be said to fit the American mental panorama of nursing, the British public's image of nursing is one that is heavily weighted towards personal qualities such as intelligence, hard work and self-sacrifice (Crossley, 1973:49-62).

The nursing profession as a direct progeny from Nightingale has been known to be female-dominated from its inception. Female nurses are the largest single group of professionals in the health care industry. Although increasing numbers of men are entering the nursing professions more than 96% of nurses worldwide are women (Strasen, 1992:1-2). The attitudes that new entrants to nursing bring and or discover after joining the profession have been pointed out as the inherent fertile ground for job satisfaction, dissatisfaction and other negative or positive manifestations in the work place. Self-image or self-concept as one of these attitudinal orientations is the set of beliefs and images people hold true about themselves based on their socialisation (Strasen, 1992:1-2). The development of gender self-concept begins at the age of 2 years and has significant implications for the roles, responsibilities and capabilities of the individual (Strasen, 1992:1-2).

The traditional gender socialisation of women is important with a particular reference to their pre-eminent professional space they occupy in nursing. This gender training has promoted dependence, a strong commitment to relationships with others, an external locus of control and a self-concept that can be very self-limiting. On the other hand the traditional gender socialisation of men has fostered independence, reliance on self or an internal locus of control and a high self-esteem which measures how much one likes and approves of one's self-image (Strasen, 1992:2). The socialisation is conducted within the context of the culture of a society, which includes complex sets of gender norms, or expectations concerning male and female behaviour, that is, how they are to think, act and perform within the society. In general, male and female behavioural traits are learned patterns of behaviour rather than pre-determined biological conditions (England, 1986:41-43).

Many women are socialised to believe that if they do the "right" things there will always be someone to take care of them. As a result only a small percentage of women prepares itself for life-long careers. Many nurses view nursing as a job they can always "fall back on" while waiting for marriages, to subsidise the family income or to return to when their children are grown. Many women do not visualise themselves as ever being economically self-sufficient (Strasen, 1992:21-22). Staats and Staats described women as "the ideal life companion" and noted that women were likely to be happiest when they were subordinating to men (Staats & Staats, 1957:74-80).

Another angle to the image of nursing is therefore born out of the way the female nurses are socialised or attitude–trained in the culture of their society before they

embark on a nursing career. Kelly (1989:259-261) has ascribed the difficulties experienced in the relationship between nurses and medical doctors to this background. The relationship between nurse and medical doctor is marred by failures to communicate and cooperate at least from the perspective of nurses. The latter have frequently reported doctors to be rude and condescending. At the same time the nurses' silence ensures the dominance of the medical profession. As in a vicious circle the attitudes of nurses themselves do little to improve the situation (Cape, 1982:32-37). But however iniquitous or otherwise the effects of socialisation might have on female nurses, they impact or carry a message to both the nurses and the profession itself (England, 1986:20-25).

5.6   SOCIALISATION OF NURSES

If gender socialisation and traditional socialisation are combined, a number of messages for nurses all characteristic of a typical nurse equally fitting a typical image of nursing would result. For example, good nurses always consider the patients' and the physicians' needs before their own. Secondly, good nurses always anticipate the needs of physicians and of patients. Thirdly, good nurses are totally responsible for the well being of patients and physicians and have the highest respect for them. Fourthly, good nurses anticipate physicians' needs and respect their judgement without coming across as being too smart or challenging. Fifthly, good nurses always follow policies and procedures and never take short-cuts or become innovative. Sixthly, good nurses always follow directions from senior nurses rather than thinking for themselves (Brown & Stones, 1971:20-37).

Throughout the history of the profession, a number of stereotypes about nurses has also developed that must be acknowledged and challenged by nurses who desire to be taken seriously in their careers. These stereotypes portray the nurse as a woman in white who represents virtue, purity and virginity. Firstly, the nurse's cap although outdated, was a remnant of the female's need to cover the head to show subservience and is rooted in religious custom. Secondly, the stereotype of the nurse as a torturer has been exhibited in cartoons and get-well cards that depict nurses attacking patients with huge syringes and enema bags. Thirdly, the nurse as a sex symbol stereotype has pervaded media depictions of nurses. Fourthly, the stereotype about the nurse being a handmaid for the physician is still prevalent in hospitals, although it is slowly changing. It is documented as the main cause of stress and frustration for nurses who provide direct patient care in hospitals (Stein, 1978: 699-703). Fifthly, the nurse is described as a battle-axe. This stereotype has largely been used by physicians to denote nurses who have been promoted through advanced education, assertiveness and career-planning to the role of nurse manager or nurse executive. Sixthly, as nurse managers become more successful and effective in their leadership roles there is a shift in the stereotype from the battle–axe supervisor to the "clipboard" nurse who does nothing but check clipboards and useless paper work. When these nurses have to return to their white uniforms and care for patients, physicians become more comfortable with them and make comments such as "It's good to see you working today" or "I hate to see all the good nurses go into management where they don't do anything important" (Sweeney & Hoffman, 1982:1093-1094).

Notwithstanding the stereotypes the future of the profession lies in the hands of nurse leaders. These are nurses in management, executive, research and clinical roles who are defining and actualising their desired visions for patient care delivery in their institutions. Nurse Managers need to focus most of their efforts on becoming exceptional leaders rather than attempting to maintain their clinical expert role. The nurse manager does not practise clinical nursing on a daily basis. In view of this she or he cannot expect or be expected to maintain clinical skills in addition to becoming an exceptional leader (Wilcox, Morgan & Baker, 1973:31-40).

To be a successful nurse manager requires shifting one's focus to developing a vision for nursing, leading and inspiring the staff and managing one-self. If a nurse manager focuses on maintaining clinical expertise, he or she will fail to assume total responsibility for becoming an expert in leadership and management issues. This usually results in failure in both the clinical and the leadership arenas. As if to emphasise the positive role of leadership, for example, in America, little has been reported that the clinical effectiveness of the immediate supervisor was very important in the successful retention of nurses. This achievement offers incentive for more nurse managers to replace their clinical skills with the leadership skills important in making their department, staff nurses and institutions more effective. It can also have a significant and positive impact on organized nursing and patient care delivery (Wright, 1957:47-52).

The roots of nurse management qualities develop from socialisation and management training. Attitudes are inculcated during early childhood and are later modified, changed, fortified or reinforced through various avenues such as higher education and work experience. The attitude of nurses over aspects of their job and the image of nursing in Botswana are implied in various writings. The issue of crucial concern in the Botswana health services is that the aspirations of nurses are not being met, for instance, in relation to job satisfaction, pay, promotion and training (Rampa, 2000:52-54). There is no better way of collecting information on these pertinent matters than through examining nurses' views about a number of areas surrounding the nursing profession in Botswana which forms part of the focus of this study.

5.7   PAST STUDIES ON NURSES' ATTITUDES OVER CERTAIN ASPECTS CONCERNING THEIR JOB

The University of Botswana's department of nursing education is a useful centre for information in respect of the research conducted by nurses as part of the nursing degree programmes. The nursing undergraduates have been singularly resourceful in spreading a wide net in a variety of research topics dealing with extant nursing problems within the health services of Botswana. All the research data have revealed a number of aspects involving the attitudes of nurses and the way the nursing profession is perceived by nurses, patients, members of the public and politicians. The following areas are examples of previous research which are analysed further in the present study's empirical chapter (see chapter 6: tables 8-13, 42 and 46). Section 5.8 and subsections 5.8.1 to 5.8.7 below also contain extracts of results from

the present study's field work in similar aspects of the nurses' job (see chapter 6: tables 8-14, 18-25 and 46).

5.7.1   Job satisfaction

Many studies carried out in Botswana reflect researchers' interest in employees' work attitudes, most notably job satisfaction. The latter has been shown to be significantly associated with numerous important work behaviours. Unfortunately work performance often turns out not to be one of those behaviours. Contrary to the intuitive notion that the happy or satisfied worker is the productive employee, many studies have shown this to be true only under relatively delimited conditions. For example, satisfied workers or employees, compared to their less satisfied counterparts tend to show a lower rate of labour turnover (Brockner, 1988:21-22).

In Rampa's (1991:41-46) study in which she investigated job satisfaction from a sample of 187 nurses at Princess Marina Hospital in Gaborone, she found that complaints about inadequate pay were voiced by a majority of 90% of the nurses. The study discovered that nurses in mine hospitals were paid between 20% to 30% more than what nurses in Princess Marina Hospital earned. Task requirements constituted another seedbed of dissatisfaction, as most of the nurses (90%) complained about spending most of their time on paper work instead of expending it on patients. In addition to the lack of time devoted to the sick 75% of nurses were deprived of autonomy in making decisions in their jobs. Under such circumstances the image of nursing would not be expected to flourish. Nurses were found to perceive that the public's view of nursing was of a very low status. Furthermore, nursing in Botswana was not recognized as a profession. Thus, 95% of nurses agreed with the item that "most people do not sufficiently appreciate the importance of nursing care to hospital patients". In elaboration of their grievances the Princess Marina hospital nurses alleged that their low-level salaries failed to consider the responsibility, the accountability and the cost of making mistakes in the course of their duties in a job that involves precious human lives. Misgivings about excessive clerical work, lack of ancillary staff such as messengers and clerks, as well as restricted opportunities for advancement were other sources of dissatisfaction (Rampa, 1991:47-50).

In a further study by Rampa (2000:15-16 & 52-54) in three hospitals namely Athlone, Lobatse mental and Scottish Livingston using questionnaires to a sample of 225 nurses, she found that firstly, the majority of nurses felt that their pay was uncompetitive. In fact six out of ten nurses believed that they were underpaid. Secondly, the investigation acknowledged that the exodus of Botswana nurses to England and other developed countries such as New Zealand was due to the poor and unacceptable working conditions in the Botswana health services. It was recognised that organisational requirements such as administration policies and nursing philosophy contributed more to the labour-turnover rate than any other occupational factor.

Thirdly, the need for teamwork was confirmed by the unhappy interaction amongst the nurses themselves. This was thought to cause a lack of co-operation and a sense

of mutual dependence among the nursing personnel which in turn interfered with the proper organisation and the capacity to carry out their duties effectively. Fourthly, the lack of autonomy in decision making regarding nursing duties was again found to be the most important dissatisfier after pay. Fifthly, complaints by the community about the deplorable nursing standards in the hospitals shocked the status of the nursing profession in the country. Finally as in her earlier 1991 study, task requirements were found to interfere with the proper fulfillment or completion of nursing duties. Paper work, as it is often called to refer to administrative or clerical duties, inhibited the efficient utilisation of available nursing personnel (Rampa, 2000:52-54).

Otimile (1995:11-25) examined job satisfaction and quality of service among 75 nurses in Scottish Livingston hospital in Molepole. Nurses complained about poor working conditions which were not conducive to job satisfaction. Too much writing in the nurses' work was suggestive of being involved more in administrative duties than in finding time for clinical work. Heavy workloads also distracted nurses from communicating with patients apart from making them too tired to do anything else. The situation was further affected by the linearly–related autonomy and seniority of nurses. Senior nurses who carried more autonomy than the junior nursing cadre, indicated that they were satisfied with the nature of their job because they were not excessively supervised. Enrolled nurses were in a worse off situation because the spectre of too many chiefs and few Indians created too many responsibilities for them but with little authority. The quality of care was compromised as a result of nurses failing to carry out some of the nursing procedures due to multiple job requirements. Thus nurses had too little time to identify their patients' problems or to give health talks to patients' relatives. All these failures added up to imply not only an unsatisfactory health care system but also a plummeting image of nursing.

Motlhasedi's (1982:25-30) study gave as evidence of the causes of job dissatisfaction the harsh working conditions, poor interpersonal relationships, personality clashes between subordinate and superior and many other ward-related problems or grievances, which remained unresolved. The prolonged nature of their dissatisfactions had adverse effects on their morale and their ability to provide satisfactory patient care. The deep-seated disillusionment forced nurses either to opt out of the health services system and move to other countries or to sit back pathetically, undecided or to withdraw without leaving the service. In either case good quality nursing care suffered directly.

The relationship between nurses and patients provides another window of opportunity to analyse the attitude of nurses not only towards patients but also towards the nursing profession itself. Thus a bifocal investigation of both nurses and patients would shade some light on how each party perceives the other.

5.7.2   Attitude of nurses towards patients

Mothobi (1981:4-6) carried out a study of sixty patients and forty-five nurses in Princess Marina, Athlone and Scottish Livingston hospitals to analyse the attitude of nurses towards their patients. The results of the investigation supported the traditional, orthodox or normative view that nurses liked their patients and their job.

This accorded with the basic precept in nursing that the latter is about caring and implied a positive image of nursing.

In a study by Ramatebele (1986:18-19) in which she investigated the perceptions of forty nurses and fifty patients in Athlone and Lobatse mental hospitals respectively, there was no significant difference in attitudes between these two samples. In other words, both groups upheld a positive image of patients. However, nurses displayed a more elevated self-conception of themselves which was reflected on their liking of people they cared for. Further, the age, the length of service and the research setting appeared to have caused nurses to have a heightened opinion of patients. For example, two nurses with working experience in the clinics were reported to demonstrate higher-order perceptions of patients than the thirty-eight other nurses who had previous experience of working in hospitals and in the National Institute of Health Sciences. In regard to the length of service it was found that the longer the nurse stayed in employment the higher her or his valued perception of patients. Similarly the older the nurse the more she or he was likely to view the importance of patients in a more favourable way. For instance, in the 39-65 age group or those nurses with more than 16 years in nursing had a higher perception of the status of patients than the younger nurses aged 18-38. An irony can be drawn between nurses' positive view of nursing and their reluctance to work in non-urban environments despite liking their job.

5.7.3 Nurses' attitude over working in remote areas

Nurses complained bitterly for being transferred from the main centres to remote areas. Some resigned from the health services as a result. However those who do proceed on transfer only do so begrudgingly and it is normally those who have no other choice but to continue working in nursing. In 1983 Tapela investigated the attitudes of Botswana nurses towards rendering health care in the remote areas. She distributed questionnaires to twenty-one married and nineteen unmarried nurses in Princess Marina hospital in Gaborone, Scottish Livingstone hospital in Malepolole, Bontleng and Broadhurst clinics in the Gaborone City Council health services (Republic of Botswana, 1997:3-4). Her results showed that nurses were averse to providing health care in rustic conditions particularly in remote areas. In this aspect both groups of nurses were united or showed no significant difference in their negative attitudes towards nursing in non-morden conditions. Participants in the survey gave various reasons for their unwillingness to move from city centres to distant rural places. For example, most of them looked askance at transfers because they claimed that such government-instigated movements did not rotate equally among the nurses. There were further allegations that some nurses were never subjected to transfers, but remained stationed in urban areas. However, those who alleged to be victims of the supposed iniquitous system of transfer resented furthermore the fact that they were not given adequate notice to enable them to prepare themselves for or before such a change. Notwithstanding the validity of such complaints the affected nurses were in principle dissatisfied with the idea of relocating (Republic of Botswana, 1995:4-5).

Providing health services in the undeveloped areas of Botswana had long been a source of dissatisfaction among nurses, not so much for the principle itself as for the way the selection of candidates was conducted. The newly–qualified nurses fretted over where in the remote areas they would be posted, how far it was from their own home villages as well as from the urban centres. Those already in the nursing service were also gnawed by the same fear and tried to find any reason to justify not leaving the modern centres including resigning from their jobs (Republic of Botswana, 2001b:2-3).

The Minister of Health argued that after independence there had been a spate of health facilities in the remote areas. In view of this it was expected that the number of nursing personnel would similarly increase in order to man those new health services points. What the Minister failed to explain, however, was what his government was doing to improve the infrastructural facilities in those distant places with a view to attract, retain or make life bearable for the nurses. The nurses could not be pacified and their complaints about transfers, appointment, increments of salaries and demotions were debated in Parliament in 1982. The government was questioned for failing to provide proper housing for nurses posted in the rural areas, while concentrating on the accommodation needs of the nursing urbanites. Politicians argued in Parliament that it would be a waste of human resources if nurses had to leave their jobs for which they had been specifically trained at government expense because the latter unreasonably failed to heed the nurses' complaints in regard to accommodation and the dearth of other living facilities in the remote areas (Republic of Botswana, 2001b:3-4).

Tapela's study was carried out under the assumption that Botswana did not have a sufficient number of nurses and therefore could not afford to have nurses resigning from the nursing service. Yet at the same time the issue of transfers of nurses into the remote areas where they were forced to endure or brave harsh living conditions to which they were not accustomed had not been satisfactorily addressed. After all, these nurses had been trained in institutions which were situated in relatively urban areas. The dissatisfaction of nurses with the rural areas placements had affected performance in their jobs as revealed by complaints of poor quality nursing care by patients in these outlying areas. The results of the study concluded that nurses harboured a negative attitude towards providing health services in the unurbanised areas. This was due to a compound of reasons such as lack of proper housing, lack of proper schooling facilities for their children, inadequate communication facilities, limited social life and contacts, a long distance from relatives, shortage of drugs and medical equipment to give satisfactory health care, poor communication between the Ministry of Health and the health facilities to which the nurses were transferred (Republic of Botswana, 2001a:2-3).

It has been noted that transfers could cause job dissatisfaction. At the same time they could also improve the utilisation of nursing human resources if the need for the transfer is explained and supported by fair and consistent policies and the potential transferees are consulted and involved in the decision-making process. It would be invidious to deal with unsatisfactory nurses by transferring them to remote areas and doing so against their will. Molemogi (1988:11-20) in her study of nurses' perception of selection methods used to transfer nurses from hospitals to outlying health centres identified that transfer-related labour turnover among the Botswana nurses was caused by the inconsistencies and the inappropriateness of such a policy. Apart

from nurses' concern about relocation they are also irked by stress and burnout resulting from their work (Murphy, Hurtell, Sauter & Keita, 1995:31).

5.7.4   Attitudes of nurses over stress and burnout

Mannathoko (1985:ii-iii & 21-23) researched the response of nurses to stress in Southern Botswana. According to Jex (1998:2-3) stress is both functional and dysfunctional depending on the individual experiencing it. Mannathoko found that in some nurses stress was viewed in a negative light seeing it as something which inhibited their proper functioning. And yet in other cases stress provided a positive drive or motivation, which enabled them to go on with their lives and which acted as a challenge. The two categories of nurses which interested the investigator were the staff nurses and the enrolled nurses whose level of functions differ in theory at least because of their different academic achievement levels and their professional training. In view of their different levels of responsibilities and in conformity with the depth of both their education and their training, it was natural to expect that the heavier the accountabilities the higher trained nurses carried the more stress prone they become and *vice versa*. The results of the study showed that there was no appreciable difference between the staff nurses and the enrolled nurses in their response to occupational stress.

Kahn and Cooper (1993:2-22) have argued that people doing the same job in the same workplace are likely to be exposed to the same stressors. The predisposing factors to stress in the nurses' work environment were found to be common to both of them. For instance, the medical statistics indicated that the number of health facilities in the country were more than the number of nurses allocated to them at the time of the study (Republic of Botswana, 1993a:2-4). Both groups of nurses were therefore subjected to the stress of overworking due to the staff shortages. This demonstrated an uneven distribution of nurses in the health facilities. In an effort to grapple with these problems nurses were faced with the prospect of taking on more functions such as the overall running of a health unit, managerial duties and a number of non-nursing duties than they could satisfactorily manage. As a result of the shortage of staff the enrolled nurses cadre ended up performing certain functions for which they were not trained. Thus the predisposing factors to occupational stress affected both categories of nurses and their response to the work-related pressure was found to be similar.

Tsheko (1988:32-40) thought that the way nurses experienced stress was related to their level of educational preparation in the nursing field. She examined a sample of 13 nurses holding diplomas in nursing and another sample of 13 with Bachelor of Education degrees in nursing. The study setting was the campuses of the National Institute of Health Sciences in Gaborone, Molepolole and Mochudi. The extent to which both groups of nurses experienced stress was found to be similar. Stress in the health sector was found not to discriminate between levels of education. The study also concluded that once the causes of stress have been identified and the appropriate methods to relieve them have been adopted, work performance and job satisfaction improved. Tsheko noted that the intensity of stress varied with individuals, that is, what one nurse perceived as most stressful another nurse perceived differently. According to Miller (1995:24-32) the nurses' work environment

was the source of external factors in the form of expected nursing roles to be performed. These external factors were hypothesised to interact with the nurses' own internal factors to produce demands which called upon the nurses' adaptive resources. When a nurse failed, for example, to maintain equilibrium between the internal and the external factors unbearable stress ensued.

Rantona (1992:15-22) showed that the work environment of nurses also contained causes of burnout, which are connected to absenteeism, ineffective health care and labour turnover. Burnout has been described as the physical, emotional and mental exhaustion that is common especially in professions that work with people. Rantona used a sample of 37 registered nurses from the two referral hospitals of Princess Marina in Gaborone and Nyangabwe in Francistown to investigate the causes of burnout among nurses in Botswana. The results showed that demographic characteristics such as age, gender, length of service and marital status were not significant. However, work pressure due to the high patient load and the performance of the many non-nursing tasks accounted for burnout in 14% of the nurses. The latter further protested against the unbroken 12 hours long night duty, which were strenuous and uncompensated for. Moreover the ratio of nurses to patients during such night duty was 1 to 40. Nurses expressed feelings of emotional exhaustion and helplessness particularly over the nursing care of patients who experienced severe pain. For example, 84% of the respondents were resentful to providing nursing care to patients suffering from immuno-suppression. Thus the majority of nurses felt entrapped in rendering nursing care in situations that were prone to producing burnout. Furthermore, according to 54% of the nurses the work environment did not permit them to be involved in influencing policy-decisions in respect of their work. A small percentage (10.8%) of nurses claimed that the lack of support from their supervisors was so demotivating that they had thought of leaving nursing.

A whole basket of factors perceived to cause burnout therefore included the lack of incentives to work, the lack of recognition, limited opportunities to go for further studies, delayed promotions and poor inter-personal relations between matrons and nurses. These variables supported Herzberg's two-factor theory of motivators and hygiene factors. The latter purport that factors such as the quality of supervision, salaries and working conditions including fringe benefits can cause dissatisfaction and burnout. On the other hand Herzberg's motivators are represented by factors such as recognition, work involvement and advancement (Rantona, 1992:23-24).

Job factors that cause stress and burnout naturally affect the manner in which nurses deliver nursing care to patients. Both nurses and patients share views about what is and what is not good quality health care.

5.7.5   Attitudes of nurses over nursing care

During 1994 Tumuhla set about assessing or evaluating nurses' perceptions of good quality care by employing a random sample of 24 patients and 16 nurses in Princess Marina and Athlone hospitals. The study was a result of long-standing complaints by both patients and members of the public regarding the poor quality of nursing care provided in the hospitals. These grievances were nurtured in an environment of

mistrust between the health service providers and the consumers. Furthermore nursing care given in government hospitals involves public spending and where this occurs there must be nursing accountability and public understanding of what to and what not to expect. It was this yawning gap, if any, between what patients and nurses perceived as good quality care that the investigation attempted to discover. The research findings confirmed Tumelo's (1982:27-30) earlier results that nurses had a positive attitude towards nursing care which comprised a number of factors such as empathy, communicating with patients and transparency over their treatment (Tumuhla, 1994:33-37).

Sometimes it is taken for granted rightly or wrongly that quality nursing care is a right to all patients and that it is the responsibility of all nurses to deliver it. It is further assumed that the dglivery of quality care is highly related to the nurses' knowledge of measures that contribute to good nursing care. Whether nurses possess such knowledge remains a moot point and lies outside the realm of this study. What is indisputable however is the claim that nurses form an important fulcrum in the health care provision, in the patient care and nurse-patient relationships and in the whole reputation of the health services. The nurses' relationships with patients are measured against the quality of nursing care they offer. And to this extent the best measurement of the quality of nursing care given is the patients' appraisal (World Health Organisation, 1996:5-10).

The nurses' training is at best expected to have equipped them with panoply of skills and knowledge such as the ability to make sound decisions and autonomy, albeit circumscribed by the level of training. A higher level of the latter is, however, designed for managing health facilities and patients independently in remote areas away from the frequency of medical doctors. For example, comforting a patient and explaining what is to be done about his or her illness are all part of the skills of good quality patient care which can be practised by nurses in the absence of doctors. However, the caveat that the knowledge gained by nurses in a training school and what happens in practice remains problematic was reiterated. The practical world of nursing requires close monitoring by nurse supervisors aided by refresher courses, seminars and workshops as well as in service education. It is the lack of the proper application of knowledge that has led to the sloppy nursing standards including the inability to make independent decisions. It is the rawness of such practices and judgements, which has led to members of the public and other voices in society to be up in arms against the nurses (Tumuhla, 1994:33-37).

5.7.6 Attitudes of nurses over autonomy and participative decision making

In general most registered nurses in Botswana uphold the belief that quality of nursing care is the ultimate goal of nursing. But they are quick to add that if quality of care is to be adequately provided autonomy in the planning of such activity and taking part in the decision making process will be essential in implementing effective patient care. Nurses in Botswana have undergone a four-year training programme designed to equip them with the knowledge and the skills to function as autonomous professionals. Autonomy is defined for the purposes of this study as the freedom to

make decisions and to control important aspects of work for which the nurse has been educated and trained (Schaufeli, Maslach & Marek, 1993:35-36).

Mabuse (1982:25-39) was interested in studying the autonomy of registered nurses in hospital settings. She took a convenience sample of 40 registered nurses working in six different hospital departments, that is, surgical ward, medical ward, paediatric ward, maternity ward, operating theatre and the outpatient department. The survey was conducted in Princess Marina hospital in Gaborone. The findings revealed that 81% of the registered nurses had a modicum of autonomy in certain isolated areas such as prescribing nursing interventions. The range of their autonomy could only be described as limited. What was more striking from the study was the lack of autonomy in the other areas of nursing such as the management of a patient's treatment which was indicated by 76% of the respondents. This was reflective of the traditional dominance of medical doctors over nurses even in areas of medical and nursing treatment in which nurses have gained experiential knowledge over and above that of doctors. Nevertheless the majority of nurses were uncertain about which roles to play in regard to patients' needs other than bedside attention. It was noted that the higher the nurse in terms of seniority the more she or he realised his or her partial autonomy. The study concluded that some evidence of the lack of autonomy existed among registered nurses in Botswana. However, the sample size was too small to make the results nationally significant. Nevertheless the government-owned newspaper took an interest in publishing the findings (Republic of Botswana, 1992:4).

It is generally accepted that autonomy in the practice of nursing is an essential factor to maintain quality of nursing care. In the face of this awareness there has been a general dissatisfaction expressed by some registered nurses in respect of the lack of autonomy in the practice of nursing in all patient care settings in Botswana. Some nurses who wish to provide quality care by utilizing the nursing process for their patients have been constrained by the directive of medical practitioners in the hospital settings. The lack of autonomy may be due to several factors. Some of these factors may be located within the body nursing itself either within the nurses themselves or their colleagues or within the bureaucratic system within which nursing is embodied. As a result some nurses have professed their futility and powerlessness in providing patient care in the absence of autonomy (Mabuse, 1982:25-39).

The lack of autonomy on the part of nurses has been associated with poor quality care and has adversely affected accountability on the part of registered nurses. The long and the short of it has been that whatever nursing actions nurses have taken, they have been determined by medical doctors as well as other health personnel such as physiotherapists. Nurses have often become frustrated when they are denied the authority and the responsibility to use their knowledge and competencies. This stifled autonomy on the part of nurses in deciding about the care of their patients has thrown some light on the relationship between the autonomy of nursing practice and good quality care (Mabuse, 1982:25-39).

Phalaze (1995:1-8) proposed that responsible decision making about patient care is the other side of autonomy. If nurses are to be regarded as professionals then they are expected to be autonomous in decision-making. The nursing practice requires that many decisions be taken each day about patient care, treatment, patient welfare and in fact a holistic perspective concerning the well-being of the patient. The

methodology for making decisions depends on individual resourcefulness and varies appreciably from one nurse to another. Some nurses have learned the act of decision-making from the observation of others, while others have undergone a learning curve in decision-making through successful and unsuccessful life experiences. A further number relies on intuition or hunch as a way of making decisions. And yet some nurses approach decision-making randomly whereas others rely on another person(s) to make or initiate decisions for them. Johnson and Morakinyo (1993:201-214) found that those nurses who were aware of their role perceptions and acted on them by utilizing a systematic process of decision-making accounted for an insignificant proportion.

Boitsheko (1988:27-31) studied ethical decision-making by 22 registered nurses from 4 different hospitals in Botswana, that is, Princess Marina hospital in Gaborone, Scottish Livingtone hospital in Molopolole, Deborah Retief Memorial hospital in Mochudi and Selibe Phikwe government hospital. She discovered that when trying to solve ethical problems such as explaining to the patient his or her diagnosis, nurses were constrained by the rules and regulations of their employing institutions. Thus nurses were left with little discretion in solving their patient problems. The research further observed that because of the bureaucratic environment in which nurses worked they refrained from making decisions which were within their professional capacity preferring to play it safe. There was evidence therefore that nurses lacked confidence in taking stern decisions not only concerning patients' ethical dilemmas but also in other areas of nursing such as compiling a nursing diagnosis and treatment in which they were competent by virtue of their training. The government daily newspaper took up the matter and commented that this was a result of the nurses' work orientation which determined that the final decisions over patients' solutions to their problems were made only by physicians (Republic of Botswana, 1995: 3-5).

The disempowerment of nurses by medical doctors runs through the nurses' skein of professional life. However, this does not in any way distort what the nurses are expected to do by the dictates of their profession. Nurses are regarded as an integral part of the total health care delivery system in Botswana, playing an equally important role in the delivery of health care services alongside medical doctors (World Health Organisation, 1996:2-4).

Empirical findings, however, confirm that although nurses like their job, they have more negative than positive attitudes over a broader spectrum of their working conditions. In particular, their restivity and wrath over pay, have nullified all the motivation and job satisfaction gained in other nursing areas such as participation and control.

5.8 PRESENT STUDY'S FINDINGS ON NURSES' ATTITUDES OVER CERTAIN ASPECTS OF THEIR JOB

The study of the public health services nurses in Botswana, found that many areas of the nurses' working conditions, are dominated by the attitude-behaviour exposition in which given attitudes explained the nurses' bahaviour in the workplace. The nurses'

bahaviour, influenced by both positive and negative attitudes, affected their work performance, as well as their work relationships. A few examples of the nurses' attitudes over certain aspects of their job are outlined.

5.8.1 Attitude of nurses over participation and control in nursing arena

Participation and control in the process of nursing decision-making involves the cognition part of attitude. Gottlier (1984:405-456) defines cognition as more or less complex knowledge and organised internal representation of reality, which is acquired by means of the individual's cognitive skills and the rough experience with reality. The majority of nurses (80%) in the Botswana public health services study exercised control and enjoyed autonomy in their work activities (see chapter 6: table 8). In the realm of nursing responsibilities, this was indicative of adopting a positive proactive attitude in organising and directing a whole range of functions such as drafting duty rotas, balancing staff levels for different shifts, as well as managing the entire clinical environment. This display of initiative by the (86%) majority of nurses (see chapter 6: table 9) was a clear demonstration of their assertive professional attitude towards being masters of their own work situation. The ability shown by the 73.5% majority of nurses to alter the way they organised their work to suit their varying nursing demands (see chapter 6: table 10) was a further extension of their freedom of choice in how they conducted their nursing duties. The attitude expressed in the professional autonomy shown by nurses was undoubtedly conducive to both their self-esteem and job satisfaction.

But as Buck (1984:6-10) has pointed out, attitudes also have both motivational and emotional contents which are often associated with goal-directed behaviour such as using discretion in the performance of one's duties, in the case of nurses. In contrast with motivation, however, emotion is often defined in terms of feelings, that is, subjective affective experiences such as pleasure or displeasure. It is also further defined as the process by which motivational potential is realised or "read out" when activated by a challenging stimulus (Buck,1984: 6-8) such as the lack of or delayed transport to transfer a patient from one hospital to another or to take a discharged patient home, in the case of the Botswana public health services. In other words emotion is seen as a "read out" mechanism in carrying information about motivational system (Buck, 1984:6-8).

But as much as motivation is intertwined with emotion, the latter also depends on cognition which refers to Allport's (1935:14-15) mental state in his definition of attitude. Buck (1984:6-9) has identified two types of cognition. Firstly, knowledge-by-acquaintance which is the immediate experience of events in the external or internal environment such as the instant experience on seeing a dialysis machine in a Botswana hospital. Secondly, knowledge-by-description which is the appraisal and labelling of, for example, the receipt of the dialysis machine as "an advanced technology in the management of kidney failure". According to Buck, knowledge-by-acquaintance is difficult to "put into words" but knowledge-by-description is communicated symbolically with relative ease (Buck, 1984:7-9). Averil (1973:286-303) has observed two themes in the process described by Buck. The first is that cognitive processes determine the quality and the intensity of emotional reaction. The second is that such processes also underlie coping activities which in turn continually

shape the emotional reaction by altering the ongoing relationship between the person and the environment. The classic trilogy of motivation, emotion and cognition sometimes called the "Big Mec" has been central to the study of both psychology and attitudes since the time of the ancient Greeks and it may well be that it is not possible to consider one adequately without simultaneously considering the others (Buck, 1988: vii-viii & 2-3).

The nurses in the public health services were in charge of their work environment and showed a high degree of autonomy in nursing areas such as initiative in implementing patients' care plans, ability to change or power over task requirements such as scheduling clinical meetings and participating in decision-making involving nursing processes. Such versatility in nursing practice was co-extensive with their exercise of choice in the type of nursing they preferred as indicated by the majority of nurses (see chapter 6: table 6).The attitude of the majority of 49% of nurses conveyed in their responses shown in chapter 6 (table 7) was a clear indication that they were consulted by their nursing managers as to their predilection of nursing areas of practice. The distribution of answers from nurses regarding examples of preferred nursing areas in chapter 6 (table 6) was a fair index of the process of consultation. There was no evidence to show that the Botswana public health services institutional requirements imposed limits on or constrained the freedom of choice on the part of its nurses. The absence of authoritarianism from nursing supervisors over the nurses' choice of type of nursing was a positive omen towards nurses' professional empowerment, autonomy and maturity. However, the nurses' free hand in the organisation of their work, the discretion over their methods of working and their initial choice of type of nursing found in the present empirical study, were contrary to Rampa's (1991:41-46 & 2000:15-16 & 52-54) results. The latter studies found that the majority of nurses in the public health services were denied autonomy in decision-making over their nursing duties. The lack of power or say in running or managing clinical affairs on the wards was blamed for demoralising nurses and causing a serious crisis in the image of nursing (Rampa, 2000:52-54). It would appear, therefore, that since the 2002-2003 time of the present study's data, the nurses have won a deserved battle, if not war, of professional recognition in their nursing areas of expertise.

Autonomy has been defined in terms of the employee having a major say in scheduling his or her work, selecting the equipment to be used and deciding on procedures to be adopted and choosing a line of work (Stamps & Piedmonte, 1986: 45). Many writers on institutional behaviour such as Weisman, Alexander and Chase (1980:341-364) have pointed to the importance of permitting each person to develop a more autonomous personality. They have addressed the high need for nurses' autonomy and the lack of professional independence in nursing as well as the problems in obtaining it. They pointed out that the biggest problems occurred in high hierarchical institutions such as hospitals. Weisman *et al.* (1980:350-364) further noted that autonomy was one of the strongest predictors of attitudes favourable to job satisfaction. In reference to the balance theory of attitude (Fishbein & Ajzen, 1975:32) the nurses' attitudes towards the selection of types of nursing and their autonomy over the organisation and management of their work were in equilibrium. The configuration between the nurses' autonomous attitudes and the participative nursing milieu share the same "dynamic character" (Fishbein, 1975:32-33) of mobilising nurses' motivational resources. This analysis is based on a cognitive appraisal in attitude-formation which is determined by the interplay between

personality and the configuration of the environmental stimulus (Averil, 1973:286-303).

Cognitive appraisal is also the cornerstone of the analysis of emotions from which three main components arise (Averil, 1973:286-303). The first is the subjective affect which includes the cognitive appraisal. The second are the physiological changes related to species-specific forms of mobilisation for action such as complaints by nurses about lack of allowance for night shifts. The third are the actions having both instrumental and expressive features, for instance, holding a demonstration for better pay. The quality or intensity of the emotion and its action depends on a cognitive appraisal of the present or anticipated significance of the adaptive commerce for the person's well-being (Averil, 1973:286-303). In stressing the importance of cognitive appraisal in the mediation of emotional states, it is useful to refer to the phenomenon called the general adaptation syndrome (GAS) which is argued by Selye (1975:25-26) to be a universal biological defence reaction aroused by any physically noxious agent or alternatively considered to be a psychological response by Lazarus and Folkman (1984:23-24). In the final analysis the favourable results in the nursing areas of participation and control (see chapter 6: tables 6-10) of the present empirical study are a combined product of both the Big Mec and GAS.

5.8.2   Attitude of nurses over their work

The concept of attitude can be perceived as a psychological response integrated with the general adaptation syndrome. In this context the plasticity of the concept permeates the nurses' many-sided behaviours such as relating the size of monetary rewards to the amount of nursing work done. The majority of the public health services nurses in the Botswana study expressed a liking for the kind of nursing they were engaged in which implied, not only a positive attitude towards their job, but also towards patient care. The responses of less than a quarter (19%) of the nurses who said that they only sometimes liked their job (see chapter 6: table 13) were not significant. The previous studies by Mothobi (1981:4-6) and Ramatebele (1986:18-23) had shown that the majority of nurses were happy with their job and enjoyed caring for their patients which carried some cachet for the image of nursing.

It may seem ironic that the nurses' attitude towards their work remained positive despite their 60% majority acknowledgement of the fact that they worked under pressure (see chapter 6: table 11). Furthermore, they identified the source of the pressure as arising from the work itself (see chapter 6: table 12). The inconsistency of or between revelling in a job and experiencing some physical or mental discomfort from pressure resulting from its performance falls under Festinger's (1957:226) theory of cognitive dissonance. The nurses' seeming dissonant attitude towards their occupational stress means that work can be conceptualised as a task with a logic of its own, requiring analysis, synthesis and control. Work has five dominant dimensions, that is, the physiological, the psychological, the social, the economic and power dimensions (Argle, 1989:86).

Although separate, they always exist together in the worker's situation and his or her relationship to work, fellow workers and management. They also have to be

managed together, yet they do not pull in the same direction because the demands of one dimension are quite different from those of another. For example, the power dimension may conflict with or overcome the power of other dimensions such as the social and the economic. Gillerman (1963:71-73) has defined "power" as the power to regulate one's working methods, to set one's goals and standards and even to have a role in determining one's rewards. This, more th0an money would seem to be the key to sustained productivity increases. According to Vroom (1964:1964) Elton Mayo considered the social dimension, that is, the worker's association with his or her fellows to be more responsible for his or her satisfaction and productivity than money. One of the basic errors of traditional approaches to working has been to proclaim one of these dimensions as "the dimension" (Argyle, 1989:86-113).

The public health services nurses adopted the psychological and social perspectives of work. According to Brown and Stones (1971:24-30) some people consider work as a career or as a means of devoting their abilities to doing something they think important. Work may, therefore, be arranged into two different categories, that is, "jobs" on the one hand which are no more than money-for-effort transactions and "careers" on the other hand which provide scope for self-development and a sense of purpose. The nurses' attitude towards their work was either based on a sense of careerism or according to Argyris (1964:37) they could have been saying to themselves that "one way to live with the job is to enjoy it". It could also be argued that the nurses were being stoic or making amends for having joined the nursing profession in the first place that firstly, "I must enjoy it in order to live with myself", thereby reducing the potentiality for dissonance. Secondly, the nurses could have been communicating the sense or fear that "I must enjoy it or else I have to go through the extremely difficult task of finding another job", thereby again minimising the probability of their own unhappiness and discomfort (Argyris, 1964:37-38). The existence of these adaptive responses explains the apparent discrepancy between attitude surveys which report a high degree of job satisfaction among many lower-level workers and the resignation, discouragement and fatalism so often found by sociologists in the working class culture (Argyris, 1964:38-39).

The public health services nurses could also have considered their work as bounden duty. Alternatively their attitude could have been a result of being taught what to expect from work, implying that attitudes to work are socially and culturally moulded (Ingham, 1970:40-45). There is a variety of socialising agencies such as the state, the local community, the family, the work group, trade unions and professional associations. The influences from these diverse social groups are based on the analogy drawn between war and work. If war is too important to be left to the generals, attitudes towards work are too important too to be left to the workers (Fox, 1976:1-2). In Vroom's view the nurses endured working under pressure because the work gave them an opportunity to express optimum personality. The job enabled them to be more active than passive; to be more independent than dependent; generally to have control over their world and to express many of their deeper and more important abilities (Vroom, 1995:163-164). Other approaches to explain the nurses' attitude towards their work include the notion that work has intrinsic meaning. The value of work in this attitude-set is sought in and through the activities of work themselves. These are seen not as a burden to be borne for the sake of their instrumental usefulness. But they are perceived as enriching experiences through which people can meet challenges and overcome obstacles, develop their aptitudes and abilities and enjoy the satisfactions of achievement. In the course of these

experiences, people undergo psychological growth, realise themselves and reach due stature as full, mature and autonomous agents (McClelland, 1987:40-42). For the Botswana public health services nurses work and the level of pay were inseparable.

5.8.3   Attitude of nurses over pay

It is a twist of the irony that the same nurses who responded that they liked their work and were prepared to absorb the stress coming from it, recorded a majority of 92% of a vehement disapproval of the level of pay they received (see chapter 6: table 14). A comparatively strong negative attitude was registered by a majority of 86% of the nurses for the inequality between the level of monetary rewards and the amount of work done by nurses (see chapter 6: table 15). Pay has been defined as dollar remuneration and fringe benefits received for the work done. The primary perspectives on pay are its overall adequacy, comparison with other employees in the same community and pay administration. Thus, probably the most important thing about pay is its relationship to what others are receiving for similar work (Stamps & Piedmonte, 1986:16-17). In the Rampa (1991:41-46) study 90% of the nurses were reported to be unhappy about their level of remuneration. The same investigation revealed that nurses working in the private health sector mine hospitals were paid up to a maximum of 30% more than the public health sector nurses employed in the government hospitals. Nine years later when Rampa (2000:52-54) conducted a similar follow-up survey, she found that the Botswana Government had not lifted its moratorium on nurses' salaries. Nurses' complaints about pay continued unabated. The majority of nurses believed that they were underpaid. Between 2002 and 2003 when the present survey was mounted the nurses' grievances over pay had shown a linear progression by two percentage points.

Corwin (1965:341-356) has written that in economic terms nurses in most countries are not considered to be income maximisers. They remain nurses because of the other perceived rewards of the profession such as the "calling" which meant in effect sacrificing satisfaction from extrinsic rewards such as pay on the alter of intrinsic happiness or the inner or inmost feeling. This viewpoint does not seem to apply to the Botswana public health services nurses whose orchestrated demands for a higher salary have been a running gauntlet against the Botswana Government for more than ten years. Although acquiescing to Corwin's concept of the "calling" with its invisible rewards, Smith (1976:33), as if in support or sympathy of the nurses, has pointed out that the phrase "to earn a living" is a happy and shorthand way of expressing the linkage between working and pay for effort. Clearly this connection was absent in the case of nurses in the public health services of Botswana who worked as nurses to earn a living.

Gruneberg (1979:56-58; Latham, 2007:41-43) has stated that money seems to be so central to people's thinking in relation to their jobs that it leads one to be suspicious about research findings which report money as being of relatively low importance. Money has a great deal of symbolic value. Gruneberg has gone further to explain that the nature of this value has been found to vary with the background of the individual concerned. It has also been reported that there are large differences in the

meaning of money according to one's stage of development and one's experiences, sex, economic status and personality (Gruneberg, 1979:57-58; Latham, 2007:43). The importance placed on money by Gruneberg has been extended by Evans (1998:84-89) who utilised the concept of drive to explain how money affected human behaviour. He hypothesised that one learned to become anxious in the presence of a variety of cues signifying the absence of money. He suggested that anxiety related to the absence of money was acquired in childhood through a process of higher-order conditioning. The first phase consisted of pairing pain with cues of warning or alarm provided by adults. In the second stage, anxiety-arousing warnings will be conditioned to a wide variety of cues indicating lack of money. After such learning the child will become anxious upon hearing phrases such as "we cannot afford to buy that, it costs too much money".

In the light of Evans'(1998:84-89) hypothesis it is possible to consider the nurses' claims for higher pay in the context of both the learning and the expectancy-value theories (Fishbein & Ajzen, 1975:22-29; Oskamp & Schultz, 2004:15-19).The nurses' voracious appetite for money could have been rooted in their childhood's classical conditioning when the word "money" (cs) was mentioned repeatedly in a family environment by parents or significant others as a condition for purchasing consumer goods such as television (ucs). After several cs-ucs cues or combinations money must have become a dominant chord in the personality of the Botswana public health services nurses wherever material goods such as car were mentioned. But because these nurses are not a homogeneous group such a personality trait or such learning would have been developed not only from the family, but also from other origins such as the media, trade unions, social references and education. Instrumental or operant conditioning could also have taken place from similar socialising agencies. For example, these nurses could have learned from the media that monetary payment was the most rewarding means of reinforcing productive or efficient work performance. The same media could have created and promoted class awareness in the Botswana society based on, amongst other things, the acquisition of various types of property such as a motor vehicle and modern housing. These possessions become status symbols in a stratified society in which nurses do not see themselves as small fries but as civil servants commanding respect which they believe and argue the Government must accord them.

A further explanation for the nurses' relentless quest for money is based on Gruneberg's (1979:57-58; Latham, 2004:43) analysis that the meaning of money could be related to one's stage of development. It was pointed out in the Introduction to Chapter 2 that Botswana since the 1970s has been a beehive of economic activity. The nurses in the public health services are caught or trapped in a developing country which is in a hurry to modernise and is experiencing an upward economic convulsion. It is not difficult to imagine nurses jolting for a place in the "economic sun" or climbing on to the economic bandwagon where money represents the centre of the universe. The rush to surpass the next person or one's neighbour by purchasing a status symbol such as the best car or house in town has crescendoed into the burning desire for more money. The expectancy-value theory is a natural sequel to the nurses' learning of the utility of money. They would have learned to regard money as the most important alternative with the highest subjective expected utility (Fishbein & Ajzen, 1975:30; Oskamp & Schultz, 2004:23) amongst all the working conditions (see chapter 6: table 14).

If the pay received by the nurses was inadequate to enable them to acquire the kind of material goods that society offered or was insufficient to avert domestic conflict over the purchasing of consumer goods, then according to Gruneberg (1979:61-62; Latham, 2004:45), the nurses' attitude towards more money was instrumental. Herzberg has criticised the attitude to work by pointing out that professional people were becoming increasingly preoccupied with extrinsic rewards. He goes further to observe that professionalism once a sign of true competence and dedication to excellence in performance, has now become a synonym for gathering the harvest of the hygiene factors of status and money. He warns that if the search for extrinsic rewards does come to predominate even in an environment so favourable to intrinsic values as professional work, the effect that can be exerted upon work attitudes by cultural pressures outside the work situation is plain to see. The survival chances of intrinsic values in less favourable work environments would then seem bleak. Herzberg blames the mass media by noting that the tendency to see work mainly in terms of its instrumental values, has been greatly strengthened by certain characteristics of modern, industrial and consumer-oriented society. Industrial businesses and commerce with their direct and indirect power over the content of radio and television, motion pictures, newspapers, magazines and advertising and selling activities have no interest in promoting the intrinsic value of work (Herzberg, 1968:40-46). While the public health services nurses' intrinsic interest in their work may have been adversely affected, if not eroded, by the frenzied taste for higher pay, at least they had cemented work relationships amongst themselves to hold onto.

5.8.4   Attitude of nurses over interpersonal relationships

As with pay the importance of co-workers figures prominently in the attitude towards working relationships. One important condition for group attraction is contact under conditions of cooperation such as in nursing. Nursing tasks require nurses to work together in order to achieve a successful clinical outcome. This means that team members value one another's contributions and self-esteem is evenly distributed or shared amongst all of them. According to McCloskey (1990:140-143) the more a worker is valued by his or her fellow workers the more positive becomes his or her attitude towards work performance. Social integration is, therefore, a tributary factor in developing positive job attitudes. Herzberg, Mausner and Snyderman (2004:47-48) also found that social aspects such as liking one's work colleagues were conducive to good working relationships. Maslow (1943:370-396) in noting the demoralising effects of social isolation in work situations, confirmed the need for social interaction with others as one of the basic lower order needs.

The public health services nurses in the Botswana study showed a high degree of positive professional interpersonal relationships at a ward level (see chapter 6: table 18). This was a peer group of nurses which shared the stress and burnout resulting from the workload aggravated by staff shortages. The interactional attitude between junior nurses and nurses' supervisors was not as strong (see chapter 6: table 19) as that found between junior nurses amongst themselves. This may be explained by the fact that the nursing care activities on the ward are mostly done by the junior nursing cadre and liking one another is part of a coping strategy. The ward nurses, therefore, survived the hardships of working under conditions of skeleton staff by

promoting cooperative attitudes towards patient care at a level where it really mattered. Previous studies conducted by Rampa (2000:15-16), Otimile (1995:11-25) and Motlhasedi (1982:25-30) had found poor interpersonal relationships amongst junior nurses which had negative consequences on the quality of patient care. Apart from staff relationships standards of care can be affected by other working conditions such as lack of transport to take home late shift nurses who finish duty at 2100 hours.

5.8.5   Nurses' attitude over aspects of working conditions

Whilst nurses cooperated with one another on the ward level and liked their job, their attitude towards certain working conditions such as pay, workload, staff shortages and lack of opportunity for further education and training was strained (see chapter 6: tables 21, 22 and 23). The workload resulted from scheduling fewer nurses for nursing duties that required more staff input. This compelled the few nurses to work under pressure in order to complete the ward tasks on time before the end of the shift. The chronic understaffing led to the perfunctory performance of duties. It made nurses tired and the build-up of fatigue continued indefinitely leading to absenteeism, diminished standards of care and increased clinical risks to patients. Mothasedi's (1982:25-30) study found that harsh working conditions such as those caused by staff shortages took a toll on the quality of nursing care. These findings were subsequently confirmed by Rampa (1991:41-46) who drew a paralleled between workload and low-level salaries paid to nurses. The work by Otimile (1995:21-23) made similar conclusions on the deleterious effects of heavy workloads on nurses and the latter's additional performance of non-nursing duties. Other investigations such as those by Mannathoko (1985:21-23), Tsheko (1988:32-40) and Rantona (1992:15-22) attributed the stress and burnout experienced by nurses to difficult working conditions. More recently, Rafferty (2006:1) confirmed that nurses working on wards where nurse to patient ratios are lower are much more likely to suffer from burnout.

Locke (1976:1320; Spector, 1997:86) has pointed out that there is evidence that a person's feelings of achievement or accomplishment are enhanced if he or she works on or completes a "whole" piece of work or if his or her personal contribution to the whole task is clear and visible. The root of the pleasure of achievement is a human being's need to cope successfully with his or her environment. Successful coping yields a sense of pride in one self. In Herzberg's (1968:120) terminology efficacy satisfies the need for psychological growth. The public health services nurses disliked staff shortages because they restrained them from completing their ward tasks. The work attributes that have been found to be related to job interest and satisfied attitude include the opportunity to use one's valued skills and abilities, responsibility, amount of work, non-arbitrary performance of work, control over work methods and work pace or autonomy and job enrichment which involves increasing responsibility and control (Locke, 1976:1319; Spector, 1997:86).Out of all these variables nurses found working under pressure which was related to workload staff shortages intolerable. Although these deplorable staff working conditions were tolerated or endured within an environment of positive interpersonal relationships amongst the staff at the ward level, nurses found it impossible to attend to specific

nursing goals whether self-set or imposed such as reassuring patients due for an operation.

The dissonant relationship streaming through the nurses' liking of the job they do (see chapter 6: table 13) and the high interpersonal relationships amongst them at ward level (see chapter 6: table 18) on the one hand and working under pressure (see chapter 6: table 11) with the source of the pressure coming from the work itself (see chapter 6: table 12), workload (see chapter 6: table 22) and shortage of staff (see chapter 6: table 23) on the other hand threatened the nurses' job involvement and self-esteem. This was due to the tiredness and the inability to pursue a task to the end. The long term impact of these discrepant attitudes is not readily ascertainable. Gruneberg (1979:33-34; Latham, 2007:17-19) has commented that examination of the relationship between success in a task and positive attitude or satisfaction has revealed the difficulty in deciding upon the cause-effect connection between the two variables. Festinger (1957:224-230), however, maintains that a given individual wishes to cleanse himself or herself of dissonance as much as possible. The image emerging from nurses working in the public health services of Botswana is not one of avoiding but wriggling deeper in a quicksand of dissonance.

5.8.6   Nurses' attitude towards intention to remain in nursing until retirement

The majority of nurses in the public health services were negative about spending all their lives in nursing (see chapter 6: table 25). This response must be interpreted to refer to nursing in general irrespective of the sector of the employer. This interpretation is supported by the fact that the replies contained in (chapter 6: table 26) indicated that the majority of 46% of nurses preferred to go back to public sector nursing if working conditions therein were improved. Since these are the same nurses who were autonomous in their job activities (see chapter 6: table 18), the refusal to continue in their employment until retiral age could only be regarded as a transient protest. At the same time while their grievances over a variety of working conditions, with pay being the most strident (see chapter 6: table 14), need to be addressed, the reasons for staying in the public health services seemed to outweigh those for leaving the service (see chapter 6: tables 24 and 34). Moreover the 59% majority of these nurses still considered their present job to contain the potential to give them something to learn (see chapter 6: table 34) which further strengthened their reason to remain or stay on.

Another reinforcing factor seemed to have been provided by the nursing managers who removed most of the non-nursing duties from the nurses' work schedules (see chapter 6: tables 32 and 33). With the complaints out of the way, the case for the nurses to remain in the public health services seemed to remain anchored on more favourable grounds than the opposite. However the preponderant discontent with pay (see chapter 6: table 14) remained almost capable of wiping out all the gains derived from favourable variables. But according to Heider's (1946:107-112) balance theory, balance exists if the person holding different attitudes about two issues believe that one is not caused by the other. In this sense it could be that the nurses' unfovourable outlook towards retiring in nursing was unrelated to their alleged

underpayment. Taking Festinger's (1957:228-230) perspective, if the nurses' planned exit from nursing before retirement was influenced by poor prospects then cognitive dissonance was present. A more immediate reason for leaving the service was hidden in the government's policy of transferring nurses from urban to rural services centres (see chapter 6: table 46).

5.8.7   Attitude of nurses over government's transfer system

The rural posting of nurses to expose them to nursing in the countryside is not considered ennobling by nurses. The government's policy of providing health services throughout the whole country has attracted a lot acrimony from nurses who are the principal agents in its implementation. Nurses have cited many reasons why they do not like to work in remote areas. They have complained of lack of proper housing, for instance, to accommodate a family of husband and wife and two children. They have named many other deficits such as absence of good schools for their children, lack of communication such as telephone, no social life after work, shortage of drugs for patients and separation from friends and relatives. Clinically the quality of nursing care deteriorates either because of the shortage of drugs, which is worsened by the lack of communication, or the strained attitudes of nurses caused by the inadequacy of medicines and by the very act of being relocated to a rural area. Nurses have opposed the transfer policy for these reasons but the government has not been able to redress these complaints. The present study found the majority of public health services nurses still opposed to the policy (see chapter 6: table 46). The familiar litany of grievances quoted was underpinned by inconsistency in the application of the directive.

Past studies such as that by Tapela (1983:11-25) which pioneered investigations into nurses' attitude towards serving in the remote health services clinics were eye-openers to dissatisfactions which had heretofore been unreported. The findings of the investigation brought to the surface both the nurses' unhappiness about the disadvantages of the transfer system and how it reverberated negatively into patient care. Whereas Tapela's study was mainly concerned about nurses' attitude towards the government's transfer system, Molemogi (1998:11-20) examined nurses' understanding of how the transfer methods were put into practice. The latter's investigation confirmed that the policy suffered from services flows of inconsistency and did not rotate equally amongst the targeted population of nurses. The government's Daily Newspaper reported Tapela's watershed discovery of nurses' feelings about transfers, but since the same complaints have been voiced twenty years later there seems to be no evidence that the government has paid heed to them. In accordance with the fourth proposition in Festinger's (1957: 226-234) theory of cognitive dissonance, the nurses have soldiered the dissonance caused by the transfer system for too long. They can only reduce it by incorporating it into their professional life and by learning to develop consonant attitudes towards their situation.

5.9 SUMMARY AND CONCLUSIONS

Attitudes are intellectually complex. At the operational level many researchers fail to distinguish between beliefs, attitudes and intentions. Thus the study of attitudes is a fertile ground of confusion and ambiguity from which investigators depart with a gentleman's agreement of agreeing to disagree. It remains unclear as to what an attitude is in view of the diversity of definitions and the multitude of variables that are included in its measurement. Moreover there are problems that are peculiar to each attitude theory. For example, the problem with dissonance theory is the possibility that measures of beliefs, attitudes, intentions or behaviours may not correspond directly to their cognitive representations. It also stands to reason that since different variables are involved the attitude theories also deal with different relationships. Thus some theories are concerned only with relationships between attitudes. Others such as the dissonance theory are concerned with relations between beliefs. Further, some theories such as the expectancy-value models and the attribution typologies specify causal relations. Still others such as the balance theory and the dissonance theory are concerned with dynamic inter-relations among variables.

However, despite the complexities and the pitfalls of the attitude theory this does not detract from the fact that it is a useful concept. This is especially so in the field of nursing where nurses may be forced to move their attitudinal position or their behaviour pattern due to the lobbying clamour of politicians, members of the public, the media, patients and other interested parties. It is this public focus on them and the institutional factors emanating directly from the ravages of their work which influence nurses' attitudes towards their job. It is pertinent therefore that the study has ascertained the attitudes of nurses over a limited number of their job factors such as the nurses' attitudes over job satisfaction, their attitudes over working in distant rural areas and their attitudes over stress and workload. A collection of these attitudes will reveal the areas of dissatisfaction or job satisfaction as the case maybe. If the former outweighs the latter necessary measures will then be taken to address the problem in order to improve the quality of patient care among other remedies. There is no better way to discover not only nurses' attitudes but also what motivates them and gives them job satisfaction than to go out to them and investigate.

The next chapter takes the theoretical strands of job satisfaction, motivation and attitudes further by throwing them into the cauldron of fieldwork, in order to test their practical manifestation in the real world of work inhabited and controlled by human variabilities or the human factor.

CHAPTER 6

EMPIRICAL STUDY

6.1   INTRODUCTION

The roots and tenets of the health care services in Botswana enmeshed with the country's economic miracle, which transformed the Botswana society over the years, formed a good handle or sound track for a research on nurses. The saying that behind every successful man or woman is a woman or a man, respectively, could be perhaps more apt as an analogue of the remarkable achievements that Botswana has made in the field of health services alongside its incipient economy. The sturdy economic development has been attained against the backdrop of a well-planned and thought-out health services infrastructure. But the notion of a service reminds one of the marketing strategy in commercial business in the private sector that the customer is king or the customer is always right. This implies that whilst the consumer of a service appraises its utility or efficacy, the provider of that service must be willing, able, motivated and happy to provide it.

The polarization between consumers of a service and its business providers in the commercial world has similar connotations between the providers of the health care services at a service point and the societal consumer in general. While the public has a free rein and is unbridled in its vociferations in respect of how the health services should be run and managed in the context of a democratic and free society, the nurses who provide such services in the institutionalized settings are guided and regulated by bureaucratic red tape. Although the latter insulates them against other occupational hazards, it at the same time renders them defenceless in the face of a mounting and vilifying criticism from members of the public, regarding the way they carry out their duties and the manner in which they conduct themselves in the course of their doing so.

The introduction to the study and chapter two have dwelt on the conflictful relationship between nurses and members of the public. It has taken studies such as the present research to attempt to bring out the nurses' position into the open, in terms of the problems they face in their work or lack of them, by asking them to participate in a survey designed to make them show, not only what makes them tick in their job, but also to rebut or otherwise the criticisms that may be leveled against the service they provide. The undercurrent feuding between them and the public can be arguably attributed to the lack of understanding or appreciation on the part of the members of the public, of the obstacles in the nurses' work environment inhibiting them from efficaciously discharging their duties. Such impediments include staff shortages and the attendant increased workload or "niggermation", as well as the inequitable remuneration packages, to itemize only a few of the large pool of variables that may cause dissatisfaction or satisfaction to the nurses as the case may be in multivariate job situations. It is what goes on in the nurses' job that redounds in the face of the health care service consumers.

This study has examined the theoretical background of factors such as motivation of staff job satisfaction and attitude of staff in detail in order to compare notes between these variables and their various sub-groups and the practical realities of what nurses say about what affects them or their performance in their jobs. The findings of the empirical investigation will be a watershed or testimony of what nurses voice or claim about themselves, the nature of their job problems, if any, what retards them or detracts from their ability or willingness to put their act together in the provision of health services and what would motivate them to deliver quality health care in order to stymie or dam back the tide of criticism of their profession by the fastidious public.

In interpreting the results of the field work, the agreement or congruence between the nurses' responses and the earlier theoretical treatment in the preceding chapters of variables that impinge on the nurses' job, together with the assumptions and the hypotheses of the study and the relevant theories advanced in the body of the chapters, will be pulled together to seek a coherent relationship or divergence between or amongst them, as the case may be.

The plan of the chapter follows a predetermined pattern for ease of reference. Section 6.1 is an introduction which, in the African mythology, beholds the arrival at the "well", that is, the heart or core of the study or the interface with the nurses who are the real study subjects who have been skirted by the main theories of motivation, job satisfaction and attitudes detailed in the relevant chapters. Section 6.2 explains the meaning or intention behind the questionnaire questions. Section 6.3 provides the statistical and logistical distribution of questionnaires. Section 6.4 involves the analysis of the field work results under the following sub-headings: 6.4.1 general background; 6.4.1.1 age profile of respondents; 6.4.1.2 nursing experience after training; 6.4.1.3 marital status of respondents; 6.4.1.4 number of respondents with children and family size and 6.4.1.5 number and age ranges of respondents' children.

Section 6.4.2 is centred on participation and control. Its subsections are as follows: 6.4.2.1 type of nursing done by respondents; 6.4.2.2 choice in the type of nursing being practised; 6.4.2.3 input in the way nurses work; 6.4.2.4 exercise of initiative or discretion in the execution of nursing duties; 6.4.2.5 ability to change the way of organizing work; 6.4.2.6 working under pressure; 6.4.2.7 source of work pressure and 6.4.2.8 discussion of results from subsections 6.4.2.1 to 6.4.2.7. Section 6.4.3 is concerned with personal satisfaction and interpersonal roles. It has six subdivisions: 6.4.3.1 liking the kind of work being done; 6.4.3.2 satisfaction with pay; 6.4.3.3 relationship between size of remuneration and amount of work done; 6.4.3.4.desired rate of increase in remuneration; 6.4.3.5 satisfaction with the other benefits; 6.4.3.6 multilevel interpersonal relationships; 6.4.3.7 interpersonal relationship between supervisors and junior nurses; 6.4.3.8 mixing of senior and junior nurses at work and 6.4.3.9 discussion of results from subsections 6.4.3.1 to 6.4.3.8. Section 6.4.4 analyses and discusses working conditions in the public health services. Its subsections include 6.4.4.1 liking of working conditions of the nursing job; 6.4.4.2 things you particularly dislike about your job; 6.4.4.3 other conditions of your job you dislike; 6.4.4.4. thought of leaving nursing; 6.4.4.5 intention to remain in nursing; 6.4.4.6 preference of where to practise your nursing career in general if terms and conditions were acceptable to you and 6.4.4.7 discussion of results from subsections 6.4.4.1 to 6.4.4.6. Section 6.4.5 investigates responses to supervisory or nurse management practices. Relevant subsections are: 6.4.5.1 working relationship with supervisor; 6.4.5.2 a chance to make decisions about your job; 6.4.5.3 talking to your

supervisor and other higher authorities and 6.4.5.4 discussion of results from subsections 6.4.5.1 to 6.4.5.3. Section 6.4.6 is interested in organizational requirements in the following subsections: 6.4.6.1 communication system in the workplace; 6.4.6.2 communication system from higher authorities; 6.4.6.3 multiple nursing duties as the bane of job satisfaction; 6.4.6.4 part of your job to which you cannot give as much time as you would like; 6.4.6.5 opportunity to learn from present post and from employing institution; 6.4.6.6 how you feel about your general association with the hospital or city council in terms of giving you an opportunity to learn and 6.4.6.7 discussion of findings from subsections 6.4.6.1 to 6.4.6.6.

Section 6.4.7 dwells on rewards and inducements. Subsection 6.4.7.1 scrutinises the appraisal system in the workplace; subsection 6.4.7.2 inward feeling of achieving something really worthwhile; 6.4.7.3 some type of recognition for your nursing accomplishments; 6.4.7.4 comparison of pay in different health sectors; 6.4.7.5 comparison of nurses' pay with that of those outside nursing holding similar educational qualifications as those of nurses; 6.4.7.6 motivation factors to improve quality care to patients; 6.4.7.7 source of satisfaction in nursing job and 6.4.7.8 discussion of findings from subsections 6.4.7.1 to 6.4.7.7. Section 6.4.8 analyses and discusses the predictability of the influence of transfers on job relationships. Its corresponding subsections include 6.4.8.1 movement from one ward to another in a hospital after working for a certain period; 6.4.8.2 frequency of movement; 6.4.8.3 nurses' reaction to change; 6.4.8.4 government transfer system and 6.4.8.5 discussion of findings from subsections 6.4.8.1 to 6.4.8.4. Section 6.5 discusses the results of interviews.

The adjunctive section 6.6 serves a contextual purpose in the chapter. It provides a sample of attitudes which underpin the behaviour of nurses in their responses to questions on motivation and job satisfaction. Attitudes are not susceptible to overt observation but can only be inferred from the nurses' reactions towards factors related to motivation and job satisfaction. In view of their inherent nature, they could not be represented in the mainstream questionnaire questions. This justifies their separate or extractable treatment in the present section. Section 6.7 comprises summary and conclusions to the chapter.

6.2   MEANING OF QUESTIONNAIRE QUESTIONS

The elements of research are essential tools in any approach to empirical investigation. For example, the researcher must collect data by asking people who have experienced certain phenomena. She or he approaches a sample of individuals who have undergone certain experiences and collects information, among other things, through interviews and the use of mail questionnaires, as was the case in this particular study. The questionnaires, however, constitute the most important data collection method of the two used in this study to collect data from respondents. Questionnaires are used when questions demand a considered rather than an immediate answer. The production of the questionnaire is based on the nature of the problem under study, which appear to be of particular interest or concern to the group under investigation (Nachmias & Nachmias, 1976:27-30; Davies, 2007:82-100).

For purposes of this study each section of the questionnaire is designed to elicit information on certain work variables that relate to motivation, job satisfaction and attitude of nurses in the Botswana public health services. Questions 1-5 are general background questions intended to establish both a personal and a domestic history as well as a nursing background. Question 1 attempts to find out the reproduction age group of the nurse to see if there is any connection between leaving or wanting to leave the health services and getting married, for instance. Question 2 probes into the experiential knowledge in nursing which enables a respondent to make a meaningful contribution to the questionnaire. Questions 3-5 are concerned with a relationship between marriage and the number of children and their ages so as to determine if a nurse would be unhappy with working conditions devoid of adequate facilities such as a nursery, suitable schools and accommodation.

Questions 6-12 focus on the participation and control variables in a work situation. Question 6 begins by asking a nurse's current type of nursing. Some wards are busier than others and if inadequately manned the workload could be a potential source of dissatisfaction. The act of choosing the type of nursing represented by question 7 denotes empowerment in decision-making, which has a bearing on job satisfaction, performance and productivity on the part of the nurse. Questions 8-10 emphases the various angles of the phenomenon of choice in the way the nurse exercises her or his right in regard to the manner in which she or he carries out her or his nursing duties. Responses to questions 11 and 12 would indicate the many possible origins of the unhealthy prospect of working under pressure, which does not augur well for job satisfaction.

As a group questions 13-20 address the variables of personal satisfaction and interpersonal roles which portray the background to remuneration and fringe benefits, as well as the human factor of occupational relations amongst different levels of staff. These are pointers to what these factors can do in respect of the attitude of the nurse towards her or his work orientations. The simple attitude towards work contained in question 13 is developed further in the rest of the other questions in this band by detailing the foundation upon which one's liking of a job is based. The end-result is the weighting attributed to pay and benefits and to interpersonal roles as contributors to job satisfaction or dissatisfaction. Questions 14-17 pry into the nurses' mental-set regarding pay and benefits. The interaction between junior and senior nursing staff is treated in questions 18-20 with its implication to the positive benefits to work and the virtues of friendly supervision.

Questions 21-26 under the rubric of working conditions in the public health services examine a number of a nurse's feelings towards her or his job. Question 21 asks the nurse to state whether she or he likes the working conditions of her or his job. This is an effort to find out if she or he derives job satisfaction or otherwise from the working conditions. Questions 22 and 23 are a follow-up to question 21 on the negative side trying to establish details of the working conditions that the nurse may not like. Questions 24 and 25 search for the potential and long-term prospects for staying in the health services. The responses to these questions would provide useful data for the health services manpower or human resources planning. Assuming that nurses prefer to remain in the health services, question 26 requires them to indicate whether they would choose public or private health services.

Questions 27-29 cover an area of supervisory or management practices. They are mostly directed at the first-line management level. This is an attempt to find out if nurse management practices at this level are conducive to job satisfaction or whether they cause job dissatisfaction or other bottlenecks in the performance of nursing duties. These questions also try to discover whether the style of management is autocratic or participative. To the extent that first-line managers are the gatekeepers to the practical nursing profession, they are major determinants of job satisfaction or dissatisfaction, motivation and professional-attitude formation and moulding. The management process and the leadership style of the first-line nurse managers are responsible for creating the hospital or clinic environment in which the nurses work.

Questions 30-35 turn attention on institutional requirement such as communication, the job itself and opportunity to learn in the hospital environment. A communication system in an institution is the life-line of managerial effectiveness. Although the emphasis is on information tricking down from higher authorities, the bottom-up communication channel is equally important. Questions 30 and 31 are intended to establish the efficiency of such a reporting system as it can either enhance job satisfaction or be a cause of job dissatisfaction. Questions 32 and 33 attempt to discriminate between nursing and non-nursing duties. The latter have been blamed for exacting an unnecessary workload on nurses and thereby contributing to factors causing job dissatisfaction. Questions 34-35 relate to the possibility of the job itself and the hospital or city council work environment providing an opportunity to learn and develop in the profession. This chance is a source of job satisfaction and motivation to an aspiring nurse.

Questions 36-42 deal with rewards and inducements which can be regarded as the mainstay of the nurses' motivation, job satisfaction and attitude-tuning variables. Basically an attempt is made to find out if nurses develop satisfaction or dissatisfaction from the level of wages. Question 36 begins with an appraisal to discover if the appraisal reports, especially the positive ones, are linked to an upward salary progression. Question 37 follows up the preceding question with an effort to connect motivation to an appraisal system. Motivation is related to the recognition of nursing accomplishments and question 38 aims to draw a linkage between the two. Questions 39 and 40 refer to pay comparisons or relativities between nurse's wages and those earned by other people holding similar educational qualifications as those of nurses but working outside nursing. Questions 41 and 42 outline the various variables that would motivate nurses to improve on the health care and those factors that would give satisfaction to nurses in their job.

Questions 43-46 direct interest into the predictability of the influence of transfers on job relationships, which invokes the saying that variety is the spice of life by asking about the movement of nurses from one ward to another in the hospital and by inquiring about the nurses' attitude towards the general government transfer system which applies to both central and local government nurses. This movement is intended to facilitate learning in new nursing environments and in turn climbing on the learning curve brings about motivation, job satisfaction and correct job attitudes.

For the sake of clarity, the responses to these questions will be analysed and discussed under various sections. Section 6.4.1 deals with the general background of respondents. Subsections 6.4.1.1; 6.4.1.2; 6.4.1.3; 6.4.1.4 and 6.4.1.5 analyse responses to the general background questions 1-5. Section 6.4.2 focuses on

participation and control factors. Its subsections 6.4.2.1; 6.4.2.2; 6.4.2.3; 6.4.2.4; 6.4.2.5; 6.4.2.6 and 6.4.2.7 analyse responses to the 6 to 12 group of questions concerned with participation and control. Subsection 6.4.2.8 gives a summary of analysis of results from section 6.4.2. Section 6.4.3 examines the variables embraced in personal satisfaction and interpersonal roles, which are represented by questions 13 to 20. The analysis of responses to these questions is carried out under subsections 6.4.3.1; 6.4.3.2; 6.4.3.3; 6.4.3.4; 6.4.3.5; 6.4.3.6; 6.4.3.7; and 6.4.3.8. Subsection 6.4.3.9 deals with a summary of analysis of findings from section 6.4.3.

Section 6.4.4 treats working conditions in the public health services. Its subsections 6.4.4.1; 6.4.4.2; 6.4.4.3; 6.4.4.4; 6.4.4.5 and 6.4.4.6 analyse responses to questions 21-26. Subsection 6.4.4.7 gives a summary of analysis of the findings from section 6.4.4. Section 6.4.5 is concerned with supervisory or nurse management practices. Its subsections 6.4.5.1; 6.4.5.2 and 6.4.5.3 provide an analysis of responses to questions 27 to 29. Subsection 6.4.5.4 discusses the findings from section 6.4.5. The responses to questions 30 to 35, which refer to organizational requirements, are analysed and discussed in section 6.4.6. The relevant subsections are 6.4.6.1; 6.4.6.2; 6.4.6.3; 6.4.6.4; 6.4.6.5 and 6.4.6.6. Subsection 6.4.6.7 discusses the findings from section 6.4.6. Rewards and inducements under section 6.4.7 and its offshoots 6.4.7.1; 6.4.7.2; 6.4.7.3; 6.4.7.4; 6.4.7.5; 6.4.7.6 and 6.4.7.7 analyse responses to questions 36 to 42. Subsection 6.4.7.8 discusses the results from section 6.4.7. The penultimate section 6.4.8 on predictability of the influence of transfers on job relationships with subsections 6.4.8.1; 6.4.8.2; 6.4.8.3 and 6.4.8.4 analyse the findings from responses to questionnaire questions 43 to 46. Subsection 6.4.8.5 discusses the results from section 6.4.7. Section 6.5 discusses the results of interviews.

Section 6.6 adds attitudes as a third angle to the research. The other angles are motivation and job satisfaction. Questionnaire items did not include identifiable questions on attitudes. Yet the latter are implied in both the motivation and job satisfaction study variables and in the behaviour which directed nurses' responses to the survey questions. The purpose of this section is to demonstrate that although attitudes were not made to stand on their own in the survey; they formed an integral part of the investigation. The significance of this section, therefore, lies in illustrating the practical manifestation of attitudes in the behaviour of respondents. This could not have been achieved in a more effective way than by giving examples of attitudes in the section to vindicate their linkage and relationship to the field of study.

6.3   DISTRIBUTION OF QUESTIONNAIRES

900 questionnaires were distributed to 9 of the 26 public hospitals and 25 public clinics (13 in Gaborone and 12 in Francistown) and 702 were returned constituting a response rate of 78%. The target population was both registered (a registered nurse is a qualified nurse who has received a broader training in the theory and practice of nursing and who plays a more responsible role in nursing) and enrolled (an enrolled nurse is a lower-grade nurse whose preparation has emphasized practical nursing and acts as an assistant nurse with less responsibility) nurses with at least two years

of work experience in the public health services. The study commenced in the southern part of the country with Athlone and Lobatse general and mental hospitals, respectively, both in Lobatse town. The mental hospital was included in the research because it has a large proportion of general nurses who have been recruited from the general hospital as a result of a shortage of mental nurses. The response from nurses in both these two hospitals was not encouraging, although the respective matron's offices were helpful in securing the return of whatever was left of the completed questionnaires after a number of them was either lost or spoiled. Questionnaires were also distributed in the Seventh Day Adventist hospital, which is west of Lobatse town with a hundred percent return rate. Thamaga and Scottish Livingstone hospitals in the Kweneng district to the west of Gaborone cooperated fully with a hundred percent return rate.

Sekgoma Memorial hospital in the northern part of the central district completed all the questionnaires lodged with the Medical Superintendent's Office. In Selibe-Phikwe general hospital in the eastern section of the large central district, questionnaires were deposited in the office of the Chief Medical Officer. They were collected after two weeks by the researcher *en route* from Sekgoma Memorial hospital with a loss of three questionnaires. In the south east district the Bamalete Lutheran hospital nurses participated in the study with the most dismal response rate. The matron's office was not forthcoming, although the Chief Medical Officer was receptive and welcomed the research effort. The Deborah Retief Memorial hospital in the Kgatleng district also displayed apathy in taking part in the survey, in spite of the visible support to the endeavour by the offices of both the Chief Medical Officer and the matron. The return rate of the questionnaires was as discouraging as that from the south east district. The Gaborone city council and the Francistown city council clinics showed significant interest in the survey. However, in the case of the former collection of the completed questionnaires was hampered by the shift work of nurses including night duty. As for the latter the Matron's office both distributed and collected back the filled questionnaires on behalf of the researcher.

The answering of questionnaires was pregnant with its own deficits. It has been learned that even if questionnaire questions were clear and unambiguous, respondents may spoil their intended meaning by shunning the instructions laid down for their completion. If, however, this aspect is satisfied, another lurking problem is the non-return of the distributed questionnaires. However, the response rate of 78% is still quite useful to reach important conclusions on the study.

6.4   ANALYSIS OF FINDINGS

The analysis of the survey responses falls under given sections with each section commanding determined sub-divisions.

6.4.1   General background

This section deals with general biographical information contained in questions 1-5 about the nurses who took part in the research, which may or may not influence their views towards the selected aspects of their job.

In this section the age of respondents determines their reproductive stages which give an estimate of the ages of their children. This data have an impact, for instance, on the difficulties experienced with the government's transfer scheme in respect of accommodation and children's facilities. The age and number of dependent children can be a menace to both married and unmarried nurses with regard to facilities such as crèches, schools and shopping centres. The married nurses may have the added stress and tension caused by having to leave the husband or wife behind on relocating. It is not easy for a married family in Botswana to move homes and jobs at the same time. This applies whether both husband and wife are nurses, or whether both of them work for the same government ministry in different jobs, or whether one of them works for a different employer including a different government ministry. The general background questions 1-5, therefore, set the scene for an anticipated analytical terrain.

6.4.1.1   Question 1: Age profile of respondents

The significance of age to motivation, job satisfaction and attitude defies a linear explanation.

Table 1   Age profile of respondents

Age in years	Number of respondents	Percentage of respondents
20-24	10	1.4%
25-29	138	19.7%
30-34	115	16.4%
35-39	178	25.4%
>40	261	37.2%
Total	702	100%

As can be discerned from the above table the majority of nurses (37.2%) were in the old or middle age band of over 40 years followed by the 35-39-age range (25.4%). The younger age group of 25-29, which made up about 20% of the total, was the third important division. The general finding reported by Herzberg, Mausner and Snyderman (2004: 46-48) on the relationship between job satisfaction and age shows that job satisfaction starts high, declines and then begins to improve again with increasing age. Herzberg and his colleagues suggest that job satisfaction increases with age because the individual comes to adjust to her or his work and life situation. Job satisfaction is initially high but declines, as expectations are not met,

only to rise again as the individual again adjusts to her or his work situation. It has further been noted that job satisfaction declines some five years before retirement. This decline has been explained as being due to a blockage in the possibilities of growth and achievement. Job satisfaction did not seem to get better with or to be attenuated by advancing age for the Botswana nurses in the public health services. For example, the majority of these nurses of whom the older ones comprised the highest proportion, expressed dissatisfaction with pay and working conditions (tables 14 and 21). Furthermore, if nurses had complained about pay, for instance, for more than ten years (Rampa, 1991:47-50 and also Rampa, 2000:52-54) without relenting, there is no evidence on the basis of the present findings, to suggest that they have become accommodative to their work conditions, because their aspirations were not fulfilled.

In essence age appeared to be a significant factor in job satisfaction. For example, Wagner, Loesch and Anderson (1977:120-130; Stride, 2007: 45-67) reported that the older the nurse the more likely that she or he was doing career planning for the future. This was not proved in the Botswana study. For example, the age range of 35 to over 40 years for the majority of the public health services nurses was representative of 62.5% of the sample (table1). As shown in table 25 the majority of 59.7% of all the nurses do not intend to remain in nursing until they retire. Due to the fact that 62.5% of the nurses represent the category of older nurses (35 years and older), it is expected that a high percentage of this 59.7% is represented by the older nurses. Taken at its face value this negative intention signifies the expectation that it is mainly the older nurses that plan to quit both nursing in the public health services and nursing in general. With the statutory retirement age set at 60 years in Botswana, it cannot be said that the older these nurses were the more they were planning for the future. Put differently, there was no correlation between older age and future planning intentions. Wagner and others' theory was not sustained on this point.

In addition (Wagner *et al.,* 1977:120-130; & Stride, 2007:87-92), found that satisfaction with pay, fringe benefits, job security and recognition from the nursing administrators increases with older age. These findings, however, are also at variance with the Botswana public health services nurses. For, example most of the nurses of whom the older ones are the majority, were not happy with their working conditions (table 21-23). This factor might have been related to the lack of symmetry between older age and planning intentions. Furthermore, older age did not help to raise these nurses' satisfaction levels with variables such as pay, fringe benefits and job security. For instance, the grievances over pay (table 14) were the strongest of all the nurses' complaints. Dissatisfactions with the other benefits (table 17) were equally significant regardless of older age. Wagner and his colleagues' theory that the older the nurse the more stable and job satisfied she or he became, therefore, did not take with or was not supported by the Botswana study.

On certain aspects of rewards and inducements such as recognition most of the nurses were not satisfied (table 38). It is within the bounds of probability that most of the responses on this icon probably came from the older genre of nurses, representing the majority of the nurses, who could have been more concerned with recognition than the younger nurses. This observation would satisfy Wagner and his partners' theory that the need for recognition increased with older ages.

To conclude, therefore, the Botswana study shows that older age is not related to more planning for the future. Nurses even thought of leaving nursing let alone planning for retirement in it. With the majority of the nurses dissatisfied with their working conditions including pay and fringe benefits such as housing, any job satisfaction there was is expected to be limited to only isolated factors such as liking the nursing task requirements and other nursing colleagues (tables 13 and 18).

Related to the question of age and job satisfaction is the aspect of tenure. Job satisfaction has been found to be related to both age and length of service (see chapter 4: section 4.4). With increased length of service, the importance to job satisfaction of factors such as self-actualization and conditions of work decreases but the importance of pay increases (see chapter 4: section 4.3). Furthermore, the older the employee the more important becomes job security and benefits accruing to longer service such as pension rights leading to a lower rate of labour turnover (see chapter 3: section 3.6). However, according to Gruneberg (1979:93; Latham, 2007: 28-36) the relationship between job satisfaction and tenure is by no means clear.

Although in essence the Botswana study did not investigate directly the relationship between age and length of service and job satisfaction factors, relevant and juxtaposed information can be extrapolated from its findings, emphasizing the latter statement by Gruneberg and Latham. For example, a significant majority of nurses (92.2%) in table 14 is not satisfied with pay. Although this 92.2% may seem to be representative of mainly the older nurses as they are the majority in this study, one must remember that the importance of pay as one of the major variables of job satisfaction cuts across all age groups. It is unrelated to both length of service and age. A majority of 67.3% of the nurses in table 21 is also dissatisfied with conditions of work, with the implication that the importance of the latter has not decreased and it has also no connection with the length of service. Although this may also seem to represent mainly the older nurses due to their being the majority in the study, it also has no connection with a particular age group or the length of service, as the importance of work conditions as a variable of job satisfaction cuts across all age groups and length of service.

The Botswana field study did not research on the link between the older age of employee and the importance of security. However, if the indication by a majority of 59.7% of the nurses (table 25) who show no intention to remain in nursing until they retire is viewed against the fact that the older nurses represent the majority of the respondents in the study, one may deduce that most of the nurses in the Botswana study who held this view have a lack of security and that this view is mainly held by the older nurses.

The older age group of nurses as indicated above as those nurses who are 35 years and older, accounts for 62.5% of the sample (table 1). This is the group that is expected to constitute the senior nurses. These nurses, being the majority in the sample, are expected to form the majority of the 79.3% who expressed a high degree of the liking of one another by saying that they liked the other nurses they worked with (table 18). Herzberg (1959:135; Vroom, 1990:15-38) emphasized the importance of human relations at work as a source of job satisfaction (see chapter 4: section 4.4.1.2.1). The strong interpersonal relationships amongst the majority of the nurses are symbolic of a commitment to their work, dedication, team spirit, unity of purpose, cohesiveness, high morale and professionalism. In a work environment characterized

by heavy workload (table 22) resulting from persevering staff shortages (table 23), the nurses called upon their motivational resources to meet the challenges of the job demands. Thus, according to Stewart (1992:225-230) (see chapter 4: section 4.3.1), the job demands were matched with aspects of the institutional environment.

Apart from bearing the brunt of pressure of work, extra workload, ancillary work and being subject to burnout and stress, the nurses are also the victims of a government transfer policy which is disliked by 37.3% of all the nurses (table 23).   The younger age group of nurses, ranging from 20-34 years is expected to be the junior nurses who account for 37.5% of the sample (table 1). These nurses in particular are the maids in waiting for promotion based on an appraisal system rated as only being fair by 51.1% of all the nurses (table 36). Therefore, it is expected that the nurses who suffered from lack of promotion which is disliked by 44.4% of all the nurses (table 22), are mostly representative of the younger nurses. It is also this group of nurses comprising mainly single nurses who form the majority of the nurses who work on the shop floor on the wards and in the clinics absorbing the pressure of work for little pay.

The junior nurses face both a difficult and demanding work environment through which they battle, steeled by motivated self-conceptions and positive attitudes towards a profession they had chosen voluntarily. Their serving work-oriented set of attitudes is founded on a strong cooperative teamwork and a professional affinity of people caught in the same plight. According to McClelland (1984:1984:182-183; Bruce, 2002:1-17) their determination to stay on the job despite difficulties such as staff shortages coupled with an increased workload, is based on the self-images developed from folklore conceptions of a security oriented job such as a government service (see chapter 3: section 3.5). However, according to Brockner (1988:1x; Silverstein, 2007:46-70), the institutional environment was controlled by the various levels of supervisors such as ward managers and the matron who employed job performance measurement instruments such as appraisals and administered rewards (see chapter 3: section 3.5). The feelings of powerlessness and anomie experienced by all the nurses, for example, over working conditions such as opportunities to go for further training and or education over which they had no influence, generate dissonance emotions (see Festinger's 1957:2-9 theory of cognitive dissonance in chapter 5: section 5.2.2.1.5).

The older age group of nurses 35 to over 40 years is composed generally of the nursing supervisors. The interpersonal relationships between the supervisors and junior nurses is described as "well" by 38.3% of the nurses and "sometimes well" by another 41.7%, but 16.1% of the nurses say that the supervisors and the junior nurses do not relate well with one another (table 19). This could be explained by the fact that communication in the form of holding both the general and ward meetings is poor or irregular. The former is a means of keeping the junior nurses abreast of matters current with the Ministry of Health. Although the latter is concerned with ward clinical issues, it is also a feedback forum for the junior nurses' grievances against their seniors.   However, the fact that senior and junior nurses mix well at work according to 52.6% of the nurses (table 20), may only hide the junior nurses' seething dissatisfaction over the incompetence of senior nurses in respect of interceding on their behalf on a number of working conditions such as lack of accelerated promotions.

It has been noted that the older the employee the more important becomes job security and benefits accruing to longer service such as pension rights, leading to job satisfaction and a lower rate of labour turnover. Longer service also implies acquiring nursing experience as examined in table 2 below.

6.4.1.2   Question 2: Nursing experience after training

Table 2   Nursing experience of respondents

Experience in years	Number of respondents	Percentage of respondents (%)
2 years	71	10.1%
2-5 years	110	15.7%
6-9 years	68	9.7%
>10 years	445	63.4%
	694*	98.9%

Key*   Some nurses omitted this part of the questionnaire

The work responsibilities of junior and senior nurses or nursing supervisors have been referred to in section 6.4.1.1. Table 2 depicts the nurses' professional years of experience, which contain their expected roles and assumed clinical knowledge. These are the years the nurses have spent practising nursing after completion of their training and registration with the Botswana Nursing Council. As can be noticed from the table, 10.1% of the of nurses have two years post training experience. Nurses with 2-5 years of nursing experience account for 15.7% and only 9.7% of nurses have practical nursing experience ranging from 6-9 years. The majority of nurses (63.4%) have practised nursing for more than 10 years. The second least experienced group of nurses are the transient or peripatetic group who are moved from one ward or clinic to another after a given period, for the purposes of orientating them to these different departments. For example, table 43 shows that the majority of nurses (55.6%) who are moved from one ward to another in the hospital, after working for a certain period, do so to gain experience. The small number of 16.4% and 7.4% of the nurses who were not moved or were sometimes moved, respectively, comprise the more experienced nurses.

Those nurses with more than 10 years experience are expected to be the potential candidates for promotion into supervisory posts in particular wards, either by virtue of having spent a number of years working on the same ward, or had specialized by way of further training in the nature of work specific to that ward. The specialization would have been motivated by an intrinsic interest in the clinical work of the designated ward and the expected extrinsic rewards such as increased pay that ensued (see chapter 3: section 3.3.1.1 for discussion of intrinsic and extrinsic motivation). The need to specialize would also have arisen from the job satisfaction enjoyed in that ward and the desire to fulfill a special need such as the exercise of autonomy (see chapter 4: section 4.4.2.2 for discussion of needs fulfillment theory). In view of the lack of opportunity for further education and training, which is disliked

by 58% of the nurses (table 23), an extra specialization qualification would confer an advantage towards promotion.

From the information obtained, 35.5% of the nurses have less than 10 years experience (table 2), which necessitated movement from one ward to another in order to familiarize themselves with different clinical work on these wards; in other wards, to learn. For instance, an eye ward would be different from a maternity ward. There is also the need to learn how to carry out certain procedures pertaining to a particular ward such as putting ointment in the eye of a patient in the eye ward. In addition different wards help nurses with varied experience to test the application of their theoretical knowledge in anatomy and physiology, for instance, in their clinical processes and nursing diagnoses of different illnesses. Analysis of the information in table 34 shows that the majority of 58.5% of the nurses regard their current post as a job in which they can continuously learn; in other words the majority views their job as having motivational value, an aspect that is promising. What is less promising, however, is the fact that according to table 35 the largest group of nurses (38%), regard the hospital or city council as providing some opportunity to learn but not much, while 19.1% of the nurses feel that these health facilities afford little opportunity to learn and 16.8% feel that no opportunity is provided.

The 15.7% of nurses with 2-5 years of nursing experience after qualification are another group of nurses poised for promotion, which starts from 5 years post training experience. For those nurses who have been fortunate to go for a nursing degree course for 3 years after 2 years practical nursing experience, the chance of accelerated promotion on return to nursing is assured. For such nurses the expectation of advancement into positions of more responsibility, not only satisfies their aspirational needs, but also provides a source of motivation, improved work performance and job satisfaction (see chapter 3: section 3.4 on work performance and motivation; chapter 4: section 4.4.1 on content theories). With their achievement motive in obtaining a higher qualification satisfied, their productive and commitment attitudes to the institution are reinforced (see chapter 5; section 5.4.1.2 on operant conditioning). But for the non-degree nurses who relied on experience alone coupled with the results from a capricious appraisal system described as "non-existent" by 4.1%, "bad" by 9.3%, "unfair" by 14.2%, "fair" by 51.1% and "good" by 12.7% of the nurses (table 36), the path to promotion was slow and could take anything from 5 to 10 years. With etiolated or reduced chances of climbing the promotion ladder the less academic nurses' self-conception towards their work is demotivated. Their sense of organizational and or institutional commitment is based on the negative values of job satisfaction and their attitude relies on the outcomes of a favourable interpersonal relationship with supervisors (see chapter 3: section 3.5 on motivated self-conception; chapter 4: section 4.4.2 on process theories and chapter 5: section 5.4.1 on classical conditioning). Many nurses with the 2-5 years post-training nursing experience operate on the ward shop floor. They are the clinical nurses, the nurses mostly in daily contact with patients, the shift workers or the nurses that make things happen throughout the hospital or the clinics.

The two nursing groups with 2 and 2-5 years nursing experience after training, making a combined total of 25.8% and the lower part of the 6-9 years experience nursing cadre, are more liable than the nurses with more than 10 years experience, to move from ward to ward for learning purposes. The majority of 58.5% of nurses are moved after a year or more (table 44), depending on the staff demands for

various wards. This longer interval before nurses change wards is caused by staff shortages. But it is a blessing in disguise because it helps nurses to consolidate their experience in given wards. However, it also at the same time retards the rotation of nurses through various wards and departments. It is of little surprise that the usual or normal rotational period of 3 to 6 months is short-changed by the ravages of staff shortages. This results in no nurses moving every 3 months and only 0.5% rotating every 6 months (table 44). The majority of 51.1% of nurses like to change wards (table 45), although the opportunity to do so may be limited by the skeleton staff situation. Only 19.1% of nurses do not like ward movements (table 45). One of the possible reasons for this dislike is that sometimes nurses get more used to particular wards than others.

The 9.7% group of nurses (table 2) with 6-9 years nursing experience after training forms the real beginning of nursing seniority. In the majority of cases these nurses would have completed the programme of moving around in different wards and acquired an overview of nursing activities in the whole hospital or city council clinics. They are most likely to be resident on one ward or clinic where they will distil all the experience obtained from a tour of learning placements and now preparing for promotion. Most of the clamour for promotion or advancement is likely to come from this camp as they vibrate with knowledge and experience. They act in supervisory positions and they present papers at seminars and workshops as part of their management training. They participate in continuous education lectures and give talks on selected topics. All these avenues are intended to catch the attention of those who wield the power of promotion. On the brink of self-actualization fulfilling their Maslowian higher-order needs, with expectant job satisfaction bursting at the seams at this particular point of their professional life, these nurses' motives are rearranged and move into top gear. They have mastered their work environment. They display a motivated self-image with an attitude driven towards high performance. Their attitude and behaviour become adjusted towards receiving higher rewards both in monetary terms and recognition (see chapter 3: section 3.4.2 on changing behaviour of motives; chapter 4: sections 4.4.1.1 on Maslow's theory and 4.4.3 on time changes in job satisfaction and chapter 5: section 5.3 on connection of attitudes to behaviour).

The 63.4% of the nurses (table 2) with more than 10 years experience after training are the real gurus or the clinical moguls of the nursing experience, who have mellowed both chronologically and professionally. The majority of them would be expected to be in supervisory positions. Some may be stationed on the wards as nursing consultants and others may be housed in offices next to the matron's office and may form part of her entourage when visiting the wards. The long years in nursing have sharpened their perceptions and judgments in the profession. They are geared towards promoting the image of nursing, together with its associated professionalism. They have settled in the profession and because they have made it to the top, they desire to show that they have developed the competencies which come with accumulated experiences. This group of nurses has achieved the psychological advantage, with which they have chosen to join nursing, of working their way up in a career of their choice. Their career is at a juncture in which both intrinsic and extrinsic motivations are in a balanced mixture. As they reap both the psychological and financial rewards, their job satisfaction level is construed within the ambit of a social reference group in which they perceive their situation to be better than that of their contemporaries. In view of the recognition accorded to these high

echelon nurses, their enhanced attitudes exude positive valances thereby increasing their performance behaviour (see chapter 3: sections 3.3.1 and 3.7; chapter 4: section 4.4.2.1 and chapter 5: section 5.4.2 on intrinsic and extrinsic motivation and psychological advantage, social reference group theory and expectancy-value theory, respectively).

In learning the ropes of their job the less experienced nurses are guided by Maslow's (1964:386-396) hierarchy of needs. They work in the ward in a team of nurses charged with high morale. Their pay levels are adequate to cater for their physiological needs. But they are also aware that they had chosen a career of nursing to meet their safety needs in a job that had security of tenure. To go further than this they are motivated to progress to the higher reaches of their profession in order to access better levels of pay. They strive to climb the mountain of promotion in a circuitous way. For example, they tolerate heavy workload in the wards caused by staff shortages. They show job satisfaction in liking the jobs they are doing. In their teamwork in the ward they like one another. They also mix well with their supervisors. They do not buckle under pressure from the job. They rotate through different wards and clinics in order to master the job and achieve the necessary level of experience. The period spent in the rural areas on a government transfer scheme is part of this experience. Team working in the wards foster recognition and approval by nursing peers. The pinnacle of the whole motivational path followed by the less experienced nurses lead to self-actualization, effected by promotion into supervisory positions or other top posts in nursing (see chapter 4: section 4.4.1.1 for fuller exposition of Maslow's theory). A motivation system has an attitude component (Reece & Brandt, 1984:70; Fairweather, 2007:29-32) which assists or prompts behaviour in a given direction. The nurses' behaviour or achievement motive is reinforced by what they expect to get from their efforts towards promotion (see chapter 5: section 5.2 and section 5.2.1.3 for discussion of the concept of attitude and expectancy value theory).

For the majority of the more experienced nurses in the over 40 years age group, worries about the basic necessities of life are no longer a preoccupation. They are expected to have reached high levels of both intrinsic and extrinsic job satisfactions with a balanced attitude towards their work and towards the profession. The Maslowian evidence of self-actualization should be evident. The interaction between intrinsic and extrinsic motivation is assumed to have produced the best in them to enable them to portray the highest image of the nursing profession (see chapter 5 section 5.3.4 image of nursing). Most of their needs have been fulfilled both in terms of life satisfaction and in the context of Maslow and Herzberg's theories (see chapter 3: section 3.3.1.1 for intrinsic and extrinsic motivation, chapter 4: section 4.4.1 and 4.4.2, on content and process theories respectively).

The majority of the nurses who are older also have a longer nursing experience, which reinforces their retention rate as the perceived ease of movement from their institutions is shackled. If the perceived availability of outside alternatives such as other jobs is a function of the age of the participant, it would be expected that such restriction would be exacerbated by marriage.

6.4.1.3   Question 3: Marital status of respondents

The antagonism between career and obligations to home and family has been a much discussed role conflict within nursing. Some studies of the relationship between turnover and job satisfaction do not find marital status to be a significant factor. Wagner *et.al.* (1977:120-130; Stride, 2007:45-67), for example, found that for *both* single and married registered nurses the reasons frequently given for terminating employment were too low salary, frustration with overwork and understaffing, a feeling of a need for a change and returning to school.

Table 3   Marital status of respondents

Marital status	Number of respondents	Percentage of respondents (%)
Single	314	44.7%
Married	322	45.9%
Separated	10	1.4%
Divorced	28	3.9%
Widowed	28	3.9%
Other	0	0
	702	99.8%

Researchers such as Huber (1973:37-48), Osipow (1973:41-58; Hartevelt, 2007:10-11) and Simpson and Simpson (1969:28-42), however, found that registered nurses left their profession primarily because their work interfered with their family responsibilities.

Being single does not necessarily imply being young. In section 6.4.1.1 the group of young nurses is considered as ranging from the age of 20 to 34 years (table 1). The majority of nurses (45.9%) are married (table 3). No assumptions are made here about older age or younger age being associated or not associated with marriage. But admittedly the normal or expected adult life trend in the Botswana society's system of values and beliefs correlates marriage with older age, all things being equal, of course. On the basis of these arbitrary guidelines, an intelligent guess would suggest that the majority of married nurses are older. Although the difference in percentage between single and married nurses is narrow, if the percentages of "separated" (1.4%) "divorced" (3.9%) and "widowed" (3.9%) (table 3) were added to the group of married nurses, this would inflate the original number of the latter to over 55% which is over half the total sample of nurses. The combination of the majority of nurses belonging to an older age group and of being married at the same time seems to make sense if it is viewed alongside the demands of the household economy.

As an example the majority of nurses (92.2%) are not satisfied with pay (table 14). It is most fitting that the dissatisfaction with pay arises from this group of married nurses who face the increased budgets of maintaining a marital home and life surrounded by extended family members from both sides of the spouses and probably from raising children as well. And yet it was argued in sections 6.4.1.1 and

6.4.1.2 (tables 1 and 2) that the older nurses were in most cases in supervisory positions which had the allure of better pay. The irony of this supposition and the dissatisfaction with pay may be subject to other explanations. Firstly, it might be possible that the Botswana nursing salaries are poor across the board for both junior and senior nurses and supervisors. Secondly, amongst the group of older nurses, there could be just a few of them occupying supervisory positions and earning higher salaries. Thirdly, the older nurses have more children than the younger nurses and their salaries are stretched to the limit. Despite all these imbalances between older age, lack of satisfaction with pay and marital status, the factor of job satisfaction in general due to longer tenure and maturity is made firmer by marriage, which in the majority of cases is associated with bearing children.

If it is believed that the single nurses are also young and are the junior nurses who receive low pay and who man most of the wards and clinics, as suggested in sections 6.4.1.1 and 6.4.1.2, then they add to the chorus of the dissatisfaction with pay expressed by older nurses. Their reasons for wanting, as opposed to needing, higher pay can be explained by the demands of a consumer society whose rising incomes have to mirror the increasingly more status conscious life styles in Botswana, which are precipitated by the miracle economic successes (see chapter 2: section 2.1). However, for both married and single parent families, children do add strain to the household finances.

6.4.1.4   Question 4: Number of respondents with children

The information regarding the number of children and their ranges in age is not only a mathematical, but also a Malthusian enquiry in respect of the responsibility for rearing children and the financial burden attached to their various needs such as schooling, depending on their number and their ages. These concerns impact on nurses' motivation, job satisfaction and attitudes towards their work.

Table 4   Number of respondents with children

Number of respondents with children	Number of children	Percentage of respondents (%)
75	0	10.7%
212	1	30.2%
196	2	27.9%
120	3	17.1%
68	4	9.7%
31	>4	4.4%
Total 702		100%

In table 4 two extremes in the data can be observed. Firstly, 10.7% of the nurses have no children. This has nothing to do with their being single, married, infertile or

unwilling to have children. Secondly, 4.4% of the sample has more than 4 children inside or outside marriage. The majority of nurses (30.2%) has one child and (27.9%) of the respondents have 2 children. Those nurses with 3 and 4 children, respectively, are 17.1% and 9.7% in that order.

Nurses with no children can be in the young and old age groups, sharing one advantage of not having the responsibility for bringing up children and the financial expenditure that goes with it. If these nurses happened to be young they will find themselves freely mobile on the government's relocation system (see chapter 2: section 2.4.3 on decentralization of health services). They will be expected to complain less about pay, enjoy more job satisfaction, be motivated to learn more in their jobs and show a positive attitude in search of promotion which can place them anywhere in the country, because of their unrestricted mobility. They will not have problems with accommodation, which is one of the working conditions disliked by 51.9% of the nurses (table 23). Because they will not be tied down with family responsibilities, they will be driven by a strong desire to speed up their promotions. They most probably will also be among the 57.8% of nurses who are dissatisfied with the lack of opportunity for further education and training (table 23). Burdened less with the scarcity of financial resources, these childless nurses will be in a position to buy their own cars and, thus, will probably not add to the dissatisfactions about the lack of transport expressed by 22.4% of the nurses (table 23).

However, if these nurses with no children are in the old age group, they will be expected to be in supervisory positions receiving a higher salary to lessen their financial worries. They will also have done time in the remote areas to satisfy the government's transfer system requirement before promotion. With no children they will have no problem with accommodation and transport, as they are likely to be settled in towns. There will be very few of these older age group nurses without children.

The 4.4% of nurses with more than 4 children (table 4) can be married or single, old or young, but are both characterized by the parental responsibilities of looking after a fairly large family. These responsibilities include psychological aspects, that is, the emotional caring and worry over children's welfare. Physical responsibilities include accommodation and children's facilities such as schools and crèches. These two parental duties are overshadowed by financial responsibilities. Nurses in this group will be more concerned about pay and other working conditions such as accommodation. Their motivation to work and their job satisfaction and attitude towards work will be affected negatively by factors in the work environment that they believe to be inadequate in matters such as pay. If these nurses belong to the younger age group, they will find the government's transfer policy difficult to implement, because of the problems of housing. They will be forced to leave children behind on transfer, or take them with them and suffer the consequences of overcrowding and the lack of schools.

The 9.7% of nurses with 4 children and the 17.1% with 3 children (table 4) can be older or younger, married or single, junior or senior nurses with one thing in common, that is, financial commitments over the family. Thus, the 4.4%, 9.7% and 17.1% groups of nurses (table 4) with varying numbers of children share similar financial experiences depending on the ages of their children. Whether promoted, or not, they will not be happy to be transferred from one part of the country to another on a

government transfer programme. The 30.2% and 27.9% of nurses (table 4) with 1 and 2 children respectively, if young, will be less encumbered if they are to move around on the government transfer policy.

If for practical purposes the 10.7%, 30.2% and 27.9% group of nurses with no children, 1 and 2 children respectively (table 4) can be considered to be the most able to go around on the government transfer system, they can also be taken to be the most likely to be young both in age and in profession. Against this background they will be the same group of nurses which inhabits the wards and clinics in a high morale of peership. Their motivational potential will be driven by needs such as for promotion and for further education and training or in general for furthering their own professional nests. Their motivational system, according to Deci and Ryan (1990:3-5), will be directed towards processes that give meaning to the satisfaction of those needs (see chapter 3: section 3.2 for details of theory). Their job satisfaction will draw upon a number of theories such as a need for fulfilment and social reference. The latter, for example, could best contribute to their team work spirit in the ward and their high interpersonal relationships could help them through the pressure of work from the extra-workload.

It has been pointed out in the last but one paragraph above that the nurses under discussion have a maximum of 2 children (table 4). Although the number of nurses' children gives some idea of the responsibility involved in caring for them, it is the ages of these children that give more precise information about the degree or extent of that responsibility.

6.4.1.5   Question 5: Number and age of respondents' children

It has been common knowledge that children's care programme at different ages incur different expenditures. For example, the clothes of a 10 year old cost more than those of a 4 year old. To the nurse parents of children of different age groups, financial outlays from the income they receive from their jobs may be different. Therefore, pay level is one of the working conditions that stands head and shoulders above others such as accommodation, whenever considering expenditures over children's welfare. In this sense talking about the number of children nurses have is not enough on its own. The picture becomes clearer when the ages of their children are analysed. This section examines some of the nurses' working conditions in the light of their children's requirements.

Table 5   Number and age ranges of respondents' children

Age band of children in years	Number of children	Percentage of children
0-4	168	20.2%
5-9	270	32.5%
>10	393	47.3%
Total	831	100

Under normal reproductive circumstances the younger the children the younger the parents with particular reference to the mothers. Table 5 shows that 20.2% of the nurses' children were of the age 0-4 years. These would be non-school going children attending crèches or staying at home. Their welfare would affect parent nurses in a number of working conditions. For instance, their young parents would be candidates of the government transfer policy. In the distant places where they would be posted, there would be a dearth of congenial facilities for children such as day care centres. The growing child would live in a deprived environment for 2 to 3 years with resultant learning disadvantages. This would cause job dissatisfaction in parent nurses towards relocation. The shortage of accommodation for the transferred nurses with children would pose another problem. The pay for these nurses is often low for them on their own let alone with children. Thus, these nurses would be on the bandwagon for more pay.

The other young group of children is 5-9 years age range (32.5%) who would most likely be school-going. The nurse parents would probably be a mixture of relatively young and old. Those belonging to the younger group have some of their working conditions affected by the welfare of their children in a similar way as the parents of the 0-4 years old children. The older group of nurses with children aged from 5-9 years might be in supervisory nursing positions earning a higher salary. But because they spend more money on this age group of children on school requirements such as uniform, their pay may be depleted to the point of dissatisfaction. The essential point is that the needs of children which grow or increase or become more expensive with their increasing ages has a toll on the nurses' aspects of working conditions such as pay which may cause job dissatisfaction.

The largest group (47.3%) of nurses' children is those over the age of 10 years. These children would most likely belong to the older group of nurses who might or might not be in senior or supervisory positions with higher pay. The expenses such as the cost of clothes transport to and from school, uniform and school lunches may cause nurses to agitate for more money. Depending on the number of children, accommodation in some cases would also become a problem for some of these nurses which may further cause job dissatisfaction.

6.4.2   Participation and control

Like any other type of employee in a conducive and empowering job environment, nurses are expected to have a share in the decisional process concerning their work. As the heading suggests this part of the questionnaire examines the degree to which they exercised choice, amongst other things, in their job situations. The seven subdivisions housed in questions 6-12 of this section attempt to piece together evidence to support or disconfirm this discretional element.

6.4.2.1   Question 6: Type of nursing done by respondents

The fields of nursing have been expanding over the years and continue to do so with the ever-increasing modern technology. However, in developing countries, such as Botswana, the orthodox hospital wards and clinics remain the focal points of health care delivery. Table 6 shows the most common typologies of nursing.

Table 6   Type of nursing done by respondents

What type of nursing are you doing?		
Question	Number of respondents	Percentage of respondents (%)
Medical	259	36.9%
Surgical	168	23.9%
Orthopedic	94	13.3%
Eyes	84	11.9%
Paediatric	84	11.9%
Gynaecology	128	18.2%
Clinic	278	39.6%
Other	217	30.9%

It will be noted that the number of respondents and their percentages in table 6 do not reflect the number of respondents surveyed because each nurse responded to more than one question. "Other" in the table denotes other types of health care outside the hospital ward mainstream such as oncology and tuberculosis nursing. Aside from this, table 6 indicates the distribution of nurses according to the type of nursing done in the government health services. The traditional heavy duty areas of nursing through which all nurses must pass such as medical, surgery, gynaecology and clinic stand out head and shoulders above the others. The highest number of nurses (39.6%) worked in the clinics. In some hospitals nurses work in special clinics such as that for human immuno-suppression virus (HIV), paediatric, surgical and orthopaedic. The hospital wards system was dominated by the medical ward with 36.9% of nurses tailed by surgical and gynaecological wards accounting for 23.9% and 18.2% of the nurses respectively. The remainder of the nurses was spread in the less busy sections of the hospitals such as the orthopaedic, the paediatric and the eye wards respectively. The extent to which nurses had a choice in the type of nursing they were engaged in warranted a separate investigation.

6.4.2.2   Question 7: Choice in the type of nursing being practised

The motivation, positive self-evaluation and job satisfaction all in one that comes with practising what one enjoys doing is well known in any learning or practical situation. This comes more naturally if one has had the liberty of choosing or taking part in making a choice in the matter. Nurses are not an exception to this managerial principle. After all nurses require all the intellectual, motivational and emotional

resources in the execution of their duties, if they are expected to provide quality care or a sterling service. Thus, having a say or being consulted or having one's opinion sought or having an input in choosing one's career path would certainly be motivational. It would not only cushion one's mind against the rough and tumble or exigency of the nursing job, if any, but open a clear vista towards job satisfaction.

Table 7   Choice in the type of nursing

Did you have a choice in this type of nursing?		
Question item	Number of respondents	Percentage of respondents (%)
Yes	343	48.9%
No	217	30.9%
Total	560*	79.8%

Key*   Some nurses did not answer this question

In table 7 above, the majority of nurses (48.9%) indicated that they had a choice in the type of nursing they were practising. This was a good starting point for motivation, job satisfaction and a positive attitude towards their nursing duties. For example, for nurses who chose to work in the clinics, it implied that they enjoyed being patronized by many different patients on a daily basis, presenting with various ailments, ranging from a wound dressing to a medical condition. For such nurses their interest in working in clinics may have developed from their rural posting on a government transfer system. It may also be an indication of their interest to go for further training to specialize in this branch of nursing. Whatever the motives, these intentions are all dimensions of job satisfaction. The notion of choice in the type of nursing exercised by these nurses is a positive sign of professional empowerment with positive implications for the image of nursing. The act of choosing itself in the context of work promotes intrinsic motivation which in turn improves work performance (see chapter 3: section 3.4 for the connection between work performance and motivation). Positive behaviour towards work performance stems from motivation. As the individual is motivated, he or she yields appropriated work behaviour (see chapter 3: section 3.3 for basis of motivation).

In view of the nurses' participation in the type of nursing they preferred, their attitude in the performance of their duties may resemble Herzberg's (1966: 62-70) "critical incidents", that is, job performance acts that lead to great satisfaction (see chapter 4: section 4.4.1.2 for Herzberg's theory). Attitudes work together with motivation to produce behaviour. Thus, a positive attitude will be linked to motivation to produce desired work performance (see chapter 5: section 5.2.1 on functions of attitudes and their connection to behaviour). The 30.9% of nurses who were deprived of choice in the type of nursing they were doing were likely to experience an attitude-behaviour inconsistency. This would show itself in signs of job dissatisfaction such as going off sick at the slightest sign of ill-health. The lack of consonance between their attitudes and their job would continue to demotivate their work performance. Their patients

would suffer from clinical depreciation resulting from these nurses' job dissatisfaction and cognitive dissonance (see chapter 5: section 5.2.2.1.5 for theory of cognitive dissonance). However, job satisfaction is not a composite variable. These nurses may be compensated by some other dimension of job satisfaction such as provision of housing in the case of clinic nurses (see chapter 4: section 4.4 on job satisfaction theories).

6.4.2.3   Question 8: Input in the way nurses work

Furthermore disregarding the freedom of choice or its absence in the type of nursing being pursued, one step more in the inquiry is whether the practising nurse determines how she or he works. The importance of such a question is to establish the ingredients or the lack of them in respect of motivation, job satisfaction and the correct attitude towards a job which are all implied in being instrumental in the way one chooses to perform one's duties. Table 8 below carries the story.

Table 8   Input in the way nurses work

Do you have an input in the way you work?		
Question item	Number of respondents	Percentage of respondents (%)
Yes	563	80.2%
No	115	16.4%
Total	678*	96.6%

Key*   A few respondents shielded themselves from this question

In both tables 7 and 8 it is noticeable that not all the nurses answered each of these two questions. The omission of some questionnaire items is a notorious artifact of the survey method of research, which, although not destroying the whole exercise, distorts or bottlenecks some statistics. Despite the shortfall in the results, however, a majority of nurses (48.9%) who responded to the question in table 7 indicate that they participate in the decision to choose the type of nursing that they prefer, compared to 30.9% who are unable to do so. The positive findings in table 7 are reinforced by a resounding majority of 80.2% of the nurses in table 8, who play a part in deciding how they work. In figurative speech the manner in which they perform their tasks is not just handed to them, like the Ten Commandments, but they have "a finger in the pie". Being part of a decision-making process implies the ability to make a discretionary judgment in arranging one's job.

Intrinsic motivation begins from the recognition of one's influence and power behind the contribution that one makes towards the performance of one's job. It is the foundation upon which competence, self-determination and commitment are built (see chapter 3: section 3.3.1 for analytical details of intrinsic and extrinsic motivation). Vroom (1964:167-172) has emphasized participative decision-making

as a source of motivation for workers and has pointed out that it raises their morale and enhances their self-esteem. When nurses have a share in decisions which concern their work, they feel a sense of ownership of those duties but they also become task-involved. The responsibility of making decisions trains their professional minds to become independent and prepare them for future promotions. This progress in their careers adds to their job satisfaction. With the power to exercise control over their work situation, their motives are rearranged from a dormant state of receiving orders and directions from their supervisors to a dynamic sense of assumed ability to make their own decisions (see chapter 3: section 3.4.2 on shuffling behaviour of motives). By virtue of taking part in decision-making, the nurses' attitudes also change from a passive acceptance of what supervisors say to an active involvement in what affects them (see chapter 5: sections 5.2.2.1.1 and 5.2.2.1.2 on classical and operant conditioning). Playing a part in how their duties are organized, therefore, motivates nurses to want to do better and to adopt a positive and willing attitude towards improving their performance. The experience of job satisfaction that comes from managing their own work activities increases the probability of wanting to do more of the same thing. This means that nurses will be motivated to increase their role(s) in matters affecting their work. In turn this will maintain the expected utility of their improved task performance (see chapter 5: sections 5.2.2.1.3 on expectancy theory).

6.4.2.4 Question 9: Exercise of initiative or discretion in the execution of nursing duties

A further elaboration of the quintessential role played by nurses in deciding on how to discharge their duties is the use of initiative or discretion. This mental or psychological or intellectual goose-stepping exercise involves prioritizing on nursing agendas which is typified by the authority to change the way one organizes one's work.

Table 9   Exercise of initiative in execution of duty

Can you exercise initiative or discretion in the way you work?		
Question item	Number of respondents	Percentage of respondents (%)
Yes	603	85.9%
No	92	13%
Total	695*	99%

Key*   A small number of respondents skipped this question

Question 9 is an extension of question 8 preceding it. After nurses have added their own imprint to decisions regarding their job, they proceed a step further to use their initiative or discretion as to how their tasks are to be ordered. Table 9 shows that a majority of 85.9% of nurses confirms that they use their initiative in this way. This is a

significant proportion of nurses who enjoy a high degree of autonomy in their job, compared to a small section of 13.1% of nurses who answer in the negative. When nurses use their initiative in deciding, for example, that they will chat to individual patients over the week-end when there is no bustle and hustle of the doctors' rounds, they feel job-empowered that they are in control of their own professional destiny.

Furthermore, when nurses use their own discretion over the arrangements of their tasks in a ward situation, for example, it gives them the image of being their own boss and of charting their own professional course. This act of initiative is endowed with high-yielding results of accountability and responsibility for performance outcomes such as quality of care. These parameters are home to a number of needs in a work situation such as the need for personal judgment, the need for achievement, the need for accomplishment and personal needs such as the need for power and recognition. These are all different dimensions of job satisfaction which are explained fully under the umbrella of content and need fulfilment theories of job satisfaction (see chapter 4: section 4.4.1 and 4.4.2.2).

6.4.2.5   Question 10: Ability to change the way of organizing work

Question 10 is an elaboration of question 9 before it, in the sense that after the nurses have used their discretion over the execution of nursing duties, they are able to put order to their nursing work context. The nurses' work context refers to the total administrative nursing work environment and the job content denotes the constituent parts of the task as a procedure for removing sutures. In table 10 below the majority of 73.5% of the nurses responded that they are able to change the way of organizing their work. Only 24.2% of the nurses show dissatisfaction in this aspect of their job.

Table 10   Ability to change the way of organizing work

Are you able to change the way you work?		
Question item	Number of respondents	Percentage of respondents (%)
Yes	516	73.5%
No	170	24.2%
Total	686*	97.7%

Key*   Not all nurses responded to the question

Organizing work is done within its work contexts and the ability to change the way of doing this has the effect of affecting the content of each particular job. The interest in the motivational consequences of job content was generated by the work of Herzberg, Mausner and Snyderman (1959:52-67). The idea was developed further by Vroom (1964:126-130) who suggested that both the content and context of a job were sources of job satisfaction and dissatisfaction, depending on the work roles of respondents. In demonstrating the autonomous ability to change the way of

organizing their work, nurses are engaged in changing the contents of their duties. On the basis of this analysis, Vroom (1995:128) has argued that increases in some desirable job context resulted in an increase in job satisfaction. Therefore, ability to change the way of organizing their work is, for the nurses, a way of increasing their job satisfaction (see chapter 4: section 4.4.1.2.1 on criticism of Herzberg's theory for detailed analysis).

The flexibility in organizing one's job is a bulwark against occupational pressure which is not a passing epiphenomenon in nursing. Working under pressure often leads to poor patient care and a hurried provision of health services.

6.4.2.6   Question 11: Working under pressure

The power to change one's work schedule not only allows one to be flexible in doing one's job but also diverts or dissipates the pressure which comes from performing tasks under duress or by rote and rigid routine. One of the ways of managing pressure is to identify its source and take positive steps to deal with the precursor.

In table 11 below the majority (60%) of nurses admitted that they worked under pressure. Those nurses who do not experience working under pressure account for 5% of the sample. Working under pressure in the Botswana public health services has been attributed to the shortage of nurses (see chapter 2: section 2.4.3 on decentralization of health services). There are, of course, other causes of working under pressure such as the ill-planning of nursing duties when extra tasks are fitted into a shift without a provisional staff allocation for them. The adverse effects of working under pressure are felt by both the nurses and patients. On the part of the former, stress, fatigue, burnout and absenteeism will set in if measures are not taken to improve or to increase the number of nurses on a ward or in a clinic. In the case of patients, clinical standards may fall and increased mistakes made by nurses may expose patients to poor patient care, negligence and increased risks in their care plans.

Table 11   Working under pressure

Do you work under pressure?		
Question item	Number of respondents	Percentage of respondents (%)
Yes	422	60.1%
No	37	5.3%
Total	459*	65.4%

Key*   Less than half of the respondents did not answer this question

According to Locke (1976:1324-1326; Spector, 1997:34-41) employees generally value working conditions which enhance their ability to work effectively. Working

under pressure in a ward or in a clinic environment with the attendant dangers of making mistakes on equipment and medication are major sources of job dissatisfaction (see chapter 4: section 4.4.4 on comparative insights into theories of job satisfaction). Unless the nurses were attracted into nursing for reasons of occupational security, with a government employer traditionally known for paternalism, they are not likely to be motivated to continue to work under working conditions which cause both physical and mental discomfort (see chapter 3: section 3.6 on motivation and recruitment). Although the nurses will be striving to maintain their job under dissonant conditions of dissatisfaction (see chapter 5: section 5.2.2.1.5 on theory of cognitive dissonance), they may be at the same time exerting themselves through the object-appraisal function of their attitudes (Terry & Hogg, 2000:43-44), to adjust to a strenuous working environment (see chapter 5: section 5.2.1 on functions of attitudes and their connection to behaviour).

6.4.2.7 Question 12: Sources of work pressure

The origin of pressure in a nurses' workplace may stem from a number of agents in the nursing environment including the nature of the work itself. Table 12 below sheds some light on the phenomenon of pressure at work.

Table 12 Source of pressure at work

What is the source of this pressure?		
Question item	Number of respondents	Percentage of respondents (%)
The work itself	605	86.2%
Sister in charge	65	9.3%
Matron	60	8.5%
Other nurses	37	5.3%
Other	68	9.7%

It is evident that questions 11 and 12 are related and the latter is a follow up of the former. After ascertaining that the majority of nurses work under pressure in table 11, the majority of 86.2% of the nurses in table 12 identify the work itself as the source of the pressure. It has been pointed out in sections 6.4.1.1 to 6.4.1.5 that the majority of nurses work on the ward shop floor and in the clinics. It has been shown, particularly in the case of the wards, that the disparity between the number of nursing duties and the number of nurses assigned to do them cause pressure on the nurses. Nursing staff levels are outside the autonomy or jurisdiction of the ward nurses. As was stated in section 6.4.2.6 the shortage of nurses within the decentralized public health services has been a chronic problem. The consequences of working under pressure on patients and nurses themselves have been outlined in section 6.4.2.6. It may be further added that when nurses are faced with a chronic situation of working under pressure from everyday jobs, they become demotivated. They also develop a long-term negative attitude towards their work with an enduring spell of job dissatisfaction (see chapter 5: section 5.2.2.1.5). These sets of unprofessional

attitudes and behaviours may become resistant to Terry and Hogg's (2000:43-44) adjustment process (see chapter 5: section 5.2.1) to bring them back to a safe clinical practice for patients.

The other source of work pressure which came from the ward sister and the matron mentioned by 9.3% and 8.5% of the nurses respectively, are not statistically significant. Other sources of pressure represented by 9.7% of the nurses come from, for example, the pharmacy's and laboratory's time deadlines for submitting patients' drug prescriptions and specimens.

As has been pointed out in table 11 above, a substantial number of nurses did not complete the questionnaire item. In table 12, however, many nurses gave multiple answers to the selected sources of pressure at work, hence the figures and the percentages do not correspond with the survey total number of participants.

6.4.2.8 Summary analysis of results for section 6.4.2: Participation and control (Questions 6-12)

One of the most important kernels of job satisfaction is autonomy or making a choice particularly in the field of nursing where there are distinct areas of professional interest. Table 7 illustrates that the majority of nurses (48.9%) had a choice of which branch of nursing they preferred. They participated in the decision leading to that choice. Having gone over this hurdle the respondents prove that they are not just cogs in a big machine but make decisions in the way they work as shown by the majority 80.2% of them in table 8. Determining one's pace in a job situation is on the same continuum as using one's initiative in the way one wishes to carry out one's duties. That discretionary element is underlined by the leverage of being able to alter the way nurses organize their work. The majority of nurses (85.9%) in table 9 have discretional authority over their work and the majority (73.5%) of them in table 10 has control over the way they organize their duties. In regard to the way nurses perform their job, the majority (60.1%) of them in table 11 feel that they are working under pressure, with only 5.3% stating that they do not experience such urgency. The source of the pressure (table 12) according to the majority (86.2%) of them is contained in the work itself. This seems to be a reflection of the heavy workload due to the shortage of nurses.

In this section it can be noticed that the majority of the nurses have a choice of the type of nursing they enjoy and they are not passive on-lookers when it comes to making a decision in respect of the way they work. It is also significant at the same time to observe that the majority of them work under pressure from the work itself despite being able to alter the way nurses organize their work. It may be mentioned that the workload in acute and busy nursing areas such as the medical and surgical wards can act as a major factor in job dissatisfaction in the long run, if the shortage of nursing personnel remains unmitigated. The shortage of nurses can also be used to explain why the majority of nurses are able to vary the arrangement of their duties. It may be further surmised that due to the pressure of work associated with the shortage of nurses the quality of nursing care may become conceivably compromised.

But whatever pressures the nurses experience in the heat of executing their duties, there are other factors such as their ability to exercise initiative and vary the tempo of their work process, which tends to reduce the frustration of a busy working environment. Participation in decisions involving one's work has been known to increase productivity and job satisfaction (Locke, 1976: 1309-1310: Spector: 1997:20-24). For example, the studies of Gruneberg (1979:75-76; Latham, 2007:28-36) and of Morse and Reimer (1956:120-129; Lehal, 2002:37-50) (see chapter 4: section 4.4.1.2 on Herzberg's theory) proved that taking part in decision making led to significant job satisfaction, although the relationship between the former and the latter was tenuous. In respect of Maslow's (1970:90-93) theory, participation and control in one's work accounts for one's mastery, achievement and recognition of one's contribution to a work situation, which in turn contributed to job satisfaction. According to Gruneberg's (1979:10; Latham, 2007:19) elaboration of Maslow's theory the latter would predict that only after the lower order needs have been satisfied will the nurse seek satisfaction and achievement. In the context of Herzberg's two factor theory, participation and control at work led to job satisfaction through the midwifery of variables such as achievement, recognition and the intrinsic interest of the work itself (Herzberg, 1966:32-40).

With reference to one of the five assumptions set out for the research which stated that nurses' participation in decision-making regarding their work, empowered, motivated and gave them satisfaction in their creative knowledge, this section concluded that the assumption was tenable.

Of course to say that the human element in job satisfaction runs through all the other considerations is tantamount to stating the obvious. But if the obvious has such overriding importance over analyzing the spectre of what makes the nurses happy at work, it deserves to be repeated without an apology.

6.4.3   Personal satisfaction and interpersonal roles

Job satisfaction is common to numerous job variables and the road leading to nurses' job satisfaction is beset by many factors such as interaction with other nurses, relationship with supervisors, the kind of nursing job done, pay and benefits all of which are additive towards producing a contented nurse.

The operative assumption is that if nurses like the job they are doing, this will create a sound background to motivation, job satisfaction and a positive attitude towards discharging their professional responsibilities. It may also mean that nurses will see the job as providing other advantages such as a chance to develop themselves perform better and earn a promotion. The question of pay is linked to a number of factors all of which are relevant to personal satisfaction on the job. Examples abound such as ability to care and rear children adequately and the buying power for many other life necessities such as a car. When the level of pay is considered to be inadequate, however, or when the workload is unrelated to the pay level as in nursing work, nurses have felt irate. But there has been no consensus of opinion as to by how much pay should be increased. These differences are viewed alongside their

impact on the nurses' attitude towards the liking of the kind of work they do. These broad issues are part of the 13-20 group of questions.

6.4.3.1   Question 13: Liking the kind of work being done

The idea of liking the type of work one does follows closely on the heels of questions contained in the preceding section. Therein the majority of nurses demonstrated that they had a choice of the kind of nursing they were doing, amongst other decisions such as exercising initiative concerning their work. If this was a correct affirmation it would be logical for them to like the type of work they do. Table 13 below shows the evidence.

Table 13 Liking the kind of work being done

Do you like the kind of work you do?		
Question item	Number of respondents	Percentage of respondents
Yes	477	67.9%
No	26	3.7%
Always	24	3.4%
Sometimes	134	19.1%
Total	661*	94.1%

Key*   Some nurses abstained from answering this question

It is noted that in table 13, 41 nurses did not show their preferences and the percentages were affected as a result. However the results indicate that the largest number of nurses (67.9%) enjoys their work. It was not unexpected that the majority of nurses liked the kind of nursing work they were doing, following a high level of autonomy displayed in the participation and control of their duties, witnessed in the preceding section (see subsections. 6.4.2.3-6.4.2.5). Some 19.1% of the nurses said that they only sometimes liked the kind of work they do. A less statistically meaningful 3.7% of the nurses were frank that they did not like the kind of work they do. An even minute number of nurses (3.4%) showed the commitment that they always liked the kind of work they do.

The number and nature of functions which nurses are called upon to perform vary tremendously from one work role to another. For example, some nurses may be responsible for infection control in the hospital. In the clinics there may be nurses assigned for dressings. In the ward some nurses may be busy with doctors' rounds. Most, if not all, nursing work roles involve the application of some skills. It was Vroom (1990:62-80) who pointed out that the attractiveness of a work role for a person is directly related to the extent to which it provides her or him with rewarding outcomes and inversely related to the degree to which it provides her or him with aversive consequences. In addition to the practical use of a skill in a nursing work

role, such as the giving of correct dose of medication, a nursing job has some wider significance for the individual nurse such as promotion or specialization in a chosen specialty area of nursing, for instance, ophthalmology nursing (eye nursing).

Although many nursing jobs demand different task requirements, they all require the application of skills to the content of the job. The importance of the various aspects of skills in job satisfaction was noted by Hoppock (1935:42-45; Boucher, 2004:22-53), as being one of the principal areas of job satisfaction. But it is invariably the content variables of the different jobs that the Botswana public health services nurses like that give them job satisfaction. As Vroom (1995:128-130) would have argued, it was the increases in those job content variables that raised the nurses' job satisfaction to a positive level of declaring that they like the kind of work they did. However, the pendulum could swing the other way and cause job dissatisfaction, as mooted by Vroom (1990:62-80) in the preceding paragraph (see chapter 4: section 4.4.4 on the insights into theories of job satisfaction). This lurking potential warning was hidden in the fact that only a very small proportion (3.4%) of the nurses always liked the kind of work they did. The answer to the semantical question implied in what makes the majority of the nurses "not always" like the kind of work they did is unknowable (see chapter 5: section 5.2.2.1.5 on theory of cognitive dissonance).

The common attitudes amongst all the nurses are that they have to knuckle down and work (see chapter 5: section 5.2.1 and 5.3 for functions of attitudes and their connection to behaviour and the image of nursing). The implications of liking the kind of work nurses do indicated by a majority of 67.9% of the nurses (table 13), are the need to learn and then aspire for promotion or branch out to go and acquire a further qualification or specialize in a particular field of nursing. These requirements are more applicable to all those nurses who desire to have an additional qualification or who are not yet settled in the profession. Thus, the work behaviour and attitudes of all these nurses are dictated and directed by both the conditions of the work environment and the changing behaviour of motives (see chapter 3: section 3.4.2). The Botswana research results do not show or did not investigate sex differences in the orientation to the nursing job being done with respect to, for example, future careerism (see chapter 5: section 5.3.1).

Like most employees, nurses ostensibly work for compensation in the form of pay and it is this attraction which may affect their attitude towards their job.

6.4.3.2   Question 14: Satisfaction with pay

In modern society pay is associated with working for the polemical reason that it buys the goods and services that are used to sustain life. In spite of the controversy surrounding its utility it is argued that it motivates the worker and enhances job satisfaction (see chapter 3: section 3.5 on motivated self-conception and attitude towards work and also chapter 4: section 4.4.2.1 on social reference group theory). Table 14 puts this assumption to test.

Table 14 Satisfaction with pay

Are you satisfied with your pay?		
Question item	Number of respondents	Percentage of respondents (%)
Yes	34	4.8%
No	647	92.2%
Total	681*	97%

Key*   21 respondents defaulted on answering this questionnaire item with the resultant shortfall on the percentages.

It may be recalled that in sub subsections 6.4.1.1-6.4.1.5 a judgmental line was drawn between the less and the more experienced nurses. The former group was envisaged to be the ward and the clinic nurses who manned and operated at these institutional levels of the public health services. It was further pointed out in the relevant sub subsections that these less experienced nurses received a lower rate of pay than the more experienced nurses or supervisors. But they were motivated by the future prospects of promotion that lay ahead of them, after serving in their positions for at least five years or more. The more experienced or supervisory nurses were regarded as earning a higher salary in the same sub subsections under discussion. It is against this background that it might be possible to unravel the baffling scenario presented in table 14 in respect of the dissatisfaction over pay revealed by nurses.

The overwhelming majority (92.2%) of nurses in table 14 are not satisfied with their pay. Only 54.8% of the nurses are happy with their salary.   The high percentage of dissatisfaction over pay cuts across the two groups of the less and the more experienced nurses. It opens a Pandora's Box over a matter that has seen the government's irresolution over a number of years. In another way it erects barriers against the common assumptions in pay schedules between the less and the more experienced nurses. Pay is highlighted as a crisis in the Botswana public health services for all the nurses regardless of grade. The high rate of dissatisfaction with pay creates a sense of urgency that all the government's efforts must be thrown into the battle to solve the pay problem for nurses. Indecision over this issue would lead to a high turnover rate of nurses from the public health services or lead to poor quality care.

The alarming dissatisfaction with pay does not render itself to a single explanation. The most all-embracing reason for this strongly negative response by nurses regarding pay, is the assumption that pay levels are poor throughout the entire nursing structure of the public health services. In other words pay is poor for all the grades of nurses and has been so for many years. It was stated in sub subsections 6.4.1.1-6.4.1.5 that Rampa's (1991:47-50) study found that the majority of 90% of the nurses in the public health services hospitals in the southern part of Botswana were dissatisfied with pay. A similar study by Rampa (2000:52-54) in the same institutions replicated the earlier study's results. The results in table 14 have confirmed Rampa's

previous findings that the nurses' dissatisfaction with pay is long term and affect all categories of nurses.

The other point of view about this unrepentant complaint over pay by nurses, may be due to the changing nature of the Botswana society, in which resurgent life styles have sharpened or awakened appetites for higher salaries (see introduction in chapter 2: section 2. 1). Another way to perceive the nurses' dissatisfaction with pay is to argue on the basis of increased expenditures from their salaries caused by the demands of their children for goods and services. It was shown in table 5 that the majority (47.3%) of the nurses' children was over 10 years of age. Most of them were therefore in primary or secondary school education. Education is no longer free in the Botswana government schools. Parents have, in addition to paying nominal school fees, to buy school uniform and general clothing for their children. The expenses incurred by nurse parents who opted to send their children to private schools for better quality education and "civilisalition", are astronomical as they faced stiffer penalties in respect of high school fees and the cost of school uniform and books. There are many other items of expenditure for children such as play stations and computer games. All these expenses might have had a toll on nurses to force them to resort to look for compensation from higher pay.

Armed with the foregoing information the ground is set for a brief navigation into the meaning or utility of pay. The factors associated with the job itself have been described as intrinsic or content factors, whilst those such as pay, supervision and others have been described as extrinsic or context factors (Gruneberg, 1979:54-55; Latham, 2007:36-40). This distinction corresponds roughly to Herzberg's distinction between motivators and hygiene factors. Whilst most recent work has concentrated on the importance of the content aspects of job satisfaction, few workers deny the importance of context factors (Gruneberg, 1979:54-55; Latham, 2007:36-40). Even Herzberg himself regards factors such as pay as of critical importance, since deficiencies in pay may prevent the individual from concentrating on those aspects of the job which are potentially fulfilling (Herzberg *et al.*, 2004:78-81). The amount of money which one receives is sometimes regarded as an indication of one's value to an institution, so that it becomes associated with achievement and recognition by one's peers (Gruneberg, 1979:56-57; Latham, 2007:36-40). This argument could have been used by all the nurses in their justification for a higher salary in table 14.

Money, then, has different meanings for different individuals and can act as an indicator of how one is appreciated by others. This should not detract, however, from the potentially important effect of money on the satisfaction that can arise from increasing one's material well being. Money can therefore be seen as an objective measure of success (Gruneberg, 1979:57-58; Latham, 2007:36-40). There are many other factors affecting satisfaction with pay such as the level of aspirations. The individual may be dissatisfied that her or his pay does not enable her or him to acquire the kind of material goods society has to offer. She or he may be dissatisfied because the level of pay received is insufficient to avert domestic conflict over the acquisition of material goods. Furthermore, she or he may be dissatisfied in relation to the amount she or he is presently receiving compared to what she or he received one, two or five years ago (Gruneberg, 1979:59-62; Latham, 2007:42-45). According to Locke (1976:1321-1322; Spector, 1997:41-43) individuals who believe that they are inequitably paid are dissatisfied with pay. Thus, the inability to purchase or obtain material goods and services could have caused both groups of nurses in the public

health services to decry their present salaries. Pay was, therefore, considered by the nurses as both a motivator and a job satisfier (see chapter 3: section 3.4 and chapter 4: section 4.4.1.1.2). Because pay had such a positive valence in the nurses' lives, it changed their attitude in the negative direction which was shown in their behaviour expressing their dissatisfaction over this factor (see chapter 5: section 2.2.1.3). Lawler and Porter (1991:426) found that sex as a job variable was related to pay satisfaction in that females were found to be more satisfied with pay than were males. Although there has been a running history of low salaries from the embryo stage of the modern public health services in Botswana (see chapter 1: section 1.1) the inflammatory degree of dissatisfaction with pay shown by nurses in table 14, most of whom are females, not only makes Lawler's claim appear like a mirage, but rejects it outright.

It is contested further that it is not just pay *per se* (by or in itself) that matters, but how much of it in relation to the amount of work done.

6.4.3.3   Question 15: Relationship between size of remuneration and amount of work done

If the ideology of pay for the work done is accepted as undeniable, the principle is further developed into establishing the relationship between the size of the remuneration paid and the amount of work done. Table 15 displays the necessary information.

Table 15 Size of remuneration and amount of work done

Is your remuneration related to the amount of work you do?		
Question item	Number of respondents	Percentage of respondents (%)
Yes	34	4.8%
No	602	85.8%
Total	636*	90.6%

Key*   Some nurses avoided answering the question

6.4.3.4   Question 16: Desired rate of increase in remuneration

The concept of the economic man or woman in economics harbours the notion of an individual striving for her or his interest and welfare. In the world of work it is argued that inadequate pay is a job aspect over which the greatest number of employees expressed dissatisfaction (Lawler, 1971:426-435). Stated in a different way pay must be sufficient, not only to keep body and soul together, but also to keep employees satisfied. If the nurses as "a body health" give a pointer or give out feelers or

antennae of their pay expectations, the constituted authorities in the health services would hopefully make use of these indicators, as a benchmark for discussion with the aim of redressing the remuneration imbalances, if found to exist. Table 16 bears the torch.

Table 16 Desired rate of increase in remuneration

If your answer to question 15 is "no" by how much do you think your remuneration should increase?		
Question item	Number of respondents	Percentage (%) of respondents
By 5-10%	8	1.1%
By 10-20%	94	13.3%
By 30-40%	238	33.9%
By over 40%	301	42.8%
Total	641*	91.3*%

Key*   Indecisive nurses refrained from committing themselves to the game of figures.

It is ironical and inconsistent that the same nurses, who voiced their dissatisfaction over pay with a massive 92.2% in table 14, turned renegade and became unsure when offered a window of opportunity to indicate by how much their salary should be pegged up.   Tentative explanations of this variance, although not conclusive, may shed some light on this behaviour. Despite the cover of anonymity, it would appear that nurses were insecure in responding to this question. It will be remembered that nurses entered nursing without a uniform level of education and are, therefore, not a homogeneous group of educationally skilled people. An imbroglio of trained nurses, who joined the profession with varying levels of education, cannot be expected to be similarly empowered, assertive and as sure-footed as a goat, in knowing what they want. Nurses are also often unaware of the nominal market remuneration rate of jobs with similar educational qualifications as theirs, to enable them to draw comparisons. Ambivalence, unknowingness, lack of assertiveness and other factors such as lethargy, therefore, could have impaired the nurses from making a decision on a question that was perhaps casuistic. However, after all this is said and done the majority of nurses (42.8%) were in no doubt that their pay should be increased by over 40% (table 16).

Although the 42.8% of the nurses (table 16) who think that their pay should be increased by more than 40%, may appear to be overambitious, they are only trying to recapture the psychological advantage which might have attracted them into nursing (see chapter 3: section 3.7 on the motivation and the recruitment process). The second highest group of nurses (33.9%) who estimate their pay increase to be in the region of 30-40% might be guided by an inner sense of fairness based on the cost of living. The 13.3% group of nurses, who suggest pay increases of 10-20%, may be relatively satisfied with their current rates of pay. A small number (1.1%) of nurses chose a pay increase of 5-10% which they simply considered, was what the

Botswana government would probably be willing to release for the here and now situation or as a fire fighting measure to correct the pay imbalances.

Dubin (1976:304) has pointed out that work or job may be thought of as an exchange of effort for money, or as an impersonal transaction based solely on monetary gain. He has argued that it is almost self evident that money functions to attract people to their work. Once in work their efforts are required to perform in a given job. Deci, Cascio and Krussel (1975:81-85) have reasoned that in the work setting the use of extrinsic rewards in the form of pay is obvious to ensure worker efforts (see chapter 3: section 3.3.1). Money is not only a reward but is also a common way of giving employees feedback on how well they are doing. It is used as a source of information on how successful an employee's performance in a job has been (Atkinson, 1958:359-372). This information is used to establish the performance-reward probability which is one variable which adds to the employee's motivation. For instance, Lawler's (1971:426-435) concept of reward value or valence referred to the individual's perceptions of the value of the reward or outcome that might be obtained by performing effectively (see chapter 5: section 5.2.2.1.3). For Lawler, for a given reward the reward value and the effort reward probability combined multiplicatively in order to determine an individual's motivation.

The above analysis can be handy in interpreting the public health nurses' dissatisfaction with pay. According to Jacques (1961:301-305), everyone has an unconscious idea of the level of work one is capable of doing. Similarly she or he is also aware of what would be an equitable level of payment for the job. Nurses undergo training and are well-equipped for the job they have to do. Although they may be unconsciously aware of how much money they should be paid, in practice the decision is outside their prerogative. However, what the public health nurses expected can be fitted into Jacques' first payment principle of c-w-p, where their capacity (c) matches the work (w) of correct payment (p), that is, a state of equilibrium. What nurses have demonstrated in table 14 is that they are presently at Jacques' second payment formula of $^{c-w/p}$ in which case the job demands represented by w are in accordance with the capacity of the individual represented by c, but payment represented by p is below par. This position gives rise to feelings of unfair treatment; hence the nurses' high rate of dissatisfaction shown in table 14.

The public health services nurses may have been attracted into nursing by various factors such as the status and security of tenure of the job (see chapter 4: section 4.4.1 and 4.4.1.1) and the prospect of professional development (see chapter 5: section 5.3). But the money rewards reinforce or sew together whatever the motives might have propelled them into the profession or which the nurses themselves might have brought into nursing. This is especially so when these monetary rewards are linked to effort. For instance, the public health nurses have complained about extra workload (table 22), shortage of staff (table 23) and working under pressure from the work itself (table 12). It can be argued that under unconducive working conditions such as these, inadequate pay is hardly communicating to them how hard or how successful their performance is. The ground for erecting a performance-reward probability, which would add to their motivation to perform better is, therefore, eroded or made dysfunctional. Underpayment also removes the condition necessary for Lawler's (1971:426-435) multiplicative combination of the money reward value and the effort reward probability, which would determine the nurses' motivation in their job. In the general economy equitable pay is associated with successful work

performance or promotion. Most of the public health services nurses would savour a natural progression in their career from junior nurses to supervisory position (sub subsections 6.4.1.1-6.4.1.5). But with their motivation, job satisfaction and positive attitudes towards their work hamstrung by low wages it is likely that their effort probability for doing so would wane.

However, pay does not exist in *vacuo* but nestles amidst a contest of other less defensible work-related benefits such as housing and transport.

6.4.3.5 Question 17: Satisfaction with the other benefits

Table 17 below shows that only 8.5% of the nurses were satisfied with the other benefits accruing from their working conditions.

Table 17 Satisfaction with the other benefits

Are you satisfied with the other benefits?		
Question item	Number of respondents	Percentage of respondents(%)
Yes	60	8.5%
No	621	88.5%
Total	681*	97%

Key*   Not all respondents answered the question

The scenario emerging from tables 14, 15, 16 and 17 respectively is that of grievances over pay and associated employment benefits. The preponderant majority of nurses (92.2%) are not happy with their pay. The reason for this is that their work-effort exertion is not equitably remunerated as shown by the majority of 85.5% of the nurses. The evident dissatisfaction with pay was extended to work-related privileges as opinionated by the resounding 88.5% of the respondents.

If inadequate pay and other benefits are major sources of dissatisfaction amongst the public health services nurses (see tables 14 and 17), both the government and the nursing managers would be tempted, if not encouraged, to find the right ball park in terms of salary review. In an effort to achieve this, hearing from the nurses themselves by how much they would like their salaries to be increased is a good starting point. This consultative gesture would form a play ground for negotiation towards an improved pay structure.

If pay can be considered as an inanimate factor contributing towards job satisfaction (see chapter 4: sections 4.4.1.1 & 4.4.1.1.1) if given in adequate amounts, human relationships too are an important source of job satisfaction, particularly in interactive nursing situations.

6.4.3.6   Question 18: Multilevel interpersonal relationships

The various hierarchical levels of nurses, albeit performing different but related duties, are brought together in an interactional relationship, for the purposes of ministering to the needs of patients. Job satisfaction occupies a centre stage in these interpersonal relationships, if patients are to receive quality care. Nurses work in groups and in shifts in which a corporate sense of belonging and freemasonry are necessary ingredients for job satisfaction (see chapter 6: section 6.5). The interaction at a peer level is part of team-working which is unavoidable, because nurses have to share their duties and hand over to other colleagues for the sake of continuity of nursing care. While the relationship among junior nurses is at one level, that between supervisors and subordinate staff is at another, in which the former gives orders to the latter. In order to nurture a mutual relationship contributory to job satisfaction, it may be facilitatory for the supervisor to adopt a condescending attitude towards the junior nursing cadre. Once this is attained, the cordial mixing or hobnobbing between the senior and the junior nursing grades will further promote net-working, job satisfaction and a quality health services delivery (see chapter 1: section 1.1 & 1.2). Tables 18, 19 and 20 illustrate the multilevel interpersonal relationships amongst nurses.

Table 18   Liking the other nurses one works with

Do you like the other nurses you work with?		
Question item	Number of respondents	Percentage(%) of respondents
Yes	557	79.3%
No	15	2.1%
Sometimes	130	18.5%
Total	702	99.9%

It is clear in table 18 that the majority of nurses (79.3%) demonstrate a high degree of liking the other nurses they worked with. Due to this plausible and appreciable show of affinity for one another amongst the nurses, it is expected not to be solely based on an individual level, but that it is dictated by the interpersonal nature of the therapeutic relationships with patients, which are characteristic of the nursing job. Nurses need to coordinate their efforts in attending to patients, in carrying out nursing procedures, in documenting and maintaining records of clinical processes such as administering medication, ward review outcomes and results of consultations with multidisciplinary members of the medical profession. These various interactions are only made possible for the benefit of the patients, if the nurses get along well with one another. As Herzberg (1966: 50-64) studied, poor interpersonal relations are one of the causes of job dissatisfaction (see chapter 4, section 4.4.1.3). One of the nurses' expectations in their job is to foster a solid framework of morale in order to achieve the object of managing the patients' treatment programmes.

Smooth interpersonal relations are the gatekeepers of this essential mission in their professional work (see chapter 5, section 5.4.2 on expectancy-value theory).

6.4.3.7 Question 19: Interpersonal relationship between supervisors and junior nurses

Table 19 below shows the pattern of relationship between the nurse supervisors and the junior nurses. For example, 42.2% of the nurses indicated that they relate well with one another. The other 41.7% of the nurses are not sure about the relationship between these two groups of nurses. They could only say that these senior and junior nurses sometimes relate well with one another. However, 16.1% of the nurses are certain that the nurse supervisors and the junior nurses do not relate well with one another.

Table 19 Interpersonal relationship between supervisors and junior nurses

Do the supervisors or senior nurses relate well with the junior nurses?		
Question item	Number of respondents	Percentage(%) of respondents
Yes	296	42.2%
No	113	16.1%
Sometimes	293	41.7%
Total	702	100%

Relating well between senior and junior nurses can be interpreted to refer to a professional relationship between the two parties. For the junior nurses it may refer to the supervisory style of the senior nurses, for example, whether a senior nurse is fair or not. Fairness may be judged by junior nurses, for instance, in the equitable distribution of week-ends off in the duty rota or roster. From the point of view of the supervisor, a relationship with a junior nurse may be based on whether the later, for example, carries out her or his clinical duties reliably and competently. This relationship between the senior and junior nurses, particularly in the ward or in the clinic, forms a basis for teamwork and group cohesiveness. It has been stated that nurses work in a collegial work environment of cooperation and that this is the inherent nature of the profession. The shift pattern of working on which group cohesiveness is based is necessitated by the need to provide a 24-hour service to patients or clients. Group membership is promoted, therefore, by relationships such as those that exist between the senior and junior nurses. This interaction is necessary, not just for the purpose of cohesiveness, but also for job satisfaction, motivation and a positive attitude towards productive work performance. According to Gruneberg (1979:68; Latham, 2007:42-43), there is satisfaction to be derived from "on the job" social interaction. By the same token, interpersonal conflict in particular, can reduce job satisfaction (see chapter 4: section 4.1). Gruneberg (1979:68-70; Latham, 2007:42-44) further maintains that because the relationship between the supervisors and junior nurses entails working in groups, group members achieve a variety of goals and satisfy certain needs. For example, they receive social support from one another and they enjoy social interaction as a pleasure in its own right, which increases their self-esteem (see also chapter 4: section 4.4.1 on content theories). The self-esteem not only gives them confidence, but also motivates them to reach higher heights of achievement (see chapter 3: section 3.2).

The nursing work shift group can be perceived as cohesive because it achieves its clinical rewards through the active participation of every nurse. Members of cohesive groups have been shown to be more job satisfied than those workers who do not work in-groups. A relationship has been found between the degree of job satisfaction and the degree of group cohesiveness (Gruneberg, 1979:68-70; Latham, 2007:42-44). Elton Mayo, for example, vigorously opposed principles of management based on the assumption that workers were strictly "economic men". To him "man's desire to be continuously associated in work with his fellows is a strong, if not the strongest human characteristic" (Vroom, 1995:119). But, of course it is the nature of the association or relationship that is at issue in this study.

Table 19 shows that less than half (42.2%) of the nurses thought that the senior nurses relate well with junior nurses. A similar proportion of nurses (41.7%) said that they only do so sometimes. Although the latter group strengthens the former, it does not count very much towards the concept of group cohesiveness. Group cohesiveness does not depend on the analogy of the weather, that sometimes it is cold and sometimes it is hot. To this extent, the "sometimes" group of nurses can be discounted. Having done that one can proceed to the 16.1% of the nurses, who are outspoken about the fact that the senior nurses do not relate well with the junior nurses. Statistically, this group is both insignificant and incomparable to the remaining 42.2% of the nurses who answered in the affirmative about the relationship between the senior and junior nurses. By disowning the "sometimes" and the 16.1% group of responses, the focus of attention becomes centred only on the 42.2% of the nurses who agreed that the senior nurses relate well with the junior nurses.

In the light of the foregoing analysis, since the aforesaid 41.7% was less than half of the sample of nurses who responded "yes" to this item of the questionnaire, it is evident that there was some undercurrent conflict in the relationship between the senior and junior nurses. This, according to Gruneberg (1979: 68; Latham, 2007: 42-43) is responsible for reducing job satisfaction. The poor chemistry between the two groups of nurses could also have the effect of reducing their self-esteem and thereby reduce their motivation. One of the consequences of nurses losing job satisfaction and motivation with the later carrying with it a negative attitude is poor quality patient care. It will be remembered that in section 6.4.2 on "participation and control", the nurses displayed a high level of job satisfaction in a number of areas of their work. For example, on the exercise of initiative the majority of the nurses (85.9%) in table 9, show high job satisfaction. This high response rate is a positive indication that the nurses' professional relationship with their supervisors, who granted such autonomy, is good or satisfactory. However, in table 12, the nurses (86.2%) complained that they were working under pressure from the work itself. This might well be the source of conflict between the senior and the junior nurses causing them not to relate well with one another. The burden of conflict is expected to be more on the part of junior nurses who do most of the work in the wards and in the clinics. The job dissatisfaction caused by this conflict is part of an attitude-behaviour inconsistency explained by the theory of cognitive dissonance (see chapter 5: section 5.2.2.1.5). It is manifested by showing job satisfaction in one respect of work and job dissatisfaction in the other. Pressure from work is due to staff shortage, which creates an extra workload. Supervisors are responsible for solving this problem, by interceding on behalf of the junior nurses with the matron's office, in the first instance. They may have been perceived to have failed to do this effectively in the eyes of the junior nurses.

6.4.3.8 Question 20: Mixing of senior and junior nurses at work

In table 20 below the majority of nurses (52.6%) expressed the opinion that the senior and junior nurses mix well with one another at work. The observation made by 36.2% of the nurses is that the two cadres of nurses sometimes mixed well with one another at work. The minority of the nurses (12.3%) said that the senior and junior nurses do not mix well with one another at work.

Table 20 Mixing of senior and junior nurses at work

Do senior and junior nurses mix well with one another at work?		
Question item	Number of respondents	Percentage(%) of respondent
Yes	369	52.6%
No	86	12.3%
Sometimes	254	36.2%
Total	709*	101.1%*

Key*   Some nurses ticked more than one option

The mixing of senior and junior nurses at work is synonymous with the interaction which was defined by Stamps and Piedmonte (1986:18) to mean the opportunities and requirements for formal and informal social and professional contact during working hours. As detailed in the summary below this has positive consequences for job satisfaction, motivation and positive attitude towards job performance (see chapter 4: sections 3.3.1 and 3.3.1.1 and chapter 5: section 5.2 and 5.2.1). In the nursing arena characterized by a rigid status hierarchy that almost ensures conflict between the lower and the higher level nurses (Stamps & Piedmonte, 1986:18), the interaction degree shown by 52.6% of the nurses, is a positive indication that the potential for improved relationship between the two groups of nurses is encouraging. The minority opinion of the 12.3% of the nurses is not statistically significant. As was pointed out above in section 6.4.3.6, the "sometimes" responses were not dependable in group relationships, and should be discarded or ignored for what they are worth.

6.4.3.9 Summary analysis of results for section 6.4.3: Personal satisfaction and interpersonal roles (Questions 13-20)

With reference to table 13 there is no doubt that the majority of the nurses (67.9%) in the sample enjoyed and liked the kind of work they were doing. It was also noted earlier in table 7 that many of them (48.9%) chose the type of nursing they wanted to pursue as well. Whether or not there is a causal linkage between the kind of work done and interpersonal relationships, the majority (79.3%) of respondents in table 18 express the liking of the other nurses that they work with. Perhaps this is because of the demands of team-working amongst nurses which is not only the bread and butter

of the profession, but is also necessitated by the situational exigencies of the nursing duties. The latter are dictated by the demands of an interface between different shifts of nurses covering a period of 24 hours and the ever-present requirements of collaborating over the care of patients and other nursing duties directed towards such care.

Getting on well with the other nursing contemporaries is extended to the good relationships with the supervisors as portrayed in tables 19 and 20, although the strength of such interaction exhibits signs of weakening at the response rate of 42.2%. Moreover the relationship bore the hallmarks of instability as it fluctuated equally between being good at one end and sometimes being well at the other. To drive the point home even more, only a meagre majority of 52.6% of the nurses showed that senior and junior nurses mix well. According to Herzberg (1993:60-67) the social contacts at work particularly at the same level in an institution such as that of the junior nurses were important sources of job satisfaction. The other factor of secondary magnitude in terms of job satisfaction is the worker's relationship with her or his supervisor such as that which occurred between junior nurses and their supervisors. The lack of social support was found by Wagner *et al.* (1977:339-343; Stride, 2007:67-69) to increase nurses' job dissatisfaction, whereas the cooperation and respect from nursing peers, as well as their recognition, contributed significantly to job satisfaction.

However, interpersonal roles amongst the junior nurses themselves and between them and their supervisors are one component of personal satisfaction. The other aspect is embedded in satisfaction with pay (see chapter 1: section1.1). The dissatisfaction with pay could not have been expressed more meaningfully than by the 92.2% majority of the nurses (table 14). The basis of this dissentient group of nurses was the claim that the amount of work they do is not related to the size of their remuneration. The implication borne in this assertion is that nurses do more work than they are paid for, thus, drawing a parallel between the amount of work and the size of the pay package. In other words, the bigger the amount of work in the minds of the nurses, the larger the pay packet. The lack of conformity between work and compensation corresponds to the second of Jacques' (1961:337-380) four permutations of the relationship between pay and work. This second equation is where the job demands equate the capacity of the nurse but payment is below par. This is represented by the equation $^{C-W/P.}$ Since occupational perks such as housing are linked to salary, it is not surprising that the majority of nurses also signified their dissatisfaction with the benefits that accrued to them, as part of their pay. In the Herzbergian terminology, contextual job factors such as pay and the associated benefits, are hygiene factors or lower-order needs in the Maslow's hierarchy. The hygienes do not on their own motivate the worker or cause job satisfaction, but if absent on the other hand; their non-existence can lead to job dissatisfaction (Herzberg, 1966:50-59).

But it can be argued that since the hygiene factors outnumber the motivators, their cumulative effect would make it imperative that they be taken seriously in a work setting. Pay, for example, has increasingly acquired more valence or importance in modern society than it had before. If, as has been proved, nurses liked their job and their nursing team-mates, it must follow that if the level of pay and other benefits were increased, they would in simple terms become motivated at face value, at least, as far as the logical analysis of this finding is concerned. To be efficient and to

perform effectively in the health services and thus provide quality care, they would be driven by high morale. The combined product of these various elements of the nurses' working conditions has the potential of being actual motivators. This is so because in real life job situations, most people in employment never really have their Maslowian higher order needs met and, to borrow Simon's (1957:35-37) term, they have to "satisfice" at lower levels (see chapter 5: section 5.2.1).

It, therefore, requires little elaboration to justify the assumption that high morale, quality patient care, efficient and effective performance in the health services, depend on the nurses' job satisfaction and motivation in their nursing environment. It has also been shown that team-working amongst the nurses, their positive interaction with their supervisors, their love for their job and the prominence of pay, impact upon their attitude towards their job and how they perceive the status of their profession in the eyes of the society.

To this extent the assumption that nurses' satisfaction with the various elements of their working conditions has a positive effect on their performance and productivity was satisfied.

At any rate the full picture of how nurses view certain aspects of their working conditions unfolds itself in the following section.

6.4.4   Working conditions in the public health services

Working conditions are an umbrella or a catch-all term for a disparate group of Herzbergian hygiene factors such as the "free" supply of uniform, transfer of nurses from one station to another, availability of loans at a reduced or below market rates of interest, number of leave days per annum, school fees allowance and an inexhaustible array of other factors. When viewed alongside pay and working conditions, if satisfactory, can cushion the effects of inadequate salary. This is how pivotal they can be in the working lives of nurses. Therefore, whatever they are and how many they are, a general question on working conditions takes the pulse of nurses' feelings and attitude towards a significant aspect of work-related factors.

Asking nurses if they like the working conditions of their work, for example, seeks a general appraisal of what their employer provides as part of their employment. If nurses loathe particular areas in their working lives, finding out whether this dislike is likely to provoke thoughts of leaving the service, provides useful indicators. The authenticity of the information extracted from their responses is checked against their intention to remain in nursing until retirement. To confirm whether nurses' discontent, if any, is confined to working conditions only, the last question probes into their employer preference if terms and conditions in their present employment were improved. Thus, questions 21-26 in this section are aimed at discovering nurses' long-term intentions in nursing.

6.4.4.1   Question 21: Liking of the working conditions of the nursing job

By virtue of their being many, the camouflage supplementary impact of working conditions on pay, or their effect on the nurses' attitude towards their job, may not be as obvious as that of direct pay. This is so, unless nursing management collates information from exit interviews, or carries out a man-power audit amongst other activities. However, the working conditions of nurses in public health services, are common to all of them and, thus, any inquiry into them elicits meaningful and unambiguous responses from the nurses, as tables 21, 22 and 23 below show, by way of general and specific questions.

Table 21   Liking of the working conditions of your job

In general do you like the working conditions of your job?		
Question item	Number of respondents	Percentage(%) of respondents
Yes	102	14.5%
No	472	67.3%
Sometimes	128	18.2%
Total	702	100%

A small proportion of 14.5% of the nurses like the working conditions of their job in general. This response is too small to carry any significant impression of job satisfaction. A similarly small number of nurses (18.2%) responded that they sometimes liked the working conditions of their job in general. The only convincing message comes from the majority of the nurses (67.3%) who answered in the negative about liking the working conditions of their job in general.

Locke (1979:1324-1325; Spector, 1997:34-46) remarked that working conditions had too many aspects to make any meaningful cogent summary of them. For example, interpersonal relationships (table 19) and the work itself (table 13) are variables of working conditions. Because of the multiplicity of working conditions, Gruneberg (1979:33-34; Latham, 2007:28-30) once noted that one of the ironies of the investigators of job satisfaction, was that they had not always been interested in the nature of the job itself. Instead, their focus, until recently, had been in trying to improve the social relationships and social situation of people in relatively poor work conditions.

It is in the above context that 67.9% of the nurses (table 13) liked the kind of work they do, as a small part of or from a basket of other working conditions. But when pressed further in (table 21), if in general, they liked the working conditions of their job, which they understood to refer to the whole "basket" or to contents of the whole "basket" of working conditions, 67.3% of them gave an emphatic thumbs down negative answer. It can be argued or inferred further, that when nurses were then questioned about their intention to remain in nursing until retirement (table 25), 60% of them carried forward their dislike of the working conditions (table 21) and gave a

negative answer, as part of reinforcing their dissatisfaction with the latter. This inference can be adjusted to be fairly consistent with the majority of the nurses' (46%) response given in table 26. When asked, in general, if terms and conditions were acceptable to them, where they would prefer to practise their nursing career, they chose the government health services, which is their present employer.

In tables 13, 21 and 25, therefore, the public health services nurses are communicating job satisfaction on one hand and on the other job dissatisfaction with little, if any, contradiction in their responses, if the latter are scrutinized, examined or analysed in context. Working conditions are hygiene factors, according to Herzberg (1966:50-54), whose absence either in total or part thereof, can cause job dissatisfaction (see chapter 4: section 4.4.1.2). The perpetual process of registering job dissatisfaction is learned, according to the theory on attitude (Chapman, 1997:3), and such learning predisposes action which may be negative (in this case) or positive (see chapter 5: section 5.2).

There is a whole array of working conditions operating in a workplace. There are too many aspects of working conditions to make any detailed summary helpful. But it has been argued that employees basically desire conditions which facilitate the attainment of their work goals or at least do not block their realization (Locke, 1976: 1325; Spector, 1997:36-37) (see chapter 4: section 4.1.2.1). The Hawthorne studies emphasized the role of the informal group and supervisory practices, in shaping employee attitudes and performance. The researchers de-emphasised the role of economic incentives on the grounds that workers are more interested in social relationships than money (Locke, 1976: 1299; Spector, 1997:39) (see chapter 4: section 4.3). As if to confirm the different aspects of working conditions, the 1959 Herzberg's writings pointed out that, to increase job satisfaction, one had to change the actual job being done. Thus, attention was rotated 180 degrees to focus on the job satisfaction inherent in the work itself. Factors associated with job satisfaction related to the job itself have been identified as the attainment of success and recognition, the application of skills, the feeling of doing something worthwhile and involvement in the job itself (Gruneberg, 1976:33-34; Latham, 2007:29) (see chapter 4: section 4.2.2.2.1).

The other work attributes that have been found to be related to job interest and job satisfaction include the opportunity to use one's valued skills and abilities, the amount of work, responsibility and the control over work methods and work pace or autonomy (Vroom, 1995:150-151). Only a job which permits the individual to apply a skill can be expected to lead to growth in self-esteem and job satisfaction. Thus, it has been found that those with a high need for personal growth are more satisfied when they are given responsibility to determine their own work methods (Gruneberg, 1975:45-46; Latham, 2007:31).

In nursing many writers such as Weisman, Alexander and Chase (1980:341-360; Cranny, Smith, Stone, 1992:30-52) have addressed the high need for the autonomy of nurses, as well as the lack of professional independence in nursing. The biggest problem occurs in institutions such as hospitals. The authors observed that autonomy was one of the most important predictors of job satisfaction in their study of registered nurses. The relationship of nurse supervisor and staff nurse has traditionally been the centre of autonomy. It has been argued that the leadership of

nurse supervisors contributes greatly to nurses' job satisfaction (Stamps & Piedmonte, 1986:17).

Herzberg (2004:52-67) (see chapter 4: section 4.4.4) also discovered that the worker's relationship with her or his immediate supervisor was one of the most frequently mentioned job satisfaction factors. The social aspects of the job which refer to the contacts made by the worker with other workers, especially those at the same level within the organisation, constituted another source of job satisfaction. However, it was not social interaction in a generalized sense that was satisfying to a given person, but specific kinds of derived outcomes such as having influence over other people and being liked by other people (Vroom, 1995:38-40). In the field of nursing, it was shown that the relationship factor including social contacts, was of primary importance in accounting for job satisfaction among registered nurses (Stamps & Piedmonte, 1986:18).

6.4.4.2   Question 22: Things you particularly dislike about your job

Table 22 below contains a few selected aspects of the working conditions, which are particularly disliked by the public health services nurses. Low pay and workload were mentioned by the nurse majorities of 67.2% and 65% respectively, as things they particularly dislike about their job. Lack of promotion and lack of recognition are particularly disliked by 44.4% and 42.6% of the nurses respectively.

Table 22   Things particularly disliked about your job

What are the things you particularly dislike about your job?		
Question item	Number of respondents	Percentage(%) of respondents
Low pay	472	67.2%
Lack of recognition	299	42.6%
Lack of promotion	312	44.4%
Workload	456	64.9%

Note: The figures and percentages in table 22 are a result of respondents ticking a multiple of options

According to Heinrichs (1990: 479), pay is a universally recognized component of job satisfaction. Where pay is in the form of money or money rewards, it is used to buy basic needs such as food (see Maslow's theory in chapter 4: section 4.4.1.1), amongst other things. Dissatisfaction with pay with its historical antecedents (see chapter 1: section 1.1), has been the most outstanding job dissatisfier as evidenced by 92.2% of the nurses (table 14). The use to which nurses put the money, in respect of themselves, their families and the society in general, have been detailed in sections 6.4.1.1-6.4.1.5 and 6.6. Estimates of the salary or pay increases desired by nurses are displayed in table 16. The majority of nurses (85.8%) have complained

that their pay does not match the amount of work they do (table 15). Their high dissatisfaction with pay is, therefore, a way of drawing attention to the lack of compatibility between their pay and workload (see dissonance as part of motivation in chapter 3: section 3.3.1.2 and 3.3.1.1).

Workload has been referred to as work demands by Heinrichs (1990:479). Its causes and its effects on the health of nurses as a job dissatisfier have been discussed in section 6.4.1.1-6.4.1.5 and 6.4.2.7 (see also chapter 2: section 2.4.3). When a ward or clinic is adequately staffed and nurses are properly scheduled to carry out their duties, performance can be measured alongside job satisfaction. However, when nurses work under pressure as a result of staff shortage, which is associated with increased workload, the relationship between performance and job satisfaction is marred and the quality of care declines. In the Lawler and Porter's (1991:426-435) basic models of expectancy theory, the individual will receive satisfaction from performance when that performance leads to rewards and when these rewards are perceived as equitable, in terms of the effort expended and comparison with the rewards of others. The public health services nurses have received low pay (table 14) for performance under both adequate and inadequate staffing conditions. The pay received was also inequitable to the effort expended. It was not unexpected, therefore, that nurses were dissatisfied with both the pay and workload. According to McCabe (2007:4-6), nurses regarded their job as a punitive object and developed negative attitudes towards it (see functions of attitudes in chapter 5: section 5.2.1).

Promotion and recognition are job satisfaction variables that are often used interchangeably. This may explain why they received 44.4% and 42.6% same percentage responses respectively in table 22. Gruneberg (1979:37-38; Latham, 2007:31-32) have pointed out that promotion is part of external validation or recognition. Promotion has been discussed in sections 6.4.1.1- 6.4.1.5. Nurses have complained that it took them too long to be promoted (see section 6.5). Promotion for nurses refers to an upward professional mobility into supervisory positions which attracts increased pay, increased self image and increased self-esteem (see chapter 5: section 5.3). Promotion is an extrinsic reward when it is associated with performance (Lawler & Porter, 1991:426-435). It can also be regarded as an intrinsic motivator when it is unrelated to rewards (Lindenfied, 1996:23-27). With regards to the public health services nurses' overwhelming majority dissatisfaction with pay, the latter may neither be an intrinsic or an extrinsic satisfier or motivator for them. According to Hezberg's (1966:50-54) argument, however, such factors as pay and working conditions are regarded as context factors which are necessary, but do not provide job satisfaction (see chapter 4: section 4.4.1.2).

It can be concluded that although low pay and workload are the outstanding bugbears disliked by nurses in their job, their greatest dissatisfaction is festooned around pay, which they regard as being discordant with the amount of work they do. Consequently, the relationship between performance and job satisfaction is skewed in the negative direction. This discrepancy makes the Herzbergian claim that pay as a hygiene factor does not provide job satisfaction ring hallow.

6.4.4.3   Question 23: Other conditions of your job you dislike

There is a myriad of working conditions (see section 6.4.4.1 above). Listed in table 23 are other conditions of the nurses' job, not liked by nurses. Shortage of staff is, for example, rated the highest on the list by 69.1% of the nurses. Its linkage to workload has been discussed above (see sections 6.4.1.1 to 6.4.1.5 and 6.4.4.1). The next other disliked condition of the nurses' job mentioned by 57.8% of the nurses, was the lack of opportunity for further education or training (see also sections 6.4.1.1-6.4.1.5). Lack of accommodation was disliked by 51.9% of the nurses. The transfer system received a dislike response rate of 37.3% of the nurses. The lack of transport, which affected mainly nurses who work late shifts, which ended at 21:00 hours and those who worked on night duty, was disliked by 22.4% of the nurses.

Table 23   Other conditions of your job you dislike

What other conditions of your job do you dislike?		
Question item	Number of respondents	Percentage (%) of respondents
Shortage of staff	485	69.1%
Transfer system	262	37.3%
Lack of opportunity for further education or training	406	57.8%
Lack of accommodation	364	51.9%
Lack of transport	157	22.4%
Other	37	5.3%

Note: As in table 22 respondents in table 23 indicated multiple preferences

Shortage of staff inherited its historical connotations from the time of the decentralization of the public health services (see chapter 2: Section 2. 4. 3). It has meaning only when it is interpreted in the context of nursing duties, wherein it evokes the notion of workload, which transfuses it with its true reality. Workload results directly from the shortage of nursing staff when few nurses chase or undertake too many duties and become the masters of none of them. When the demands of these duties exceed their abilities, stress is said to occur (Jex, 1998:2). Stress is then followed by strain, which refers to the multitude of ways employees may use to respond to stresses. Such methods of response by employees include absenteeism, poor performance and turnover (Jex, 1998:2-3). Because this occurs in a work environment, stress and strain can be analysed through the perspective of the person environment fit theory (French, Caplan & Harrison, 1982:27). The theory argues that the goodness of fit between the subjective person and the subjective work environment affects employee performance. As a result of a prolonged job stress, due to the job demands at the workplace that tax or exceed an individual's resources, burnout develops (French *et al.* 1982:27).

Shortage of staff through its mechanism of workload destroys professional interest in a job, as the nurses hurriedly complete tasks without much thought of what they are doing. Nursing becomes like any other job such as working in the laundry. Personal professional need such as quality of care and being accountable for one's omissions and commissions become sidelined or are given a non-committal observance (see need fulfillment theory in chapter 4: section 4.4.2.2). Job dissatisfaction results from the inability to promote the interests of the patients. For example, patients who may be too weak to feed themselves are left without nutrition, because nurses have no time, because of staff shortage and workload. Plates of food, which has not been eaten, are removed from the patients' bedsides for the bin or for pigs. Thus, shortage of staff creates an environment in which institutional objectives such as protecting and supporting the health of individual patients are glossed over (see chapter 3: section 3.4.1). Schaufeli, Maslach and Marek (1993:9) have pointed to the whole diversity of manifestation of job dissatisfaction caused by the shortage of staff and workload such as absenteeism, professional depression, low morale and vital exhaustion amongst many others.

Lack of opportunity for further education or training has been related to lack of promotion, and both have been discussed in sections 6.4.4 above and 6.5 below. They have both caused job dissatisfaction, lack of motivation and negative nurses' attitudes towards their job, because they have been seen as blocking career progression. Further education or training and promotion are part of esteem needs (Maslow, 1970:91-92) which include achievement, recognition and approval of others (see Maslow's theory in chapter 4: section 4.4.1.1). When these are blocked, the path leading to self-actualization is barricaded too. Self-actualization forms part of intrinsic motivation (see chapter 3: section 3.3.1) which drives nurses through upward occupational mobility into top positions of professional authority such as matron. Relevant higher qualifications in nursing such as a degree have been regarded as a fast lane to promotion. For those nurses who do not possess the necessary academic subjects to pursue university degree courses, midwifery training to specialize in that area of nursing, has been the alternative. For both of these routes, which are sponsored by the government, nurses have complained that the selection is protracted, inconsistent and unfair.

Lack of accommodation and the transfer system also combine in the same fashion, as lack of opportunity for further education or training and promotion, to cause job dissatisfaction to a particular group of nurses. The affected or targeted category is that of the less experienced nurses who have not yet done or undergone the government's 2-3 years remote areas nursing experience. The problems these nurses face on transfer from one station to another have been discussed earlier (see sections 6.4.1.1-6.4.1.5). The decentralisation of the health services brought with it, not only the shortage of staff to man these rural nursing posts, but also the lack of accommodation in these remote areas (see chapter 2: section 2.4.3) for transferred nurses. The transfer system, as an instrument used by the government, to disperse nurses to the outlying postings, even causes as previously stated more suffering to nurses with children, because of the lack of accommodation. Yet by complying with the government's transfer system, the nurses see it as a learning process or experience in which they are expected to play an active part (see operant conditioning in chapter 5: section 5.2.2.1.2), but the institutional environment (see chapter 3: section 3.4.1), that is, the lack of accommodation in the remote health services settings, is not conducive to their health and welfare. The lack of personal

needs (see chapter 4: section 4.4.2.2) that are necessary for professional growth in nursing, leads to job dissatisfaction and negative change of attitude (see chapter 5: section 5.2.1) on the part of nurses.

To recapitulate, four percentages of respondents from each of the tables 22 and 23 are singularly important. In general the majority of nurses (64.9%) do not like the working conditions and there are a few aspects of these factors that they particularly dislike. For example, a large number of nurses (67.2%) was not happy with low pay and a further 64.9% of the nurses found the workload to be an unpleasant working condition. Other factors such as lack of promotion and lack of recognition were disliked by 44.4% and 42.6% respectively. Shortage of nursing staff which is a direct or an indirect cause of workload was mentioned by a majority of 69.1% of the nurses as an unacceptable working condition. Lack of opportunity for further education or training as part of other conditions of service, attracted the dislike of 57.8% of the nurses. Lack of accommodation for nurses, either at their normal hospital or clinic station or transfer to another location, was reported by 51.9% of the nurses to be a problem, while the transfer system was disliked by 37.3% of the nurses.

In summary the principal dissatisfiers to nurses that stand out more clearly than others are low pay, workload, shortage of staff, lack of opportunity to further one's education and the lack of accommodation. As is known by all nurses, pay is out of the control of nurse managers as it is determined and set nationally by the government. Workload may be partly attributed to nursing decision-makers, about the true and accurate position, with regard to the extra work caused by the shortage of nurses, and partly by competing non-nursing duties imposed upon them. It is significant that nurses deplored outright the working conditions in general before they singled out those factors that are at the top of the list in respect of job dissatisfaction.

If nurses are seething with discomfort and frustration as a result of unsatisfactory working conditions, they would be compelled to consider alternative coping mechanisms and the choice may not be wide.

6.4.4.4   Question 24: Thought of leaving nursing

The thought of leaving nursing is not a light decision for nurses, for it involves forfeiting all the benefits from the three years training. It may well be for this reason that the real potential threat to leave nursing, as shown in table 24 below, came from only 33% of the nurses, who said that they very often think of doing so. The largest group of nurses (35.6%) consists of "fence sitters" who sometimes think of leaving nursing. Some of the possible reasons for doing so could be dissatisfaction with pay (table 14) and the working conditions in general (table 21). In table 24 the majority of nurses (35.6%) sometimes think of leaving nursing. But the more serious threat comes from 33% of the nurses who very often think of leaving nursing. Fortunately, however, these are not in the majority. The other responses of 13.9% of the nurses who often thought of leaving nursing and the 17.4% of the nurses who never thought of leaving nursing are not of significant statistical importance.

Table 24   Thought of leaving nursing

How often have you thought of leaving nursing?		
Question item	Number of respondents	Percentage(%) of respondents
Very often	232	33.0%
Often	98	13.9%
Sometimes	250	35.6%
Never	122	17.4%
Total	702	99.9%

The thought of quitting nursing in practical terms has sometimes been easier said than done. There are a number of reasons for not converting the rhetoric into reality. Firstly, alternative opportunities for employment are few.   Secondly, nurses are preoccupied with wastage of their specific training and preparation for a nursing job, if they were to move into other work outside the public health services.   This benevolent thought, not only works for them, but is also an advantage to the government that has spent national resources in sponsoring their training including post-basic specialization. Thirdly, sometimes a sense of national pride in providing a noble service to one's country gets the better part of the nurses. For these and other personal-to-holder excuses, the thought of leaving nursing becomes a hysterical threat, to have pertinent problems in the health services addressed and corrected. Tables 24, 25 and 26 reveal nurses' thoughts about their career.

6.4.4.5   Question 25: Intention to remain in nursing until retirement

The intention to remain in nursing until retirement is supported by 38.5% of the nurses in table 25 below. But the majority of nurses (59.7%) replied that they have no intention to remain in nursing until they retired.   The seeming contradiction between responses in tables 13, 21 and 25 has been explained above (see section 6.4.4.1). It is reiterated that the majority response in table 26, contains a veiled rebuttal of what the majority of nurses said in table 25. This makes the response in table 25 appear as an urge of momentary frustration with the working conditions (table 21).

Table 25   Intention to remain in nursing until you retire

Do you intend to remain in nursing until you retire?		
Question item	Number of respondents	Percentage(%) of respondents
Yes	270	38.5%
No	419	59.7%
Total	689*	98.2%

Key*   Some respondents avoided answering the question

6.4.4.6   Question 26: Preference of where to practise your nursing career in general if terms and conditions were acceptable to you

Terms and conditions are another way of referring to working conditions. If these were acceptable, the majority of nurses (46.3%) in table 26 would prefer to continue to practise their nursing career in government health services, which are one and the same thing as the public health services, where the respondents are presently employed. The attraction to remain in government health services is not based on earning power, as shown by 19.1% of the nurses in table 39. One of the possible explanations could be the security of a public service employment. The refusal to remain in nursing until retirement shown by the majority of 59.7% of the nurses in table 25 could have been, therefore, a protest sign against the working conditions disliked by a majority of 67.3% of the nurses in table 21. Those nurses (24.6%) in table 26, who would prefer to practise their nursing career in the private health services, believe that they could earn more money therein, as shown by a majority of 44% of the nurses in table 39. The rest of the nurses (21.2%) in table 26 would prefer to devote to their nursing occupation in other institutions such as large companies which operate clinics for their employees.

Table 26   Preference of where to practice your nursing career

In general, if terms and conditions were acceptable to you where would you prefer to practise your career?		
Question item	Number of respondents	Percentage(%) of respondents
Government health services	325	46.3%
Private health services	173	24.6%
Other	149	21.2%
Total	647*	92.1%*

Key*   Not all respondents answered this question

The thought of leaving nursing is caused by a number of factors, for instance, unfavourable working conditions (table 21). Its significance is a potential source of labour turnover especially if it is prolonged and unalleviated. If job dissatisfaction, which is the hub around which the reasons behind this feeling emanates, is not addressed head-on and resolved, then it becomes a breeding ground for poor quality health care, absenteeism and labour turnover (see chapter 1: sections 1.3 and 1.4). The results in table 24 show that the highest number of nurses (35.6%) in the sample said that they sometimes thought of leaving nursing. Almost a similar percentage (33%) of respondents reported that they very often thought of quitting nursing. Although the thoughts of sometimes and very often wanting to leave the health services, are each less than half the sample of nurses, they contain a strong element of job dissatisfaction as in total they represent 68.6% of the respondents. It is possible that, viewed against this background, the public health services are faced with the prospects of losing nurses in the future, if corrective measures are not adopted in time.

The most dramatic evidence of job dissatisfaction in nursing is the decision to leave the field altogether, as Stamps and Piedmonte (1986:9-11) noted (see chapter 4: section 4.3). The lack of intention to remain in nursing until retirement, expressed by the majority of 59.7% of the nurses in table 25, forms part of such a decision. The nurses thought of leaving because of the dissatisfaction with the working conditions in their work situation (table 21). What Price (1977:38-52) called career disillusionment, was a compendium of thorny issues within the working conditions, such as a shortage of staff, lack of opportunity for advancement and low pay, among many others, that was the last straw that precipitated the nurses' thoughts to leave (table 14 and chapter 2: section 2.4.3).

A withdrawal decision was, not only caused by diminishing job satisfaction, but also by unmet expectations on which the nurses' psychological advantage was based on joining nursing (see chapter 3: section 3.6 and chapter 5: subsection 5.2.2.1.3). In other words, the process of balancing the potential rewards with desired expectations in nursing, as Porter and Lawler (1993:32-49) argued, has been derailed by the lack of motivation, job dissatisfaction and negative attitudes, all contained in the working conditions. Stamps and Piedmonte (1986:9-11) have contended that extrinsic rewards attract people to a job, but it is intrinsic rewards that are important in determining the retention decision (see chapter 3: section 3.3.1). According to Festinger (1957:22-27), however, both extrinsic and intrinsic factors are important, because they are interdependent and interactive (see chapter 3: section 3.3.1.1). This interdependence was removed in the case of public heath services nurses, because of a number of limiting factors within the whole bundle of working conditions, such as workload and low pay (table 22), together with many others (see chapter 1: section 1.2 and 1.4). The nurses' withdrawal behaviour was a result of the motivational system being thrown into disarray (see chapter 3: sections 3.2 and 3.3). Those nurses who may choose to stay until retirement, according to Stamps and Piedmonte's (1986:9-11) prognosis, may show other forms of distancing behaviour, such as poor performance and absenteeism, if the working conditions are not improved.

It has been pointed out that attitudes are connected to behaviour (see chapter 5: section 5.2.1). Jex (1998:2-3) has observed that poor performance and absenteeism, as preludes to labour turnover were caused by behavioural strains.

The thought of leaving nursing is a value-expressive function of attitude (Terry & Hogg, 2000:45-47), in which the self-concept (see chapter 3: section 3.5) of nurses and the image of nursing (see chapter 5: section 5.3), have been denied by the institutional constraints and rigidity such as the long-standing complaints about low salaries (see chapter 1: section 1.2). The final recourse on the part of nurses was the thought of leaving nursing. The balance theory would argue that when the nurses' institutional work environment and the nurses' attitudes no longer shared the same "dynamic character" (Fishbein & Ajzen, 1975:31-32; Oskamp & Schultz, 2004:27-29), that is, no longer in equilibrium, the thought of leaving nursing was aroused (see chapter 5: section 5.2.2.1.4). The nurses' thoughts or attitudes became negative towards a continued stay in nursing.

The nurses' intention to leave nursing, evidenced by the 60% majority of nurses, who do not intend to remain in nursing until retirement, can also be explained through the dynamics of a motivator, which has gone for too long without being appeased or satisfied (Kaplan & Norton, 1996:129-132) and has drifted out of prominence, by taking the exit route (see chapter 3: section 3.4.2). Pay is a good example (see chapter 4: section 4.4.1.2.1). But pay brings with it most of Maslow's (1970:91-92) needs such as economic security and esteem needs (see chapter 4: section 4.4.1.1). When these needs are deficient, again the nurses' intention to leave nursing may be triggered off. But however one looks at the thought of leaving nursing, it is a crystal ball through which to view the future intentions of nurses.

A corollary to the thought of leaving nursing is an attempt to establish the long-term intention of nurses until retiral. Remaining in nursing until retiring age, may not only be a sign of loyalty, commitment and job satisfaction, but may also be reflective of what other choices nurses have for their professional mobility. Table 25 reveals that the majority of nurses (59.7%) indicated that they had no intention of remaining in nursing until retiring age. This is in defiance of the fact that nurses may have limited chances, of pursuing a health related career outside the health services. If the intention by nurses is to throw to the wind, the choice of a secure job in nursing, in order to venture into an unknown world of other types of employment, it can only be concluded that their level of dissatisfaction with nursing, has reached intolerable heights. On the optimistic side, however, although the number of nurses, who plan to remain in the health services until retirement, is less than half at 38.5%, one can derive satisfaction from the fact that, some measure of job satisfaction in nursing cannot be slighted. This small nucleus of presumably satisfied nurses, willing to retire in nursing, can be expanded if remedial steps towards rectifying job dissatisfiers, contained mainly in the working conditions can be taken.

It is further encouraging, to both the nurse managers and government that nurses have not lost faith in nursing completely. This is shown by a majority 46.3% of the nurses in table 26, who confirmed a preference of practising their nursing career in the public health services, if the working conditions were improved. The shift by nurses, into the private health services was insignificant at 24.6%. To all intents and purposes, therefore, the residual liking of public health services by nurses is almost twice as strong as the desire to work in the private health sector. This lingering desire in the minds of nurses, to continue to work in the government health sector, can be harnessed to form a sound launching pad, for the attraction and retention of nurses, if the health services authorities take full cognisance of the nurses' warning shots.

6.4.4.7 Summary analysis of results for section 6.4.4: Working conditions in the public health services (Questions 21-26)

It has been stated that working conditions in the public health services are conjoined to pay. Because these contextual factors are peculiar to an institution, nurses work within a given set of working conditions, which either facilitate or block the attainment of their main work goals, such as the delivery of good quality health care. The attainment or blocking of nurses' objectives in the health services depends on job satisfaction or the lack of it. Gruneberg (1979:36; Latham, 2007:31) noted (see chapter 4: section 4.4.2.1) that there was a relationship between job satisfaction and the achievement of certain goals under certain working conditions. According to Vroom (1995:150-152) and Herzberg (1966:49-67) (see chapter 3: section 3.3) the achievement of given standards of competence and job satisfaction are enhanced by pleasant working conditions. It will be recalled that the majority of 67.3% of the nurses (table 21), expressed a dislike of the working conditions, in general or as a package, without being specific as to which aspects or which particular factors, constituted a curse to their professional lives. Locke (1979:1215-1224; Spector, 1997:36) (see chapter 4: section 4.4.1.2.1) has emphasised the importance of a satisfactory background of working conditions, to enable workers to achieve job satisfaction and productivity.

The specific working conditions that posed as great dissatisfiers to the nurses are low pay and shortage of staff (tables 22 and 23). Pay is one of the leading or dominant variables amongst the extrinsic or context factors. In terms of Herzberg's differentiation between motivators and hygiene factors, pay and the shortage of staff are classed as hygienes. Gruneberg (1979:55; Latham, 2007:43), placed pay at the top of the list, of other context factors such as security (see chapter 4:4.4.5), work groups, supervision, participation, role conflict and ambiguity and organizational requirements. Lawler and Porter (1991:426-435) (see chapter 4: section 4.3) found that pay was a single job aspect, over which the greatest number of employees expressed dissatisfaction. They further argued that it was not always the actual level of pay, which was related to job satisfaction, but the amount of pay received in relation to others, with whom one is comparing oneself.

Shortage of staff has been associated with increased workload, poor health care delivery and a number of other factors, all contributing to job dissatisfaction. The nursing fraternity has inadvertently, tended to link workload with expected pay increases, or with a matching level of pay, to compensate for the might or the higher level of energy, expended on having to do more work, sometimes outside the normal or ordinary call of duty. But causes of pay satisfaction are not simple and uncontroversial. Firstly, individuals make a comparison between themselves and others, based on a list of factors such as level of skill and the amount of effort (see chapter 5: section 4.4.2.1 and chapter 1: section 1.1). The argument is that the equality of payment for a given input must be related to the amount of pay that similar individuals receive for similar inputs. Secondly, there are other factors, which are likely to affect satisfaction with pay, for example, the level of aspirations. Thus, an individual may be dissatisfied for a number of reasons, for instance, because her or his pay does not enable her or him to acquire the kind of goods and services that society has to offer (see chapter 6: section 6.4.1.1 – 6.4.1.5). The problem is so complex that most research findings have given up the idea of arriving at a universal

determinant of pay satisfaction (Gruneberg, 1979:61-62; Latham, 2007:37-41) (see chapter 4: section 4.4.4 & 4.4.5).

The complexity surrounding the affinity between pay and personal satisfaction can be extended to the other various components of the working conditions. What has been shown in the study is that working conditions in general, are related to job satisfaction and the latter itself, is inseparable from motivation and job attitudes (see chapter 3: section 3.5). It requires little effort, therefore, to conclude that the hypothesis that the perceptions of nurses in respect of the various components of their working conditions, as being related to their feelings about job satisfaction, motivation and job attitudes has been fulfilled (see chapter 1: section 1.5). Further workload and staff shortage, as part of the extrinsic factors have been exposed as contributors to nurses' job dissatisfaction that may lead to poor quality patient care and potential labour turnover. Thus, the corresponding assumptions underscoring the importance of workload and staff shortage, as job factors causing negative attitudes towards patient care amongst nurses, has also been satisfied (see chapter 1: section 1.5).

The other aspect of working conditions, apart from factors that impinge on the work itself, is the human side or the interactive component, involving nurse managers who supervise the work of junior nurses, in a designated work unit. The physical and psychological exhaustion, burnout or stress on the part of nurses, brought about by the workload and the staff shortage job factors, can be worsened by a type or style of supervisor, for example, in the ward or in the entire health facility or institution. Democratic, participatory or authoritarian leadership style practised by nurse managers, imply whether junior nurses on the shop floor, are consulted or allowed to participate in decision making, or are simply commanded in the way they carry out their duties. Whichever way these types of supervisory practices emerge, they have job satisfaction consequences to nurses.

6.4.5   Supervisory or nurse management practices

Nurses work within the system of teams and shifts and are supervised by a hierarchy of nursing authority. The team leader in a ward environment is a ward sister, charge hand or head nurse. Although she or he may have other senior nurses below her or him, she or he remains the lynchpin of supervisory practices at this particular work unit. She or he creates a ward personality or a work atmosphere which may or may not promote job satisfaction amongst the nurses at the substratum or the operative level of the ward. The interpersonal relationships between the nurses and the ward nursing sister, if satisfactory, motivating and healthy, can foster a team spirit imbued with positive attitudes amongst the nurses, around which they can rally to nourish job satisfaction (see chapter 6: section 6.4.3.6). Three main questions in the supervisory practices lexicon, as detailed in tables 27, 28 and 29, solicit responses from nurses with regard to their working relationship with their supervisor.

6.4.5.1   Question 27: Working relationship with supervisor

Stamps and Piedmont (1986:18) wrote that the nursing arena is characterized by a rigid status hierarchy that almost ensures conflict between the lower and the higher level workers. The majority of nurses (67.1%) in table 27 did not show evidence of such conflict with their supervisors. The two levels shared a good working relationship. Festinger (1957:1-3) would argue that there was a consistency or consonance between the nurses' cognitions of professional supervisory practices and the supervisor's expected behaviour that creates a good rapport and a good working relationship between the nurses and their supervisors (see chapter 5: section 5.2.2.1.5). This lack of dissonance between the nurses and their supervisors must have raised the nurses' motivated self conceptions and created a positive attitude towards their work (see chapter 3: section 3.5).

Table 27 Working relationship with supervisor

Do you have a good working relationship with your supervisor?		
Question item	Number of respondents	Percentage (%) of respondents
Yes	471	67.1%
No	32	4.6%
Sometimes	199	28.3%
Total	702	100%

The nurses' good working relationship with their supervisors, must also have given them a sense or feeling of belonging, self-esteem and recognition, all of which lead to motivation, job satisfaction and proactive attitudes (see chapter 4: sections 4.4.1.1 & 4.4.1.1.1). When nurses have a motivated attitude through a good working relationship with their supervisors and receiving social support from the latter, their intrinsic motivation increases their job performance (see chapter 3: section 3.4). On the part of the supervisors, according to Vroom (1995:109), to have created a good working relationship with the nurses, they must have shown a supervisory behaviour indicative of friendship, mutual trust, respect and warmth. There is considerable evidence, therefore, that the satisfaction of subordinates is related to the employee-orientation supervisory practice (Vroom, 1995:109-110), as well as a job situation which satisfies the individual's needs, values and expectations (see chapter 4: section 4.4.5). It is against this background that high level job satisfaction, motivation and productive attitudes amongst the nurses can reduce real and potential turnover, grievances and absences (see chapter 1: section 1.2).

Not all nurses, however, have a good working relationship with their supervisor, as shown by 4.6% of the nurses (table 27) who do not. Although the "rebellious" percentage is insignificant, it serves to remind the supervisors that there is a blot in their supervisory practices. In other words there is a conflict between this small group of nurses and their supervisors, in their working relationship, which may appear confined to these two parties for a time, but has the potential to spill over on to other nurses. When this happens, like a conflagration, it will destroy the morale in the

nursing team, cause loss of motivation, cause job dissatisfaction, affect performance and competencies (see chapter 3: section 3.4) and promote negative attitudes and behaviours amongst the nurses. Apart from spawning this infectious work atmosphere, this small number of nurses can be expected to show signs of job dissatisfaction, such as poor performance in the form of clinical incompetence, low motivation and lethargic attitudes towards work, absenteeism and lack of cooperation with other nurses (see chapter 1: section 1.4).

It could also be said that there is a flitting conflict between the 28.3% nurse respondents and the supervisors (table 27). These are the nurses who said that they sometimes have a good working relationship with their supervisors. The net effect of this vacillating attitude and behaviour between the nurses and their supervisors, called for a corrective action. This is required in order to convert them or attract them into the 67.1% group of nurses who have a good working relationship with their supervisors. This is necessary as this on and off or "sometimes" attitude on the part of nurses, exposes patients to the risks of negligence, on days when the relationship between the nurses and their supervisors is not good (see chapter 6: section 6.4.3.6).

6.4.5.2   Question 28: A chance to make decisions about your job

One would not be gullible to believe that the supervisors, with whom nurses had a good working relationship, would decline them a chance to make decisions about their job. One is an extension of the other. The probability of that coincidence occurring would be stronger than the obverse situation. Thus, the majority of nurses (59.3%) in table 28 below were given a chance, to make decisions about their job. This was an expression of job satisfaction, since the recognition of the nurses' competence shown by the supervisors, must have instilled a sense of pride, self-esteem and achievement in the nurses and boosted their intrinsic motivation in their work (see chapter 4: section 4.4.1.2 and chapter 3: section 3: 3.1). This was not the first time that the majority of nurses had enjoyed autonomy in their job. For example, they had a choice in the way they carried out their duties and they chose the way they organized their work [see chapter 6: sections 6.4.2.2 (table 7), 6.4.2.3 (table 8), 6.4.2.4 (table 9) and 6.4.2.5 (table 10)].

Table 28   A chance to make decisions about your job

Does your supervisor give you a chance to make decisions about your job?		
Question item	Number of respondents	Percentage(%) of respondents
Yes	416	59.3%
No	55	7.8%
Sometimes	204	29.1%
Never	13	1.9%
Total	688*	98.1%*

Key*   Not all respondents answered the question

The study of Morse and Reimer (1956:120-129), found that employees given increased participation in decision making concerning their job, showed significant improvement in their attitudes. Because attitudes are connected to behaviour (see chapter 5: section 5.2.1), it can be said that the nurses who were given a chance to make decisions about their job were motivated. The motivator came from the acknowledgement and recognition, of the nurses' professional worth or standing by their supervisors, which had an uplifting effect on their attitudes or performance (Herzberg, 1966:83-84) (see chapter 3: section 3.2). For the supervisor to give a chance to subordinate nurses, to make decisions about their job, she or he must have found the nurses to be reliable, competent, cooperative and able to complete work assignments all of which were the hallmarks of motivation and compliant attitudes on the part of nurses (see chapter 3: section 3.4).

A small number of nurses (7.8%), however, thought that their supervisor did not give them a chance to make decisions about their job. One might be tempted to hazard a conjecture that most of the nurses, if not all, in this group, probably do not have a good working relationship with their supervisor. Viewing it another way, it was highly improbable that a supervisor with a good working relationship with subordinate nurses would refuse to give them a chance to make decisions about their job, unless there were other intervening variables, such as incompetence and unreliability. These nurses, therefore, work in an environment of job dissatisfaction, low motivation and morale and negative attitude towards the supervisor, other nurses and their work, which put the patients at the risk of lack of duty care (see chapter 4: section 4.4.1.2 and 4.4.1.2.1). The 7.8% minority nurses' dissenting voice, is a reminder to the supervisors that not all is well in their arsenal of supervisory practices. The underlying or implied conflict that caused the supervisor not to give a chance to the 7.8% of nurses to make decisions about their job needs to be resolved (see chapter 6: section 6.4.5.1), in order to pave the way for safe practice by these nurses. The frivolity of the 1.9% of nurses who said that their supervisor never gave them a chance to make decisions about their job is too insignificant to consider.

The 29.1% of nurses, whose supervisor sometimes gave them a chance to make decisions about their job, poses a potential clinical risk to patients (see chapter 6: sections 6.4.3.6 and 6.4.5.1 above). For example, Gruneberg (1979:75-76; Latham, 2007:60-62) (see chapter 4: section 4.4.5) found that the effects of participation in

decision making on attitudes caused a significant improvement in job satisfaction (see also chapter 5: section 5.2). Stamps and Piedmonte (1986:3-5) (see chapter 4: section 4.4.5) pointed out that there was a relationship between job satisfaction and productivity. In the light of this analysis, the lurking risk in the practice of the 29.1% "sometimes" group of nurses, both with regard to productivity and clinical job performance was exposed during the occasions when the supervisors did not give them a chance to make decisions about their job.

6.4.5.3   Question 29: Talking to your supervisor and other higher authorities

Table 29 below shows that a majority of 50.6% of nurses, found it easy to talk to their supervisor and other higher authorities. Finding it easy to talk to a supervisor and other higher authorities, such as a matron, implied that the nurses had a good working relationship with these different levels of nursing hierarchy. The cause could be extended to include, for example, the management style of the supervisor, the type of leadership role and the nature of supervisory practices. For the purposes of this question, the personalities of nurses are considered constant and infallible.

Table 29   Talking to your nursing supervisor and other higher authorities

Do you find it easy to talk to your supervisor and other higher authorities?		
Question item	Number of respondents	Percentage(%) of respondents
Yes	355	50.6%
No	112	16.0%
Sometimes	220	31.3%
Never	15	2.1%
Total	702	100%

The notion of finding it easy to talk to a supervisor further connotes the image of a supervisor who is considerate and friendly and who gives elbow-room or leeway to subordinate nurses in a number of nursing areas. For example, such a supervisor would allow nurses to participate in decision making concerning their job. The same supervisor would permit initiative, autonomy and freedom to subordinate nurses in the organisation of their work. These factors would promote work performance and motivation of the nurses (see chapter 3: section 3.4). They would create job satisfaction by satisfying the nurses' esteem needs (see chapter 4: section 4.4.1.1). They would also fulfill the nurses' expectations (see chapter 5: section 5.2.2.3), enshrined in the nursing profession, that they are held accountable for their actions and omissions.

The type of supervisor described above is more likely to be democratic rather than authoritarian. A democratic supervisor would allow interaction, with her or his subordinate nurses, which facilitates good interpersonal relationships between the two parties. Such a supervisor would also be easy for the nurses to talk to about any

grievances, for example, emanating from the working conditions such as pay and promotion. In explaining the effects of supervision on job satisfaction, Vroom (1995:107) (see chapter 4: section 4.4.5), used two somewhat different approaches. One was directed toward the "personality" of the supervisor and the other toward her or his behaviour in the work situation. The personality of the supervisor was typically assumed to be reflected in her or his behaviour, in matters concerning, for example, intelligence, approachability, fairness and transparency. On the other hand, her or his behaviour in the work situation, was determined through descriptions of this behaviour, by the supervisor herself or himself, by her or his subordinates and peers. The subordinate nurses would have described the supervisor they found easy to talk to as being extraverted, somebody who did not keep herself or himself to herself or himself. The nursing job requires continuous interaction and consultation and this is only possible with such a supervisor.

The 16% of nurses, who indicated that they did not find it easy to talk to their supervisors and other higher authorities, are to be expected to work in a nursing environment starved of communication with an "important" person in their nursing processes. They lacked direction in their work. They were deprived of learning by the presence of a supervisor they did not find easy to talk to. They could not suggest anything. They could not use their initiative in their work for fear of risking the security of their job (see chapter 4: section 4.41.1). They could not participate in decision-making regarding their job and their learning was inhibited by such an unfriendly working environment. Most importantly, these nurses could not perform their duties well, let alone maintain quality of care, because they could not consult or check with their supervisor about their nursing procedures or processes. In consequence, thereof, patients suffered. Finding it not easy to talk to their supervisor lowered these nurses' self-concept, it removed intrinsic motivation (see chapter 3.4 and 3.3.1), and regressed their attitudes towards work (see chapter 5: section 5.2). According to Herzberg *et al.* (2004:70-72) (see chapter 4: section 4.4.1.2), conflict in incidents such as supervision and interpersonal relationships, was a cause of job dissatisfaction. Conflict was implied between the nurses and the supervisor to whom the nurses did not find it easy to talk.

The 31.3% of nurses, who sometimes found it easy to talk to their supervisor and other higher authorities, were ambivalent about the personality of the supervisor. The difficulties faced by these nurses, of operating in a grey area of supervision, in which they only used the "good days" when they found it easy to talk to their supervisor, were that they had to be in a hurry to extract all the information they needed from the supervisor during that limited time. But then clinical problems involving patients cannot be pigeonholed into the good-mood periods only. During the "bad days" when the subordinate nurses did not find it easy to talk to the supervisor, they burrowed themselves into silence and hankered after better days. This sizeable group of nurses was forced to sacrifice the daily patient care on the alter of the supervisor's mood swings. The hidden conflict that seems to explain relationships based on "sometimes" variations, needs to be addressed for the benefit of all parties, that is, the supervisor, the subordinate nurses and the patients. If left unresolved, nurses in such predicaments of sometimes not finding it easy to talk to their supervisor, would suffer from lack of motivation, lack of promotion, retrogressive attitudes that are both negative to themselves because of a reduced self concept (see chapter 3: section 3.4) and a diminished self-esteem (see chapter 4: section 4.4.1.1), coupled with the blurred prospects of a career progression path. The

additive effect of all these factors is to plunge these nurses into an abyss of job dissatisfaction, demotivation and negative attitudes.

For some 2.1% of nurses there was no "sometimes" but never in fact found it easy to talk to their supervisor and other higher authorities. This tiny figure was a negative accreditation of the supervisor's inability to provide access for subordinate nurses to talk to her or him. But it was also indicative of a fractional source of conflict that the supervisor should extinguish from her or his armoury of supervisory repertoires. It is, however, statistically too insignificant to expend energy on.

6.4.5.4 Summary analysis of results for section 6.4.5: Supervisory or nurse management practices (Questions 27-29)

The evidence-contained in tables 27, 28 and 29 indicates that the majority of nurses was happy in their working relationships with their first-line nurse managers or their supervisors in the ward. For instance, the majority of 67.1% of nurses reported that they had a harmonious working relationship with their supervisor (table 27). As if to confirm that their supervisors employed a democratic or participatory style of management, the majority of nurses (59.3%) reported that they were given an opportunity to make decisions regarding their duties (table 28). A fitting consequence of the participatory type of management was shown by the majority of nurses, who said that they found it easy to talk to their supervisors. It was intended that this ease of access to supervisors, would be extended to other higher nursing authorities, which would be indicative of a pervasive user-friendly and participative nursing leadership ethos.

There can be little doubt that the good working relationship, enjoyed by nurses with their supervisor, promotes motivation, job satisfaction and conducive attitudes. Only a minuscule 28.3% of the nurses said that they sometimes had a good inter-personal relationship with their supervisor (table 27). Supervisory practices, by immediate and top nurse managers, did not seem, therefore, to be a source of friction, as many of the nurses found it easy to talk to their superiors. However, a further analysis in the context of management theories, would help further to elucidate the important niche, occupied by supervisory practices, in the wider arena of working conditions.

A supervisor, who is unable to engender motivation through sustainable satisfactory working relationships with her or his subordinates and does not permit participatory decision making in the workplace and further impedes access of communication to herself or himself, will create not only feelings of job dissatisfaction, but also an aura of uncertainty and insecurity. Role ambiguity and role conflict have been found to be associated with low levels of satisfaction with the work itself, as well as low levels of satisfaction with supervisory behaviour, pay and promotion (Gruneberg, 1979:80-82; Latham, 2007:56). The Hawthorne studies argued that supervision was the most important determinant of worker attitudes. The relationship between the first line supervisors such as ward nursing sister and the individual employee, for instance, junior nurses in the ward, was found to be more important in determining the attitude, morale, general happiness or ward bonhomie and efficiency of the worker than any other single factor (Vroom, 1995:105). Herzberg *et al.* (2004:62-70) (see chapter 4:

section 4.4.3) found supervision to be a source of job satisfaction ahead of job security, job content, company policy, opportunity for advancement and wages as well as other factors of working conditions.

Vroom (1990:75-77) has pointed out that subordinates like supervisors who are both considerate and employee-centred and who prompt them towards performance goals. The basis of this functional attraction is the accruing of job values. For example, a subordinate will like her or his supervisor to the extent that she or he perceives the supervisor as a person who can provide her or him with the opportunity of attaining important job values. In the ward, for instance, the ward sister provides a gateway to promotion for junior nurses through management tools such as an appraisal system. In this model the ward supervisor, is seen as a job-value facilitator and a job enricher (Locke, 1976:1326; Spector, 1997:73). In performing these roles the supervisor is involved in interactions with her or his subordinates and it is these interpersonal relationships which are at the centre of supervisory practices. To the extent that the latter are essential in the promotion of job satisfaction, the assumption that nurses' perceptions of supervisory practices are related to their perceptions of job satisfaction, motivation and attitude is upheld.

Supervisory practices are, however, properly understood and realized within an institutional setting, guided by rules and regulations, which set the tone and the limits on how supervisors behave towards junior staff. The institutional requirements may be a product of higher nursing management style, running down to the lower supervisory ranks. Thus, an organizational requirement such as a communication system in a hospital, may be imbued with a particular management approach or flavour, which sets constraints on how supervisors guide and direct the junior nursing staff on the interpretation of their duties.

6.4.6   Organizational requirements

Organizational requirements in an institution, which is overseen by supervisors and higher nurse management echelons, are important elements of job satisfaction, motivation and job attitudes on the part of junior nurses (see chapter 1: section 1.4). Nurses want to be kept informed, for example, about events in their hospital, ranging from information about new staff to seminars, workshops and continuous education programmes. This makes their stay in the hospital interesting and enjoyable.

Communications, particularly written and telephonic, from the Ministry of Health and nurse leaders such as the matron, are key organizational parameters in the management of public health services. The need becomes more acute with the government's transfer of nurses into remote areas. Nurses affected by such policy, have complained endlessly about the loss of contact with relatives and family, as well as the nursing fraternity, caused by the lack of communication. Locally within institutions such as a hospital, the effect of the absence of or inadequate communication is evident when meetings between junior nurses and supervisors are not held regularly. Such contacts form a forum for learning for junior staff both about the job and future professional prospects offered by the employer. This not only promotes the image of the institution and nursing but also helps retain nurses. Apart

from keeping nurses in the dark about their progression, lack of communication between them and their supervisors has been perceived as a cause of disempowerment on the part of nurses from laying claims to proper professional boundaries to their duties. As a result, for example, the edges of nursing and non-nursing duties become blurred. This leaves in trail feelings of demotivation, job dissatisfaction, low morale and defeated attitudes. In substance questions 30-35 highlight the functional and administrative requisites of a health services institution.

6.4.6.1   Question 30: Communication system in the workplace

When nurses knuckle down to do their job in the ward, they would be happy if they were given a leeway by their supervisors in choosing the order of performing their duties. However, the most durable motivating factor is the availability of the opportunity to learn and to grow on the job and to enjoy the challenge that this provides and the satisfaction that often comes with it (see chapter 3: section 3.3.1). Communication plays a central role in making these possibilities achievable. The nurses depend on a communication system from both the matron's office flowing through supervisors and from the Ministry of Health, for information regarding their promotion, learning opportunities such as attendance at workshops and seminars and opportunities for further education and training. Tables 30 and 31 examine the conduct of communication in the workplace.

Table 30   Communication system in your workplace

How is the communication system in your workplace?		
Question Item	Number of respondents	Percentage(%) of respondents
Good	173	24.6%
Fair	346	49.3%
Bad	97	13.8%
Very Bad	68	9.7%
Total	684*	97.4%*

Key*   A few nurses omitted the question

Almost a quarter (24.6%) of the nurses in table 30 found communication in their workplace to be good and 9.7% thought that it was very bad. These two extreme positions explain a lot about nurses' work environment. If communication can be viewed for the sake of argument, as immediate and distant or specific and general, a number of factors can be read into the effects of the lack of communication. In a hospital ward or clinic, for instance, a ward or clinic nursing sister is at the centre of communication, not only in the arrangement of duties but also in the sense of keeping her subordinate nurses informed about many happenings concerning the work unit. The nursing sister in charge needs to report back to her or his station on the meetings she or he holds with other senior officers. She or he is also expected to

report on staff projections for her or his workplace and on new equipment being ordered for the unit and staff movements, budgetary matters, seminars and workshops and on many other events that may affect her or his unit staff. Distant or general communication involves a number of things coming from outside the clinic or ward, for example, scholarship allocations for nurses wishing to further their studies and other forms of communication originating from the higher nursing authorities, such as the matron's office and the Ministry of Health. When nurses work in an environment devoid of effective communication from the person in charge, their work becomes burdensome, they are demotivated because they work in the dark, morale is reduced, absenteeism may increase and the workplace becomes a breeding ground for discontent and job dissatisfaction (see chapter 1: section 1.3).

The majority of nurses (49.3%), however, indicated that communication was fair. If this is taken to mean that it was satisfactory, the inference is that its existential purpose was only for the survival of the nurses in the work place. If one conjures up an image of this type of communication, one could imagine that, instead of receiving timeous information on certain matters, nurses suffered from a time lag in receiving communication both specific and general. Nurses deserve better than this, if their job satisfaction and motivation levels are to remain high enough for their services to be retained in the long run.

As far as the 13.8% of nurses was concerned, the communication system in their workplace was bad. If this proportion of nurses was added to the 9.7% of nurses, who rated the communication system as very bad, the total would be 23.5%, which was very close to the 24.6% of nurses, who said that the communication system in their workplace was good. Since both the 9.7% and the 13.8% were responses on the negative side of the communication system, the combined result would make the problem appear bigger, which it is, than if the answers were viewed separately. By the same measure, it would minimize the significance of the 24.6% of nurses, who graded the communication system in the workplace as good. This small exercise is designed to show that there is a case for ambiguity in which the communication system is doing different things to different nurses. When nurses have to operate within a communication system which seems to be as good as it is bad their motivation, job satisfaction and attitudes become as ill-defined as they are clarified, thus, maiming if not destroying the fabric of a meaningful improvement.

A communication system is as much a management tool as it is part of supervisory practices. Its ramifications as a supervisory instrument are wide and variable. For instance, nurses have to manage a nursing environment, which relies on continuous communication, not only upwards and downwards, but also laterally to patients and other members of the multidisciplinary or inter-disciplinary team such as doctors, chiropodists and social workers. The communication system is the lubricating mechanism between these different parts of the nursing environment. Although the supervisor needs the communication system as much as the nurses, it is under her or his jurisdiction. But both parties are intrinsically motivated by the use of the communication system, although in different directions. For the supervisor, the communication system enables her or him to access nurses and the matron's office and the outside nursing fraternity. The nurses need the communication system to be informed about their work, their performance and any recognition due to them, and to be advised about their extrinsic rewards, such as pay rises and other matters affecting changes in their working conditions such as transfer policy.

For the nurses specifically, therefore, the communication system intermediates between their intrinsic motivation (see chapter 3: section 3.3.1). But it has been pointed out above that both the supervisory and the nursing structures are intrinsically motivated to manage their communication environment. White (1959:297-333) called this intrinsic propensity "effectance motivation" (see chapter 3: section 3.3.1), because both the two hierarchies of nurses and supervisors were in theory innately motivated and capable of being effective in dealing with their environment all things being equal. A bad communication system, therefore, causes loss of intrinsic and extrinsic motivation. Ross (1996:121-149) coined the word "amotivation" to refer to the helplessness caused by an environmental factor, such as a bad communication system.

Whereas motivation to perform some act should be enhanced by the presence of either intrinsic or extrinsic rewards, the motivation to perform should be greater in a situation in which both intrinsic and extrinsic motives are aroused (Geen, Beaty & Arkin, 1992:279-290). A communication system such as an appraisal system would be able to achieve such an objective. An appraisal held quarterly, half-yearly or annually, would enable supervisors to discover if there were nurses, for example, who were satisfied with their pay, but did not like their job, or were satisfied with their job, but dissatisfied with pay or were both dissatisfied with pay and the job itself. An appraisal system would also communicate performance feedback and productivity to the nurses. Performance feedback is affected by both self-concept and self-esteem needs, which lead to feelings of self-confidence, worth, strength, capability and adequacy and a sense of being useful and necessary (McClelland, 1990:39-40) (see chapter 3: section 3.2). When nurses are informed through a communication system such as an appraisal or a performance interview, how they are doing, whether negatively or positively, they undergo a learning process (see chapter 5: section 5.4.2.1.2) in which they are motivated either from a low to a high level or from a high level to excellence, whatever the measuring scale is. Whichever way or direction they follow, they change their behaviour and attitude for the better, if they aspire to career advancement. All this depends on a good communication system.

Interpersonal relationships and performance are also enhanced by a variety of communication methods. Examples of communication for nurses include ward meetings, meetings with the matron, seminars and workshops in which interaction between nurses and their supervisors takes place. It is in such conferences that nurses are able to air their concerns about their job, including their grievances. They are not only able to meet the supervisor in a group, but also take advantage themselves of being together in one place to share ideas and to get to know one another. Buck (1988: 2-5) commented that in "group professions" such as nursing, there are two fundamental goals in social motivation, that is, firstly, to meet the expectations of others and secondly, to gain the affection of others. Only an effective communication system can make it possible for both these needs to be met for both the supervisor and the subordinate nurses in their common nursing environment.

There seems to be an entity relationship running through performance standards, interpersonal relationships, buttressed up by sound supervisory practices, an efficient and effective communication system and morale, culminating in giving an institution its personality. After the latter is established, it takes a good communication system to maintain it through the medium of staff morale. Revans (1980:165) noted in his studies of morale that managerial effort in hospitals is realized through a good

communication system, in particular when the latter addressed matters pertaining to staff morale. Concerns expected from work such as income, security and stature in the community, comprise the first group of morale issues. The second group is concerned with job interest, opportunity for advancement and prestige within the institution. The third category includes highly personal satisfactions derived from the job such as growth, achievement, power and job mastery. These factors are arranged in a sort of hierarchy, that is, when there is dissatisfaction with the first group of experiences, nothing in the other two is likely to matter very much. Dissatisfaction in the second group can prevent the third from becoming significant. Dissatisfactions in the third group usually have trivial effect unless the first two groups are not well-satisfied (Gellerman, 1963:254-255). It can be noted that morale includes some of the most important working conditions such as pay and opportunity for advancement, which have demoralized, demotivated, dissatisfied and changed the nurses attitudes into bitter critics of their environment. These are some of the symptoms and signs of a bad communication system, which has failed to resolve some of the nurses' concerns and fears.

6.4.6.2   Question 31: Communication system from higher authorities

Table 31, if anything, shows that the main culprit in poor communication is the higher nursing authorities as only 11.3% of the nurses rated communication from such powers as being good. As a matter of fact 14.5% of the nurses reported the same level of communication as being very bad. The majority of the nurses (32.1%), however, believed that the communication network from the higher authorities was fair. The results displayed in table 31 seem to confirm or reinforce the general picture conveyed in table 30. As has been pointed out in the preceding paragraph, a "fair" indication of the communication system, although acceptable in the main, may not be capable of sustaining the degree of motivation, job satisfaction and a productive attitude required to render quality care in the health services in the long term. If the 24.2% of nurses, who believed that the communication system from higher authorities was bad, was placed on the same side of the equation as the 14.5% of nurses, who reckoned that the same communication system was very bad, the portrait of the whole communication system from higher authorities, conveyed by a total of 38.7% of nurses becomes bleaker.

Table 31   Communication system from higher authorities

How is the communication system from higher authorities?		
Question Item	Number of respondents	Percentage(%) of respondents
Good	79	11.3%
Fair	225	32.1%
Bad	170	24.2%
Very Bad	102	14.5%
Total	576*	82.1%*

Key*   Some nurses overlooked this question

The nursing supervisors are the transmission chains of information from the higher authorities to the nurses in the clinics and hospital wards. With a total of 38.7% of the nurses regarding the passage of information or the communication system as bad and very bad, it is possible to examine a number of scenarios. Firstly, it may be that the communication system, both written and oral is bad at all hierarchical levels. In that case the whole structure of the communication system needs to be revamped. Secondly, the communication system may be stymied by the nursing supervisors. If that supposition or suggestion is valid, it leads to the assumption that the supervisors are not knowledgeable about the efficacy of the communication system. Thirdly, the communication system may be structured or narrowed at the matron's or the nursing head of the hospital's level where she or he and her or his associates, for example, do not disseminate information from higher authorities to the nurses. There may be other reasons why the communication system from higher authorities does not shunt down information to the nurses, but the temptation to scrutinize the personnel holding or occupying positions of authority or influence in the communication system, is too strong to be shaken off.

This factor, coupled with the criteria on which promotions, which place supervisors in positions of authority, are carried out, may contain the answers to the deficiencies in the communication system. One might also add that whilst the guidelines on which promotions are based must be examined closely, career advancement premised on nursing degree qualifications should be reviewed and not be regarded as an automatic or unquestioned passage into higher nursing structures. Once merit, efficiency, effectiveness and professionalism, which do not necessarily go hand in hand with nursing qualifications, are employed as yardsticks for promotions, this will eliminate square pegs which may have been fitted into round holes in the nursing supervisory or higher structures. It is not being denied here that higher education brings with it delicate finesse and professional credit into nursing, but that it is ill-advised to use it as an exclusive weapon for promotion, but in combination with or consideration of other factors. Once the personnel variable is out of the way, a culture of the written word needs to be revisited, re-emphasised, re-stressed or re-instilled into the supervisory practices, together with the emphasis on the essentiality of communication to the nurses, to keep them abreast of events of interest to them. This will help maintain high levels of motivation amongst the nurses, create high morale in their attitudes and enable them to enjoy job satisfaction, which will be

reflected in their increased standards of job performance and sterling service to patients. This will stop the community from complaining about nurses' negligent attitudes towards patients (see chapter 1: section 1.2). An efficient communication system from higher authorities would, therefore, maintain nurses' efficiency, continuity of care to patients and guard transparency in the whole nursing environment, which will sustain motivation, job satisfaction and progressive attitudes on the part of nurses. However, nurses still have to deal with other matters concerning their working conditions such as too many nursing duties, which spoil the broth of job satisfaction.

6.4.6.3   Question 32: Multiple nursing duties: the bane of job satisfaction

Communication from the top, for instance, from the matron's office both in the hospital and in the clinics, boils down to a general policy which is communicated to the ward or clinic nursing sister about the nurses' duties, that is, what they are expected to do and not to do in their work places. The number of duties performed by nurses rightfully or wrongfully, has been a subject of historical debate in the nursing literature from the time immemorial. Tables 32 and 33 highlight nurses' views in this respect.

Table 32   Number of duties performed in your job which you consider to be relatively unimportant or unnecessary

How many duties do you perform in your job which you consider to be relatively unimportant or unnecessary?		
Question item	Number of respondents	Percentage(%) of respondents
Quite a few	202	28.8%
A few	194	27.6%
Very few	64	9.1%
None	120	17.1%
Total	580*	82.6%

Key*   A sizeable number of nurses did not respond to this question

The inter and intra-dispersion of results in tables 32 and 33, are fairly even and the magnitude of the complaints are almost similar. For instance, the majority of nurses (28.8%) in table 32, pointed out that there was quite a few number of duties they performed which they considered to be relatively unimportant or necessary. Taken on its face value, this indicates that these nurses were more often than not, carrying out duties which detracted them from providing quality nursing care (see chapter 1: section 1.1). This feeling on the part of nurses could not have helped to motivate them or to give them job satisfaction, as their professional thirst for "proper" nursing care was not quenched (see chapter 5: section 5.3). The emotions dissipated over nursing duties that can be left out but which have to be done because of "policy" from

the higher nursing offices or from an overzealous nursing supervisor, can be quite traumatic to a conscientious nurse. The proportion of nurses who considered that there were a few duties which were unnecessary for nurses to perform, was 27.6% almost the same as that of the earlier group which complained of quite a few of such duties. Although 17.1% of the nurses reasoned that there were no unnecessary duties in their job portfolio, the voices of dissent were somewhat stronger than those of the satisfied nurses. Although there has been a slow improvement in weeding out the non-related nursing chores since the time of Rampa's (1991:45-54) study, the continued performance of these duties has remained, not only a source of annoyance to nurses, but has also overburdened them both on the wards and in the clinics.

6.4.6.4   Question 33: Part of your job to which you cannot give as much time as you would like

Related to unimportant nursing jobs, is the 19.8% majority of nurses in table 33 who confirmed that there were fairly large parts of their job to which they failed to give attention, most probably because they spent most of their time carrying out duties that were outside the core of nursing. Almost a similar number of nurses (18.7%) showed that there were quite large aspects of their job which they were forced to forego because of a lack of time. However, a more dissatisfied group of nurses (16.1%), came out more forcibly in the open to point out that there were very large parts of their nursing job over which they could not spend as much time as they would have wished. When the 16.1%, 18.7% and 19.8% gradations of job dissatisfaction, respectively, are considered together, their message make the 10.8% of nurses, who maintained that there was almost no part of their job which was deprived of attention appear like a sole voice in a wide sea of protest.

Table 33 Part of your job to which you cannot give as much time as you would like

Is there any part of your job to which you cannot give as much time as you would like?		
Question item	Number of respondents	Percentage(%) of respondents
Very large	113	16.1%
Quite large	131	18.7%
Fairly large	139	19.8%
Almost none	76	10.8%
Total	459*	65.4%

Key*   A substantial proportion of respondents glossed over the question

Since the dominant majority of nurses in tables 32 and 33, revealed that they performed duties that were relatively unnecessary to their mainstay nursing job, it

can be reasonably assumed that many of such duties were not patient-related. It is known that the non-nursing duties that nurses traditionally complain about include a lot of paper work and laundry, only to name two of them. The result is that nurses are not able to spend time directly on the patients, that is, talking to the patient and reassuring her or him about the outcome of her or his illness. Such concerns by the nurses do take away some of the job satisfaction they would otherwise have enjoyed. However, the balance between what in particular affects attitude and what causes job satisfaction, job dissatisfaction and motivation is not easy to strike.

Hence the opportunity to continue to learn on the job and the chance availed by a health institution to provide a learning nursing environment, become imperative sources of inspiration in the face of imponderable roadblocks in the nursing job at the workplace (see chapter 5: section 5.3). Such motivating facilities, may assist nurses to surmount the difficulties of job dissatisfaction, or at least survive in their midst. But if there is no joy in the job itself and in the employer who provides it, then the nurses' odds may be locked at zero.

6.4.6.5   Question 34: Opportunity to learn from present post and from employing institution

When nurses are frustrated by unsatisfactory aspects of their working conditions, they may obtain their staying power from the potential of the job and the employing institution as sources of continuous learning (see chapter 5: section 5.2.2.1). The opportunity to learn on the job entails exposure to different fields of nursing and eventually being allowed to specialize in an elected particular area of nursing interest. This may be referred to as a horizontal learning progressing, as opposed to a vertical educational mobility involving a higher or a degree level of education in nursing. Of course, nurses may both horizontalise and verticalise their further training and education if they follow the area of nursing specialisation to a degree stage. Tables 34 and 35 throw some light on how nurses feel about the learning aspect on the job and as offered by the employer.

Table 34 Present post as a job in which you can continuously learn

How do you feel about your present post as a job in which you can continuously learn?		
Question item	Number of respondents	Percentage(%) of respondents
Can still learn a great deal	411	58.5%
Can still learn a little	42	6.0%
Can still learn something but not much	92	13.1%
Nothing more to learn	37	5.7%
Total	582*	83.3%*

Key*   Lack of participation by all nurses in answering the question

It has been said with reference to life in general that variety is the spice of life. More to the point, a job whose content is challenging and whose institutional environment is stimulating, or a job with opportunities to learn further in the form of cumulative experience, has a potential for job satisfaction, motivation and an interested attitude (see chapter 4: section 4.4.4). According to table 34 the majority (58.5%) of nurses regarded their present posts in the hospitals and city councils as a job in which they could still learn a great deal. The need or thirst for learning in a post is a challenge to nurses who rely on their supervisors to guide and assist them. As this is only possible through an effective communication system and good interpersonal relationships with supervisors both of which are less than 50% satisfactory according to tables 19 and 30, the expression of this aspiration is thwarted.

While this response might have come from junior nurses, who had not yet gone through all the hospital wards and or departments or the different clinics and thus had the need to learn, the polar opposite was that of the 5.7% of nurses who said that they had nothing more to learn from their present posts. One would expect the 58.5% group of nurses to be in the 2-5 years band (table 2) of post-qualification or training nursing experience, in which case they were full of morale, with high job satisfaction, buzzing with motivation and driven by a prospective job attitude. The response from the 5.7% category of nurses could have come from a few experienced nurses in the 6-9 years band (table 2) of nursing experience, who had completed all the "rounds" of wards or clinics and had acquired all the necessary nursing experience to await promotion. Having reached saturation point, with nothing more to learn, the experienced nurses were only motivated by prospects of career advancement. If this path was blocked, one would expect these nurses to display poor job performance and attitude, absenteeism, job dissatisfaction, lack of motivation and eventual labour turnover (see section 6.4.1.1-6.4.1.5).

The 13.1% nurses who could still learn something from their present posts but not much could be viewed as having reached almost the same level of experience as the 5.7% of the nurses referred to above.   These 13.1% of nurses would be suspected of beginning to feel a depreciation of motivation, losing job satisfaction and developing retarded job attitudes, especially with the knowledge or awareness that

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the more experienced nurses ahead of them had not moved much in terms of promotion. The 6% proportion of nurses who could still learn a little in their present posts was likely to be less experienced than the 13.1% group of nurses.   Although the 5.7%, 6% and 13.1% groups of nurses did not bear much statistical significance, they seemed to follow a predetermined order of potential upward professional mobility, in respect of levels of experience. For example, the 5.7% were logically the first qualifying group for promotion, followed by the 13.1% and the 6% in that order, if promotions were conducted on the basis of seniority of nursing experience, other things being equal. If inferences are anything to go by, therefore, the Botswana research findings reaffirm at best that not everyone wants the same out of a work situation and that different groups of people have different work attitudes(see chapter 5: section 5.3).

6.4.6.6   Question 35: How do you feel about your general association with the hospital or city council in terms of giving you an opportunity to learn?

While the present professional spark ignited by the chance to learn on the job will keep the "wolf" of job dissatisfaction away, the environment in which the job is carried out, characterized by its set of rules and regulations, may either promote or actively inhibit learning. As shown in table 35 only 7.1% of the nurses felt that their employers provided them with a great deal of opportunity to learn. This small percentage is a far cry from the high indication accorded to the job as a source of learning. The gloomy and demotivating picture painted of the hospitals and councils as employing agents, leaves a sour taste in the mouth of any management enthusiast. It requires a serious introspection on the part of the nurse managers who run them.

The majority of 38% of the nurses who reported that there was some opportunity to learn afforded by the hospitals and councils although not much, was wiped out by the two extremes of 7.1% (a great deal of opportunity to learn) and 16.8% (no opportunity at all to learn) respectively, which depicted a decadent portrait of hospitals and councils as centres devoid of offering learning to nurses. However, some faint support came from 19.1% of the nurses who opined or gave the opinion that the hospitals and councils provided a little opportunity to learn.   But this appeared like a small voice in the wilderness.

Table 35   How you feel about your general association with the hospital or city council in terms of giving you an opportunity to learn

How do you feel about your general association with the hospital or city council in terms of giving you an opportunity to learn?		
Question item	Number of respondents	Percentage(%) of respondents
Provides a great deal of opportunity	50	7.1%
Provides a little opportunity	134	19.1%
Provides some opportunity but not much	267	38.0%
Provides no opportunity at all	118	16.8%
Total	569*	81%

Key*   None response by many nurses

6.4.6.7   Summary analysis of results for section 6.4.6: Organizational requirements (Questions 30-35)

The domain of organizational requirement lies outside the direct control of nurses. It is a playing field dominated by nurse managers, assisted by inflexible guidelines which may be indifferent to the interest of nurses.   As such, organizational requirements can be a fertile source of job dissatisfaction and a cockpit of frustrated attitude, anger, stress and demotivation.

Since all aspects of work which have a bearing on both supervisors and employees are centred on the organisation as a whole, it is not surprising that organizational requirements are the main source of job satisfaction or dissatisfaction. Many terms such as organizational culture, organizational personality and organizational climate (McDaniel, 1995:5-22) (see chapter 1: section 1.4), have been used to refer to the different aspects of organizational requirements.   It has been seen that the organisation determined a number of work variables such as communication, nurses' duties, learning environment and in fact all or most of the working conditions. As a golden rule the organisation has a larger share of control over all these factors than the nurses' immediate supervisor.

Friedlander and Margulies (1991:246-248) (see chapter 4: section 4.3), examined the relationship between organizational climate and job satisfaction and found that the former affected the latter as well as personal relationships, more than other aspects of job satisfaction.   It is axiomatic that the organizational members make the organisation what it is. In the case of nursing institutions the organizational requirements are interpreted, maintained and upheld by the nursing supervisors. If the supervisors are not progressive in thinking in adopting a favourable interpretation of the organizational requirements on behalf of the nurses, the latter will be mulcted

of any potential ability to contribute positively towards creating a motivating job and satisfying and learning work environment in which they will be committed.

According to Mowday *et al.* (1979:224-246) (see chapter 4: section 4.4.1.2.1), organisational commitment determines the extent to which an individual accepted the organization's goals and values. It also enabled an individual to exert effort on behalf of the organisation and a desire to maintain membership in the organisation. It has been noted that on one hand the majority of nurses described the communication system in the workplace as fair (table 30). The majority of nurses also saw present posts as jobs in which they could continuously learn a great deal (table 34). On the other hand, however, the majority of them expressed dissatisfaction with the number of duties they performed in their job, which they considered to be relatively unimportant, or unnecessary (table 32). The nursing institutions themselves were poorly rated for giving nurses little opportunity to learn (table 35). It is these two areas of organisational requirements that may chip away at the nurses' organisational commitment. To this extent the assumption that high morale, quality patient care and efficient and effective performance in the health services, depend on nurses' job satisfaction and motivation in their work environment has been fulfilled.

What remains transparent, however, is the nurses' satisfaction with their job (table 13) which will continue to motivate them and promote their commitment to the overall goals and objectives of the health services profession itself, if not the institution. Whether they will receive rewards and inducements to sustain such a motivational streak is a different matter.

6.4.7   Rewards and inducements

Nurses need to be rewarded for the achievement of nursing feats. Being rewarded is not just an aspect of managerialism but is also an act of being recognized for what one has achieved and in the case of nurses for what they have achieved in respect of the quality of nursing care. Rewards are properly understood in the context of recognition for one's accomplishment, for example, a reward given to the most efficient nurse of the year in a hospital. Such a laureate may receive a text book on nursing as a reward or some other item chosen for the occasion, for instance, a cash reward. It is for the latter reason that rewards can sometimes be confused with pay or salary. The main purpose of a reward is to motivate the recipient thereof. In the process of giving an inducement to perform better or to be more productive it is hoped and expected that the receiver of the accolade will not only be motivated but will also be job satisfied and have her or his work attitude improved. In order to prepare for an objective instrument on which to peg the reason for giving a reward, an appraisal system, for example, is often used.

An appraisal system does more than measure performance.   It is a correctional instrument and an attitude reformer in as far as it points out strengths and weaknesses in nurses' work performance. Then through a process of feedback improvements are made on bad performance. Similarly good or productive work behaviour is recognized and rewarded. Used properly and purposefully an appraisal system is an effective communication instrument.   In addition to being a platform for

an objective assessment of achievement, it promotes professionalism and the image of nursing and inculcates desirable attitudes. The latter are the storehouse for motivation and job satisfaction in a workplace. Once those are achieved, any unfavorable comparison in pay, for example, between the public and the private sector health services as well as the non-nursing employers will be weakened, if not nullified. Seen in this way, questions 36-42 are an extension of the communication system searching for intrinsic and extrinsic factors, correct attitudes towards work and motivation and job satisfaction in nurses.

6.4.7.1　Question 36: Appraisal system in your workplace

An appraisal system can be utilized as an institution-wide measurement of performance conducted quarterly or annually. While this may apply to a whole hospital or city council clinics, there may be other yardsticks employed on a ward level leading to designations such as the most effective ward nurse communicator of the year also attracting a reward. Thus, the appraisal system as an instrument of monitoring the rendition of quality health care services, lays the groundwork for a reward system and a means for recognizing high nursing goals. Tables 36, 37 and 38 attempt to bring out the nurses' responses to the effects of a workplace appraisal system and the inward feeling of being recognized for achieving something really worth while in nursing, both as aspects of rewards and inducements. If rewards lead to inducements then the seeds for motivation, job satisfaction and productive attitudes are said to have been sown (see chapter 3: section 3.3.1).

Table 36　Appraisal system in your workplace

How is the appraisal system in your workplace?		
Question item	Number of respondents	Percentage(%) of respondents
None	29	4.1%
Bad	65	9.3%
Unfair	100	14.2%
Fair	359	51.1%
Good	89	12.7%
Total	642*	91.4%*

Key*　　Not all the nurses answered the question

The extent to which a nurse knows whether she or he is doing well or not in her or his job, is both a part of a good communication system in the health services and a reflection of the type of nurse management practices in place. Nurse Managers and supervisors operate at different levels of the management system, all of which involve human relationships. The latter form the fulcrum of a good and effective supervision, on which a formal appraisal system is based. But it cannot be assumed that any appraisal system, no matter how seemingly elaborate it may appear, can

cover every nut and bolt of the human relationship at work. This leaves the individual supervisors to carry the torch, by supplementing the form-filling type of appraisal, with a verbal "well-done" remark, or a pat on the shoulder of a subordinate nurse, as a sign of appreciation, which gives her or him a sense of awareness about her or his meritorious performance.

In table 36 the majority of nurses (51.1%) regarded the appraisal system in their workplace as fair. This implied that there was some degree of job satisfaction in how nurses were informed about their performance. The other far-reaching effects of the appraisals in the public health services include promotion, selection for further training or education and salary increments. It is these needs and many others that must be met under an appraisal system that is rated by an appeasing minority (12.7%) of nurses as being good. The rest of the nurses, as shown in the table, were spread over responses such as 14.2% thought that the appraisal system was unfair, 9.3% felt that it was bad and 4.1% did not believe that nurses were appraised at all.

Although over half of the sample of nurses indicated that the appraisal system in their workplace was fair, this cannot be taken as a complete measure of its effectiveness in the public health services (see also section 6.4.1.1-6.4.1.5 and 6.4.6.1).   Nurses should to a large extent be able to have a more positive and job-empowering feedback on their performance if they are to play an active part in improving nursing standards (see Chapter 1: section 1.4). They would be more able to do so under a good appraisal system, which has been developed by a reputable external management system agency. With this in place skillful supervisors trained in its use will ensure that it is not administered unfairly.

6.4.7.2   Question 37: Inward feeling of achieving something really worthwhile

Another aspect of appraisal is internalized by the person concerned. Thus, the inward feeling that one has achieved something really worthwhile is part of an individual's internal locus of self-appraisal. It is related to a motivational force and a self-satisfied attitude as well as a sense of achievement which spurs a person on her or his job (see chapter 3: section 3.3.1.1). In table 37 only 2.9% of the sampled nurses experienced this feeling all the time. The majority of the nurses (24.6%) felt very often that they had achieved something really worthwhile independently of the external appraisal system.   The same feeling was often present in 17.1% of the nurses. Those nurses, who had this feeling fairly often and once in a while, were represented by 11.9% and 12.7%, respectively. However, the smallest percentage (10.8%) of nurses replied that they seldom experienced this inward reality of achieving something really worthwhile in their job. Nevertheless, it is encouraging that at least a quarter of the nurses in the study, felt that they had achieved some inner job satisfaction very often in what they were doing. These nurses were intrinsically motivated and job satisfied, with a work performance attitude directed by their self-image, self-sacrifice and a sense of careerism (see chapter 5: section 5.3).

Table 37   Inward feeling of achieving something really worthwhile

Outside of any regular measurement of your job such as appraisal report, how often have you inwardly felt that you have achieved something really worthwhile?		
Question item	Number of respondents	Percentage(%) of respondents
All the time	21	2.9%
Very often	173	24.6%
Often	120	17.1%
Fairly often	84	11.9%
Once in a while	89	12.7%
Very seldom	76	10.8%
Total	563*	80.0%*

Key*   This question had a poor reception from respondents

6.4.7.3   Question 38: Some type of recognition for your nursing accomplishments

Whilst the internal feeling of achieving something of value in one's job is intangible and cannot be x-rayed, photographed or validated by an external agent such as a nurse manager and thus defies recognition, other tangible nursing accomplishments which are carried out and achieved under the dome of a nurse supervisor, are subject to visible recognition by the latter, if they are to form a basis of motivation, job and attitude satisfaction in the achiever (see chapter 3: section 3.3.1). Table 38 is illustrative of a dreary picture of managerial dereliction in this area of nurse management as the largest proportion of nurses (33.6%) almost never received some type of recognition for their nursing accomplishments. The second largest number of nurses (29.9%), reported that they had very seldom received some type of recognition for their nursing endeavours. The dissatisfactions expressed by these two groups of nurses are reflective of the nurses who could be described as having reached the anticlimax of Maslow's (1970:91-92) self-actualization stage (see chapter 4: section 4.4.1.1). Only the minorities of nurses were on the positive side, with 12% of them saying that they had quite often been accorded recognition for their achievements in nursing. The most optimistic position was taken by 5.6% of the nurses who pointed out that they had very often been recognized for their nursing efforts.

In its simplest form, a recognition for a nursing accomplishment might range from, for example, being given an afternoon off, to being appointed secretary to ward conferences. If nurse supervisors are not able to look after the pennies, they would find it more difficult to take care of the pounds, as it were. The results in table 38 give testimony to the inability of nurse supervisory practices to offer little inducement, not only for motivation and job satisfaction, but also for morale and the

encouragement of quality nursing care, positive attitude and high standards of nursing in general.

Table 38 Some type of recognition for your nursing accomplishments

How often in your job have you received some type of recognition for your nursing accomplishments?		
Question item	Number of respondents	Percentage(%) of respondents
Very often	39	5.6%
Quite Often	84	12.0%
Very Seldom	210	29.9%
Almost never	236	33.6%
Total	569*	81.0%*

Key*   Nurses showed a poor response to the question

Recognition is attributed to the desire for self-esteem or a positive self-concept. Locke (1976:39-65; Spector, 1997:34-35) (see chapter 4: section 4.3) found that recognition was one of the most frequently mentioned events that caused job satisfaction and dissatisfaction. Most employees valued being praised for their work. Moreover recognition is functional.   It provides feedback with regard to the competence of one's job performance. However, there are individual differences in the value placed upon the effect that recognition has on people. For instance, individuals with low self-esteem tend to be dependent on recognition and they are also more emotionally affected by it than other people. In addition to this claim there is evidence that females are more sensitive than males to the interpersonal job factors of this type (Herzberg *et al.*, 2004:35-47).

Sometimes there are these gaps in workplace managerial psychology and supervisory imbalances that drive a wedge between the nurse and her or his professional commitment. In the final analysis, nurses may begin to feel that they are being taken for granted in the public health services and start to quibble and prevaricate in the ideas of either leaving nursing altogether, or making a comparison of working conditions with the private health sector with obvious intentions. The dissatisfaction with the lack of inducement may be taken further and be linked to pay. When nurses sense such inequalities in pay and other inducements, whether imagined or real, particularly between the public and the private health sector services, they draw comparison, not only between the two sectors in terms of remuneration, but also between nursing salaries and those of people working outside nursing, holding similar school leaving educational qualifications as the nurses.

6.4.7.4   Question 39: Comparison of pay in different health sectors

Nurses working in the public health services compare their pay with that of nurses employed in the private health sector. Although this comparison may be spawned by other job dissatisfactions in the public health sector, it is part of the green pasture syndrome, if viewed dispassionately. Logically nurses would then probably choose the employer who pays more, all things being equal. In this instance, more salary acts as an inducement, both in terms of job and employer change, as well as an assumption of improved quality of care. Thus, this intra-nursing comparison between the public and the private health sector enclaves is one way of seeking inducements. The other form of comparison, applies to nurses in the public health sector making a salary comparison between them and those of non-nurses working in other jobs but holding similar entrance educational qualifications as the nurses. The rationale underpinning these pay comparisons on the part of public health service nurses, is to establish grounds for inducements, motivation, job satisfaction, productive attitudes and the will to stay on in the same job and hopefully be sufficiently motivated and induced to perform better and render a sterling service. The comparison thesis is borne out in tables 39 and 40.

The predilection for the private health services shown in table 39, is based on the belief by the majority of 44% of nurses that they were better paying, in terms of salary than the public health services. It has already been noted that the public health sector offered little inducements to nurses to entice them to perform better or deliver better quality health care. The inducements-contributions balance theory once stated by March and Simon (1958:236-273) (see chapter 3: section 3.5) appears to be at work and relevant to explain the loss of job satisfaction on the part of public health services nurses as their contributions were not matched by inducements from their supervisors. According to this approach, the balance is in the interests of both the employer and the worker as any disparity in its operation will trigger off an adverse reaction on either party. The theory is not only used to explain job satisfaction, motivation and job attitudes, but also a host of other work related factors. However, notwithstanding the possible shift by the public health sector nurses towards the private sector health services, the former was not about to lose all its nurses to the latter, as 19.1% of the respondents were of the opinion that they could earn more in the government or public health services. A slightly higher percentage (21.7%) of nurses considered occupation outside nursing, as alternatives to give them a more earning power.

Table 39 Comparison of pay in different health sectors

Do you think you can earn more in private nursing or in other occupation than in government nursing?		
Question item	Number of respondents	Percentage(%) of respondents
Private nursing	309	44.0%
Government nursing	134	19.1%
Other occupation	152	21.7%
Total	595*	84.8%*

Key*   The shortfall is due to non-response by a substantial number of respondents

6.4.7.5   Question 40: Comparison of nurses' pay with that of those outside nursing holding similar educational qualifications as those of nurses

The results in table 40 go a step further to confirm the belief on the part of the public health sector nurses that privatised health services as well as other non-health related occupations were better paying than the public health services. The evidence was adduced from the majority of nurses (38%) who complained that the salaries were worse than those of their contemporaries who were employed outside nursing. However, this was counter-balanced by the 25.1% of nurses, who expressed the opinion that they were better paid than people working outside nursing. These were loyalist nurses, who made valiant effort to forge ahead in their commitment to the public health services.   The middle-of-the-road view that nurses and non-nurses working outside nursing were similarly remunerated was voiced by 16.4% of the respondents. Those nurses who were oblivious and indifferent to pay comparisons and did not know how their pay fared against that of people working in occupations outside nursing accounted for 17.9% of the respondents.

After comparisons in pay between different health sectors and non-health sectors have been made, it must be realised that pay is but only one of the factors that induce and motivate nurses to improve their standards of health care (see chapter 4: section 4.4.4). In addition to monetary compensation, there is a whole world of other infinite job factors that contribute significantly to the motivation, attitude enhancement and the job satisfaction that nurses cherish and desire in their everyday work.

Table 40 Comparison of nurses' pay with that of those outside nursing holding similar educational qualifications as those of nurses

How does your pay compare with the pay of those outside nursing holding similar educational qualifications as yours?		
Question item	Number of respondents	Percentage(%) of respondent
Better	176	25.1%
Same	115	16.4%
Worse	267	38.0%
Do not know	126	17.9%
Total	684*	97.4%*

Key*   A few nurses failed to respond to the question

6.4.7.6   Question 41: Motivation factors to improve quality care to patients

The number of workplace factors that motivate, improve attitudes and yield job satisfaction is legion. The limited number of job factors examined in tables 41 and 42, are peculiar to the health care industry and in particular to the public health services. However, despite the paucity of the motivational, implied attitudinal and job satisfaction factors displayed in the tables, they provide a road map to what lies at the core of the nurses' aspirations, ambitions, expectations and desires in respect of their job.

Table 41 Motivation factors to improve quality care to patients

What would motivate you to improve quality care to patients in your nursing job?		
Question item	Number of respondents	Percentage(%) of respondents
Good salary	568	80.9%
Sufficient working conditions	500	71.2%
Reduced workload	416	59.3%
Opportunity for promotion	375	53.4%
Opportunity for continuous education	448	63.8%
Opportunity to participate in decision making	330	47.0%
Opportunity for recognition of work done	380	54.1%
Autonomy in your work arrangement	246	35.0%
Positive interpersonal relationships	317	45.2%
Positive supervisory relationships	312	44.4%
The work itself	272	38.7%
Professional status	280	39.9%

Note: The figures and percentages in table 41 are a result of respondents ticking a multiple of options

In table 41 the highest motivation is salary. A massive 80.9% of nurses indicated that they would be able to improve their quality of care to patients, if they receive a "good" salary. The definition of a good salary is controversial. It will be remembered that in table 17, there was no unanimity on how much nurses wished their remuneration to be increased. This illustrated the diversity of views about what a good salary can mean to different people. There are, therefore, arguments and counter-arguments about the role of salary as a motivator. Although there is no doubt that salary has assumed an elevated degree of importance in modern times, one would expect that its utility may be more pronounced in developing countries than in the developed or industrialized nations.

Pay or salary is part of the working conditions, which were the second highest source of motivation, with 71.2% of the respondents expressing a willingness to improve their standards of nursing if the working conditions were made good. Out of these conditions, the opportunity for continuous education emerged as the third most important harbinger of motivation, according to 63.8% of the nurses. Reduced workload as a job motivator was mentioned by 59.3% of the nurses. The psychological need for the recognition of the work done and the opportunity for promotion were stated by 54.1% and 53.4% of the nurses, respectively, as promoters of motivation. The lesser motivating variables, attracting less than 50% of the study sample, included 47% for the opportunity to participate in decision- making, 45.2% for positive interpersonal relationships, 44.4% for positive supervisory relationships, 39.9% for professional status, 38.7% for the work itself and 35% for exercising autonomy at work.

6.4.7.7 Question 42: Source of satisfaction in nursing job

Job satisfaction and motivation are intertwined and inseparable factors or concepts which may appear to be readily understood at a superficial level, but which become less intractable at a more detailed plane or abstraction. Furthermore, attitudes and behaviour are also connected to motivation (see chapter 5: section 5.2.1). In table 42, as in table 41, salary again occupies the top notch as evidenced by the majority of 76.1% of the nurses. In the Light of the danger involved in nursing patients suffering from infectious diseases, the second highest group of nurses (69.1%), espoused the view that payment of a risk allowance or "dirty" money, for caring for such patients would give them job satisfaction. Good working conditions as job satisfiers were mentioned by 68.2% of the nurses. An example of such contextual factors is the provision of an adequate number of nurses in each shift which was stated by 63.1% of the respondents as job satisfying. This is the side of reduced workload contained in table 41. Good fringe benefits as sources of job satisfaction on one hand were referred to by 60.1% of the nurses. On the other hand 53.7% and 49.6% of the nurses, respectively, adopted the opinion that opportunity to go for workshops and seminars, as well as high morale in teamwork, contributed to job satisfaction. Other less important forerunners of job satisfaction were effective communication systems, positive relationships with co-workers and the work itself. These were informed by 47.4%, 43.3% and 42.9% of respondents, respectively.

Table 42 Source of satisfaction in nursing job

What would give you satisfaction in your nursing job?		
Question item	Number of respondents	Percentage(%) of respondents
Good salary	534	76.1%
Other considerations such as risk allowance	485	69.1%
Abolition of the transfer system	241	34.3%
Good working conditions	479	68.2%
Good fringe benefits such as housing	422	60.1%
Enough nurses on each shift	443	63.1%
Effective communication system	333	47.4%
Opportunity to go to workshops	377	53.7%
Positive relationships with coworkers	304	43.3%
High morale in team work	348	49.6%
The work itself	301	42.9%

Note: The figures and percentages in table 42 are a result of respondents ticking a multiple of options

6.4.7.8 Summary analysis of results for section 6.4.7: Rewards and inducements (Questions 36-42)

It was confirmed in table 39 that nurses thought that they could earn more money in private nursing than they received in the public health services. That orientation in their work attitudes signifies the value they placed on money as a motivator. The motivational potential of a high salary was further highlighted in tables 41 and 42. The nurses' dissatisfaction with their pay was further brought out in table 40, when they complained that their pay was worse than that paid to the non-nursing personnel of similar educational qualifications as theirs employed outside the health services. In such circumstances it was not surprising for Gruneberg (1979:54-55; Latham, 2007:40-42) (see chapter 4: section 4.4.5) to point out that pay was one of the main context factors in a work situation. In additional to this argument Lawler and Porter (1991:426-435) (see chapter 4: section 4.4.1.1. & 4.4.1.1.1) found that pay was the one job aspect with which the majority of employees expressed dissatisfaction. However, the semantics of pay are tenuous. For example, Stamps and Piedmonte (1986:16-18) (see chapter 4: section 4.4.2.2.1), although accepting that pay was a very important factor, argued that good pay alone did not lead to job satisfaction.

The debate surrounding what motivates employees and what gives them job satisfaction remains polemical. In other words, job motivators and job satisfiers have no universal applicability or consensus. However, in a hospital institution some of the efforts made by nurse managers to create motivation and satisfaction in nurses include moving them around from one department or ward to another after a given period. Furthermore, the public health services nurses are subjected to relocations from one health facility in one area to another in a different part of the country through a transfer system. The intended objective behind such peripatetic movements is to search for motivation and job satisfaction, by preventing nurses from being bored and becoming part of the furniture of one particular health facility.

In the light of the findings under rewards and inducements, as one of the groups of working conditions, the assumption that nurses' satisfaction with various elements of their working conditions, such as pay, has a positive effect on their performance, productivity, attitude and professional standing, has been proved.

6.4.8 Predictability of the influence of transfers on job relationships

The nurse management grounds and the government's objectives, respectively, in moving nurses from one ward to another or transferring them from one station to another, are to maintain motivation, enhance job satisfaction and reinforce positive attitudes by exposing them to various different nursing experiences and to enable them to acquire variable skills. Tables 43, 44, 45 and 46 show how nurses view these changes and transfers.

6.4.8.1 Question 43: Movement from one ward to another in a hospital after working for a certain period

In table 43 below, the movement from one ward to another after working for a certain period, is confirmed by a majority of 55.6% of the nurses. This change is intended to facilitate learning through an active engagement in the activities of each ward. For example, working in theatre involves knowing a variety of trays or packs containing appropriate instruments for each type of operation. It trains a nurse to know the procedures, preparation and the instruments for each kind of operation. As a nurse acquires experience in theatre nursing, the requisite knowledge and the paraphernalia of this branch of nursing are validated and reinforced by both the supervisor and the surgeon(s). Factors that have been found to influence this type of learning, involving an attitude change or instrumental conditioning, include the frequency of reinforcement (Fishbein & Ajzen, 1975:23; Oskamp & Schultz, 2004:21) (see chapter 5: section 5.2.2.1.2).

As the nurse gains more experience in this type of work, she or he is driven by intrinsic motivation, based on the need to achieve competence and self-determination (Lindenfied, 1996:23-27) (see chapter 3: section 3.3.1) preparatory to promotion into a supervisory position. In the process of mastering the theatre job, the nurse will derive job satisfaction from her or his own achievement and from the approval of and recognition from those team members around her or him (Maslow, 1970:91-92) (see chapter 4: section 4.4.1.1). This portrait of events is representative of the psychological advantage of the majority of nurses who moved from one ward to another after spending a given period of time in each ward.

The number of nurses, who said that they were not moved from one ward to another, after working for a certain period or were sometimes moved, was not significant at 16.4% and 7.4%, respectively.

Table 43   Movement from one ward to another in a hospital after working for a certain period

In the hospital are you moved from one ward to another after working for a certain period?		
Question item	Number of respondents	Percentage(%) of respondents
Yes	390	55.6%
No	115	16.4%
Sometimes	52	7.4%
Not applicable	7	1.0%
Total	564*	80.4%*

Key*   Many respondents failed to answer this question

6.4.8.2   Question 44: Frequency of movement

Table 44 Frequency of movement

How often are you moved?		
Question item	Number of respondents	Percentage(%) of respondents
Every 3 months	0	0%
Every 6 months	3	0.4%
Every 9 months	0	0%
After a 1 year or more	411	58.5%
Variable	107	15.2%
Never	18	2.6%
Not applicable	73	10.4%
Total	612*	87.1%

Key*   A number of nurses refrained from completing this questionnaire item

Table 44 shows that the majority of nurses (58.5%), were moved from one ward to another after 1 or more years. This length of period provided ample time for the consolidation of learning and the chance to decode whether or not a particular nurse likes to specialize in that area of nursing. The experience of practising nursing in one ward for this duration can prove to be both positive and negative. On one hand, if the Herzebergian motivators involving the work itself, achievement, promotion, recognition and responsibility acted as a source of job satisfaction (Deci, 1992:113-120) (see chapter 4: section 4.4.1.2) in a given ward, the nurse might become reluctant or less inclined to leave or change. On the other hand, if the work environment, in which the nurse is working, is deprived of motivators and job satisfiers and is possibly complicated by soured attitudes and poor interpersonal relationships with both the supervisor and the other nurses, the nurse may prefer to or need to move from the ward. The inconsistency between the work environment and the expectations of the nurse, in other words have nurtured a negative attitude on the part of the nurse.   Festinger does not see any alternatives to the psychological feeling of the inconsistency which he calls dissonance. He assumes that the individual concerned will wish to cleanse herself or himself of dissonance as much as possible (Festinger, 1957:2) (see chapter 5: section 5.2.2.1.5).   The unhappy and demotivated nurse will, therefore, desire to leave or change the ward to rid herself or himself of a disagreeable work situation.

The other responses in table 44 from nurses such as 0.4%, 15.2%, 2.6% and 10.4%, respectively, are not significant enough for a useful analysis here.

6.4.8.3　Question 45: Nurses' reaction to change

In table 45 a majority of 51.1% of nurses said that they like the change from one ward to another after working for a certain period. These may be the type of nurses who perceived their current job needs such as learning and getting exposure to a variety of nursing experiences from different wards and supervisors as a challenge. They scouted for any special interest in the nursing faculties for the purposes of furthering their education and or training.　They also consider these changes as enhancing their promotion opportunities. Vroom's (1995:126-130) (see chapter 4: section 4.4.2.2) multiplicative model of needs points out that an individual's job satisfaction is a product of the relative importance of various work related and personal needs.　The extent to which these ward changes or movements fulfilled the above nurses' needs is, therefore, a measure of their job satisfaction.

Table 45　Nurses' reaction to change

Do you like this change?		
Question item	Number of respondents	Percentage(%) of respondents
Yes	359	51.1%
No	134	19.1%
Not applicable	81	11.5%
Total	574*	81.7%*

Key*　　The shortfall is due to none response by some respondents

This group of nurses can also be said to have learned to have both high expectations of rewards such as promotion, a high sense of power to influence their environment and to be driven by an achievement motive (Brockner, 1988:6-7) (see chapter 3: section 3.5). They were aware that to have an "all-around" or broad experience and knowledge in nursing, one must spread one's wings in order to stand in good stead for promotion and for further training. This seemed to justify their liking of the change of wards.　From an attitude perspective, the behaviour of these nurses indicated that they, not only wanted to influence their environment, but they were also prepared to adapt to it, in the event of its being hostile or unwelcoming to them.　Thus, it seems as if these nurses use their navigatory attitudes to help them learn about their environment or social world (Piaget, 1952:5) (see chapter 5: section 5.2).　Piaget further argues that the adaptation of attitude results in an increase in the inter-changes between the environment and its victim (Piaget, 1952:5) such as in the case of these nurses.　It is argued that it is this ability to change attitude on the part of these venturesome nurses which remove "fear" or reluctance from them from prowling in any nursing environment necessitated by movement from one ward to another.

The 19.1% of nurses who did not like the change from one ward to another may have found a suitable ward which met their motivation, attitude and job satisfaction needs and they do not want to lose that by moving.

6.4.8.4   Question 46: Government transfer system

65% of the nurses in table 46 did not like the government's transfer system. Their reasons for disliking this policy are that it causes various forms of social dislocation. For example, the transfer system disrupts nurses' social network which includes families, work colleagues, neighbourhood relations and the membership of social clubs. There are also physical discomforts in moving from the urban well-lit areas into far-away places without electricity in which darkness reigns coupled with the lack of accommodation, lack of communication and lack of facilities, especially for children. Nurses feel "ex-communicated" and professionally isolated from the mainstream nursing, during the period of the transfer (see sections 6.4.1.1 to 6.4.1.5 and 6.4.4.3, 6.4.8.3). For the majority of nurses, therefore, the government transfer system is part of the working conditions or one of Herzberg's "critical incidents", which causes job dissatisfaction (Morse & Weiss, 1992:115-129) (see chapter 4: section 4.4.1.2). These nurses do not feel motivated to go out there in the distant areas in order to qualify for promotion later or to acquire the experience that the government believes is necessary to turn them into all-knowing practical nurses. But it is intriguing that only 34.3% of the nurses in table 42 indicated that the abolition of the transfer system would give them satisfaction in their nursing job.

Table 46   Government transfer system

Do you like the government transfer system?		
Question item	Number of respondents	Percentage (%) of respondents
Yes	60	8.5%
No	456	65%
Not applicable	123	17.5%
Total	639*	91%*

Key*   Some respondents avoided answering the question

Table 46 demonstrates that the government finds itself on a warpath with nurses over the transfer system which introverts their minds into negative attitudes, to regard the transfer system as a punitive object, rather than a beneficial learning experience (Terry & Hogg, 2000:43-49) (see chapter 5: section 5.2.1). Thus, the transfer system is a detestable feature of the work environment to the nurses, which not only causes job dissatisfaction, but also impacts negatively upon their self-concepts, which form part of their motivational system. According to Brockner (1988: ix) (see chapter 3: section 3.5), the situationist perspective of motivation argues that features of the work environment determine job attitudes and behaviours. With most of the nurses not in favour of the government transfer system, it can be predicted that their performance, behaviour and attitudes in the remote areas' health facilities may fall short of the government's expectations.

The dislike of the government transfer system by the majority of nurses is open to other analytical approaches, for example, their learned attitudes to work. The

orientation towards work is learned early in the process of growing up, according to Gruneberg (1979:48; Latham, 2007:34). Attitudes to work are absorbed from parents, friends and the general subculture in which the individual lives. For some individuals this will involve taking on the so-called "protestant ethic" work ethic which involves the belief that hard work is morally good. Counter to the view that an individual will or will not become job involved, according to her or his upbringing and background, is the idea that job involvement is determined by the actual situation in which an individual finds herself or himself (Argyris, 1993:141-167).

It is probable that the nurses' dislike of the government's transfer system has been related to Gruneberg's theory referred to above. For instance, most non-nursing individual workers move from one urban area to another, because there are no industries in the remote areas. Since the majority of nurses do not like the transfer system, their job involvement which is an essential aspect of job satisfaction, motivation and interested attitude is suspect. Gruneberg (1979:52; Latham, 2007:37) pointed out that both the individual factors, including the personalities of these nurses and the factors on the job or surrounding the job itself, such as the deficient working environment in the remote areas clinics with limited nursing equipment, affect the nurses' job involvement. Quite simply, therefore, the demotivated, job dissatisfied and the negatively job involved nurses cannot be expected to provide good quality care to patients under the given circumstances, which Argyris (1993:141-167), referred to as the inhibitory effects of the work environment on job performance.

The government transfer system, however, for nurses with high growth needs, with high motivation, who enjoy job satisfaction from novelty and whose attitudes are pointed in a positive direction, is an opportunity for professional development, a chance to exercise autonomy and a sound preparation for future promotion. The majority of nurses in table 46 do not show these characteristics as 65% indicated that they do not like the government's transfer system. The government may, therefore, have to listen or bow to their views.

It is also most likely that those nurses eligible for a transfer viewed their working conditions as a raw deal because, for example, they were forced by a government transfer policy to have a stint of 2 to 3 years in the remote areas. The rationale of the transfer policy on the part of the government as revealed in the interview with nurses is to develop, widen or deepen the nurses' professional expertise, acumen or practical experience in the management of public rural health services, without immediate recourse to medical consultation. Another subtle government intention mooted in the interview with nurses is to subdue the nurses' superiority complex, assumed or real, over rustic people and their living conditions, brought about by having been trained in modern centres with air conditioned corridors and developed health services facilities. In total the government's grand aim is to create a balanced nursing practitioner. But of course the government could not, as it were, make the omelette without breaking the eggs; hence the relocation agenda.

6.4.8.5 Summary analysis of results for section 6.4.8: Predictability of the influence of transfers on job relationships (Questions 43-46)

According to the results in table 43, the majority (55.6%) of the nurses indicated that they were moved from one ward to another. The time lag for the movement was after one year or more, as confirmed by the largest group (58.5%) of nurses in table 44. A further positive direction was shown by the majority of 51.1% of the nurses in table 45 who pointed out that they like this change of wards. Although the movement may not always be in favour of the individual nurses, as some of them may be moved to busier wards or departments than others, the intention is honourable. In this regard nurse managers deserve to be applauded for making an effort to stimulate motivation and job satisfaction amongst the nurses. After the nurses have gone through most, if not all, the wards and departments they are expected to have gained not only enough experience, but also developed a fortified attitude and motivational system to facilitate their retention in the hospital. However, the exposure to the various wards may, on the other hand achieve a negative orientation in the attitude of the deviant or dissident nurses. But this does not negate the benefits of such a management principle. Generally the change from one ward to another is intended to coincide with the main appraisal report, which is compiled annually as a build up from quarterly appraisals.

Since demographically the largest number of nurses was over 40 years of age, it can be argued that the change of wards was, for most of these nurses, not for the crowned purpose of gaining experience in nursing, but for satisfying their quest for job satisfaction. It may also well be that the movement through different departments assisted them in scouting for a nursing area for specialisation (see section 6.4.1.1-6.4.1.5). Once that was identified, it was later followed by a desire to have an opportunity to further one's additional training and or education, which was one of the motivators and professional attitude-builders isolated in table 41.

While the hospital inter-departmental movement of nurses was under the auspices of the nurse managers, the government transfer system entailing movement from urban to rural, urban to urban, rural to rural and rural to urban was a different matter altogether. Nurses, like other civil servants, are subject to transfer to different health facilities throughout the country for a theoretical period of 2 to 3 years or more. They can also be transferred on promotion, when the higher post to be filled is being offered outside their present stations. The disputants of the transfer system, which has been given various labels such as obnoxious and inhuman, allege that it ignores family ties and proximity to home villages on the part of the transferees. The government has argued that, although the transfer system considers the rendition of the health services in any part of the country as an over-riding priority, it is human and judicious in the sense that it does not vitiate individual circumstances, if they are brought to its attention. However, notwithstanding the government's rationalization of its policy, table 46 shows that the majority of nurses (65%) do not like the transfer system.

But it is puzzling that although the largest number of these nurses (table 46) did not like the government's transfer system, a minority of 34.3% of the nurses in table 42 indicated that the abolition of the transfer system will give them job satisfaction. This is tantamount to a contradiction of interests. One would have expected that the

majority of the nurses who did not like the government's transfer system (table 46) also favoured the sounding of its death knell (table 42) to the same extent if not more. Accordingly, the response rates to both questions 42 and 46 on this item should have been either similarly or equally rated or the former should have confirmed the latter with a higher percentage rate. However, be that as it may, the nurses could also have interpreted the questionnaire item in question 42 (table 42) as if it refers to the transfer system only which they do not like, as confirmed in question 46 (table 46) and not to the removal of the transfer system. This lower rating of the abolition of the transfer system in table 42 could further have been caused by the respondents having to compare it with other question items which they regarded as giving them more job satisfaction than the abolition of the transfer system.

Furthermore, although the majority of 65% of the nurses (table 46) did not like the government's transfer system, the majority of 55.6% of the nurses (table 43) confirmed that they like the movement in the hospital from one ward to another after working for a certain period. Therefore, in summary the majority of the nurses are in favour of movement as a job satisfier and motivator as long as this movement is restricted to movement from one ward to another in a hospital and not related to transfer to other places which are associated with physical discomforts as referred to above.

The transfer policy is but one element of the context conditions which together with other hygiene factors such as social relationships, permeate the whole fabric of the working conditions in which most of the variables are enveloped. To this extent tables 41 and 42, contain a synopsis of the most outstanding job factors that are unique to the public health sector. These job cornerstones also formed a broad background to the hypotheses and assumptions, on which the study was predicated. In the process of comparing collated responses to the questionnaire items with important or significant job satisfaction and motivation factors outlined in the different sections of the questionnaire, it has been found that all the hypotheses and the assumptions set out for the research have *mutatis mutandis* (with varying degrees of emphasis) been proved in sequential sections of the questionnaire document. They were also corroborated to a limited extent in the interview statements.

6.5 RESULTS OF INTERVIEWS

Table 47 Nurses' views on some aspects of their work environment

How do you feel about the following in the public health services?					
Question items	Number of respondents		Percentage(%) of respondents		
	Satisfied	Dissatisfied	Satisfied	Dissatisfied	Total
Pay and fringe benefits	4	27	12.9%	87.1%	100
Work content/the job itself	26	5	83.9%	16.1%	100
Working conditions	4	27	12.9%	87.1%	100
Opportunity for advancement	13	18	41.9%	58.1%	100
Motivation/incentives	4	27	12.9%	87.1%	100

A small sample of 31 public health services nurses was interviewed using structured interview guidelines. Although the results could not be taken as representative of all the nurses in such institutions, they carried meaning amongst other findings from the mail questionnaire. In table 47 the unqualified responses to whether or not they are happy with pay and fringe benefits in the government health services, showed that the majority of 87.1% of the nurses are dissatisfied. Only 12.9% of nurses are satisfied with pay and fringe benefits. However, opinions differed on identified areas of job dissatisfaction. For example, 58.1% of nurses were dissatisfied with the way promotions or opportunities for advancement were conducted or the criteria, if any, on which they were based and the procedures followed. The promotions were criticised for taking too long, such as five years or more and were viewed as not being necessarily based on seniority or approved performance standards. For instance, graduate nurses had a better chance of a speedy and accelerated promotion as high-fliers over their senior non-graduate nurses, irrespective of the latter possessing extra practical qualifications such as midwifery. However, a fairly high percentage of 41.9% of the nurses are happy with promotions. On the question of work content or the job itself, 83.9% of the nurses are satisfied. A small proportion of 16.1% of the nurses are dissatisfied. Working conditions, like pay and fringe benefits, are not liked by many nurses as 87.1% of them are dissatisfied. Only 12.9% of the nurses are pleased with the working conditions.

None of the nurses interviewed was satisfied with accommodation either with its scarcity, the type, the conditions of tenancy or the procedures followed to obtain it. On transfer to remote areas or to another station, nurses revealed in the interview that they are subjected to shared accommodation, with an almost callous disregard of their needs for privacy or the dictates of their marital status. However, nurses pointed out that they are aware that the government justifies its transfer policy on the grounds that it is intended to give them broader practical nursing experience and

clinical skills to manage rural health centres without daily medical supervision. In discussing this issue nurses were also conscious of the fact that the government believes that its policy helps to break down the unequal or superior attitude between urban dwellers and rural people and bridge the gap between the "us and them" attitude. Nurses further said during interview that they are dissatisfied with the lack of recognition of the efforts they make in carrying out their duties sometimes, if not always, under the most trying of conditions. For instance, it was stated that those nurses who perform above others in their respective areas of nursing, are not rewarded by the nurse managers or administrators. Moreover nurses work long and unsocial hours on night duty, not infrequently, with only two nurses caring for over 40 patients under the pressure of unmitigated workload. The fact that they are at the same time exposed to the deadly infectious diseases, such as immune-suppression, with no compensatory financial measures in place, further reduces their motivation. When the nurses interviewed were asked how much salary increase they consider necessary, their suggestions ranked from 20% to 50%. The only person in the sample who was satisfied with pay was a higher rank nurse in the grade of Principal Registered Nurse.

In view of the many variables causing job dissatisfaction, a majority of 87.1% of the nurses in table 47 reported that they were not motivated in their job. They pointed out that the government had to correct a number of wrongs, if it aimed at commanding a motivated workforce of nurses, able and willing to deliver a high standard of health care. A statistically insignificant 12.9% of the nurses are satisfied with the work incentives. Most of the job dissatisfiers were wedded to a broad group of working conditions. Table 47 shows the tabulated results of the interviewed nurses' views on some aspects of their work environment that caused job dissatisfaction.

There are shared similarities between some of the findings shown in table 47 and those found in the questionnaires. For example, a majority of nurses (83.9%) in table 47, are satisfied with the nursing job itself or with what their job entailed, although they absorbed a great pressure from the job itself and other inseparable and inherent job factors such as shortage of staff (table 23) and the additional burden of attending to non-nursing chores which increase their workload (table 22). The dissatisfaction over pay and the working conditions in general is replicated in the questionnaire responses (tables 14 and 21 respectively). The interviews detailed some job dissatisfiers such as the salary, by pointing out that it was not enough to go round a number of daily living activities, such as paying school fees for children, rent, food and other essential goods and services. The argument as to whether or not the public health services offer opportunities for advancement which included promotion, further education and training, is tailed by other intervening variables such as the working relationship with supervisor (table 27). However, the core of all the dissatisfactions (table 47) is pay and fringe benefits, working conditions and incentives each of which dissatisfied 87.1% of the nurses respectively.

The results of the fieldwork have to a large extent lent support to the various theories advanced particularly in chapters 3, 4 and 5. Within the limitations of the study, both the empirical findings and the relevant theories share an agreement that motivation, job satisfaction and attitudes are the mainstay of the nurses' working life. The causal agents of motivation, attitudes and job satisfaction are limitless and abound within the confines of a wide cover of working conditions. However, whereas the variables of

motivation and job satisfaction can almost stand on their own for analytical purposes, the same cannot be said for attitudes. The latter can only be inferred from behaviour, which itself can be "read out" from motivation and job satisfaction. A few examples of attitudes from the empirical study will illustrate their connection to behaviour.

6.6 SOME EXAMPLES OF NURSES' ATTITUDES AS PART OF MOTIVATION AND JOB SATISFACTION

Attitudes are necessary to enable individuals to organize their emotional responses to the material world efficiently, to identify with or differentiate themselves from other people and cope with their inner psychological problems. This is in addition to playing a major role in the individuals' personality paradigms. However, attitudes go beyond organizing individuals' psychological economy, because they also initiate behaviour (Wicker, 1991:178) (see chapter 5: section 5.2.1). Behaviours are reasonably easy to identify, but attitudes are not directly observable. They can only be assessed through behavioural expressions (Sample & Warland, 1991:292-304) (see chapter 5: section 5.2.1). In view of the fact that attitudes defy direct observation, they are embedded in both motivation and job satisfaction variables which express themselves in behaviour. The following examples of nurses' attitudes towards certain aspects of their job are also amenable to analysis in the context of motivation and job satisfaction.

6.6.1 Nurses' attitudes towards liking the kind of work they do

It has been stated in section 6.4.8.4 that attitudes to work are learned from sources such as the general subculture, friends and parents (Gruneberg, 1979:48; Latham, 2007:32). When the majority of nurses (67.9%), say that they like the kind of work they do (table 13), they are expressing an attitude towards work which they have acquired from any of the sources mentioned above. The public health services nurses may also be concerned about their self-image as professional people, who must show outwardly at least, if not inwardly, that they joined the nursing profession with good intentions. To do otherwise would expose them to cognitions of attitude-behaviour inconsistency (Festinger, 1957:9) (see chapter 5: section 5.2.2.1.5) which would be contrary to the psychological advantage (Gellerman, 1963:225; Baldoni, 2005:98) (see chapter 3: section 3.6) which led them to choose to work for the public health services in the first place. It is this self-image or its protection, which not only persuades the nurses or appear to persuade them to like the job they do, but also influences their behaviour and performance in the workplace by directing how they think, act and use their work to enhance and develop their self-esteem (Brockner, 1990:22-24) (see chapter 5: section 5.3). However, the foregoing does not rule out or preclude the possibility that the nurses may be driven by intrinsic motivation to like their job (McClelland, 1990:115-116) (see chapter 3: section 3.3.1). Nevertheless, since self-image is related to the performance-job satisfaction relationship (Brockner, 1990:23), the nurses may use it as part of their attitude towards work which has been modelled on personal qualities, such as intelligence, hard work and self-sacrifice (Crossley, 1993:49-62) (see chapter 5: section 5.3).

In liking their job the nurses may not only be using the ego defensive function (Katz, 1960:103) (see chapter 5: section 5.2.1) of their attitude to work, but may also be showing evidence of their job involvement which is determined by higher order needs. It has been found that workers with higher order needs are more likely to become involved in jobs which give the opportunity to satisfy these needs. It can be argued that for nurses to like their jobs under adverse conditions of situational factors such as working under pressure from the job itself (table 11 and 12), they must be motivated by strong higher order needs (Gruneberg, 1979:50-51; Latham, 2007:33-34). Although the strength of their higher order needs may be dependent on their motivational systems, it is within the bounds of probability that these nurses may have singularly chosen to enter the nursing field, because they had no real alternative employment, either because of the scarcity of jobs or because of the limitations of their own marketability or qualifications (Gellerman, 1963:235; Baldoni, 2005:120) (see chapter 3: section 3.6). In view of such possibilities it is reasonable, strategical and progmatical for these nurses to like the only job they have. Ehlrich (1999:29-34) has pointed out that learning how to behave in a manner consistent with one's attitudes is a primary objective of socialization at all stages of the life cycle (see also classical conditioning in chapter 5: section 5.2.21.1). The nurses may have learned that liking the job they have, obtained under restricted and uncompetitive circumstances, is the only sensible way to behave. Thus, the attitude which may have been learned by nurses, is shown in their behaviour in displaying liking the job they are currently doing. One of the earliest studies of the attitude-behaviour relationship was conducted by Lapiere (1934:230-237). The later investigation by Wicker (1999:41-78) found statistically significant correlations between attitude and behaviour.

One may also simply perceive these nurses who like the kind of work they do, as achievement-motivated adults, who may have always regarded themselves as destined to accomplish great things. Liking their job may be a means towards this aim. In selecting their goals and persevering toward them, such as liking their job even under unfavourable work conditions, they are only doing what they feel is appropriate for someone like themselves (McClelland, 1984:182-183; Bruce, 2002:38-40) (see chapter 3: section 3.5). To this extent, the nurses' attitudes may be helping them to deal with the material reality through the object-appraisal function, or the social reality through the social- adjustment function and the inner psychological reality through the externalization function (Smith, Bruner & White, 1956:30-32) (see chapter 5: section 5.2.1). These nurses' attitudinal functions may be aided by their self-concepts which they have brought to the job. These self-concepts are an amalgam of many factors such as the reception their parents gave them, the roles they have learned to play convincingly with their peers, their record of past success and failure and their notion of what rewards they deserve (White, 1995:298-330) (see chapter 3: section 3.5). The nurses' liking of the job they do is, therefore, an attitude toward their work which is influenced to a great extent by whether or not the job lets them be the kind of persons they think they are (White, 1995:299-335). By virtue of them liking their job, there appears to be a consistency between their attitudes towards work and the situational factors surrounding their job.

6.6.2   Nurses' attitudes towards working under pressure

The majority of nurses (60.1%) in table 11, admitted to working under pressure, knowing that the source of the pressure comes from the work itself, according to 86.2% of the nurses in table 12. These are probably the same nurses who like the job they do (table 13). It can be said that accepting to work under pressure is therefore an attitude to work that is in accord with their liking of the job they do. But according to Gruneberg (1979:48; Latham, 2007:32) (see chapter 4: section 4.4.1.2.1), these nurses' attitudes towards work are derived from learning based on the "protestant ethic", which is the belief that hard work is morally good. It can also be that the attitude to accept to work under pressure arises from the fact that these nurses are job involved, which is part of the nature of the nursing job (Argyris, 1973:141) (see chapter 4: section 4.4.5). The nurses are also willing to work under pressure because they obtain satisfaction from the job itself and they feel motivated to deal with the mental challenge posed by the job (Locke, 1979:1319; Spector, 1997:62) (see chapter 4: section 4.3). The attitude towards working under pressure, therefore, becomes to be treated as part of the "side-effects" of the job they enjoy. The job may also involve the application of their nursing skills, a feeling of involvement, a feeling of doing something worthwhile and the potential for success and recognition (Gruneberg, 1979:33-34; Latham, 2007:17-19) (see chapter 4: section 4.4.2.1).

The nurses' self-esteem is enhanced by carrying out a job that they enjoy for its own sake, which is important for the relationship between success and job satisfaction (Gruneberg, 1979:36; Latham, 2007:23) (see chapter 5: section 5.3). It is the satisfaction of the self-esteem needs that leads to the nurses' reinforcement and remotivation to work under pressure (Gruneberg, 1979:10; Latham, 2007:22) (see chapter 4: section 4.4.1.1.1). The attitude to work under pressure is probably exacerbated by the mental challenge they face from having to carry out a number of nursing tasks under the tight time schedule of a shift. The challenge of new learning, the exercise of autonomy, the responsibility for making decisions regarding the organisation of work and coping with the difficulties inherent in the job (Locke, 1979:1319; Spector, 1997:62) (see chapter 4: section 4.4.1.2.1) are all factors that bolster up the nurses' attitude to work under pressure.

The nurses work under pressure because they accept the challenge of the work and are interested and involved in the job. The work challenge stimulates the nurses' commitment and involvement, because it requires the exercise of individual judgment and choice which make them the main causal agents in their job performance. The actions and outcomes for which they take responsibility nourish their ego. In other words, they see more of themselves in the job and the challenge of coping with this gives them commitment to whatever goals they may be seeking (Mowday, Steers & Porter, 1991:24-347) such as promotion. The nurses' attitude to work under pressure, therefore, permit them to achieve certain goals or value states, such as allowing them to organize their knowledge in the execution of their duties, maintaining their self-esteem and enjoying the freedom of expressing their views in how their task goals can be accomplished (Katz: 1964:103-204) (see chapter 5: section 5.2.2.1.3).

Rosenberg's (1965:123-124) (see chapter 5: section 5.2.2.13) theory of cognitive-affective consistency argues that humans have a need to achieve and maintain cognitive consistency in their attitudes, intentions and behaviour. The public health services nurses like their job and working under pressure is integral to maintaining a cognitive-affective consistency in their attitudes, which are directed towards achieving immediate and future nursing goals. According to Crossley (1993:49-62) (see chapter 5: section 5.3), in working or accepting to work under pressure, the nurses may be defending their self-image and the image of nursing which involve hard work and self-sacrifice (see also Gruneberg, 1979:48; Latham, 2007:32 above). They may have chosen this approach to work to sustain the psychological advantage (Gellerman, 1963:235; Baldoni, 2005:120) (see chapter 3: section 3. 6) which they brought into nursing at the time of recruitment and selection.

6.6.3   Nurses' attitudes towards the relationship between size of remuneration and amount of work done

The attitude of a large majority of nurses (85.8%) in table 15 towards their work and pay, is that the amount of work they do is too much in comparison with their level of pay. The perceived connection between the amount of work done and the amount of pay received, cannot be regarded as automatic, as both are areas of managerial consideration, measurement and calculation. The nurses' attitude may be interpreted in the context of a learning theory. It may be argued that according to classical conditioning, nurses learned to like money, which can be regarded as an unconditioned response (ucr) at the sight of work, which developed into a conditioned stimulus (cs) (Fishbein & Ajzen, 1975:22; Oskamp & Schultz, 2004:14) (see chapter 5: section 5.2.2.1.1). After several pairings of conditioned stimulus (work) and the unconditioned response (money), nurses have learned to associate any amount of work with a high level of pay even when the level of work is normal for the level of pay.

Another way of examining the nurses' attitude is that they learned it or are influenced by the values and beliefs of the society or culture in which they live (Republic of Botswana, 1990:70) (see chapter 2: section 2.1). The analysis of this attitude is extended further by Katz (1960:103) who points out that the instrumental function of attitudes is concerned with their utility. Their usefulness in the case of public health services nurses is to help them obtain rewards and avoid the punishment or disadvantage, of being left behind in a society that puts a heavy premium on increasing incomes in order to cope with the outer world. According to Smith, Bruner and White (1956:30-37) (see chapter 5: section 5.4.2.1), the nurses' dissatisfied attitude towards what they consider to be low pay, compared to the amount of work they do, helps them to deal with the material world through the object-appraisal function of their attitudes. Furthermore, the perceived imbalance between the amount of pay and the amount of work done, is a clear case of cognitive dissonance (Festinger, 1957:9) (see chapter 5: section 5.2.2.1.5), that is, there is inconsistency between the amount of rewards and the quantity of work performed. The nurses' attitude is, therefore, an attempt to bridge the gap between the cognitions of pay and work. It may be observed that the dissonance between the level of pay and the amount of work is so prominent in the nurses' minds that it transcends earlier positive

attitudes such as accepting to work under pressure (table 11) and liking the kind of work they do (table 13).

6.6.4   Nurses' attitude towards liking of the working conditions of the nursing job

The majority of nurses (67.3%) do not like their working conditions in general (table 21). Their dislike violates Strasen's (1992:22-26) (see chapter 5: section 5.3.1) theory of the traditional socialization of nurses. For example, nurses always follow policies and procedures. Nurses are totally responsible for the well-being of their patients. In showing a dislike of their working conditions, the nurses' attitude-sets are apprising the whole concept of nursing in a negative way (Strasen, 1992:22-26). Furthermore, by disliking their working conditions, nurses may be accused of adopting a critical attitude towards nursing and thereby reinforce the impoverished image of nursing, which they are expected to promote (Mackay, 1990:1-3) (see chapter 5: section 5.3). Moreover, nurses are not alone in shaping the image of nursing. They are assisted by patients, members of the public and other agencies such as Red Cross. By showing a disapproval of their working conditions they are negating the cause of their profession. However, supporters or sympathizers of the nurses' position claim that nurses are entitled to defend their own image in the first place. Showing a negative attitude towards expectations which do not meet one's self-concept or self-evaluation is an ego-defensive function of an individual's attitude (Katz, 1960:104) (see chapter 5: section 5.2.1).

The stages of one's ego development can be traced from an early age (McClelland, 1984:182; Bruce, 2002: 39) (see chapter 3: section 3.4). The public health services nurses may have considered that part of their career progression is to achieve certain goals such as nurse management positions or specialisms in chosen areas of nursing.   To do so, they expect their working conditions to be organized in a facilitative way to enable them to reach these professional heights that would reinforce their self-images. The disapprobation of their working conditions can be regarded, therefore, as a reaction against shortfalls in their estimation and evaluation of their self-worth. Gellerman (1963:234-235; Baldoni, 2005:118-120) (see chapter 3: section 3.6) argues further that these nurses may have perceived nursing as an employment option best suiting their psychological advantage. Turning their attitudes against the working conditions of a profession, which they consider as matching their self-motivations, is a severe reaction towards what they believe to be obstacles to their planned life-time expectations. If the nurses' attitudes are seen in this light their message to the nurse managers is negatively ominous.

The nurses are keenly and actually aware that working conditions are pivotal to their motivation, job satisfaction and the long term cultivation of their positive attitudes towards their profession. But the present nature of these hygiene factors (Herzberg, 1959:62), as nurses conceive them, is such that they fail to provide for the need for self actualization (Maslow, 1970:60-62) (see chapter 4: section 4.4.1.1) and to establish an individual identity (Terry & Hogg, 2000:45-47) (see chapter 5: section 5.2). The attitudes that nurses have acquired through a socialization process (Strasen, 1992:22-24) (see chapter 5: section 5.3.1), for instance, have given them a

sufficient basis for interpreting much of what they think to be important for them. The working conditions in their current state fail to meet what they perceive to be central in maintaining their self-image of nursing (Mackay, 1990:1-3) (see chapter 5: section 5.3) which they visioned on entry into the profession. To the public health services nurses, therefore, the working conditions in general, have failed to underpin or under gird their subjective utility (Fishbein & Ajzen, 1975:30; Oskamp & Schultz, 2004:26) (see chapter 5: section 5.2.2.1.3) designed to direct behavioural choices and positive attitudes towards a profession of their choice.

6.6.5   Attitude of nurses towards satisfaction with pay

The nurses' negative attitude towards pay is one of the strongest of their dislikes of working conditions. In table 14, 92.2% of the nurses registered a dissatisfied attitude towards pay. This is the most celebrated of the value-expressive functions of nurses' attitudes. According to Katz, (1960:105) (see chapter 5: section 5.2.1), the nurses are only expressing attitudes appropriate to their personal values and their self-concepts. The public health services nurses' dissatisfaction with pay has midwife other negative attitudes such as the lack of intention to remain in nursing until retirement (table 25). Festnger's (1957:8-9) (see chapter 5: section 5.2.2.1.5) cognitive dissonance theory holds that human beings will endeavour to maintain consistency among any cognitions that they perceive to be related to one another in any way. The nurses may believe that in conformity with their self-concepts and the self-image of the nurse (Strasen, 1992: viii) (see chapter 5: section 5.3), pay is one of the most motivating and satisfying of all the working conditions. Their revolting attitude towards what they conceive to be low pay, not even commensurate with the quality of work they do (table15), therefore, comes as no surprise. Gellerman (1963:188; Baldoni, 2005:75) (see chapter 3: section 3.6) in support of nurses, has pointed out that one of the chief indicators of an individual's attitude towards work, is pay. The degree, to which nurses estimated by how much their pay lagged behind their expectations, is shown by their responses in table 17, in which they suggest an increase of over 40%.

The nurses' image of nursing, as envisioned at the time of recruitment may have been one of viewing the profession as offering a steady salary in an environment of progressive career development (Thomas, 2002:67) (see chapter 3: section 3.6). The image of the public health services as an institution, may have motivated the nurses to prefer it as a prospective employer with some value-expectations (Fishbein & Ajzen, 1975:29; Oskamp & Schultz, 2004:15-16) (see chapter 5: section 5.2.2.1.3) of a high pay that have not been realised. Katz (1960:103) (see chapter 5: section 5.2.1) has suggested that people want to understand events such as financial rewards, which impinge directly on their own lives. The knowledge function of attitudes assumes that each individual has a need to give adequate structure to her or his universe. The negative attitude of the nurses towards their pay levels, as seen through their high expectations of the self-image of nursing, was worsened by the realization that their calls or demands for an increase in pay made over a long period, have not been heeded and they continue to remain as worse off as before. The nurses' claims for higher pay may have been affected by a "reference group syndrome", by which they compare themselves with other worker groups, such as

those in non-nursing jobs, whose allegedly elevated status in respect of better pay they may wish to equal or exceed (Brockner, Gardner, Bierman, Machan, Thomas, Weiss, Winters and Mitchell,1983:199-209) (see chapter 3: section 3.5).

The support for the view that attitudes towards work are affected by the relative amount of pay that others with whom one is comparing earn, comes from the work of equity theorists (McClelland, 1991:321-333) (see chapter 4: section 4.4.2.1). Lawler and Porter (1991:426-435) contrasts the discrepancy theory with the equity theory. The former holds the view that pay satisfaction depends upon the difference between obtained pay and valued pay. The latter views pay satisfaction as a function of obtained pay in relation to the individual's perceived inputs and outputs in comparison to other people holding similar jobs. The heart of the problem for the nurses lies in the fact that the gap between obtained and valued pay is greater than their perceived job inputs and outputs. The dissatisfied attitude towards their pay is, therefore, an attempt to reduce or resolve the dissonance resulting from these two cognitions (Festinger, 1957:2-6) (see chapter 5: section 5.2.2.1.5). Another reason for the nurses' feeling of dissonance is that according to Strasen (1992:vi) (see chapter 5: section 5.3), the level of pay is an inseparable element of both the image of the nursing profession and of the nurses' self-image.

The nurses' negative attitude towards pay is an indication to the government that their value in the public health services is not being recognized. This is in spite of the fact that they play an active part at every level of the decentralized health services system (Republic of Botswana, 1994:7-8) (see chapter 2: section 2.4.3). If their actions and achievements are to continue to contribute to the collective image of the nursing profession in the country, the government needs to seriously take the nurses' pay values into account. After all, the desire on the part of nurses, according to Locke (1979:1322; Spector, 1997:64), is for justice or fairness or for the returns or rewards commensurate with the amount of work they do and the professional responsibilities and accountability they assume in their job. Once a balance is struck between pay and work, the nurses' work attitude, self-esteem and self-image can become productive, satisfied and motivated. Strasen's (1992:18) (see chapter 5: section 5.3) self-esteem performance cycle shows a positive correlation between high self-esteem and high performance, which are all connected to the level of pay.

6.6.6   Attitude of nurses towards other nurses they work with

Vroom (1995:119) (see chapter 4: section 4.4.2.2.2) points out that a relationship exists between social interaction, job satisfaction and attitude to work. The majority of nurses (79.3%) show liking for the other nurses they work with (table 18). It has been stated in section 6.4.1.1.-6.4.1.5, that the affinity between nurses was necessitated by the need for cooperative working both in the wards and clinics. The reliance on one another and hence the need to like one another served the purpose of overcoming difficulties caused by staffing bottlenecks and pressure of work resulting there from. According to Sample and Warland, (1991:292-304) (see chapter 5: section 5.5.2.1), this behavioural expression of cooperative attitudes is brought about by nursing environmental constraints. Nurses are compelled to transmit positive attitudes towards one another in order to achieve performance goals

which are dictated by shift working. The positive interpersonal relationships and the inter-dependence of nurses on one another, increase or reinforce their self-esteem and self-mage (Strasen, 1992:viii) (see chapter 5: section 5,3), which leads to job satisfaction, motivation and increased performance or productivity (Deci, 1992:113-120).

Attitudes are never static. In view of their dynamism, they serve many purposes (Chapman, 1997:3-4) (see chapter 5: section 5.2). The optimistic attitude of nurses and their liking of one another in their working relationships have many purposes. For example, the interface of the nurses' activities is the patient. Nurses' unfavourable and negative attitudes towards one another would detract from teamwork, team spirit and morale, which would interfere with patients' continuity of care. Firstly, the nurses' need to like one another, not only benefits the patients, but also gives support to the nurses themselves against stress arising from the work itself. Secondly, nurses need to like one another at work in order to overcome nursing environmental constraints such as shortages of staff which increase the workload. Thirdly, nurses need to get along with one another to maintain satisfactory work standards of performance. The changeability and adaptability of nurses' attitudes over all these areas are reflective of the versatility of attitudes (Chapman, 1997:4) (see chapter 5: section 5.2). Thus, the nurses' cooperative attitudes towards one another and their liking of one another have perceptible consequences for their work performance and patients' welfare, care and productivity (Gruneberg, 1979:105; Latham, 2007:89).

In showing a strong sense of partnership amongst themselves, nurses are demonstrating the unity of the components of the self-image model for the nursing profession (Strasen, 1992: viii) (see section 5.3), which can only be maintained through a professional relationship based on the mutual cooperation of nurses. Extolling the virtues of this model nurses are adopting the value-expressive function of their attitudes (Katz, 1960:102-104) (see chapter 5: section 5.2.1) from which they derive satisfaction and motivation. In other words they are expressing attitudes that are appropriate to their personal values and concepts. These images of themselves may have been brought forward from the time they chose employment in nursing, because it suited their psychological advantage (Gellerman, 1963:151-155; Baldoni, 2005:58) (see chapter 3: section 3.6).

After finding themselves in nursing, nurses are socialized into their roles. According to Strasen's (1992:22-26) (see chapter 5: section 5.3.1) model of a typical nurse, nurses always consider the patients' needs before their own and follow policies and procedures from senior nurses. These conditions, amongst others, could not be met in a working atmosphere in which nurses do not like one another. To this extent, therefore, the act of liking one another by nurses is directed and enforced by the demands of their job. Nurses may also have learned through their active personal participation or operant conditioning (Fishbein & Ajzein, 1975:23; Oskamp & Schultz, 2004:15) (see chapter 5: section 5.2.2.1.2) that nursing objectives are achieved through working attitudes that promote positive and cooperative interpersonal relationships underpinned by liking one another in the workplace.

6.6.7 Attitudes of nurses towards lack of opportunity for further education and training

Frustration as a result of lack of power which comes from education, can contribute to role incongruity and role strain, which lead to lack of motivation, job dissatisfaction and negative attitudes (Hardy, 1978:40-68). The impact of higher education in nursing is; therefore, felt in the power it gives them the opportunity for self-expression and creativity. According to Godfrey (1995:89-104) and also implied in Strasen's (1992:viii) nurses' self-image model (see chapter 5: section 5.3), education affects work attitudes and it is inversely related to job satisfaction. The majority (58%) of nurses (table 23) were dissatisfied with the lack of opportunity for further education and training. As explained in sections 6.4.1.1-6.4.1.5, further education for nurses refers to a degree course in nursing after at least two years of working experience as a qualified nurse. On completion of the programme, the nurse returns to her or his previous job, with enhanced chances of paralleled progression into the officer cadre of supervisors as a graduate nurse. Further training means non-graduate specialized training such as midwifery which after completion, equips the nurse for a different route of parallel progression into the chosen specialist areas of nursing such as maternity ward.

The nurses' attitudes towards both these potential gateways to future career progression or promotion are that they are marred with impediments. Because the courses are government-sponsored, nurses have complained and criticised the selection criteria used as unfair, dubious, double standard, favourist and slow. The nurses have pointed out that the number of candidates released at any one time to go for further education and training is too small. The government has counter-argued that it has to consider staff shortages to close the gaps that are left by those released from service, for a period ranging from 18 months for midwifery training, to three years for graduate education. The nurses and the government have not reached a mutually satisfactory understanding in this matter, hence the registered dissatisfied attitude on the part of nurses. These complaints have left many nurses dissatisfied and have caused them to lose motivation in their jobs and to adopt negative attitudes toward their future in the profession.

Katz's (1960:103-106) (see chapter 5: section 5.2.1) points out that one of the functions of attitudes states that people may not seek knowledge for purposes required by the educator or social reformer, but they need it to understand the events which impinge directly on their own lives. The public health services nurses are thirsting for further education and training to further their own career progression and to acquire a breadth of view of their own profession. Further education and training are ways of improving the standing or the image of nursing. Nursing education can be used to focus on the self-image model for the nursing professional, that is, the thoughts and beliefs of the nurse. The specialized training can be directed at the actions, performances and achievements of the nurse, (Strasen, 1992:viii) (see chapter 5: section 5.3). Changing the thoughts and beliefs of individual nurses will in turn determine their self-image and subsequently their actions and performances (Strasen, 1992:viii-ix) (see chapter 5: section 5.3).

The public health services nurses would want to achieve these aims through a two pronged approach of higher education and training. This would enhance their

performance, influence their behaviour in a positive and productive way, inculcate correct work attitudes and develop and preserve their self-esteem (Brockner, 1988:22-24) (see chapter 5: section 5.3). It has been shown that people with high self-esteem are motivated, perform better, they are job satisfied, have improved work attitudes, work harder in response to negative feedback and are less likely to be affected by acute stress in the work environment (Strasen, 1992:18-19) (see chapter 5: section 5.3). Most significantly, self-esteem is directly correlated with high job satisfaction (Strasen, 1992:18: Figure 1.1) (see chapter 5: section 5.3).

Further education and training can also be used as a means of removing some of the negative stereotypes of nurses, such as that of perceiving female nurses as sex symbols and the nurse being regarded as a handmaid for the physician (Strasen, 1992:22-26) (see chapter 5: section 5.3.1). There is no better way of preparing a future for nurses, not only free of these negative images of nursing, but also of developing a future vision for nursing managed by well informed nurse managers than furthering and promoting the further education and training of nurses. To lead effectively, inspire staff and at the same time manage oneself, the nurse leader requires appropriate skills that come from further education and training. The public health services nurses' negative attitude towards the lack of opportunity for further education and training, interpreted in the context of the foregoing argument, can only be seen as an informed cry and a prognosticated vision for developing skillful, competent, effective and able future nurses and nurse managers, who can successfully manage both the clinical and nurse leadership nursing arenas.

6.7　　　SUMMARY AND CONCLUSIONS

The analysis of the findings from the questionnaire confirmed that the majority of nurses were aged between 35 and over 40 years. Furthermore, the majority of nurses had more than ten years nursing experience. This in itself means that most of these nurses had mellowed in the nursing profession and had amassed a wealth of experience. No relationship was found between age and job satisfaction, motivation and attitude towards work, among the nurses. The Wagner *et al.'s* (1977) theory that the older the nurse, the more stable and job satisfied she or he becomes, was not proved. The proportion between married and single nurses was almost equal. There was a minimal significance between the marital and non-marital status of nurses in respect of all the questionnaire items. Most of the nurses had one to three children, most whom were aged from five to over ten years.

The majority of nurses enjoyed their job, together with good interpersonal relationships with their fellow nursing colleagues. This gave them a high sense of belonging which maintained their morale in a work environment in which they worked under pressure, due to staff shortage and increased workload. Despite these hardships associated with the work itself, it was evident that the majority of nurses had a great deal of autonomy, not only in the way they carried out their duties, but had also been allowed a participative choice in the type of nursing they were practising. As a result of this, the majority of nurses showed a high level of job satisfaction, motivation and satisfied attitude in this section of the questionnaire. Taking part in decision-making also facilitated the use of discretion and initiative in

the manner in which the nurses executed and interpreted their nursing duties. The majority of nurses was, therefore, satisfied and motivated with the content or the nature of the job itself and showed a positive work attitude, in spite of pressure to which they were subjected in trying to meet their programmed professional objectives.

In the area of personal satisfaction and interpersonal roles, the majority of nurses had a good working relationship with their supervisors as well as their nursing compeers. According to the majority of nurses, their supervisors gave them a chance to make decisions concerning their job. The nurses also found it easy to talk to their supervisors and to approach other higher authorities through their supervisors in respect of matters impinging on their job. The mixing of senior and junior nurses, which was mentioned by the majority of nurses, summed up the good working relationships between these two levels of nurses. The nurses' work attitudes were encouraged by the democratic and participative supervisory policies. They felt motivated to do more and expand their professional horizons with resultant job satisfaction.

But there was a remarkable shift of attitude by the majority of nurses over working conditions in general and with reference to particular aspects thereof. For example, a majority of nurses expressed job dissatisfaction, lack of motivation and negative attitudes towards the shortage of staff, which was negatively related to workload. They disliked the government's transfer policy of nurses to remote areas and loathed the lack of opportunity to go for further education and training. An overwhelming majority of nurses was not happy with the level of pay. They complained about what they considered to be a serious discrepancy between the work effort and the size of the remunerative package or emoluments. They clamoured for a salary increase of more than 40% to seal this gap.

Other less fertile sources of worry to the nurses in the workplace, include the communication system, which was described as only being fair by the majority of nurses. As part of the lack of effective communication between the nurses and their supervisors, more than a quarter of the nurses, said that they were still haunted by the spectre of ancillary duties, which they regarded as relatively unimportant to their work. Another form of communication which was not highly rated by the nurses was the appraisal system. The majority of nurses described it as fair. The defects of the communication system were also felt in the failure by nursing managers to recognize nursing accomplishments. The majority of nurses said that their nursing achievements were almost never recognized. However, the movement from ward to ward applicable in the hospital and intra-clinic movements to facilitate learning and the acquisition of experience was positively supported and confirmed by the majority of nurses. As a consequence of this change of work environment, the majority of nurses stated that they were able to learn continuously in their present posts.

The opportunity for continuous education was the third highest source of motivation, after sufficient working conditions and a good salary, in ascending order. The job satisfiers were also headed by a good salary, other considerations such as a risk allowance and good working conditions, in descending order. The nurses' strong negative attitude towards pay was scrutinized using attitude theories, together with other examples of attitudes, such as nurses' attitude towards their liking of the working conditions. The results of interviews were closely related to the

questionnaire findings. For example, the majority of nurses were not satisfied or motivated by both pay and working conditions. They were, however, motivated by and satisfied with the work itself, to which they showed a positive work attitude.

Notwithstanding the high dissatisfaction with pay, nurses martyred themselves to their job, sustained, not by freemasonry or collegial cooperation, but also by an indestructible unity towards their profession. But it must be remembered that whatever job satisfaction nurses salvaged from other work sources such as the use of discretion in the control of their workflow, it was dissipated or submerged and obliterated by a high number of complaints over pay inadequacies. This was more so in view of the revelatory fact that the survey data indicated that salary occupied a top position in the league of motivators and job satisfiers. In the light of this, it is isolated and scrutinized briefly in the context of Jacques' theory of work and pay.

One of the most fascinating and controversial theories for the determination of payment is that developed by Professor Jacques of Brunel University more than 40 years ago. Jacques tackles the problem of equitable payment from a number of angles. Firstly, he seeks a means to determine the appropriate payment and status for individuals for the work they do so that each one has a sense of fair and just return for her or his work. Secondly, he determined a pattern of payment that is economically sound. Referring to the laws which govern wage-fixing as the laws of the jungle, in which the most powerful groups survive what he called a sort of social Darwinism, and exert power over the less powerful groups, he proposed a "scientific" and "objective" system which eschewed political power and negotiation. In his conceptual trilogy of work-payment-capacity (w.p.c.), he asserted that everyone has an unconscious feeling of the level of work she or he is capable and of the equitable payment levels for both the level of work she or he is doing and the level of work she or he is capable of doing, so that an individual can be in a state of equilibrium, that is, a situation where the demands of the job are consistent with the personal capacity for doing it (c-w), and the rate of payment received must be regarded as fair and equitable. Jacques represented the equilibrium position as c-w-p. Although by permutation thirteen different alignments of these variables are possible, only four illustrations will be given here.

The first is c-w-p, where the capacity matches the work of correct payment, that is, a state of equilibrium. The second equation is where $^{c\text{-}w/p}$ in which case the job demands are in accordance with the capacity of the individual, but payment is below par. This is a situation which is likely to give rise to feelings of inequitable treatment. The third alignment is that of $^{c\text{-}p/w}$ in which the individual's capacity exceeds the work demands upon her or him, but where payment is consistent with her or his capacity. This is a situation which is likely to give rise to feelings of frustration. The fourth arrangement is where $^{p/w/c}$ in which case payment is too high for the level of work and where the level of work is above the individual's capacity, thereby, breeding a strong stress-inducing situation. In most work agreements, payment is made in the form of money. Thus, "money wages" are payment made to workers for placing their ability and energy at the disposal of an employer. During the last half-century people's views have changed regarding the relative importance of money. But the fact that has remained consistent is that money is still a sensitive and crucial element of the reward compensation package. According to Opsahl and Dunnette (1966) and Lupton and Bowey (1974) matters affecting payment for work, the rate for the job and various types of incentive schemes are capable of evoking very strong emotions.

Hence nurses who professed to be operating at Jacques' second equation reverberated a strong feeling of injustice.

The main threads of job satisfaction, attitudes and motivation, which have run through various chapters, including the empirical results, will be drawn together and conflated in the next chapter dealing with the summary of the thesis and the conclusions reached.

CHAPTER 7

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

7.1   INTRODUCTION

Since nurses are an indispensable fulcrum in the provision of health care services the whole standing and the image of the health care industry depends on how well they perform their duties. It has been argued that nurses carry out their functions under the public gaze and the close scrutiny of members of the public, politicians and patients themselves. The pressure that nurses have to endure or to strain under from the public onlookers, the media and the non-governmental organizations, calls for an immense steadfastness of attitudes, in order to continue to provide quality care to patients. The public criticism of nurses does not only cause a negative shift in their attitudinal map, but might also get into a point of departure, in respect of whether or not they leave the health services or will simply continue to limp along, in a world of limbo providing poor and unhurried health care. The labour turnover of nurses causes staff shortages, which when added to the lethargic attitudes of those remaining in the health services, worsens the quality of patient care. With this in mind, therefore, the study of the three most relevant job factors in the health services was a prophylactic measure towards the retention of nurses.

The concepts of motivation, job satisfaction and attitudes have been studied in depth and they also form an integral part of the questionnaire. The principal aim of dissecting the essential variables in the questionnaire such as institutional, organisational or environmental, as well as the personal or internal factors peculiar to each individual nurse, was to isolate which job factors helped to keep nurses on the job on the one hand and which ones on the other, led to dissatisfaction and thus eventually to labour turnover. The theory of motivation was found to be highly complex. But at its simplest operational level, it is based on factors external to the person such as the content and the context of a work environment and factors internal to the individual, for example, family upbringing.

The job satisfaction approach is not easier or less complex than the motivational perspective. Its bottom line borrows heavily from that of motivation. Both motivation and job satisfaction are festooned by many variables and it has been shown that although all of them are related to performance or productivity, they do not follow the common logic that job satisfaction leads to high performance, or that a motivated employee performs better than a non-motivated one. Having defied such commonsense assumptions, motivation and job satisfaction are still correlated to or with performance. In other words they provide the necessary but insufficient conditions for high performance in a given employee.

In the same breath attitudes which everybody has or should have or is expected to have, have a mosaic orientation to everyday life and runs through every aspect of human life. Thus, it can be said that when one person motivates another, he or she is changing an attitude and similarly when one is satisfied with a job, one's attitude is also altered in a positive direction. The swing of attitudes is in both negative and

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positive trajectories. But it is mostly the positive attitudes that are sought to improve the quality of health care.

The empirical chapter investigated the public health services nurses' motivation, job satisfaction and attitudes in their work environment. It examined the balance sheet of these variables, so as to show the nurse managers or the administrators and the other parties such as the elite circles in society, the debits and the credits of the public health services and most importantly the nurses' views about these factors in their work situation. Depending on the reception of what emerges from the analysis of the field work results, a positive way or path will be charted towards improving the public health services to the satisfaction and benediction of all the stakeholders including the nurses themselves.

An empirical investigation is essential, in gathering and collating information or data which is not based on theory alone. Social scientists contend that commonsense on its own, is insufficient to explain those parts of human behaviour such as social and economic. Such explanations are subsumed under the name of science, which aims at general explanations extending to a wide range of similar phenomena. Although science is by no means the only method by which people have attempted to explain human phenomena, it has become over the years the most acceptable way of collecting data on human problems, because social scientists are critical of the knowledge obtained by any other means.

The scientific approach is based on the assumption that the world can be known only, as experience is processed through human intelligence. People's experiences or the empirical evidence of their senses, serve scientists as data when trying to explain, for example, psychological and social phenomena. These explanations define boundaries of the scientific body of knowledge. Deductive or probabilistic scientific explanations explicate those antecedent factors in a situation that are held responsible for the occurrence of a particular phenomenon.

There are four main necessary conditions on which to draw causal inferences. Firstly, demonstrating covariation which simply means that two or more phenomena vary together. Secondly, eliminating a spurious relation which requires the scientist to demonstrate that the observed covariation is non-spurious. The latter is defined as a correlation between two phenomena that cannot be explained by the presence of a third factor. Thirdly, establishing the time order of the occurrence, which requires the researcher to demonstrate that one phenomenon occurs first or changes prior to another phenomenon. Fourthly, theorising which is problematic because of the lack of consensus among social scientists on what is meant by a theory.

Social scientists engage in scientific activities which are thought to enhance the goals of science, since they relate to the four operations involved in establishing explanations. The principal types of activities each of which comprises a stage in the research process include problems, hypotheses, research designs, measurement, data collection, data analysis and empirical generalisations.

There are four basic elements of research. Firstly, concepts which are defined as abstract symbols representing an object, a property of an object or a certain phenomenon such as role or status. Secondly, definitions which are of two types, that is, conceptual and operational. Definitions that describe concepts using other

concepts are conceptual. For example, one conceptual definition of intelligence might be "the ability to think in an abstract manner". Since this is only one way of defining intelligence, it might be noted that a conceptual definition is neither true nor false. An operational definition is a series of instructions describing operations that the researcher must carry out in order to demonstrate the existence of an empirical occurrence represented by a concept. Operational definitions bridge the gap between the theoretical-conceptual and the empirical- observational levels.

Thirdly, variables such as social class and political participation are empirically applicable concepts that take on two or more values. Fourthly, assumptions or hypotheses are tentative answers to research problems and are expressed in the form of a relationship between independent and dependent variables. Hypotheses are tentative because their veracity or validity can only be evaluated after they have been tested or proved empirically.

In this study hypotheses and assumptions were tested against questionnaire items which were designed to collate information from nurses working in the public health services. The idea that in trying to identify a problem it is essential to collect the views of people, who share the same professional arena, formed the basis of the questionnaire as an instrument of research. The responses derived from the target population were analysed to yield various interpretations. For instance, the culmination of the relationship between the theories of motivation, job satisfaction and attitudes and the practical views of nurses is brought out more clearly in the summary below, which also examines the empirical findings in juxtaposition to relevant management theories.

7.2 SUMMARY

Previous researches conducted on nurses in the health services of Botswana, had concentrated on a number of topics such as job satisfaction and attitudes. In these studies motivation was assumed to be part of job satisfaction. The present study decided to break new ground by separating motivation from job satisfaction. It also went a little further by choosing a topic that embraced motivation, job satisfaction and attitudes and treated each variable equally with a heavy accent. Befittingly, one of the major aims of this study was to carry out in-depth examination of motivation with the ultimate objective of striking a balance between an individual's motivation in employment and the institution's goal setting. The congruence or the lack of it, between the individual's and the institution's motivational system, determined the nature of employment relationship. The extensive studies on job satisfaction and attitudes scrutinised both the general theories in the respective fields and contextualised variables relevant to the nursing field. The data collected from the questionnaires and interviews were then treated as comparative exchange points between theory and practice.

Since nurses comprise the greatest part of the Botswana government's civil service, the research's *raison d'etre* storied the annals of the nursing profession, against the beginnings of the Botswana public service. As the Botswana society developed, with development being understood as economic growth plus social change, the nursing

profession and the Botswana community grew with it. The disparate elements of societal change consequential on development in a non-homogeneous population are many and varied. Examples include capital accumulation, rises in incomes associated with relativities and inequities, increments in consumption functions, the quest for knowledge, increased awareness of people's rights in a democracy and the multivariate role of the government and its judiciary responsibilities. These are some of the common benefits that accompany the seed-bed of development. Overriding most, if not all, these developmental acquisitions, is the concept of equity, which refers to a simple sense of fairness in the distribution of the primary goods and services that characterise the Botswana social order. The Botswana society's heightened consciousness in general, brought about by increased and increasing levels of education, created an assertive community with particular reference to the delivery of public health services.

The Botswana community's strident demands on the nurses for improved health services and nursing care were counterpoised by the nurses' claims of imbalances in their payment system. One of the adverse effects of capital accumulation which has affected the public health services nurses since independence is super exploitation. This refers to the appropriation of more than the surplus value produced by the nurses' labour beyond the wages they receive. It also involves the appropriation of the consumption fund which the nurses need for the reproduction of labour power and survival. Three fundamental or declarative forms of super exploitation produced by capital accumulation, as they apply to the Botswana public health services nurses, can be identified. Firstly, an increase in the intensity of work. Nurses work under conditions of increased workload and pressure from the work itself, in the hospitals and clinics. Remote areas nursing involves working outside normal working hours such as being on-call over and above the normal day working hours or when the affected nurses are formally or officially off duty. Secondly, extension of the working day, when nurses are expected to work long hours on night duty. Thirdly, payment of the labour power below its value has been one of the most outstanding complaints by nurses. To pay labour power for its value signifies for the nurses finding the whole of the conditions necessary to produce and reproduce their labour power, among which the wage plays an important, but not the only part. For forty years since Botswana attained its independence nurses have complained of low wages.

At the inception of independence, the Botswana government decided to make the country's public health services the centre of nation-building. That decision gave prominence to the role of nurses as they became a critical factor in the nurturing of the new human resources that were to pioneer the economic and health-related well-being of the new nation. The main threads which connect the Botswana community with the public health services dominated by nurses were developed from here. The nurses' role was, therefore, juxtaposed with the community's expectations of the health services.

When, however, the nursing profession developed further, incorporating new pandemic dimensions in pathology, for example, the human immune-deficiency virus (HIV) and innovative branches of nursing such as infection-control, the roles of nurses expanded and became more demanding both with regard to time and effort. But the community's cognitive orientation towards nursing remained at a static conventional vocational level, which viewed nurses as dedicated public servants, devoid of any economic ambitions in the labour market. The community's rhetoric

about nurses, therefore, lagged behind the modern nursing reality in which nurses no longer entertained hopes, but were driven by desires for higher pay like other employees in the formal employment market. Since it is the nurses who bear the duty of care in the health services towards the community as well as the patients, the present study rotated its attention towards the nurses. The triangular study variables of motivation, job satisfaction and attitudes of nurses, are intended to establish the nurses' expectations from the health services whose mission they fore fronted from the beginning. The nurses' aspirations will form the basis of improving the quality and standards of care in the health services.

The impediments to the nurses' provision of good practice and quality care in the public health services, have been shrouded in a varied number of adverse work environmental factors. Nurses, for example, have complained of low wages. They have compared their wage rates to those of a typist working in industry, who has undergone a relatively short period of training, compared to the nurses' three year training in a school of nursing. Nurses have also employed other grounds for arguing their case for a higher salary such as the degree of responsibility and accountability they hold in their job. They have claimed, not unreasonably, that these two considerations accrue more to nurses who look after human lives than to typists who tend to machines. Although the specter of low salaries is pervasive through the health services system, it is not the only factor that affects the motivation, the job satisfaction and the attitudes of nurses. A variety of other insurmountable roadblocks to the efficacious delivery of the health services hover around the shortage of staff which increases the workload and unending pressure on the nurses from the work itself. The nurses' rungs to the upward professional mobility is also visited by unmotivating working conditions such as unfair promotions and the lack of recognition for high performing nurses coupled with contentious policies typified by the urban to rural transfers. The professional misfortunes that have made common cause with nurses have been worsened by the newspapers, members of the public, politicians and non governmental agencies. These parties have not shown sympathy with the nurses' work problems, but have instead individually or severally gone on a bandwagon to criticise nurses of negligent attitudes towards patients, amongst other things.

As a result of countless volleys of complaints and grievances against nurses voiced by many sources, the Minister of Health has undertaken whistle stop tours of the public health services institutions, addressing staff. The Minister in his capacity as a government representative has acknowledged the difficulties faced by nurses in their job. But he has at the same time maintained that the general public is unhappy with the levels of care in the health services. The members of the public as service users themselves, at one point or another, have expressed serious concern about the nurses' lack of interest in their patients evidenced by long waiting times in the hospitals and clinics. These criticisms have disturbed the nurses further by driving a wedge between them and the public and other societal agencies such as the media, about the nature of the job that nurses do and their frustrations over their work environmental dissatisfactions.

In the face of these misgivings about nurses' performance and the poor image of the public health services, nurses themselves took the initiative to confirm or disconfirm grounds for complaints about their job. For example Motlhasedi's 1982 survey of the causes of job satisfaction amongst nurses, found that a number of job dissatisfiers

such as work load and staff shortages all under the umbrella cover of working conditions, were responsible for the lack of motivation, job satisfaction and positive attitudes amongst the nurses. It was the long, enduring absence of job satisfaction, motivation and pro-active attitudes amongst the nurses that caused their poor performance in the public health services. A further nursing study by Tapela in 1983, established that nurses were dissatisfied with and demotivated by transfers into remote areas.   Because of the hardships they faced such as the lack of communication in such undeveloped distant postings, their interest in their job declined. To a larger extent, therefore, nurses validated the root causes of their complaints. As a result the debate surrounding the shortcomings of the public health services and the nurses' grievances was tabled in Parliament.   Although the commission of enquiry which had led to these issues being raised in Parliament necessitated changes to the nursing organisational structure at the Ministry of Health level, there was no significant alleviation of the nurses' dissatisfactions. The unresolved nature of the nurses' plight, epitomised by the three principal areas of nursing concern, represented by motivation, job satisfaction and attitudes constituted the research problem for the present study.

The responsibility and trust for developing the nation's health, reposed in the hands of the health services, called for an efficient and productive nursing service. This alone gave an aura of importance to the public health services in particular, because of their subordinate relationship with the government. In their crucible role of shaping the health of the nation, the public health services cannot be considered in abstract but in conjunction with their nurses who give them their existence and meaning. The achievement of a healthy nation, which impacts on the country's economic performance, depends on the health of the human resources. The nurses, therefore, as the indispensable agents of the public health services, play a decided role in maintaining the economic well-being of the nation.   If their problems are left unattended, their performance will decline, with negative consequences for the government.   Moreover, the public health services have in the past experienced labour turnover as a result of dissatisfied nurses leaving to join the private health sector or join the industry. Herein lies the importance of the present study in trying to create an awareness of the problems that nurses have, in order to retain their services and continue to build the health of the nation.

Bridging the gap in expectations between the government and the nurses and between the latter and the general public, in respect of the performance of the nurses and the public health services, lies at the centre of this study. To achieve this objective, the nurses' problems, complaints or grievances need to be understood in their true perspective. With this in mind this study has pooled the views of both senior and junior nurses with varying degrees of nursing experience. The detailed nurses' dissatisfaction will be of interest to the Nursing and Midwifery Council of Botswana, the Ministry of Health and the nurse managers. The research results will broaden the minds of policy makers about nursing problems and assist other interested parties such as the non-governmental agencies and the general public to understand the nurses' views about their work. The overall idea of acting on the research's findings will be to change direction for the better in the interpretation of nurses' working conditions. This will foster an efficient nursing work force, which is well motivated and job satisfied, with attitudes that are positively oriented towards providing high standards of nursing.

The investigation of the nurses' employment features was, therefore, intended to identify the effective performance by nurses. The opposite side of this approach was to establish the origin of the nurses' complaints in the public health services which caused their poor performance, poor patient care and dissatisfaction by the general public. The nurses' work place effectiveness is said to depend on a combination or mixture of organisational factors such as rewards, recognition, peer group relationships and scheduling of duties, amongst others, which predict motivation, job satisfaction and positive attitudes. The aim of the study was to find out the organisational culture of factors which had a positive effect on nurses' performance. Such data serve to awaken the decision makers in the Ministry of Health and the various levels of hospital managers as to the causes of nurses' apathy, negative attitudes, lack of motivation and lack of job satisfaction. The knowledge and information thus acquired form the baseline for a management warning system whose purpose is to maintain a dialogue between nurses and the public health services authorities. Amongst other considerations, this communication arrangement will enable the public health services managers to adopt an attitude of preparedness regarding job factors such as motivation, job satisfaction and attitudes, in order to retain nurses, improve their performance, improve the image of the public health services and close the gulf between the nurses and the service users of the public health services.

The hypotheses and assumptions of the study included a number of elements common to the job factors under investigation and related to the chosen nursing environment. The results of the data analysis confirmed all the proposed suppositions. This was a major break through, because the mail questionnaire which was the main instrument of investigation covered a third of the total number of public health services nurses, drawn from nine hospitals and twenty five council clinics. The questionnaire results were supplemented by responses from a small sample of interviewed nurses. The survey considered only qualified nurses with a minimum of two years work experience. Botswana has a mixture of both private and public health services. The former comprises private hospitals and mine hospitals together with their associated clinics. The latter is made up of government and mission hospitals and their related clinics. The study was restricted to the public health services.

The approach to the investigation was based on theoretical work taken from the theories on motivation, job satisfaction and attitudes. The material for this secondary source of information was derived from a variety of books, journals, periodicals, magazines and government documents. Questionnaires were used to solicit information from a large group of nurses. Although this method is quantitative and impersonal, it is cheaper than the interview approach. However, the latter, in a structured form, was also used for a limited number of the sample. Interviews, as a primary source of information, add quality and depth to the data obtained through the questionnaire technique. All the collected data were treated, analysed and interpreted within the framework of the theoretical variables under study, that is, motivation, job satisfaction and attitudes. It was the ideas, opinions, responses, views and reactions from the nurses themselves that determined where theory and reality met, parted, agreed or disagreed or were conjoined. The social ore extracted from this wealth of information, provided the knowledge-base for the public health services managers to grasp what motivates and job satisfies nurses and what stimulates in them positive attitudes towards their work.

The inter-relatedness of these study factors has been captured in the arrangement of the seven thesis chapters. The introductory chapter one is a road map or a trajectory, which points the way towards the unfolding study that lies ahead. It contains the hypothesis and assumptions, the research method, the aim and the significance of the investigation. Chapter two is an evaluation of the existing public health services, with their history of origin from the time of independence. It is also a haven of government policies which steered them through their period of development. Chapters three, four and five focus on the theories of motivation, job satisfaction and attitudes, respectively. Chapter three traces the motivational system from early childhood to adulthood. In the process, the motivational profile of a potential employee emerges. The chapter concludes that if in the employment context, the individual's motives are congruent with those of the employer or form a happy mixture with those of the management, a productive working relationship will be established. It is also argued that a motivated employee is most likely to be a happy worker. Chapter four develops this thread further, by taking over from where chapter three ends. It extends the connection between motivation and job satisfaction, by identifying a number of variables such as the opportunity to go for further education or training, as causes of job satisfaction, but which can equally be motivating. Motivation and job satisfaction affect behaviour. The nuances between the latter and the attitudes are taken up by chapter five. In the end, in a job environment at least, attitudes can be said to be motivated and satisfied, bringing to mind the telescopic configuration of the three variables of motivation, job satisfaction and attitudes. Chapter six presents the results of the fieldwork, based on the questions framed out of the relevant theories advanced in the theoretical chapters. Chapter seven draws upon the various themes detailed in all the preceding chapters in order to summarise, draw conclusions and tender some recommendations towards the improvement of the shortcomings or deficiencies in the public health services.

Corrections in the management of the public health services and their nurses are informed by or must be made against the backdrop of their history as chapter two outlines. The historical development of the health services in Botswana, although impaired at first, by the dearth of both skilled nursing personnel and financial resources, took off meaningfully in the 1970s. Their ascendance has been ascribed to the discovery of the economic strength, previously dormant in the mining industry and the suave and skillful political leadership. When these factors were merged into an instrumental partnership, the planning of the health facilities took a decisive direction. The galvanizing of the economic and the manpower resources was directed at creating national health services, whose chief aim was to prolong, not only the lives of the Batswana, but also to nurture a healthy and productive workforce. The few mission hospitals that were mainly curative centres were the rallying points for the inchoate and nascent health services infrastructure. The primary health care paradigm was espoused as the most pragmatic approach to cater for a scattered population.

The thrust in bringing health care services to the people manifested itself in the form of clinics, which increased in number each year until the recent times, when they outstripped the availability of nurses to man them. This is not to say that the number of nurses was not increasing but that it could not catch up with the ever-multiplying number of such facilities. As the years wore on, new hospitals were built to complement the clinics but again these also could not be staffed adequately. Thus, more clinics and hospitals begot more nurses. The gap or imbalance between the

staffing requirements of the increased number of health services and the number of nurses required to operate them, has never been closed or resolved to the present date.

With the recent wave of awareness of human rights, including the right to health care on the part of the populace, brought about by modernity, the expectations by the community, of quality health care services, have highlighted deficiencies which have consequently led to a persistent criticism of nurses. The latter have in turn made their employers aware of the shortcomings in their work environment, particularly relating to the lack of motivation and job satisfaction, which cut across their productive attitudes. These are broad work variables, which reside amidst the nurses and which take a toll on their ability to provide sterling services. In figurative speech, nurses may be asking for an improvement in their working conditions as a *quid pro quo* (thing given as compensation), for rendering better health services. The role nurses play at different levels of the provision of public health services justifies this observation.

Nurses are involved in the integrated approach to the provision of public health services, beginning at the community level. For example, the Ministry of Health policy which targets the children's programmes such as immunisation is run and managed by nurses. The national nutrition policy is another basic government-directed approach to preventive public health services which is realised through the work of nurses. Taking cognisance of the central role of nurses who are found in every locality, the government, after independence, decided to organise the public health services according to the localities in order to run away from the colonial system of hospital-based and curative health services. The construction of clinics and health posts in the rural areas was not only designed to enable many people to access public health services, but was also concordant with the government's decision to extend the preventive and the curative health care programmes in to the remote areas. The government's policy of the rural postings of nurses was tailored to coincide with its intended aim of comprehensive health care services in the whole country. This broad structure of necessity required a hierarchical arrangement of the health services to accommodate the different skill levels of nurses. For instance, the health posts, the clinics, the health centres, the district and the primary hospitals as well as the referral and or curative health care facilities, are maintained by nurses of varying nursing qualifications.

The hierarchy of the public health services heralded the concept of decentralisation which spelled out the pragmatic structural relationships between the central and the local government in the shared administration of these health facilities. The public health services nurses assumed the brunt of the difficult working conditions such as staff shortages, under the dome of these two government authorities. Although participation in the public health services, particularly by the rural folk, could be enhanced by decentralisation, the actual community involvement by nurses and other health workers such as extension workers and members of the local communities themselves was maximised by the primary health care approach. This strategy emphasised community participation by integrating the preventive, the promotive and the rehabilitative approaches. The primary health care orientation to the provision of public health services has been adopted by the government as the most practical approach to the grand goal of attaining health for all. Community participation had its antecedents in the colonial times when it meant the community being engaged in

self-help projects such as building roads and schools. The notion was linked to a demarcated geographical area, for instance, a district, a region, a village or a ward in a village. The modern forms of participation, however, lay stress on health-related activities such as health education led and managed by given members of the community, with the rest of other community members taking part. Health community participation programmes, although retaining the local ingredient, have been strengthened and formalised by the government by the introduction of the family welfare educators who were the pioneer members of the health teams.

The idea of taking health care services to the people was, therefore, reinforced by the nascent experience of the family welfare educators who were resident in the communities they served. As the novelty of this sparsely trained cadre of health care workers became modernised, it was incorporated into the health services run by nurses and became subjected to the supervision by the latter. Thus, the nurses and the family welfare educators became the informed mainstream community health participants, who attracted a group of other purposeful and interested parties such as the village development committees and the village extension team. The latter comprised school teachers, nurses, family welfare educators and agricultural demonstrators. These disparate groups were under the control of district health teams which were headed by a medical doctor and included other personnel such as health inspector, public health nurse and the social welfare officer. The district health team is responsible for all the health activities in its area. For example, by virtue of its participation in the preventive public health services, it holds regular courses for nurses to equip them for effective participation in the community health services. The Ministry of Health provides a professional guide to all the role players in the community health services by means of a national health policy. The country's guiding policy instrument integrates all the public health services activities and improves the nursing manpower through training, believing as it does, that the real benefits of better health are social rather than financial.

The national health policy is fully cognisant of the nurses' indispensable place, not only in the community health activities but also in the efficient and effective development and management of the nation's public health services. In such circumstances the need to explore and establish what motivates nurses to perform better becomes significant. Nurse Managers require to store in their management repertoire a working knowledge of motivation. In order to transfer or convert their knowledge of motivation into a productive practice, they need a sound background knowledge-base of motivation.

The concept of motivation is a wide area of debate punctuated by a lack of consensus about what motivation causes or does not cause or what it does or does not do to different people, in respect of their performance in a work situation. There are many influences of motivation such as early childhood experiences or family background, level of education and direct work experiences. These background factors comprise a mixture of internal and external causes of motivation, that is, those predisposing factors that arise from inside the individual and those that are provoked or brought about by outside agents such as the workplace. The controversy surrounding the motivation theory has never been completely settled, despite the remarkable progress made in identifying factors that motivate. This is so, not only because there are many types of motivation or approaches to motivation such as biological or physiological, but also because at the centre of the theory lies

the individual or human being who is unique and whose behaviour cannot be captured in a single theory, which was in any case founded and written by other human beings with similar or dissimilar personality traits. This explains why incentive systems based on researched motivation factors have not been always successful in terms of work performance. Maslow's need hierarchy theory and Herzberg's two-factor theory have attempted to explain a person's behaviour in graphic details but have all suffered from the exceptions that are based on or embedded in individual differences.

Motivation is more readily observable in the field of work than in any other aspect of life. It is in the workplace that the interaction between intrinsic and extrinsic motivation takes place. The co-existence of these two types of motivation in one person at the same time has constituted one front of debate. The relationship between these two types of motivation has not been easy to specify. Some theorists such as Geen and others (1984) have pointed out that these two kinds of motivation are exclusive of each other. On the other hand it has been argued that when the two approaches to motivation are added together they enhance motivation to a greater height, although in one direction only than if one operated on its own. Practical situations which have been cited as examples of combining the two grades of motivation include that of some people who earn a good salary but dislike their jobs intensely, whereas others may enjoy their jobs very much even though the pay may be poor. Efforts based on these ideas were used to create jobs that were interesting and challenging or internally rewarding and jobs that were financially remunerative or externally rewarding.

A train of thought that developed later in the 1960s challenged the assumptions expostulated above. It was claimed that these two motivations did not exist in isolation of each other and furthermore they were not additive. It was found that one direct result of empowering extrinsic motivation was to reduce intrinsic motivation with the resultant effect of showing that the two forms of motivation were interdependent. However, the claim of interdependence was clouded by the locus of causality for a person's behaviour, whether this lies outside or inside himself or herself. The basis of the overall motivation can change from intrinsic to extrinsic. For example, if the extrinsic reward is removed, a change from intrinsic to extrinsic motivation can have the after-effect of diminishing the overall motivation. Monetary rewards have been used as external reasons for behaving in this way. But their effect has been questionable and inconclusive. The shift of the locus of causality from intrinsic to extrinsic motivation and the reverse process has also caused some difficulties such as the change in intrinsic motivation when extrinsic rewards are withheld (De Charms, 1968).

The interaction between intrinsic and extrinsic sources of motivation has further relevance in the attitudes or satisfaction towards work. For instance, intrinsic motivation is equated with an individual's decision that he or she performs an act for its own sake. Psychologists and educators tend to agree that intrinsic motivation is a more desirable state than extrinsic motivation, although the reasons for this claim are not often clarified. However, it is argued that the intrinsically-motivated person finds his or her work inherently satisfying.

Both intrinsic and extrinsic motivation has origins in a number of motivational theories. For example, Deci and Ryan (1990) state that motivation is developed from

a set of assumptions surrounding the nature of people and the factors that cause them to act or behave in certain ways. These assumptions are distilled into mechanistic and organismic theories. The former views the behaviour of a human being as a result of a passive interaction between psychological drives and environmental stimuli. The latter theory acknowledges that people have intrinsic needs which drive them to initiate behaviours instead of being reactive to the environment. The dynamics of motivation are extended further by Freud's (1940) psychoanalytic theory, which views individuals as striving to gratify personal needs. The behaviour of people in pursuit of these chosen needs differs in the direction it takes and the intensity with which it is pursued. For instance, hunger motivation is considered as a classical example of how behaviour is governed by the need for food. Thorndike's (1913) law of effect is another way of studying motivation by analysing behaviour. The law describes human behaviour as liable to being motivated by rewards. In other words rewards motivate a positive effect in a human being whereas punishments produce the opposite effect. Atkinson and Feather (1966) have pointed out that rewards represent value for people and individuals work towards attaining them. When individuals are successful at something, they form a mental connection between the act and the reward that followed it and this relationship or motivation produces the expectation that if the act is repeated, it will be rewarded. The basis for motivation, therefore, is the expectation of the consequences of behaviour when that behaviour has value for the person.

McClelland (1992) has argued that some people in society have been born with a given amount of intrinsic motivation which drives them to achieve, while others have to rely on environmental factors to stimulate them towards a goal. For Herzberg (1966), however, motivation is not inborn or endogenous but is manipulated or controlled by people in charge of an environment such as that of work. His two-factor theory of motivation based on maintenance factors such as salary and working conditions and his motivation, in the form of achievement and recognition, are all subject to managerial performance or control. When motivators are satisfied, a person is said to have achieved a sense of personal growth from work. Maslow's (1964) view of motivation is that the latter does not come from one source but from five systems. While Maslow perceives human behaviour to be motivated by a need system, Rogers (1963), occupying a humanist chair of psychology, believes that people are motivated by the demands of social interaction. Both Maslow and Rogers try to explain the field of motivation by specifying the origins of a particular motivational state such as that arising from food deprivation and the restriction of choice, respectively.

The study of motivation is, therefore, flooded with many different schools of thought the examples of which have been given above. The common meeting point of all the motivational theories is that they address the direction of behaviour. All this behaviour is directed towards the satisfaction of needs. Freud (1965) combined the notion of need with the concept of personality and grafted both of them onto motivation and behaviour. For instance, he proclaimed that the energy need for behaviour resides within the *id* personality which is directly responsive to needs. Freud's personality structures such as the *id*, the *ego* and the *super-ego,* therefore played a role in motivation and behaviour. Furthermore the behavioural perspective on motivation grew alongside the learning theory and is closely connected to it. Thorndike (1913), for example, observed that behaviours followed by satisfying rewards were performed better than unrewarded behaviour. This idea served as the

foundation of a cognitive view of motivation and of a model of motivation based on rewards. Cognitive motivation had its origin from Lewin (1951) who expanded the principles of Gestalt psychology into the study of motivation. Gestalt psychologists suggested that individuals organised their precepts into certain patterns of thought. Lewin extrapolated this idea and applied it to motivation by stating that people's patterns of consciousness formed a phenomenal field. Individuals were motivated at all times to bring this field into the greatest possible consistency of organisation. If anything disrupted this pattern tension developed and it was tension in the field that motivated a person to seek a goal that resolved and reduced the tension. One of Lewin's cognitive processes determined the goals with the highest pay off that people were likely to pursue. Thus, this emphasised the conscious and purposive nature of human beheviour driven by motivation.

Like Lewin before them Heider (1988) and Kelly (1989) developed the cognitive approach into an attributions theory of motivation. Attributions in motivation represent the perceived causes for the outcomes of behaviour. For instance, the factors thought to have caused past success and failure contribute significantly to the motivation of future behaviours. While attributional concepts have meaning for motivation because they affect expectations, Maslow's theory of motivation rests its importance on a number of need systems. The distinction between the lower and higher needs provides the basis of his theoretical work on motivation. McGregor (1964) explained further the needs theory of motivation, by relating it to the context of work when he referred to Theory X and Theory Y. Both theories are the antithesis of the other. The former theory proposes that most people shy away from work, while the latter maintains that people are not innately negative towards work but develop an attitude toward it based on their experience which may be positive or negative. Theory Y directs its influence at integrating the individual's goals with those of the institution rather than at the submersion of one by the other. In his synthesis of motivation theories Hamilton observes that because motives are inferred from behaviour, the study of motivation depends very much on the theory of behaviour which itself is guided by the presence or absence of goals in whatever life context.

The origins of the idea of motivation are rooted in the past history. Plato was one of the earliest cognitive psychologists who believed that people's ideas and thoughts were based on the brain selection of attitude and behaviour. Although he did not distinguish sharply between the motivational and the non-motivational determinants of behaviour, other writers such as St Augustine identified them for him. The separation of structural and motivational factors became more explicit with St Augustine and other Christian brothers who replaced Plato's virtue-seeking man with a pleasure-loving one. Rationality which is a logical manipulation of ideas is clearly a structural factor, whereas the resolution to maximise virtue has been seen as a motivational principle. Thus, St Augustine's shadow still falls over people as they praise or more often blame a man or woman for his or her motives. It has been argued further that motives are implied in the fact that all of the people and all of the animals are known to be always busy doing something. To explain their behaviour involves, not so much as checking out their motives as why they insist on doing what they are doing and why after having done so for so long they desist and begin doing something else.

The foregoing analysis has revealed the importance of co-coordinating cognitive theory with motivation. It has also shown, not only how cognition controls action, but

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that cognitive processes have a more direct functional significance for action. For example, it is proposed that the content of the thought of eating an apple instigates the action inclination for the rank activity of wanting to eat. This process of thinking has troubled the attribution theorists who are concerned with the perceptions of casualty or the perceived reasons for a particular event's occurrence. However, what seems to be in no doubt is the fact that the distinction between personal and environmental causes of behaviour is implicit in almost all theories of motivation. Hull (1943) for instance, surmised that behaviour was in part influenced by an independent drive in the form of a person or incentive or by environmental factors. As an example, an instrumental behaviour might be undertaken because a person is hungry, that is, a push motivation or because the goal object is particularly attractive, that is, a pull motivation.

These two types of motivation have been likened to intrinsic and extrinsic motivation. Intrinsic needs differ from extrinsic desires in that they are not based in tissue deficits. They do not push to be satisfied and then disappear into oblivion after this has been done. The two motivational concepts acquire more clarity in the arena of work than in any other aspect of life. People, for example, work for various reasons such as rewards and promotions. Because these variables are under the control of management, they are extrinsic motivators. But the behaviour that originates within the employee herself or himself and is under her or his self control is termed intrinsic. However, most people might engage in a mixture of these motivations for different reasons. Similarly, the interaction of intrinsic and extrinsic motivation constitutes another area of debate. For instance, some people might receive stupendous salaries but dislike their jobs, while others might obtain low wages from their work and yet like their jobs very much. Thus, monetary rewards may be persuasive or forceful in most modern day cultures but there might be many other intrinsic and extrinsic reasons for behaving in an asymmetric way or in some other way. Nevertheless, there are boundary conditions that intervene between the interaction between intrinsic and extrinsic motivation. One of the conditions that resides in the two types of motivations is dissonance. The latter involves experiencing an incompatible state of mind as a result of holding two cognitions that are dissimilar. Thus, dissonance forms the limiting factor between the working of extrinsic and intrinsic motivation. Furthermore, the attribution theory also imposes limitations on the dissonance theory of motivation as the two kinds of motivations make different predictions when the tables are turned. However, the common battleground for all the grades of motivation is the nexus between work performance and motivation.

Lepper *et al.* (1993) have argued that extrinsic rewards could have the effect of distracting people's attention from an activity and thereby lower the gratification they could gain from it. There has also been considerable evidence that factors apart from rewards which have the effect of promoting or reducing intrinsic motivation can affect performance. Furthermore, it has been observed that changes in intrinsic motivation can occur without changes in performance. One of the reasons why performance may not be consistent is the discontinuity or disjuncture between effort, performance and ability. It seems, therefore, that to achieve efficiency of performance depends on a number of factors such as the performance-reward probability as a variable which adds to the employee's motivation. Both the effort-performance and the performance-reward probability are based on the interest of the employee to reach his or her expected level of motivation. The thrust of the manager's job hovers around setting objectives that will motivate employees. But the

problem confronting the manager in assessing job performance is that the latter requires measuring several factors at the same time. Effective performance in a job, therefore, demands demonstrating a systemic sequence of behaviours that produce specific results required by the job. This is done alongside maintaining policies, procedures and conditions of the Institutional environment.

The climate of the work environment created by policies and procedures, for example, may have an impact on the worker's motivation to perform. In a sense, therefore, the proper functioning of employees' motives may be affected by the nature of the work environment. Other conditions such as the culture or the personality of the institution may also have a bearing on the worker's motivation to perform. In addition the job itself may exude certain motivating features such as flexibility, which will aid or enhance its performance. The individual employee's characteristics such as his or her competences, self-image and the possession of a body of knowledge all go towards aiding motivation to perform. From the foregoing it would appear obvious that the work environment on its own does not do all the motivating but only provides a pliable or plastic opportunity for the individual worker's natural motivation traits to flourish or find expression. However, management may create a barrier to an individual worker's expression if his or her motives. Likert (1961) has pointed out that workers feel a sense of responsibility for their work but become frustrated if they are expropriated of the power to control it. Argyris (1971) and McGregor (1964) have rallied behind Likert by questioning whether managerial practices have encouraged self-reliance on the part of employees or strangled it. According to McClelland (1984) the manipulation of the work environment by managers to suit their own purposes was based on their power. He defined power as the ability to require others to behave in ways that satisfied one's purposes. Freud (1940) simply spoke of the managers' pleasure-seeking motives in controlling workers.

What these theorists had in common was the acknowledgement that the dynamics of motives in employment were complex. Gellerman (1963) elucidated further on the complexity by pointing out that everyone has many motives and nobody has the same mixture of them as everybody else. This in effect means that there is no single method of generating motivation to keep morale and productivity high for everyone everywhere. It also means that in employment terms people are motivated to work for different reasons. For example, some individuals may work chiefly for money and others may work because they desire security. There are still others who may go to work for the pure joy of working, whilst some seek employment because they would have nothing to do with themselves if they did not work. It is incumbent upon managers at work who have to exercise authority on workers to realise the diversity of human motives. These differences in motivation arise from different environments in which people were brought up and the life experiences that formed part of their early biographies.

Apart from the diversity of motives, their understanding is also made difficult by the way they organise themselves in an individual. They seem to acquire a structure and to follow a logic of their own which is reminiscent of Maslow's (1943) hierarchy of needs with some motives more powerful than others. However, unlike Maslow's typology, the structure of motives is not fixed. A reshuffling of motives occurs as they replace one another when those that have been satisfied are submerged and others move up the ladder of prominence. Some motives may persist indefinitely if they

represent, for example, a need that was severely frustrated in childhood. But those motives that are diminished or extinguished when enough rewards are given are said to operate as "satisfiers". The motives that cannot be "appeased" behave like Herzberg's (1966) "motivators". They will continue to play a commanding role in an individual's career for a long time despite repeated successes. Motivators are likely to be highly subjective and personalised experiences such as feelings of growth, achievement and significance. Kaplan and Norton (1996) have related them to the mastery of the work environment. In a similar fashion to their diversity the dynamics of motives operate in a rather devious way, making them all the hardest to understand. Moreover, their quality is made deceptive by the masking, the substitution and the maturation processes. Motivation is not, therefore, a particularly simple process and this explains why many schemes for motivating workers such as Scanlon fail to achieve results.

However, despite the apparent inconsistency pervading motives, self-conception remains the core determinant of an individual's motivational system. The individual will behave in a manner which befits the kind of person the individual thinks he or she ought to be. This self-image has its roots in the early part of life. In the adult life the individual may simply be giving chase to the destination of what he or she is going to be or ought to be. The unravelling of motives does not deviate from the planned motivational journey under girded by the self-concept. In a child, for instance, the sense of self-worth is validated and conferred by the positive attitudes of the significant others. This affects the child's willingness or unwillingness to attempt to do things well as opposed to his or her ability to do them well. Thus, a highly capable individual may attempt to do very little because his or her environment is invalidated and he or she may feel unworthy of the rewards that come with achievement. In this way, the negative sense of competence and self-worth will match each other. From this example, the self concept that people bring to work, therefore, is an admixture of many factors. It comprises the self-image that was created by his or her parents, the roles that he or she learned to play competently with his or her peers and his or her record of past successes and failures. The individual's attitude towards his or her work will also be influenced by whether the job allows him or her to be the type of person he or she thinks he or she is.

One way of valuing one's worth at work is the level of the value attached to a given level of income. Income becomes a status symbol by which one compares oneself with others either positively or negatively. The reference groups consist of, for example, neighbours, friends and people with "published" incomes such as government employees. Although the self- concept comes from within the individual, the latter is compelled to compare himself or herself with others because the self-image is affected by the work environment. The situationist theorists such as Brockner (1988), emphasise that the features of the work environment are important determinants of the workers' attitudes and behaviours. An individual worker's preconceptions about his or her work environment influence whether he or she will have an optimistic or a pessimistic attitude towards work. Put in another way, the working behaviour and attitudes of an individual worker are affected by whether or not the working environment is omnipotent, controllable, benevolent or harsh. There can be combinations of possible environmental perceptions. For instance, the individual employee may acquire the capacity to influence events in his or her environment. In other less fortunate situations the events in the work environment may be master over the individual worker. But in any case through his or her own

experience the individual employee comes to regard his or her environment, as possessing a certain potential for providing him or her with things such as rewards that he or she may want. Such expectations of reward may have implications for the individual's motives and behaviour.

For example, the individual who has learned to have high expectations of reward and power will have a dominant achievement motive. The other individual who might have learned to have reward expectations but had less power over his or her environment maybe influenced by the security motive to protect whatever he or she has. Thus, the monetary theories of motivation have failed in their credibility because they tried to generalise the employee's perception of his or her interests. The empirical findings of the Botswana study of the public health services nurses, for instance, showed that nurses were motivated by a variety of interests in their job. The majority of nurses regarded autonomy in the way they organised and conducted their work as an important aspect of their professional life. The freedom to use their initiative and discretion and to participate in decision making in matters directly pertaining to their areas of nursing expertise gave them or created in them a strong sense of responsibility, accountability and commitment. The nurses were further motivated by the participatory supervisory practices which aided and abetted their positive involvement in their job. Enlightened and democratic management policies, was an area of interest in the nurses' practice which enabled them to control their work-environment. The Botswana investigation also revealed that pay was the highest dominator of interest and the strongest motivator in the nurses' working lives. It seemed that pay was linked to the nurses' self-image as well as to the image of the nursing profession itself. Other significant areas of work interests found amongst the nurses include the motivations they received from their interpersonal roles and the learning potential of their present jobs. The positive relationships amongst the nurses and their supervisors motivated nurses to work as a team and it raised their morale. The challenge that the nurses obtained from their present jobs which still contained the potential experience they needed to learn for their future career progression was a source of motivation to the nurses.

A job-seeker, therefore, may look for employment for a number of reasons or while in it may exhibit a variety of interests. He or she may choose a job because it suits his or her interests and psychological advantage. For, instance, the security-conscious individual will search for an employer with a high reputation for paternalism. For the achievement-oriented individual a firm that will rapidly advance him or her to a position of prestige is ideal. Another individual who fears unpredictable changes in his or her salary will choose a job with a steady income-stream. A prospective employer's image, therefore, results from an accumulation by potential individual employees of all kinds of information which they tie together into a loose bundle of impressions. It is these original images which may negate or promote, not only motivation, but also job satisfaction in the course of the chosen employment.

Locke (1976) conceptualised job satisfaction as a positive emotional feeling a person has as a result of the appraisal of his or her job. Thus, to the extent that one's job satisfies his or her values and meets his or her needs, job satisfaction is present. An individual's needs may be physical such as the satisfaction of hunger or may be psychological such as the need for growth or for career progression to higher levels in one's job. It is in the area of psychological needs that motivation and job satisfaction share a strong relationship. In this context according to Seybolt (1993),

they both denote an individual's emotional reactions to a particular job. Related terms such as morale and job involvement only add nuance to motivation and job satisfaction. Job experiences exemplified by motivation and job satisfaction have had a long history since the time of the industrial revolution. Karl Marx was one of the earliest critics of job feelings which were devoid of motivation and job satisfaction. Ironically, however, at this time psychologists were less concerned with motivation and or job satisfaction than with productivity. In management Frederick Taylor (1911) developed further the psychological preoccupation with productivity by selecting the "right workers" for the job and designing the appropriate equipment which led to an increase in production. Taylor's scientific management philosophy assumed that a worker who received high pay and who suffered least fatigue was satisfied and productive.

The Hawthorne studies were the next historical source of workers' reactions to job situations. Masterminded by Elton Mayo, the Hawthorne researchers stressed the importance of the informal group and supervisory practices in job satisfaction and motivating the worker to be productive. The employee's job satisfaction was derived from colleagial relationships and participatory supervisory practices. However, whereas Taylor had emphasised monetary rewards as a source of motivation and job satisfaction, Elton Mayo down-played the role of money. He instead argued that the workers' social relationships were more important than economic calculations. Although the Hawthorne studies failed to conclude that friendly supervision of workers and the presence of job satisfaction led to productivity, they were convinced that human relationships in organisations were the key to job satisfaction. Other subsequent attempts to study the nature and causes of job satisfaction did not start until the 1930's. For example, Hoppock's (1935) survey method to study job satisfaction was a landmark. His results pointed to the existence of a number of factors that affected job satisfaction ranging from fatigue to achievement. After a strenuous discussion of job satisfaction, he concluded that since people were not easily satisfied in a job, they learned to adapt to it. Later fellow writers such as Herzberg, Mausner and Snyderman (1959), conscious of the intricate debate on job satisfaction, changed course and sought to examine the job itself in search of job satisfaction instead of concentrating on numerous factors that impacted on the latter. One way of improving the job and thereby create job satisfaction was to build into it an adequate level of responsibility and discretion in order to enable employees to grow psychologically. Herzberg's (1966) two-factor theory which distinguished motivators from job satisfiers formed the basis for the physical design of jobs which was considered to effect job satisfaction, working together with other variable such as social relationships and participatory supervisory systems.

Notwithstanding the efforts to focus on the job itself as the main source of job satisfaction, the mainstream approach to job satisfaction dominated by a multitude of factors remained pre-eminent. Supporters of this view distilled these factors into three major schools of thought. The first was the physical-economic school which regarded physical working conditions and pay as major job satisfaction milestones. Taylor was a major proponent of this approach. The second was the human relations school whose concern was focused on the role of cohesive work groups and friendly employee management relations. The Hawthorne investigators dominated this school. Finally. the growth school emphasised that job satisfaction was obtained through growth in skill, efficiency, responsibility and mentally-challenging work. The authors of this approach included Herzberg. These historical

schools of thought painted a background on which relevant theories of job satisfaction were mounted. For instance, Maslow's (1943) needs-hierarchy theory claimed that workers were motivated and satisfied by an ordered group of wants ranging from psychological needs such as hunger to personal growth. Maslow's work was the foundation of job enrichment efforts which were developed by other theorists such as Herzberg. Following changes to jobs making them more meaningful, occupational sociologists and industrial psychologists found that attendance records of workers improved. These statistics revealed that motivated and satisfied employees showed fewer days off and fewer physical complaints. Furthermore, they took more responsibility in their jobs. The humanists' theories argued that once job satisfaction was increased as a result of increasing its content, productivity also increased. In the light of modern economics this claim had its appeal. The emphasis upon synchronising the employees' abilities with the demands of their jobs was contributory to both effective institutional functioning and employee adjustment.

Most of the theories of job satisfaction were later condensed into two broad groups represented by content and process theories. Content theories describe factors which influence job satisfaction of which Maslow's needs hierarchy and Herzberg's two-factor theory are examples. Maslow identified five groups of needs. Physiological needs such as food, occupied the first group. The second group was concerned with safety and security needs such as tenure in work. The third division of needs is the affections at work from interpersonal relationships. The recognition and the approval by others formed the fourth category of needs. The fifth hierarchy of needs comprised self-actualization. These needs were set in an order of dominance so that lower needs were satisfied first before the higher-order wants were met. However, Maslow's theory has been criticised on the grounds that there was no evidence that his basket of needs was in fact real. For instance, it has been argued that Maslow had no reason to suppose that a person has a need for self esteem. The lack of acknowledging differences in values between men and women and between different cultures was another criticism of Maslow. Thus, although Maslow's theory may be appealing to common sense there is little solid support for its major claim for a fixed hierarchy of needs which automatically governs action.

Herzberg's two factor theory is closely akin to Maslow's hierarchy of needs theory. For example, Herzberg also referred to a person's physiological needs and psychological growth which were synonymous with Maslow's first and fifth hierarchy of needs or lower-order and higher-order needs, respectively. Herzberg distinguished two set of factors which were involved in job satisfaction. The motivators such as achievement and recognition led to job satisfaction. These corresponded to Maslow's self-autonomy and self-actualization. Herzberg's hygiene factors such as pay and physical working conditions equated Maslow's lower order needs. According to Herzberg hygienes were context factors which did not cause job satisfaction. Like Maslow's, Herzberg's theory was criticised for its dual nature which depicted man or woman as functioning in accordance with two opposite principles. His claim of unilateralism or unidirectionalism in the operation of human needs, as well as the absence of a parallel between a person's needs and the motivator and hygiene factors, was exposed. Herzberg's incident classification system attracted further criticism, particularly his categorization of the "work itself" and "working conditions". Statistical inconsistencies such as basing his results on frequency data alone, coupled with the denial of individual differences among employees as to their

sources of satisfaction and dissatisfaction, troubled Herzberg's critics. Despite some noticeable faults with Herzberg' theory, however, his theory has been accredited as having made a major contribution, in general, to both the human knowledge and to the understanding of the nature of job satisfaction in particular.

Process theories explain the interaction of variables such as expectations and needs which combine with the characteristics of a job to produce job satisfaction. The social reference group theory is one of the process theories which argues that job satisfaction is based on the comparison of one's pay, for example, with what others are getting. Dissatisfaction is, therefore, thought to arise if the comparison is unfavourable. An important part of the social reference theory, also called the equity theory, is that job satisfaction is thought to occur when a person's comparison of his or her inputs and outputs from a job, matches that of others in a similar occupation. However, it is interesting to note that the theory acknowledges that job dissatisfaction may be caused by both over-rewarding and under compensation. Its central ingredient nevertheless, is the ratio between what a person gets from his or her job relative to what he or she puts into it and the comparison with a reference group of his or her own choice. In criticising the theory doubts have been cast over what makes up a reference group. It has been argued that the choice of reference groups is influenced by individuals' personalities. A further argument is that those who are most affected by their reference groups have a low self-esteem. They follow the herd. People with a high-self esteem tend to be more independent in their decisions. Further queries have been raised as to whether people's expectations and their relationship to what the job gives in reality have any connection to the understanding of job satisfaction. Moreover, people differ in what they see and like in a job and this is most likely to affect the extent to which they are satisfied.

The need fulfilment theory is another approach which accounts for job satisfaction in terms of the discrepancy between the individual's needs and what the job offers. Job satisfaction from this perspective is a function of the positive relationship, of the degree to which a person's needs are satisfied in the work situation. The theory has two sub-systems. The discrepancy model of the need fulfilment theory is concerned with the difference between what a person needs and the extent to which the work environment fulfills these needs. The reasoning is that the more the workers want a particular outcome, for instance, more pay, the more dissatisfied they will become with the increasing discrepancy between the desired and the actual amount of that outcome. However, the discrepancy model which is also referred to as the subtractive model, has been criticised for its inability to distinguish between the different shades of meaning of job satisfaction. The multiplicative model which is the second sub-theory of the need fulfilment theory, points out that a person's job satisfaction is a product of the relative importance of the various work-related factors and personal needs. Although this model can actually assign weights for job satisfaction components, its shortfalls are that it does not take into consideration the job satisfaction perceptions of other workers or peer groups in similar situations. The need fulfilment models of job satisfaction, although attractive in logic, have been criticised by writers such as Locke (1976), on the use of the very term "need", arguing that it is what people value, not needs, that is important in job satisfaction.

Most of these theories deal with different dimensions of job satisfaction such as the intrinsic factor, the financial aspect and elements of working conditions. The characteristics of the individual employee in relation to job satisfaction have been

addressed directly or indirectly in all these theories. It has been argued that individuals condition their reactions to different aspects of the work situation. For instance, some persons develop different adaptation levels as a result of the kind of experience acquired in different work situations. This might explain why when people are asked if they are satisfied with their job, they tend to choose response sets which give a socially acceptable answer, giving a positive indication of job satisfaction. The fact that some work situations provide more than one type of reward tends to give a false impression of job satisfaction. This might be so because higher rates of job satisfaction from higher-reward sources, may dwarf lower rates from other less attractive aspects of the job. The inter-relationships between different aspects of the job may also affect job satisfaction. For example, changes in one aspect of a job such as supervision may cause changes in another aspect such as the content of the work thereby affecting job satisfaction. However, no matter how job satisfaction is viewed, it is subject to time changes in its interpretation.

Studies in job satisfaction have been criticised for taking a static view of the latter instead of considering it as a changing variable affected by time changes. For instance, a motivator at one point in time might become a hygiene factor at another period of time. In an institution, as Gruneberg (1979) found out, changes in job satisfaction may be affected by tenure. Gruneberg, for example, found increased job satisfaction with company policy amongst administrators after a period of ten years. He also found that changes in the administrators' interpersonal relationships with other people working in the company were affected by time. Peaks and troughs in job satisfaction were periodised and there was evidence that job satisfaction was subject to an increasing adjustment to the work situation. Thus, Gruneberg (1979) found in a group of clerical workers that job components such as interaction with others, satisfaction with the job itself and institutional policies started with a lower level of job satisfaction but later increased after fifteen years.

However, the relevance of theories of job satisfaction to any given work situation is inconclusive although some theories are more effective than others. For example, it is argued that the two highest rated theories that enhance the understanding of job satisfaction are the subtractive discrepancy model of the need fulfillment theory and the social-reference group theory. The latter's importance lies in the fact that it embraces perceptions of one's peer group. The former's main thrust is on the differing values that people place on the components of their work. Herzberg's theory for instance, is concerned with the difficulties of measuring levels of job satisfaction. All these theories provide valuable information about the expressed needs and concerns of employees. However, the disadvantage of these theories is that they do not reflect the most current developments that have taken place in respect of worker alienation and the redesign of the workplace. Nord (1993) has also pointed out that the job satisfaction perspective built onto these theories fails to take into consideration the hierarchical power system in which most work in the majority of societies is rooted. This criticism is important especially when considering the practical application of this theoretical approach to the various health institutions such as hospitals. An understanding of institutional factors that influences job satisfaction is not always recognised in most of these theories. Consequently, these theories are all based on the theoretical assumption about the existence of human needs and their relation to job satisfaction. Theories of human wants are complex, ranging from Darwin's instincts and drives to Maslow's highest level of human need in the form of self-actualisation.

Many theories of job satisfaction have been haunted by the complexity of determining the most basic requirement of what makes workers happy or unhappy. The earlier studies such as that of Maslow stressed the individual's physiological needs and sidelined the behavioural outcomes. Studies that tried to link job satisfaction with productivity were inconclusive. For example, Brayfield and Crockets (1991) did not find any relationship between satisfaction and job performance in their review of literature. Meanwhile, Vroom (1992) found only a modest correlation between job satisfaction and performance. Recent studies have been more likely to view job satisfaction as the outcome of rewards rather than productivity. In fact a stronger correlation has been found between job satisfaction and absenteeism, turnover rate and accidents, all of which are more likely to be regarded as behavioural variables.

Doubts have now been raised as to whether the right questions have been asked about job satisfaction in the first place. For example, it has been suggested that frustration not job satisfaction causes lower levels of performance. Another observation has been that the conditions, under which negative behaviours occur, may depend upon both the personal and the group characteristics. Furthermore, most of the recent research has examined the role of the institutional factors in determining job satisfaction, with an emphasis that represents a significant shift from the earlier studies. For instance, Bartol (1991) found institutional factors to be significant predictors of labour turnover. Matching employees' work orientation with the nature of their jobs would, therefore, improve worker satisfaction more. However, each theoretical approach to job satisfaction has its usefulness but it is characterised at the same time by its weaknesses and its strengths which negative its attempts to reach a common unifying theory.

Despite these theoretical difficulties of trying to reach a shared job satisfaction orientation, the mainstream theory of job satisfaction remains divided into two basic classes. Firstly, there are the content theories which give an account of the needs, values and expectations which are important in determining individuals' degrees of job satisfaction. The main contributors to this group of theories include Maslow and Herzberg. It is argued that there has been no real evidence to support Maslow's theory in spite of its general allure. Herzberg's theory can be compared to Maslow's need hierarchy in that those factors which cause dissatisfaction when not satisfied represent the lower level needs of Maslow's theory. Similarly, those factors which cause satisfaction when satisfied are comparable to the Maslowian higher order needs. However, as with Maslow, the major problem with Herzberg's theory is the lack of evidence to support it save that from the critical incident technique.

Regardless of the merits or shortfalls of Herzberg's theory, the latter has made great historical contributions in changing the emphasis of job satisfaction away from the "human relations" school's concern with human contacts at work, to the importance of the job itself as crucial to an understanding of job satisfaction. Herzberg has been in the forefront of the movement to redesign jobs in order to create possibilities for individuals' psychological growth. Nevertheless, Herzberg has been criticised for under- rating the importance of individual differences in his understanding of job satisfaction. Collin and Young (2000) have pointed out that simply viewing the job itself purely in terms of opportunities for psychological growth without at the same time looking at the person who is expected to fill the job, whose values are liable to change depending on what he or she desires to be fulfilled in the job, was a

fundamental mistake. However, specifically how the individual interacts with the job is another area of dispute.

The gap left by Herzberg's theory in undervaluing the role played by individual differences in the understanding of job satisfaction, is filled up by the process theories. The latter are the second basic group of job satisfaction theories which emphasize the interaction between the individual's expectations, his or her needs, his or her values and what the job offers, as the source of satisfaction and dissatisfaction. The equity theory within the process theories argues that job satisfaction emerges when the person concerned compares his or her inputs into the job with the subsequent outputs. How the individual compares himself or herself with others comes under the scrutiny of the reference group theories. The latter stress the importance of peer groups in determining what the individual deems to be reasonable to expect from his or her job in respect of rewards and what is reasonable to give in terms of effort. Basically, process theorists such as Vroom (1992) have tried to account for job satisfaction by trying to match individual needs with what the job provides. Two sub-types of the need fulfillment theory within the group of process theories have been singled out for this purpose. These are the subtractive (discrepancy) and the multiplicative models, both of which have shown their limitations. For example, the subtractive model has failed to take account of the importance of different needs, while the multiplicative approach has been unable to distinguish between how much a need is desired and how much of the need is wanted.

However, whatever the limitations and differences of using any theory of job satisfaction, the latter involves the matching of the individual's needs, values and expectations with what the job offers. But in the complex field of job behaviour it is unlikely that any single theory will account for all the phenomena all the time. Different job situations will demand different expectations and values. As Locke (1996) has pointed out, taking all variabilities into account, the field of job satisfaction has not worked out a generally acceptable theory. For example, the empirical results of the Botswana study of the public health services nurses showed varied areas of job satisfaction. Autonomy in the decision-making process, the use of initiative and discretion in the planning, organisation and execution of nursing duties were a source of job satisfaction for a majority of nurses. The ability and the freedom to direct nursing activities, over which they were accountable, created a high sense of self-esteem and a potential source of learning. Another area of job satisfaction found amongst the nurses, involved interpersonal roles and relationships with one another. The team framework within which nurses worked required cooperative professional relationships which fostered high morale on which job satisfaction was based. Combined with the supportive relationships that came from the supervisory practices, the public health services nurses established a strong baseline of job satisfaction from both their interpersonal and supervisory relationships.

The Botswana research also found that nurses were satisfied with certain aspects of their working conditions such as movement from one ward or department to another. This facilitated their learning and acquisition of skills and experience which prepared them for promotion. The latter is a form of recognition or reward for one's contribution to a job or profession. Recognition was regarded by a majority of the Botswana public health services nurses as a source of job satisfaction. Although it was linked to other areas of nurses' concern that also yielded job satisfaction such as

opportunity for further education or training, promotion as a form of recognition attracted more emphasis than other elements of non-monetary rewards. The appraisal system as a form of communication was mentioned by a majority of nurses to be a source of job satisfaction. It was a supervisory instrument that was connected to recognition. Apart from being used to determine how nurses were performing in their jobs, the appraisal carried wider implications in nurses' professional lives such as being awarded a scholarship to go and study abroad. In the nursing job situation, therefore, areas of job satisfaction were not necessarily similar to those of other jobs such as the motor industry because expectations differed. It is these differences which have impeded the formulation of a universal theory of job satisfaction.

Job satisfaction at a commonsense level of thinking seems easy to comprehend because it is associated with the ordinary idea of being happy in life in general. This is so because the areas of work or non-work share many factors which affect satisfaction with life in general. The concept of job satisfaction itself has no single agreed definition. However, the major difference between definitions is in terms of the different ways in which aspects of job satisfaction are combined. Nonetheless, the absence of a universal agreement on the definition of job satisfaction has not discouraged some authors from trying to express impressions in this area. As if definition difficulties were not enough job satisfaction is also entangled with other concepts such as morale. Despite this, however, the concept has not been crowded out as theories on job satisfaction have attempted to show.

Maslow's (1970) theory of job satisfaction ekes out its existence from lower-order and higher-order needs which motivate and satisfy an individual at two different levels. It is these motivations and job satisfactions which lead an individual to behave in a prescribed way in the workplace. Herzberg's (1966) treatise on the two-factor theory of motivation and job satisfaction also refers to motivators and job satisfiers with consequences on an individual's direction of behaviour in pursuance of these factors. Other approaches to job satisfaction such as the process theories focus on the needs, values and expectations that individuals have in respect of their jobs. An example of the process theories is the social reference group theory which considers expectations that a person has about his or her environment as a frame of reference.

However, both the content and the context of process theories have not answered exactly how an individual interacts with his or her job. This failure has left the theory of job satisfaction inconclusive. How job satisfaction and motivation link in an individual to affect performance is a further subject of dispute. One of the reasons for studying both job satisfaction and motivation is that they impact on work performance or productivity and also affect a person's stay in the job and his or her willingness to attend work regularly. Already emerging from this perspective is the fact that motivation and job satisfaction operate in tandem with attitudes. The interchangeability between the terms "job satisfaction and job attitudes" adds a further twist to the lack of consensus on the theory of job satisfaction.

An attitude is an individual's disposition to evaluate an object or a symbol of an object in a particular way. An attitude has two parts, that is, a cognitive aspect which deals with what a person knows about things and an affective part which refers to how a person feels about those things. Thus, one can speak of an attitude in several ways. For instance, one can denote an attitude as a system with a consistent and a

coherent structure. One can also label attitudes as a system which can be learned. Furthermore, one can relate to the direction, the intensity and the centrality of an attitude, that is, how close it is to the person's system of values. An attitude set, the salience and the visibility of an attitude are different ways of viewing an attitude. However, the difficulty surrounding attitudes is that although they refer to a behaviour reality based on a need, they are not necessarily the same as behaviour (Khale, 1984).

For example, in the field of work every individual may feel the need for money to satisfy material needs. Depending on the intensity of the need for money, individuals may display different behaviours. A person who emphasises the need for money in his or her relationship with the other working conditions, for instance, will be attracted more strongly by the offer of a higher salary elsewhere and thereby leave his or her job, in spite of the other working conditions being favourable. This particular individual will be expressing an attitude appropriate to his or her personal values and to his or her concept of being himself or herself. This value-expressive function is only one of the four functions of attitudes identified by Katz (1960) and Terry and Hogg (2000).

A number of theories is used to portray different shades of an attitude. One such example is the theory of cognitive dissonance. As stated by Festinger (1957), one of the theory's propositions claims that inconsistencies between cognitions generate a feeling of cognitive dissonance in the individual. For instance, a person who likes his or her job will experience dissonance if the remuneration he or she obtains from work does not match his or her expectations or fails to meet his or her material needs. The dissonance theory, thus, has a close connection to or with the cause(s) of job dissatisfaction. One way of testing the expectations of a dissonance theory amongst the nurses was to conduct a field research by means of a questionnaire. The responses to the questionnaire revealed not only the attitudes of nurses towards their job but also their feelings in respect of the motivation and the job satisfaction or the lack of them that they derived from their job.

Recent definitions of attitudes straddle theoretical perspectives and place emphasis on social cognition. Some researchers such as Kruglanski (1979) have implicitly stated that cognition has become a significantly unifying force across all the theories on attitudes. For example, the cognitive perspective tries to resolve the debate between an attitude as a predisposition to respond and the view that attitudes never lead to behavioural response. According to Khale (1984) Piaget was one of the earliest exponents of the cognitive function of attitudes who pointed out that the concept facilitated the process of adaptation to one's social environment. Allport (1935) developed further the cognitive approach to attitudes by emphasising its indispensability in the field of social psychology. He identified three components of an attitude. Firstly, he considered an attitude as a state of readiness which enabled a person to perceive things and people around him or her in certain ways. Secondly, attitudes are learned and are organised through experience. Thirdly, attitudes are dynamic with motivational properties to cause a person to seek or to avoid the objects about which they are organised.

Attitudes contain components of beliefs and values. Reece and Brandt (1984) state that attitudes are a state of mind backed up by feelings. They point out that a person acquires many attitudes during his or her lifetime. There are several ways of

acquiring attitudes. For instance, in childhood attitudes are developed by looking and listening. In adulthood attitudes may be attained through a process of identification, cultural imprints and through the experience of reward and punishment. Eiser (1986) states that attitudes refer to feelings or thoughts such as those of like and dislike, approval or disapproval and attraction or repulsion. Such feelings will tend to be reflected in what people say and do and in the way they react to what others say and do. Because attitudes are experiences of some issue or object, people who hold different attitudes towards an object will differ in what they believe is true or false about that object. An attitude, therefore, is a subjective experience involving an evaluation of something or somebody. Eiser argues further that attitude statements are distinguished from other types of descriptive statements, not that they describe different kinds of phenomena, but mainly because they involve a value judgement.

The evaluation of phenomena resulting in value judgement implies that a person is an active perceiver and interpreter of events fundamental to the concept of "cognitive consistency". The latter notion refers to people's predisposition to organise their attitudes and beliefs into some internally consistent structures. There are three types of consistency. Firstly, a person may be observed to consistently perform the same response or set of responses in the presence of a given stimulus object. This stimulus- response consistency may be taken as reflecting an attitude toward an object. However, a definition of this kind fails to distinguish an attitude from other kindred concepts such as habit, trait, drive or motive. Secondly, there may be a degree of consistency between different responses in respect of the same object. That is, instead of the requirement that some response be made with respect to an object, the requirement in this case is that whatever the responses are that are elicited by the object; they should be consistent with one another. This response-response consistency has also been taken as indicative of an attitude toward the object. However, like the stimulus-response consistency, the concept of response-response consistency fails to discriminate between attitude, trait, motive and habit. Thirdly, even in the absence of a stimulus-response or a response-response consistency, a set of behaviours may exhibit evaluative consistency over time. For example, on different occasions a person may perform different behaviours with respect to an object.

Most social investigators agree that an attitude can be described as a learned predisposition to respond in a consistently favourable or unfavourable manner with respect to a given object. However, as Fishbein and Ajzen (1975) point out, consensus on this description of attitude does not eliminate the existing disagreements among attitude researchers but merely serves to obscure the differences by providing a nomenclature with multiple interpretations. Nevertheless, the common intermediary between all the diverse theories on attitude is the mental state. From this, all the various attributes such as emotions, beliefs, cognitions, likes and dislikes are derived. The mainstay ingredients in the concept of attitude, are the theoretical formations that an attitude is acquired through learning and experience in a given environment context.   Allport (1935) goes beyond most other writers on attitudes by proclaiming that attitudes have motivational qualities causing a person to behave in certain ways.

Attempts to explain discriminatory behaviour, for example, have made reference to attitudes, stereotypes and prejudice.   In industry, studies on performance, absenteeism and labour turnover have also referred to attitudes, job satisfaction and

morale.   According to Fishbein and Ajzen (1975) concepts such as attitudes, behavioural intentions and the attribution of disposition have been used to explain a wide variety of interpersonal behaviour.   Many labels, therefore, have been incorporated into the concept of attitude. This has undoubtedly caused ambiguity in the definition of attitude.   The diversity of attitude definitions and the lack of agreement on an explicit meaning of the concept have led most investigators to choose a particular attitude measurement that seems to fit their study. Smith (1976) has observed that an individual's attitudes operate at three levels. Firstly, a person's attitude helps him or her to deal with the material reality through the object-appraisal function.   Secondly, a person deals with social reality through the social adjustment function.   Thirdly, an individual grapples with his or her inner psychological reality through the externalisation function.

Although Smith's functional categorisation of attitudes has contributed to a large part of the many psychological discussions of attitudes, his method is not the only way of treating the subject. Katz's (1960) typology, for instance, attributes four functions to attitudes. The first is the adjustment or the instrument or the utilitarian function which helps the individual to obtain rewards and to avoid punishment in the outer world. This function includes the individual to interact more frequently with those objects that are most likely to continue satisfying him or her. Therefore, with reference to attitudes helping the individual to cope with the real world of reward and punishment, the adjustment function overlaps with both of Smith's object appraisal and social adjustment functions. The second is the ego-defensive function which refers to the ways by which individuals' attributes defend their self-image. The third is the value-expressive function of attitudes through which individuals derive satisfaction from expressing attitudes that are appropriate to their personal values and self-concepts. Although the existence of the need for self-expression is not accepted by all psychologists, it is a prominent characteristic of several theories of personality. For example, the need to establish an individual identity as described by Erickson (1968) and humanistic psychology as well as the need for self-actualisation as described by Maslow (1968), are cases in point. Katz's fourth attitude function is the knowledge function of attitudes which proposes that each individual has a need to give an adequate structure to his or her universe, that is, the need to understand events which impinge directly or indirectly on his or her life.

According to Zimbardo and Leippe (1991), there was a muted acceptance of the fact that attitudes organise people's emotional responses to the outside world. It was also generally recognised that attitudes played an important part in the formation of people's personalities.   However, the greatest controversy over the function of attitudes was centred on their connection to behaviour. The criticism of the attitude-behaviour relationship was sparked off by Lapierre's 1934 study in which wide discrepancies were found between these two kinds of data. Following Lapierre's findings a number of comparisons of human bahaviour and verbal statements was conducted.   For example, Corey (1937) found an insignificant correlation between behaviour and attitudes. However, Wicker's (1969) summary of empirical studies on attitude-behaviour relationships found conflicting results with about 50% of them showing some correlations of more than 40% between attitude and behaviour. Ajzen (1988) has pointed out that the failure to account completely for the occurrence of behaviour was unsurprising. This was because researchers had used inappropriate measures of either attitudes or behaviour or both. They had also held inappropriate

expectations about the expression of attitudes on given kinds of behaviours or had overemphasised the effect of a particular set of attitudes on given kinds of behaviour.

Therefore, to study the relationship between attitudes and behaviour one needs to be sure whether one is studying one or the other. Behaviour, for instance, is reasonably easy to identify although behavioural measures might not be accurate. Attitudes are not directly observable and since they can only be assessed through behavioural expressions, it may be doubtful as to whether or not one is correlating an attitude with bahaviour, or one behaviour with another. One might ask further questions. For example, one might want to know whether one's measure of attitudes and behaviour is set at the same level of difficulty. Furthermore, one might also wonder whether the measurement techniques of attitude-behaviour relationships were accurate. Apart from the connection between attitudes and behaviour the learning process involved in connecting the two variables is an essential aspect of their relationship. People may fail to learn behaviours which would appropriately express their attitudes. Ehlrich (1999) has pointed out that the existence of many institutions and techniques designed to teach people how to behave in a way compatible with their attitudes is evidence of the need to learn such behaviours. If attitudes have no access to appropriate behaviours they may exist for a long time without any observable behavioural expression. Ajzen (1991) has argued that sometimes researchers hold wrong expectations about the expression of attitudes in certain behaviours when there are no means to cause them to express or to activate themselves in a given behaviour. This has often generated an attitude-behaviour controversy.

There are many other factors that may affect the attitude-behaviour relationship. For example, the importance of social norms in the public and private expressions of attitude-related behaviour was found to be overwhelming in the Minard's (1952) study of coal miners. The attitude-behaviour consistency can also be affected by values, competing motives and personality characteristics. For instance, an extroverted person may be more likely than an introvert to express any attitude into a publicly observable behaviour. Similarly, an authoritarian may wait for commands or orders from above before he or she can express his or her own attitude in a behaviour form. Furthermore, a manic-depressive person may express an attitude in many different behavioural forms on some days and hardly any at other times. In addition to these different personality characteristics some people may acquire particular habit patterns that direct them to express only a practised set of the attitude-behaviour relationship. For example, the desk clerk in the La Pierre's study could only resort to a set of habits associated with the performance of his job when confronted by foreign customers. This involved smiling at each potential customer and presenting the hotel register for signature. Triandis (1971) defined habit as a pattern of learned behaviour with no pronounced emotional component. A behavioural expression of attitudes may also be constrained by the individual's environmental circumstances. Ajzen (1991) gave the example of a letter-press printing enthusiast who discovered where he could buy printing equipment but learned that he had no money to buy the essential machine. His lack of printing behaviour could be ascribed to environmental constraints rather than to an inconsistency between attitudes and behaviour.

Thus, although attitudes may remain an important part of the inner self, they are poor predictions of behaviour. They are reflected only weakly and inaccurately by a person's external behaviour. It is acknowledged that only the most powerful attitudes are likely to find their way towards expression. However, in general terms,

behaviours may show little of significance about a person's attitudes. Instead behaviours may reveal a person's perception of his or her social norms, incentives, environmental constrains and other important influences on overt behaviour such as beliefs. In view of these uncertainties Ajzen (1988) has argued that if an investigator wishes to know about an individual's attitudes and their importance to that individual, he or she may basically need to ask the particular individual what the individual's attitudes are. This may in the process require ignoring that individual's gross behaviour patterns. This would fit in with the observation that people's behaviours do not closely match their attitudes. According to Khale (1984) by questioning the individual about his or her attitudes, the researcher is in effect probing the thoughts of the individual. It is these thoughts and emotions which form a pointer to the understanding of the directions of attitudes. Whether or not a person correctly perceives his or her environment, it is his or her perceptions and the relationships amongst them that dictate what or which attitudes will be demonstrated. Because the analysis of attitudes involves a number of variables, theories are useful instruments in organising the multitude of these factors into a systematic whole.

Like any other area of study the field of attitudes abounds with many theories. Most of the contemporary attitude theories originated from two major schools of thought. Firstly, there are various learning theories of attitude which are based on the stimulus-response approach of the behaviour theory. Secondly, theories of cognitive consistency are another large group which is influenced by the cognitive approach. Therefore, a distinction is often made between behaviour theories of attitude and cognitive consistency theories which blurs the difference between a theory's origin and the phenomena it deals with. Because of this difficulty Olson and Zanna (1993) have suggested that the distinction between behaviour and consistency theories be replaced by a more unified theoretical presentation.

However, according to Fishbein and Ajzen (1975) learning theories are dominated by two basic paradigms, that is, classical and operant or instrumental conditioning. The principles of conditioning involve an unconditioned stimulus (ucs) which elicits automatically without previous learning one or more overt unconditioned responses (ucr). The classical conditioning paradigm begins with an unconditioned stimulus that is always followed by some characteristic unconditioned response. Classical conditioning theory is also known as respondent or Pavlovian conditioning. The theory depends on repeatedly pairing an eliciting or unconditioned stimulus which is capable of producing some desired response with an originally neutral stimulus which cannot initially produce the desired response. This eventually leads to the originally neutral stimulus becoming a conditioned stimulus which is capable of producing the desired response. For instance, Pavlov who invented the theory paired a bell (neutral stimulus) with a meat powder (unconditioned stimulus) when eliciting saliva from his guinea-pig or experimental dogs (desired response). Eventually, the bell (now conditioned stimulus) elicited salivation even in the absence of meat powder.

Khale (1984) defined attitude as a learned implicit anticipatory response. He viewed attitude as an unobservable response to an object that occurs prior to or in the absence of any overt response. The implicit mediating response represents the meaning of the object and attitude refers only to the evaluative part of the total meaning response. Most learning theories of attitude are concerned with the ways in which attitudes are acquired. They focus on how implicit or evaluative responses become associated with a given stimulus object. For example, the stimulation

involved in a child who has frequently eaten McDonald burger produces, for instance, overt responses such as suckling, salivating and swallowing. Additionally, an implicit response with a positive evaluative component has occurred prior to or in conjunction with the overt response. According to the mediational conditioning principle, there will be a tendency for this implicit response to become associated with the burger itself, that is, the child develops a favourable attitude toward the burger. Once this association has been learned, any other stimulus frequently paired with the burger, will also tend to elicit the positive mediating response. Thus, Fishbein and Azjen (1975) argued that according to the principle of conditioning, if the burger is always given by the child's uncle, a positive attitude toward the uncle should develop.

In contrast to classical conditioning, operant conditioning or trial and error learning or instrumental or Skinnerian conditioning, is a more free-form theory in which the organism initially emits many different responses. One of these responses is reinforced, which means that the response is instrumental to obtaining some reward or avoiding some punishment. The chance of the re-occurrence of the reinforced response increases with each reinforced trial and the response is said to be learned when it occurs with high probability. For example, a mother gives her child a piece of chocolate every time the child picks up his or her toys but not when he or she cries or demands it by throwing objects at the mother. The reinforcer (chocolate) will thus strengthen the response and the child will learn to pick up his or her toys. Instrumental conditioning is influenced by factors such as the frequency of reinforcement, the temporal relation between the response and the reinforcement schedules of reinforcement and the magnitude of the reinforcer. When a given response reduces the drive state by leading to an appropriate reward or by enabling the organism to avoid punishment, the response is said to be reinforced and the reward is known as the reinforcer. There are two kinds of reinforcers. Primary reinforcers are rewards that are unlearned reducers of drive states such as food and water. Secondary reinforcers were previous neutral stimuli which acquired reinforcement properties because they had been associated with primary reinforcers. Just as a conditioned stimulus (cs) elicits an unconditioned response (ucr), a stimulus that is repeatedly paired with a reward will take on some of the reinforcing properties of the reward itself.

In operant conditioning, therefore, the experimenter waits until a targeted response is freely emitted by the subject before he or she reinforces the response if an increase in the response frequency is desired or punishes the behaviour if a decrease in the response frequency is preferred. The subject's behaviour is eventually shaped to the point that he or she learns to behave appropriately although Khale (1948) has raised doubts as to whether the shaping involves attitudes. Furthermore, Tolman (1948) wrote that people also learned "expectations" which are beliefs that a given response will be followed by some event. Since "events" could be either positive or negative "reinforcers" or could have positive or negative valence, Fishbein and Azjen (1975) developed the argument that people would learn to perform or increase their probability of performing behaviour especially in the light of positively valenced events.

Fishbein and Azjen's reasoning ushers in the beginning of the cognitive consistency theories which, unlike the learning theories which rely on the stimulus-response approach to behaviour, are based on a cognitive approach. One of the cognitive consistency theories is the expectancy-value theory whose best representative is the

subjective expected utility (seu) model of behavioural decision theory. According to the latter the more an action or policy is instrumental to obtaining positively-valued goals and preventing negatively-valued ones, the more favourable is the person's attitude toward the object. Katz (1960) has pointed out that attitudes permit the individual to achieve certain goals or values. For example, attitudes allow the individual to organise knowledge, to maintain self-esteem and to express his or her views. In Rosenberg's (1965) view, these consistency theories derive their origin from Heider's (1958) principle of balance. Heider concluded that if the attitudes toward a person and event are similar, the event is easily ascribed to the person. He further explained that a balanced configuration exists if the attitudes toward the parts of a causal unit are similar. In other words a balanced state exists when the two entities composing a unit have the same dynamic character. Furthermore, equilibrium occurs when the person's attitudes or sentiments compared to the two entities are either positive or negative. Fishbein and Ajzen (1975) have argued that it is of interest to note that within the balance theory inconsistency may exist between two beliefs and two attitudes or between a belief and an attitude. However, the consistency theory that has attracted most attention is the dissonance theory which may be viewed as dealing only with the inconsistency between beliefs or between attitudes.

The cognitive dissonance theory is not limited to attitudinal consistency or to attitudes-behaviour consistency but has also exerted influence on research and theoretical discussions. In its pure form it proposed that human beings will strive to maintain consistency or consonance among any cognitions that they perceive to be related to one another in any way. Cognitions in this sense refer to the things that a person knows about himself or herself, about his or her behaviour, or about his or her surroundings. Therefore, a person is assumed to look for consistency between the knowledge that he or she holds and his or her attitude toward an object. A person is also thought to search for consistency between his or her knowledge and his or her particular behaviour toward the object. Consistency prevails between a person's knowledge that the object possesses certain characteristics and his or her knowledge based on his or her value system that these characteristics are good or bad. Festinger's (1957) early writing on the consistency theory made four original propositions. Firstly, he suggested that inconsistencies between cognitions generate a feeling of dissonance in the individual. The individual experiences a particular kind of feeling as a consequence of perceiving such an inconsistency. That psychological state is called dissonance. Secondly, the individual experiences dissonance as unpleasant and he or she is, therefore, motivated to reduce or avoid it. Festinger compares cognitive dissonance to hunger and other states of physical tension and assumes that the individual responds to dissonance as he or she would ordinarily do to hunger by seeking to terminate the state.

Thirdly, the intensity of the motive to reduce dissonance is dependent upon the total amount of dissonance experienced which is in turn dependent upon various quantitative relationships between cognitions. For any two inconsistent cognitions considered together, the amount of dissonance generated will depend on the importance of the cognitions. The more important they both are the greater the dissonance. The total amount of dissonance an individual experiences at any one time will be dependent upon the number of dissonant relations he or she feels in proportion to the number of consonant or consistent relations he or she perceives. Fourthly, when dissonance is present, the person in addition to trying to reduce it will

also actively avoid situations and information which would be likely to increase the dissonance. In a sense the hypothesis asserts that the person will seek information consonant with his or her attitudes and other cognitions, as well as avoid dissonant information.

Festinger's theory of cognitive dissonance distils into relations between two basic cognitive elements. Firstly, the theory refers to the things that a person knows about himself or herself or about his or her behaviour. Secondly, it refers to the person's surroundings. Three terms, that is, dissonance, consonance and irrelevance are used to describe three kinds of relations that may exist between any two cognitive elements. For example, two elements such as "I know I smoke" and "I know smoking causes cancer" are in a dissonant relation because the obverse of one element follows from the other. However, if either one follows from the other when considering a pair of elements, then the relationship between them is consonant. For instance, if "I know I smoke" follows from the element "I know I enjoy smoking", then the two elements are agreeable. An irrelevant relation is demonstrated by the two elements "I know I smoke" and "I know Susan is my sister". Festinger describes four basic situations that give rise to cognitive dissonance such as decision-making, forced compliance, voluntary and involuntary exposure to dissonant information and disagreement with other persons. For example, whenever a person makes a choice between two or more alternatives, dissonance is assumed to exist. The knowledge that the unchosen alternative has unfavorable aspects is dissonant with both the person's knowledge and with his or her choice. The theory in this situation claims that either increasing one's evaluation of the chosen alternative or decreasing one's evaluation of the chosen alternative or decreasing one's assessment of the unchosen alternatives may reduce dissonance. The amount of change will be related to the magnitude of dissonance involved. In a forced compliance situation, an individual is induced to perform a behaviour that is inconsistent with his or her beliefs or attitudes. For example, a prisoner of war may be subjected to threat of punishment if he or she does not comply with certain orders.

Festinger's theory deals with the organisation and dynamics of the cognitive system. The latter is blank at birth but progressively develops as new cognitive elements add on accumulatively to previously acquired ones. Any knowledge, opinion or belief about the environment, about oneself or about one's behaviour, can be defined as a cognitive element. The adding of new elements to the cognitive system is not a simple accumulative process but an integration of cognitions. Each cognitive element is said to establish a dynamic relation with some elements of the pre-existing system. The dynamic relation between two cognitive elements is said to be either constant or dissonant. The strength of the pressure to reduce the dissonance is a direct function of the magnitude or intensity of the dissonance. From the definitions of dissonant and consonant relations, it follows that dissonance reduction ultimately depends on a change in the cognitive system. Some theorists such as Freedman (1965) who believe in the utility of dissonant information, pointed out that there is a tendency to prefer consonant information although there is little indication that people make an effort to avoid dissonant information. Other writers such as Sears (1968) argue for a preference for dissonant information when it might be useful in coping with reality, for instance, a desire to locate a dentist's surgery. Dissonance theorists acknowledge that dissonant knowledge may sometimes be useful and may, therefore, be sought rather than avoided. Festinger himself has admitted that the existence of dissonance is after all one among many determinants of behaviour.

Consequently, it is not surprising that sometimes these other factors override the effects of pressure to reduce dissonance.

The main import of the attitude theories of which the dissonance theory is part, is to expose the variety of shades of meaning in the concept of attitude. The measurement of attitude is a further development, not only in quantifying attitudes toward a given object, but also in lending cogency and credence to the notion of attitude itself. Although attempts at measuring attitudes have not been perfected, accurate scales of measurement have acquired practical useful proportions. The most widely used techniques of attitude measurement include the Thurstone method, the Likert scaling and the Semantic differential which according to Ajzen (1991) have attracted a fair share of attention. In the majority of the applications of the Thurstone and Likert techniques, the measurement of an attitude's affective aspects is emphasised although the cognitive and conative (desire to perform an action) qualities are often intermixed with the affective judgement. The Semantic differential generally separates the affective from the conative aspects of an attitude. The affective features of attitudes have captured the researchers' greatest interest. They have also been useful to the average individual who wants to know first whether something is good or bad before he or she has anything to do with it. However, the individual's beliefs about an object's potency, activity or other dimensions of meaning may also be crucial to his or her overall attitude or behaviour toward an object.

Attitude measurement in nursing would serve a multiplicity of purposes such as assessing nurses' attitude inclinations towards many dimensions of their job. For example, the measurement of attitude in differing aspects of their working conditions such as salary, promotion, supervisory practices and autonomy in decision-making, *inter alia*, may help management to plan for motivation, job satisfaction and productive attitude-orientation towards work. The image of nursing as perceived by the nurses themselves is a testing ground for nurses' attitudes towards their own profession. How nurses define nursing and their expectancy-value system of nursing goes a long way towards their job performance and commitment to the goals of the profession.

The promotion of the image of nursing is not only done by the nurses themselves but by a variety of other agencies. For example, Brown and Stone (1971) suggested ways of improving the nurses' attitudes by correcting the poor image of nursing. They challenged the media to portray nursing in a more positive light. The authors recommended the improvement of the physician-nurse relationships in the hospitals. They also reminded the health care institutions of the need to evaluate the nurses' compensation packages. All these measures were designed to create a more positive attitude amongst the nurses. Strassen (1992) has pointed out that the poor level of pay has engendered negative attitudes amongst the nurses forcing them to leave nursing. Inadequate pay has also negatively impacted on the image of the nursing profession as well as that of the nurses. According to Strassen's self-image model for the nursing profession, the nurses' thoughts and beliefs determine their self-image. The latter in turn determines the nurse's actions, performance and achievements. Each nurse's actions and achievements later affect the collective image of professional nursing. The model, therefore, recommends that changing the thoughts and beliefs of the individual nurses will in turn determine their self-image and subsequently their actions and performance. Brockner (1988) has claimed that the self-image itself influences behaviour and performance in the workplace by

affecting the way one thinks, acts and uses one's work role to enhance, preserve or develop one's self-esteem. To this extent, therefore, self-image can be said to be related to a job-performance-satisfaction relationship. If self-esteem is equated to an attitude or part thereof, Brokner concluded that high self-esteem was directly and positively correlated with high job performance. Comparatively, therefore, nurses with high self-esteem or positive attitudes towards their work, are likely to be more productive than their counterparts with low self-esteem.

Deriving from such background factors affecting work attitudes are two seemingly conflicting images of nursing. The first describes a nurse as attributed with a humanitarian and altruistic attitude, full of sympathy and compassion and possessing outstanding capacities in creating rapport with patients. The second is the image of a nurse, displaying the attitude of a well-trained and technically efficient professional who is relatively independent of the feeling components. The attitudes, images and self-esteem that entrants into the nursing profession bring with them are the fertile ground for these nursing images and for the subsequent negative or positive manifestations of performance in the workplace. Self-image or self-concepts as an attitudinal orientation is based on or develops from a process of socialisation. The latter fosters, amongst other things, a strong commitment to relationships with others and promotes a high self-esteem which measures how much one likes and approves of one's self-image and influences behaviour. Behavioural traits are part of the attitude-behaviour relationship. They are learned patterns of behavior which are by-products of socialisation.

Kelly (1989) has used the socialisation process to explain the attitude of nurses in hospitals towards medical doctors. Kelly has argued that because nurses are socialised or attitude-trained before they join nursing, the difficulties experienced in the relationship between nurses and medical doctors and the dominance of the former by the latter can be ascribed to the nurses' socialised inferior attitude. Such deleterious effects of socialisation claimed their largest toll on female nurses. Since the latter are the most numerous group in the nursing profession, the iniquitous impact of socialisation's negative effects, have been easy to observe. Thus, if gender and traditional socialisation were combined, the characteristics of a typical female nurse, befitting a typical image of nursing, would emerge. For example, good nurses always consider the patients' and physicians' needs before their own. Good nurses follow policies and procedures and never take short-cuts or become innovative. Good nurses always follow directions from senior nurses rather than think for themselves. Other negative attitude stereotypes used to portray female nurses include describing them as women in white, who represent virtue, purity and virginity. Nurses have also been described as handmaids for the physicians in hospitals.

The Botswana nurses, for example, have tried to unshackle these negative images and attitudes by conducting empirical investigations amongst the nurses themselves. Their studies have covered a few areas of the nurses' job concerns. For instance, Mothobi's (1981) study revealed that nurses' attitudes towards their patients remained positive despite their dissatisfactions with other areas of their job. Motlhasedi (1982) established that the main causes of nurses' job dissatisfaction were harsh working conditions and poor interpersonal relationships between nurses and their supervisors. Mabuse's (1982) findings about nurses' attitudes over autonomy and participative decision-making indicated that they were not accorded

sufficient authority and independence in their nursing spheres. Nurses' attitudes over working in remote areas were studied by Tapela (1983) who found that they were unhappy with the government's transfer system. The research by Mannathoko (1985) into the nurses' attitudes over stress and burnout confirmed that the complaints were caused by pressure from work as a result of excessive workload. In 1986 Ramatebele's investigation of the nurses' attitudes over patient care confirmed the results of Mothobi's earlier study. Rampa's two studies on job satisfaction in Botswana hospitals in 1991 and 2000 discovered that the majority of nurses were dissatisfied with pay, clerical duties and lack of autonomy in decision-making, amongst other negative attitudes. Following in the footsteps of Mothobi (1981) and Ramatebele (1986), Tumuhla's (1994) study of nurses' attitudes towards the nursing care of their patients also yielded positive results. Phalaze (1995) replicated the previous study by Mabuse (1982) with similar findings. Otimile (1995) summarised that most of the nurses' complaints about their job came from certain elements in their working conditions such as heavy workloads caused by staff shortages.

Whereas the previous Botswana studies on nurses chose their research topics at random, the present study examined nurses' attitudes only as one of two other variables, namely, motivation and job satisfaction. However, some areas of attitude study in the present empirical investigation show both similar and dissimilar results from those of the earlier findings. For example, contrary to the previous studies' findings in the area of autonomy in decision-making and participation and control, the present study revealed a different picture. The supervisory practices were found to be so democratised and liberated that nurses had gained sufficient leeway over the years to be independent and to make autonomous decisions in nursing areas under their control. Thus, the attitudes of both the nursing supervisors and the nurses had changed in a positive way. The nurses had become more assertive in the exercise of their roles. The ability to run the nursing affairs that fell under their purview was an extension of their freedom in selecting the field of nursing they wished to practise at the beginning of their nursing careers, as shown in tables 6 to 10 of chapter 6. As in the past studies of Mothobi (1981), Ramatebele (1986) and Tumuhla (1994), the results of the current research confirmed that nurses' attitudes in respect of patients' care remained steadfastly positive. Thus, both the present research findings and the past results in this aspect of the nurses' job showed a progressive professional trend of attitude in the commitment to the care of patients. Nurses had not, inspite of distractions caused by dissatisfactions in certain areas of their job, lost sight of the central objective in nursing. The dissatisfactions and negative attitudes of nurses over pay, found by Rampa (1991 and 2000), were also substantiated to the same degree of negativism, if not worse, in the current study, as shown in tables 14 and 16 of chapter 6. The call for higher pay was more reinforced in the present findings than before. Nurses' negative attitudes towards pay seem to have hardened during the passage of time, exacerbated by the government's unyielding attitude over granting concessions related to increases in pay.

The present study's findings regarding nurses' attitudes over a number of working conditions were a mixed bag. For instance, the majority of nurses did not like working conditions such as pay, workload and staff shortages. There was congruence between the past results and the current study's findings that the majority of nurses showed a negative attitude towards the government's transfer policy. Nurses' attitudes over interpersonal relationships amongst themselves and between them and their nursing supervisors were found to be positive in the present

study. However, the cumulative effects of the nurses' negative attitudes over most of the working conditions in the present study were shown in their unwillingness to reach a retiral age in nursing. However, the depth of the nurses' attitudes, not only towards their work, but also towards motivation and job satisfaction in the workplace, is given more detail in the chapter on empirical findings.

The biographical data of the Botswana public health services nurses were characterised by almost an equal number of both married and unmarried nurses in the sample most of whom were women. The majority of the married nurses was older and had more children than the younger nurses of below thirty-five years of age. The combination of being married and having more children and possibly of longer tenure in the nursing job implied different financial requirements in respect of pay and other recognitions at work such as promotion. Tables 1 to 4 in chapter six provide statistical evidence for various interpretations. The total percentage of nurses who had children was high at 89.3%. This was evidence that both the married and single nurses had children and their economic expectations, therefore, particularly in terms of pay, were likely to be the same. The majority of the nurses' children were over ten years of age, followed by those aged five to nine years. The older group of children was likely to have started school which tended to increase the nurses' economic burden as they were expected by the government to contribute towards the education of their children. The more children in school or out of school nurses had, the more financial pressures they felt. It was, therefore, the marital status or the lack of it, number of years in service on the part of older nurses, the number of nurses with children, the age of the latter and other expectations from employment such as the duty of care by the employer, that created a background scene of parameters that had a direct or indirect influence on the nurses' attitudes, motivation and job satisfaction.

Under the participation and control group of variables, the majority of nurses chose to practise their nursing in the clinics, medical and surgical wards. They were permitted to exercise choice. They took part in the decision-making process regarding professional areas of interest. Participation in a decision-making process, according to Vroom (1964), constitutes the first step towards motivation, job satisfaction and the favourable change of attitude towards an employee's job. The public health services nurses, as shown in tables 6, 7 and 8 of chapter six, were also given the freedom to choose the way they preferred to perform their duties in their clinics or wards. The pride that came from being consulted about one's nursing preferences and the liberty to decide on how to go about doing one's job were motivational instruments that ensured job satisfaction and encouraged positive attitudes towards the nurses' job. There is also clear evidence in tables 9 and 10 of chapter six that the majority of nurses exercised initiative and discretion in the execution of their duties without interference or directions from their supervisors. In other words, they were able to set or decide on targets and prioritise their nursing responsibilities, as they themselves, using their own professional judgement saw fit. The nursing environment is full of many activities such as the provision of care to patients, observations and treatment strategies or regimes, writing reports, administration of drugs, amongst others, which when carried out under the active participation and control of the nurses themselves, provides a strong base for job satisfaction, motivation and productive attitudes.

However, despite the autonomous control of their work environment, the majority of nurses worked under a long-standing pressure from their job which was caused by staff shortages. Tables 11 and 12 of chapter six trace the source of pressure from the work itself which was done by fewer hands. The urgency in trying to complete an increased number of duties in a given shift schedule for prolonged periods caused stress and burnout in nurses. It also compromised the standards of quality care, putting both patients and staff at risk. The nurses were sustained fortunately by the control of their work environment and other job satisfactions such as enjoying the job they were doing for its own sake. Under the personal satisfaction and interpersonal roles variables, the majority of nurses liked the kind of work in which they were involved in their chosen wards and clinics. They were not only satisfied with the nature of the work they did but they were also motivated by the thought that this was what they wanted to do. Their attitudes were oriented towards making the best out of their choices which defined the territorial boundaries of their anticipated future professional progression. As most of the nurses' work was done, not single-handedly, but within an atmosphere of team or collaborative working, good relationships were a facilitative necessity. Tables 18 to 20 in chapter six confirm harmonious collaborations at three levels.

Firstly, 79.3% majority of nurses showed a liking for their work colleagues or the other fellow nurses they worked with. This favourable tendency was germane to the demands of a "hands-on" nursing job. Working in a ward or clinic on a shift system, conscious of the fact they depended on one another for the continuity of care and other nursing duties, added a sense of purpose to the nurses' motivation and job satisfaction. It also continuously renewed their motivated attitudes to keep on working in the adversity of irreducible workloads. Secondly, another source of nourishment to the nurses' liking of their job was the relationship between them and their supervisors or senior nurses. The weak 42.2% majority of nurses who said that they related well with their supervisors was slightly higher than the percentage of nurses who reported that they sometimes showed a similar kind of relationship to their supervisors. As the public health services nurses controlled their work situation, the role of the supervisors was reduced to maintaining protocols and policies. The practical achievement of nursing goals was, therefore, in the hands of the nurses themselves. This weight of professional responsibility, not only raised the nurses' self-esteem and development or sharpened their skills, but also stored the potential motivational force designed for future higher positions. Thirdly, although the majority of 52.6% of nurses was happy with the knowledge that senior nurses mixed well with them, this had no significant consequence with regards to how the nurses worked, save the satisfaction and motivation that they worked under the full glare of their seniors who shared the same nursing platform with them. This recognition, however, gave their attitudes a positive shape towards their work. In general these corporative and interactive multilevel interpersonal relationships cushioned nurses from some of the unsavoury aspects of their job such as low salaries.

Most of the public health services nurses (92.2%) were not satisfied with pay. This was singularly the most dissatisfying and demotivating aspect of their job that plummeted their attitudes. The low level of pay had been a subject of complaint to the government for many years without resolution. Most of the nurses had school-going children and found it difficult to balance their domestic budgets against the economic demands of both household and school expenditures. Although nurses were short on capital, they were not short on burn-out as their amount of work was

increased due to the reduced number of nurses. Thus, they were forced to work under pressure due to circumstances beyond their control. It was in the light of this discrepancy that a majority of 85.8% of the nurses complained that there was no relationship between what they earned and the amount of work they did. The public health services nurses found themselves stretched to the limit for a miserable pay and with little, if any, probability by the government of improving the situation by increasing staffing levels, either in the immediate or distant future. As if to catch up with their losses in salaries over a considerable period, the majority of 42.8% of nurses proposed pay increases of over 40%. Over and above remunerative considerations, the nurses' terms and conditions of service included other benefits such as staff accommodation and transport, especially for nurses on a late shift finishing at 2100 hours when public means of traveling had ceased from operating. Even on such fringe benefits the level of nurses' dissatisfaction was high as expressed by the majority of 88% who thought that the government did not care enough. The compound picture contained in tables 14 to 17 of chapter six is that of the public health services nurses who found it difficult to maintain active work attitudes in the face of such dissatisfaction and lack of motivation. The poor image of nurses exposed by low wages and associated benefits which formed part of their working conditions, opened or initiated curiosity over the whole package of working conditions.

Working conditions in the public health services are the centre of the nurses' working life. They are part of the psychological advantage of why they chose nursing against other competing job opportunities. These working conditions permeate almost all the aspects of the nurses' working life and they are also connected to their general life situation. It is this linkage to the general life circumstances that makes them the make or break point for the nurses. They are a measure of attraction for recruitment purposes, for example. Their content or context such as the benefits they offer to the nurses, determine the status or standing of the latter in the community. On the negative side of the work balance sheet, they may be a source of poor work performance, low productivity, declining quality of health services and many other things that can go wrong when workers are not happy with the work environment. Tables 21 to 26 in chapter six, paint a portrait of the nurses' attitude towards their working conditions. The 67.3% majority of the public health services nurses voted with their feet against their working conditions. They responded that in general they did not like the working conditions of their job. Only 14.5% of the nurses liked such terms and conditions of their work, with 18.2% of the other nurses saying that they sometimes did so. Within that generalised dislike of the working conditions, there were stronger feelings of dissatisfaction towards some as against others. But the general imprecations against the working conditions were clear and evident in the ears of the nurse managers.

There were four working conditions that the public health services nurses particularly disliked. Firstly, the biggest majority of 67.2% of the nurses particularly disliked low pay. Secondly, another majority of 65% of the nurses particularly disliked workload. Thirdly, some 44.4% of the nurses indicated that they particularly disliked the slow or sometimes the lack of promotion in their job. Fourthly, the particular dislike about their job stated by 42.6% of the nurses was the lack of recognition. According to the nurses' complaints, if promotion did come eventually, it would take five to ten years of waiting. For some nurses promotion represented their understanding of recognition. For others, although promotion was a form of recognition, they did not wish to wait for

promotion to be recognised. Promotion to them was the ultimate point or a reflection of the recognition of their nursing achievements which should have been recognised at every occurrence in their nursing career. There were other working conditions disliked by nurses. For example, the majority (69.1%) of the public health services nurses disliked the shortage of staff. It will be remembered that the latter was related to workload in that fewer nurses had to undertake an increased number of duties. The lack of opportunity for further education or training was another working condition disliked by 57.8% of the nurses. More than half (51.9%) of the nurses disliked the lack of accommodation. The acute shortage of housing in cities and towns where larger health services facilities such as referral hospitals are located and requiring larger settlements of nurses had not been addressed sufficiently by the government. The transfer system which required nurses to leave their jobs in towns to go and spend 2 to 3 years in remote areas was one of the working conditions disliked by 37.3% of the nurses. The lack of transport for nurses which affected a small group of nurses who work-rotated on a late shift ending at 2100 hours was insignificantly disliked by 22.4% of the nurses.

The additive effects of all these dissatisfactions and demotivations were transparent in how nurses viewed their continued employment with the public health services. In table 24 the public health services nurses expressed their attitudes towards nursing. Whereas 35.6% of the nurses admitted that they sometimes thought of leaving nursing, 33% of the other nurses were more negative in their attitudes as they very often thought of leaving their nursing job. The rest of the other responses by 13.9% of the nurses who said that they often thought of leaving and by 17.4% of the nurses who never entertained ideas of leaving nursing were insignificant. Probing the thoughts of the public health services nurses further by inquiring whether they intended to remain in nursing until they retired revealed that a majority of 60% replied in the negative. This seemed as if part of the 33%, 13.9% and 35.6% of the nurses, who very often, often and sometimes thought of leaving nursing, respectively, had reconstituted their thoughts into a more definite decision not remain in nursing until they retired. Only 38.5% of the nurses were prepared to stay in nursing until retirement. However, although the results in table 26 which showed that the 46.3% majority of the nurses preferred to practise their nursing career in government health services if in general the terms and conditions were acceptable might appear cryptic, it only revealed the true nature of the nurses' complaints. The public health services nurses were not ambivalent about their position but clear- minded that the only axe they had to grind with their employers was over unacceptable working conditions. Once this stumbling block was removed, they chose to work in the government health services. This should send a strong message and reminder to the public health services managers that although the nurses' commitment and loyalty are not to be doubted, they should not be taken for granted. It cannot be over-emphasised, therefore, that the improvement of nurses' working conditions should be targeted as a primary area of concern.

However, apart from the public health services nurses' disharmony with the working conditions, they got on well with their supervisors. This might have explained why they liked their work as revisited in table 13 of chapter six. The majority of 67.1% of the nurses shared good working relationships with their supervisors as borne out in tables 27 to 29 of chapter six. Only a tiny minority of 4.6% of the nurses did not work well with their supervisors. One of the reasons that promoted a good working relationship for those nurses that were happy with their supervisors was that the

latter permitted them to make decisions about their job. It was this opportunity to decide about their nursing job that satisfied and motivated the 59.3% majority of the nurses to enjoy working with their supervisors. This positive attitude on the part of nurses was made easier by the accessibility of their supervisors in their nursing environment. The nurses could talk and discuss with their supervisors any problems they encountered in their work. The nurses also found it easy to talk to other higher authorities such as the matron. The ease with which the public health services nurses could speak to their supervisors, as well as other higher authorities, was verified by the 50.6% majority of the nurses. The less encouraging responses came from a minority of 31.3% and 2.1% of the nurses. The former said that their supervisors sometimes gave them a chance to make decisions concerning their job but the latter disputed that they were ever given such a chance. With regards to talking terms, 31% of the nurses stated that they sometimes found it easy to talk to their supervisors and other higher authorities. However, a clear minority of 16% of the nurses felt that they did not find it easy either to talk to their supervisors or to other higher authorities.

But regrettably, the good working relationships reported between the majority of the public health services nurses and their supervisors was not sustained by effective communication in the workplace. This was evident in tables 30 and 31 of chapter six in which only 24.6% of the nurses rated it as good. The rest of the nurses, that is, 49.3%, 13.8% and 9.7%, regarded the communication system in their workplace as fair, bad and very bad, respectively. Communication system in the hospital environment involves ward nurses at ward level or nurses in other departments such as the Accident and Emergency and the matron's office. A similar arrangement also reigned in the clinics with the clinic nurses' matron being located in the City Council offices. At both ward and clinic levels meetings were held infrequently and the written records of the problems that affected nurses were not kept. Information discussed at the senior nurses' meetings with the matron, attended by the charge nurses, was sometimes not written down and made available to the ward nurses. Furthermore, communication from higher nurse managers outside the hospital or city council offices such as the Ministry of Health and the Ministry of Local Government, respectively, to the hospital or city council offices, was not sometimes filtered down to the nurses through their ward or clinic supervisor. Only 11.3% of the nurses believed that the communication system from higher authorities was good. Most of the nurses comprising 32.1%, 24.2% and 14.5%, thought that it was fair, bad and very bad, respectively. The net effect of the inefficient communication system was to rob the nurses of the benefits of the good working relationships such as motivation, job satisfaction and positive attitudes that the nurses had nurtured with their supervisors.

The detraction from these gains continued as there were further areas of the public health services nurses' concern which could have been solved directly or indirectly with effectual communication. For example, in tables 32 and 33 of chapter six, nurses suffered under the burden of performing duties that they considered to be relatively unimportant or unnecessary. According to 28.8% of the nurses quite a few of the duties carried out by nurses were unnecessary or unimportant. Examples include cleaning patients' drawers and tables and collecting plates and cutlery from their beds. An almost identical response by 27.6% of the nurses indicated that there were a few duties done by nurses that were relatively unimportant or unnecessary. The answers from 9.1% and 17.1% of the nurses were that there were very few or no duties undertaken by nurses that were relatively unimportant or unnecessary.

Although the percentages of responses were insignificant by themselves or on face value they were pregnant with a reminder to the nurse managers' minds that there were still pockets of jobs in the nurses' duties that needed to be weeded out. The reason for their removal was that they interfered with the nurses' professional allocation of time which must be devoted primarily to the patients' needs and care. For instance, 16.1%, 18.7% and 19.8% of the nurses perceived that there was a very large part, a quite large part and a fairly large part of their job, respectively, to which they could not give as much time as they would have liked. With effective communication system in the workplace these complaints would not have existed because the supervisors would have seen or would have been made aware of their irrelevance in the nursing duties schedules. In the absence of this awareness the nurses' clinical governance was shadowed by factors that reduced their job satisfaction and motivation and ill-directed or misdirected their job attitudes.

Again in search of motivation, job satisfaction and productive job attitudes, learning in the job as an isolated aspect of the public health services nurses' job was examined alongside its association with the employing institution. What the public health services nurses failed to obtain from their supervision in respect of efficient communication was supplemented by their chance to learn continuously in their jobs as evidenced in tables 34 and 35 of chapter six. The majority of 58.5% of the nurses asserted that they could still learn a great deal in their present posts. Those dissatisfied and unmotivated nurses who complained that they could still learn something but not much and those who had nothing more to learn were in the minority groups of 13.1% and 5.7% respectively. Continuously learning in a job was motivating because it was a challenge and a mark of its complexity requiring the acquisition of new skills such as the innovative methods of treating cancer in the oncology ward. The opportunity to learn from their jobs, for the majority of the nurses, removed boredom and made them feel happy and motivated. It also cultivated hopeful attitudes that their new knowledge would hold them in good stead in their quest for promotion in the future. This scenario was expressed by a majority of 38% of the nurses who appreciated their general association with the hospital or city council as providing them with some opportunity to learn but not much. Part of the opportunity to learn offered by a hospital or a clinic was made possible by a rotational system in which nurses moved from one ward or clinic to another. For 19.1% of the nurses a hospital or clinic provided a little opportunity to learn or as felt by 16.8% of the nurses, provided no opportunity to learn at all.

Jobs are thought to be motivating and satisfying if they provide an opportunity to learn which improves attitudes towards work. It was clear that the public health services nurses were not impressed with their general association with the hospital or city council in terms of the latter giving them an opportunity to learn. They were also unhappy about other institutional failures in communication such as the appraisal system as seen in tables 36 to 38 in chapter six. The appraisal system which was conducted twice a year was a means of communication between the nurses and their supervisors and ultimately the nurse managers in the Ministry of Health. For the nurses the appraisal system was designed to communicate their performance to their supervisors. The latter in conjunction with the nurse managers would reward the performance if it met prescribed criteria with a salary increment or would determine if there were training needs, in order to bring the performance to the required standard. The concern by nurses over the appraisal system was over its contents or the

nursing areas of performance that it covered or its design and the significance attached to its report by the supervisors and nurse managers.

The appraisal was conducted twice a year. The main appraisal which attracted managerial action was done at the end of the year. The outcome of this appraisal formed the basis upon which the nurses' yearly marginal salary increments were made. As pointed out above the appraisals could be used for promotion, demotion or personal or staff development purposes. Appraisal reports were completed by the appraisees and the immediate superiors closeted together in an office. These appraisal meetings became, for some nurses, avenues for acrimonious debates and settling of personal accounts or vendettas that the supervisors had nursed against their subordinates. As such they took on a confrontationalist flavour and the reports were not professionally completed. The appraisal reports were, therefore, not a true reflection of some nurses' performance, but a superior's opinion of the subordinate nurse, based on subjective criteria such as the interpersonal relationship between them. The appraisal forms were also poorly designed as they did not show enough details of the major nurses' performance areas against a timescale. For instance, the effectiveness of nursing care plans and their review dates, were not stated. There were no targets set against which to achieve given objectives. The appraisal system was, therefore, seen by nurses as a poor communication instrument in respect of their performance. The way the appraisal reports were collated and utilised did not satisfy or motivate them to work towards improving their attitudes towards their work.

Against this background, the 51.1% majority of nurses could only rate the appraisal system at their workplace as fair. An insignificant 12.7% and 9.3% minority of the nurses said that it was good and bad, respectively. Another minority of 14.2% of the nurses considered the appraisal system at their workplace to be unfair. The smallest 4.1% minority of nurses simply felt that there was no appraisal system at all in their workplace. This was an implication that the appraisal system was so dysfunctional that it could be regarded as none-existent. Completed appraisal reports were forwarded to the Ministry of Health nurse managers via the matron's office for rating and conversion into individualized assessments of performance, competence, efficiency and effectiveness on which appropriate managerial action was later taken. But what could not be measured, however, was what could be called conscience appraisal, for lack of a better word. This referred to what nurses inwardly felt that they had achieved something really worthwhile outside the regular and formal measurement of their performance on their job such as appraisal reports. Although the response to such an intangible self-appraisal of the care the nurses gave to their patients was scattered in small percentages, it was evident of the deep-seated motivation and job satisfaction that arose from the nurses' genuine attitudes towards their job. A very small 2.9% of the nurses confessed that apart from a regular measurement of their job performance they had often felt inwardly that they had achieved something really worthwhile. Slightly higher percentages of 24.6%, 17.1% and 12%, 12.7% and 10.8% stated that they had very often, often, fairly often, once in a while and very seldom, respectively; felt inwardly that they had achieved something really worthwhile outside the regular measurement of their job. Some nurses did not respond to this part of the questionnaire.

This inmate motivation and satisfied job attitudes were a form of recognition from the inner self that these nurses had achieved certain accomplishments which were not visibly seen in the outside world. What was noticed in the real world were the

supervisors' various types of behaviour such as verbal praise, receipt of reward, promotion and monetary gain. This is what nurses expected when they received some type of recognition for their nursing accomplishments. A slightly higher proportion of 12% of the nurses reported that they quite often received some type of 5.6% of the nurses said that they often received some type of recognition for their accomplishments. A slightly higher proportion of 12% of the nurses reported that they quite often received some type of recognition for their nursing outcomes. The larger majorities of 29.9% and 33.6% replied that they very seldom and almost never, respectively, received some type of recognition for their nursing feats. It is re-emphasised that the appraisal system is a way of communicating with nurses from superiors about nurses' work performance, in order to maintain a transparent account of their competencies, skills, trainability and leadership potential. It is a means of showing an interest in the nurses' careers, to promote quality care, to motivate and to create an organisational climate amongst nurses which induces job satisfaction and cultivate durable or enduring favourable attitudes towards work. In this regard the appraisal system went further than its use as a promotional tool and as a basis for raising income or salary and even as a job performance measurement.

After the public health services nurses' lukewarm appraisal of their appraisal of the appraisal system in their workplace, another way of checking on their attitudes towards the institutions they worked for, was to ask them a question connected to their index motivator and job satisfier, which was identified as pay. One way of doing this was to compare the pay in the government nursing with that in the private sector, in order to test the nurses' responses. Tables 39 and 40 in chapter six tabulated the relevant answers on this aspect. The majority of nurses (44%) thought that they could earn more money in private than in government nursing. Only 19.1% of the nurses said the opposite. In order to compare the notion of pay further, the nurses were asked how their pay compared with that of their counterparts holding similar educational qualifications but working outside nursing. The reply by the majority of 38% of nurses was that their pay was worse than that of their contemporaries working outside nursing. This answer was consistent with the nurses' belief that if private sector paid better, other jobs, for example, in the private sector outside nursing, also necessarily paid better. The lesser majority of 25.1% of the nurses, however, disagreed and were positive that their pay in government nursing was better than that of their peers working outside nursing holding similar educational qualifications.

Engaging nurses in an exercise of comparison regarding earnings gives an indication of their attitudes over the influence of other predictable behaviours on job relationships. For example, the majority of 55.6% of the nurses acknowledge that they were moved from one ward to another in the hospital after working for a certain period. Only 16.4% of the nurses were not moved. Movement from one ward to another was a rotational routine to expedite the nurses' learning experiences in different wards. The frequency of movement varied from three months on a ward to more than one year in the same health care unit. Tables 43 to 46 in chapter six revealed that the majority of 58.5% of the public health services nurses was moved from a ward after one year or more. There were no nurses who changed wards after a period of three months. Nurses had, therefore, to stay or work in a ward for at least a year in order to consolidate their experience of what they had learned. Pursuant to this advantage, the majority of 51.1% of the nurses liked this change. In actual fact if some of them had their own way, they would have preferred to stay longer, if not

indefinitely. Only 19.1% of the nurses was not in favour of the change from one ward to another. When it came to a government transfer system which moved nurses not from ward to ward but from a ward or clinic to a remote area health facility, a majority of 65% of the nurses did not like the transfer system. Only 8.5% of them were in favour. The government transfer system, like a ward to ward movement, was created to enable nurses to acquire rural nursing experience.

After surveying the nurses' cognitions about their job from various facets of their working conditions, some outstanding motivators and job satisfiers enmeshed with attitudes were identified. Motivation and job satisfaction are part of the attitude behaviour presentation. However, the public health services nurses isolated strong motivators from variables in their working conditions. Six motivators in ascending order were pertinent. Firstly, opportunities for promotion as a form of recognition for high performance, for skills acquired, for achievements in training and or education, for seniority and for specialisation in a particular area of nursing, amongst other reasons for career progression, were regarded by 53.4% of the nurses a motivator. Secondly, opportunity for recognition of work done, for example, quality of care given to a particular child in a children's ward, by a specialist nurse, was mentioned by 54.1% of the nurses. Thirdly, reduced workload was a motivator for 59.3 % of the nurses. This reduced stress and improved the quality and standard of care given to patients. Fourthly, a higher majority of 63.8% of the nurses considered the opportunity for continuous education as a motivator. This involved nurses attending lectures arranged by doctors in the hospital fortnightly to update them on modern trends and treatment in nursing. The knowledge in current nursing practices obtained from these lectures assisted nurses to become more effective in their approach to nursing care. Fifthly, a majority of 71.2% of the nurses preferred sufficient working conditions as a motivator. In the main body of the research findings, working conditions were central to the working experiences of most nurses. Sufficient working conditions referred to favourable working conditions conducive to safe nursing practices such as reduced workload and effective appraisal system and communication system. Finally, the sixth highest position was occupied by 80.9% majority of the nurses who chose good salary as the foremost motivator. The effects of the negative level of pay on motivation, job satisfaction and attitudes such as the nurses' unwillingness to remain in nursing until retirement have been detailed in the main field results. The less important motivators mentioned by nurses were, in descending order, opportunity to participate in decision-making (47%), positive interpersonal relationships (45.2%), positive supervisory relationships (44.4%), professional status (39.9%), the work itself (38.7%) and the autonomy in the working arrangement (35%).

The order of choice by the majority of the public health services nurses of what gave them satisfaction in their nursing job was similar to their pattern of preference for motivators. In ascending order it emerged that firstly, 49.6% of the nurses thought that high morale in team work gave them satisfaction in their nursing job. Secondly, 53.7% of the nurses regarded opportunity to go to workshops as providing them with satisfaction in doing their nursing job. Workshops brought nurses together to share nursing experiences as well as improve their nursing knowledge. Thirdly, 60.1% of the nurses was in favour of good fringe benefits such as housing as giving them satisfaction in their nursing job. Fourthly, enough nurses on each shift was the one thing that gave satisfaction to 63.1% of the nurses to work in their nursing job. The fifth factor recognised by 68.2% of the nurses as providing them with satisfaction in

their nursing job was good working conditions. In the sixth notch claimed by 69.1% majority of the nurses, were other considerations such as risk allowance which gave nurses satisfaction in their nursing job.   This was stated in the context of the pandemic infections such as the acquired immune deficiency syndrome (Aids). Finally, the highest 76.1% majority of the nurses considered good salary to be their most preferred factor that gave them satisfaction in their nursing job.

According to the behaviour-attitude theory advanced by Tannenbaum (1957), the motivation and job satisfaction expressed by the public health services nurses in their nursing job were also part of their attitudes.   The nurses' attitudes were shown in their behaviour and the choices and decisions they made in respect of their job. For example, nurses displayed positive attitudes when they responded in the survey that they participated in the decision-making process involving their job. Thus, being in control of professional judgements in their job was also a source of job satisfaction and motivation.   Furthermore, the public health services nurses exhibited a positive attitude towards their work when they confirmed that they liked their job despite working under the pressure caused by the increased workload due to staff shortages. Embodied in their attitudes was the satisfaction that they obtained from the job itself. The motivation derived from the implied interesting contents of the job overcame the negative aspects of the work context such as the pressure, the workload and the staff shortages. The team work spirit which sustained the nurses' attitudes to work under the stress of extra work was anchored in the motivation and job satisfaction that came from their interpersonal relationships.   The public health services nurses showed selective attitudes towards their working conditions.   For example, they disliked the government's transfer system. They did not like the wages they were paid which they considered to compare unfavourably to the amount of work they did. They showed a negative commitment to stay in the nursing service until retirement. The nurses' positive or negative attitudes towards certain aspects of their working conditions were a manifestation of their underlying motivation and job satisfaction. To a large extent, therefore, their motivation and job satisfaction or the lack of them, were enveloped in their attitudes.

The major areas of the survey findings were corroborated by the interview results from a small sample of nurses as shown in table 47 of chapter six. For example, the majority of nurses (87.1%) were dissatisfied with pay and fringe benefits. The fringe benefits were, for instance, in the form of assistance given to nurses such as hospital transport during unsocial hours when there was no public transport and accommodation, particularly for nurses who had been relocated. The motivation, job satisfaction and positive attitudes displayed by the nurses in their feeling towards the work content of their job or the work itself was evident in the majority of 83.9% of the nurses who were satisfied with their work.   However, the public health services nurses disliked their working conditions in general. Although the majority of 87% of nurses were dissatisfied with their working conditions, generally, they liked some of them such as supervisory practices and the autonomy they enjoyed in making decisions about their job. Opportunities for advancement which included recognition in general and promotion in particular dissatisfied a moderate majority of 58.1% of the nurses. When all the job variables of the public health services nurses were lumped together, a majority of 87.1% of the nurses was dissatisfied with the motivation or incentives contained in their job. The point of departure in the limited degree of the significance that could be attached to the results of a small interview

sample, therefore, was that its findings mirrored those of the main survey in the major areas of the nurses' working conditions.

It will be recalled that the essence of the main survey in the empirical chapter was centred on nurses. Nurses' indications as regards motivation, job satisfaction and their attitudes related to their work were extracted from nine sections of the questionnaire. They were generally satisfied with how they participated in the decision-making process concerning their job and with how they controlled the work processes. For example, they took part in choosing the type of nursing that they preferred such as intensive care, instead of being compelled to go in there by the matron. On the job, nurses exercised initiative in the way they carried out their duties and because they had a say in the way they worked they could change the organisation of their tasks. Although they worked under pressure the latter came from the work itself and not from a ward nursing sister or some other nursing authority.

However, their personal satisfaction was spoiled by their dissatisfaction with pay as well as with the other benefits from their employment. The main substance of their complaint was that pay was not related to the amount of work they churned out or slogged away. Consequently, the majority claim was that their salary should be increased by more than 40% from its present level. Other than these dissatisfactions the respondents were happy with the relationship they had with the other nurses. They were also pleased with the interpersonal roles between their supervisors and the nurses in general.

But in the area of working conditions, nurses expressed dissatisfaction particularly with pay, workload, slow or lack of promotion and lack of recognition of their nursing achievements. The other conditions which vexed the nurses were the shortage of staff, the lack of opportunity to pursue further education or training, the lack of accommodation especially on transfer to a new station, the lack of transport to take them home after an evening shift and the government transfer policy which posts nurses to everywhere in the country including the remote areas. As a result of all these working discomforts, the majority of the nurses had sometimes thought, not only of leaving the public health services to join the private health sector, but also to quit nursing altogether.

Not all the lamented working conditions could be blamed on the supervisors, however, as the latter wore a participatory mantle in their interactions with the nurses. For example, they allowed nurses under their control to make decisions about how they executed their duties. In the event of any nursing problem the nurses found it easy to approach or to speak to their supervisors. In this aspect of their work, therefore, the nurses' job satisfaction was sustained by the supervisors' democratic approach to their supervisory role.

The supervisory practices were made possible by a system of communication which was described as fair by the majority of nurses. However, as a result of understaffing, communication as regards which nursing duties to be left out and which to be included in the nurses' schedule, broke down. Nurses found themselves undertaking a number of unnecessary duties which resulted in fairly large parts of important nursing procedures being neglected. Nevertheless, the nurses' consolation came from the satisfaction that their jobs were interesting and they could

still learn a great deal from them. This opportunity to learn was of course facilitated by their respective health facilities or health units or wards.

The appraisal system acclaimed to be fair by the majority of the nurses, was an important vehicle of a communication system which although subjective, facilitated promotion, selection for further training or education and performance improvement through a feedback process. But like any other device created by man the appraisal system only measured what was subjectively measurable. Over and above what was revealed by the appraisal many nurses enjoyed an inward psychological feeling of achievement over what they had done for their patients. However, their mirth was short-lived by the nurse managers' lack of recognition for their visible nursing accomplishments. It was such dissatisfactions which implanted new and deviant ideas in the nurses' minds. For example, the majority of them began to imagine that they could earn more money by joining the private sector health services. They also considered that compared to their nursing salaries jobs outside nursing offered better pay.

Against the background of such misgivings about the public health services, nurses picked out or identified what they considered to be the most essential job variables. The top motivator job factors included, in order of weighting, good salary, good working conditions, opportunity for continuous education, reduced workload and opportunity for the recognition of nursing achievements. The most important five job satisfiers in descending order also included good salary, allowances such as for night duty, good working conditions, adequate nursing staffing and good fringe benefits such as subsidised accommodation. The total list of all such factors which may not be exclusive of each other is decidedly long. This challenge and the intricate and the inter-dependent nature of motivation, job satisfaction and attitudes have characterised the theory and practice of all these factors throughout the whole thesis. To continue to extend the argument any further would land one on a wild goose chase.

7.3   CONCLUSIONS

The planned investigation set out at the beginning of the study unfolded and blossomed through the vertical and the horizontal linkages of the entire lengths and breaths of all the chapters. The economic growth in the country, accompanied by enlightened social changes such as increased literacy, heightened the Botswana public's awareness of human rights. The decentralisation of the Botswana public health services was concomitant to the country's economic betterment. The decentralized public health services brought health care to most people in both the rural and urban areas. However, the improved provision of the public health services brought with them the insatiable demands and expectations on the part of the public consumers. For instance, while the expanded public health services infrastructure and the resultant shortage of nurses were trying to manage a difficult situation, the general public became intolerant of the constraints within which they operated. The nurses ran the gauntlet between the bottlenecks of the public health services whose working conditions did not meet their expectations and the boisterous public health services consumers. Thus, with the Botswana public health services nurses acting

as the centre of the universe the academic theories of motivation, job satisfaction and attitudes were tested for their practical application against the empirical data collated from the nurses' survey.

Motivation identifies the kinds of needs people have and the kinds of goals they seek. The individual who has these needs, desires or goals is then motivated to engage in some kind of directed behaviour. It is not known with certainty, however, what sort of behaviour the motivated person will show. The motivational process which ignited the behavioural process refers to the mechanics which move the person concerned from the motivated state to some specific kind of behaviour. In this sense, therefore, a motivational process denotes the direction of behaviour. To study the motivational process is difficult because one can only see the outcome of motivation, that is, the actual behaviour is completely internal to the individual involved in behaving. In a work situation the employee's performance which is part of the behaviour influenced by motivation is affected by various factors such as the job characteristics. The question is whether the latter should combine in a multiplicative or additive manner in order to yield the most effective interaction effects. In the Herzberg and Michigan studies, the job characteristics such as control and job difficulty were found to have an overwhelming influence on the job behaviour when they operated independently. This suggested that increases in one job characteristic can induce an increase in employee motivation even when the other job characteristics remained unchanged. However, job aspects can only be meaningfully interpreted in the context of the work environment such as the working conditions including the supervisory practices.

Motivation in a workplace, therefore, gives meaning to the speculation about a worker's purpose in doing something. This purpose may be shown in some obvious goal such as money, security, prestige or promotion. Hidden in the particular goals that people appear to be striving for are other objectives such as one's estimated abilities. Thus, the Botswana public health services nurses were in a perpetual pursuit of whatever they regarded as their deserved role such as the status they thought nurses should have in the Botswana society. They chose good salary as their highest motivator and satisfier in their nursing job. In this way they were trying to convert their subjective ideas about themselves such as their competencies and projected truths idealised by a good salary. In the final analysis their ultimate motivation was to make real their self-concept of what nurses should be or what rank should be accorded to them in order to live in a manner that befitted that preferred role. On a hopeful note if the nurses' best motives prevailed in the end against the worst, that would enable them to enter the realm of job satisfaction.

Job satisfaction was one of the causal factors in job behaviour identified by the Hawthorne studies. While the latter studies showed that job satisfaction in the form of the level of performance at work was related to job behaviour, Herzberg and others found that satisfying job experiences such as achievement and recognition often increased the individual's self-confidence. The Hawthorne researchers also discovered that when certain changes were made in the work such as the incentive system and the type and degree of supervision both performance and morale improved. The Botswana public health services nurses' self-esteem, self-concept and self-evaluation were raised by the autonomy that they enjoyed in controlling their work processes. The sense of responsibility entrusted in them enabled them to enjoy their job and to be motivated sufficiently to withstand the stresses and pressures exacerbated by staff shortages. These job content and contextual variables led to job

satisfaction despite the existence of situational constraints. It is acknowledged that the experience of job dissatisfaction itself is an unpleasant psychological state. Its presence implies conflict since it means that the employee is holding a job that he or she would prefer to avoid at least in some respects. This in itself suggests the possibility of a relationship between job satisfaction, motivation and mental health.

Kornhauser, for example, found consistent relationships between job satisfaction and the total mental health index which included indices such as self-esteem, personal morale and motivation. The Botswana public health services nurses experienced conflict in their working conditions which affected their values and beliefs of nursing and how the latter should be perceived in the Botswana community. The difficulties experienced by nurses in their relationship with the public health services consumers who criticised the standards of nursing and quality of care provoked their basic sense of job satisfaction and dissatisfaction. The most obvious behavioural prediction related to job dissatisfaction was, for example, absences, termination and lateness. The public health services nurses working in the clinics were criticised by members of the Botswana public for opening clinics late and for the unexplained absences of nurses. Some nurses resigned from their nursing jobs as a negative reaction to the government's transfer system which relocated nurses to health facilities such as clinics in the remote areas of the country. Furthermore, nurses complained about the lack of opportunities, for instance, to go for further training and education. The selection process of nurses for such staff development opportunities was criticised for its lack of fairness, lack of merit and for its favouritism. As a consequence of a combination of some of these job dissatisfactions the majority of nurses was not willing to continue working in nursing until retirement unless the terms and conditions of their services were acceptable to them.

Job satisfaction, therefore, either in itself or in combination with the conditions both in the individual and in the job environment which bring it about, has a number of consequences for the individual. For instance, it can affect his or her attitude towards himself or herself and his or her psychological health. It may also play a casual role in other types of on-the-job behaviour such as absenteeism and labour turnover. Frederick Taylor's research in the early twentieth century linked job satisfaction to a variety of individual social and organisational factors such as motivation, morale and supervision. His efforts led to a more structured approach to job theories. Firstly, the content theories focus on the particular needs and values that must be satisfied for an individual before he or she can be happy with his or her job. Herzberg and Maslow are the main theorists in this group. Secondly, process theories describe the relationship between job satisfaction and its environment including the needs, values and the expectations that people have in relation to job satisfaction. However, these theories have to adapt to timeframes in job satisfaction that are brought about by the changing values and expectations which are integral to societal changes. For example, the Botswana public health services nurses regarded pay as their top motivator and job satisfier. But the earlier studies such as that by Herzberg had not treated monetary rewards as central to job satisfaction. Moreover, the autonomy in decision-making enjoyed by the nurses in their job was non-existent in the carrot and stick superior-subordinate work relationship era of Frederick Taylor.

However, although definitive theories of job satisfaction have been formulated they are rendered elusive by the difficulty of determining what goes on in each employee's

mind and what attitude he or she is likely to have towards his or her job even toward himself or herself. Job attitudes contain job experiences which affect work performance. Motivation and job satisfaction manifest themselves through the employee's job attitude-behaviour theory. For example, the public health services nurses have been compelled to become vocal in defense of their profession in the light of mounting criticism from members of the public. They have also shifted their attitudinal position towards their job by demanding for an increase in their pay. They have challenged the government by pointing out that their pay is outpaced by the amount of work they do. They have further shown dissatisfaction attitudes towards job factors such as the government's transfer system which requires them to be transferred to work in areas distant from their homes and families.

The skein of motivation and job satisfaction factors and how they were linked to attitudes pierced the entire length of the thesis. Some motivators and job satisfaction factors can be identified but the path leading them to work performance is waylaid with uncertainties. They are difficult and controversial concepts over which there is no unanimity of agreement about how they stimulate performance in an individual. Various theories have been analysed and their contribution to job satisfaction and motivation have been noted. However, there are other factors such as family background, childhood experiences, achievement orientation, and level of education and personality traits that affect the extent or degree to which a given person will be motivated to perform better in a job and to be predisposed to derive job satisfaction when job satisfaction factors are present.

A further difficulty with these concepts lies in the fact that what motivates one person may amotivate another or may not arouse any motivation at all and what gives job satisfaction to one individual may do the opposite for another. It is not known whether or not both motivation and job satisfaction are bed fellows or where motivation ends and job satisfaction begins or the reverse order. Any direct link between these two variables has been disputed by a number of writers such as Locke (1976). For instance, it has been argued that a person who is motivated in his or her work does not necessarily obtain job satisfaction from so doing. Similarly an employee who is satisfied with his or her job is not necessarily motivated. Thus the scenario conveyed is that of both motivation and job satisfaction going about in different dresses imbued with attitudes and yet if one were to catch and analyse them there would be no strawberry mark found in one and not found in the other.

When the two concepts form a pact and join with attitudes they are said to cause behaviour. Thus behaviour towards work in a motivated person is thought to lead to productivity. The latter is further thought either to lead to job satisfaction or to be caused by it. The correlation if any, therefore, between motivation, job satisfaction, attitude and work performance is tortuous. Nevertheless in the practical field of management incentive schemes based on motivation and job satisfaction theories have been devised with encouraging results. However their success has been mediated by the type of industry in which they are applied.

In the health services the nurses' responses revealed that they were satisfied with certain broad areas of their work such as participation and control, personal satisfaction and interpersonal roles and supervisory practices. In other words they took part in making decisions involving their work and they controlled the flow of their duties. The interpersonal relationships between junior nurses themselves in the first

instance and the supervisors were found to be conducive to job satisfaction. The supervisory practices did not block communication between junior and senior nurses. This may be ascribed to the fact that the supervisory style was of a liberal and democratic nature which permitted nurses to make their own decisions. The nursing work aspects bordered by working conditions, rewards and inducements were, however, not marked with enthusiasm. Nurses were not content with their working conditions such as pay and workload. They were incensed with low pay because they believed that they could earn more in the private health sector. The nurses' grievances and dissatisfactions were brought out more forcibly into the open in the form of a basket of motivators and job satisfiers whose opposite were the ruin of their nursing lives. It is from such a host of factors that the ideas for recommendations aimed at improving the quality of the health services delivery and retaining the providers of such services can be germinated. Suffice it to point out, however, at the point of exit, that this is done against the knowledge that all the hypotheses and assumptions set out at the beginning of the study were satisfied or supported in varying degrees of utility.

7.4 RECOMMENDATIONS

Having mapped out from the questionnaire responses, sources of job satisfaction and motivation and the nursing areas that cause dissatisfaction and the way the latter affect nurses' attitudes in rendering health care services, it was noted that some factors such as pay were more prominent than others in causing job dissatisfaction.

The dissatisfaction arising from poor pay cannot be pushed back into the background anymore. Over the years the tide has not subsided despite the government's review of the nurses salaries during the last two to three years. It is high time that the government discarded the complacent attitude regarding the pay for nurses who have in the past often been taken for granted by both the government and the general public at large due to the stubborn but slowly-dying Nightingale attitude which viewed nurses as a devoted and disciplined force of angels. The retention of qualified or skilled nurses or their willingness or motivation to provide quality health care to patients cannot be separated from their claims for pay relativities or comparability. Firstly, therefore, the government must make an overall improvement in the nurses' pay if it hopes to solve the problem of the chronic shortage of trained nursing staff. It is recommended that annual salary surveys be instituted as routine procedure followed by salary reviews.

Secondly, it is recommended that a periodic review of the working conditions of which pay is only a small part, be done in consultation with the nurses themselves or their representatives. The government's response is slow, for example, over nurses' demands for certain allowances. Working conditions as a major source of nurses' dissatisfactions is controlled by both the government and the nurse managers. For instance, pay, accommodation and the transfer policy come under the government's purview, while other conditions such as promotion and the recognition of nursing achievements, are subject to the nurse manager's initiative. One of the most inimical working conditions is workload brought about by under-staffing.

If it can be argued for a moment, all things being equal, that the shortage of nurses was a direct result of their leaving their job because they were dissatisfied with pay and the other working conditions, then most certainly the government has an important role to play by removing the sources of those dissatisfactions under its jurisdiction and thereafter exerting its influence over nurse managers to similarly attend to those under their authority. After all it will be recalled that the nurses' responses in the questionnaire indicated that they would be prepared to continue to work in the government health services if their terms and conditions were improved. This was heartening and a good omen to both the government and the nurse managers.

Extracting from the attitude-behaviour theory, motivation and job satisfaction are often embedded in attitudes. Therefore, adjunctive to the evaluation of working conditions from time to time, thirdly, it is recommended that attitude surveys be conducted every two years, to monitor the nurses' "professional pulse".

Fourthly, it is recommended that communication, especially in the hospitals, between nurse managers and the nurses and between nurse managers and the government, requires strengthening if the left hand is to know what the right hand is doing. As is often the case, bottlenecks in the communication system may occur at either of these two "switchboards". Fifthly, it is recommended that a nurse bank system or a ring-in service system in the future, both of which require an arrangement with a nurse manager in charge, may prove worthwhile for nurses who wish to work as part-timers. This may go a long way towards alleviating staff shortages in large hospitals such as Princess Marina.

Sixthly, it is recommended that the office of an industrial or public relations officer in busy and expanding hospitals may be needed in the future to improve the image and the personality of the institution. The proposed office may also act as a liaison bridge between the country and other hospitals either within Botswana or overseas or investors and potential donors, as well as non-governmental agencies, all of which may assist the hospital by donating hospital equipment or such other kind of help. Seventhly, it is recommended that the implementation of the government transfer policy may require a re-evaluation to determine if it is the policy itself in general that the nurses detest, its implementers or the procedure or the process of conducting the implementation. Eighthly, if after review the government decides to continue with the policy, it is recommended that adequate or suitable housing facilities be provided.

Ninethly, armed with a drawn up list of motivators, job satisfiers and attitude changers, the perpetual challenge to the nurse manager is rendered easier. It is recommended that the responsibility of the latter who operates on the nursing shop floor and that of the government as the patron of the national health services lies in taping, selecting and manipulating a mixture of appropriate and efficacious policies that promote motivation, job satisfaction and industrious attitudes in such a way as to stimulate nurses to provide quality health care. Because the nurses' work environment conditions are in a constant flux due to the advances in nursing technology as well as the incessant demands of an increasingly modern society, the nurse manager is placed under pressure to play a pivotal role in nursing. This responsibility revolves round monitoring the nurses' central work variables by means of a regular, well-planned and orchestrated survey of the nurses' work environment in

order to review their expectations in keeping with the changing geography of the health services and the nursing standards.

Finally, the research found that the thirst for advancement in knowledge amongst the Botswana public health services nurses was infectious. However, its acquisition was being impaired by an irregular government administration policy which was criticised for its protracted bureaucratic delays in its selection and implementation criteria of nurses who applied to go for further training or education. Taking the nurses' complaints on board, it is recommended that for the government to invest in a broader base or pool of competent, knowledgeable and skilled nurses, it needs to innovate on a more efficient procedure based on fairness or equity, transparency and defensible or justifiable standards, for releasing nurses for more advanced key skills development.

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APPENDICES

A   **CORRESPONDENCE PERTAINING TO THIS STUDY**

B   **QUESTIONNAIRE**

C   **GUIDELINES FOR A STRUCTURED INTERVIEW FOR NURSES IN THE PUBLIC HEALTH SERVICES OF BOTSWANA**

A   CORRESPONDENCE

B   **QUESTIONNAIRE**

C   GUIDELINES FOR A STRUCTURED INTERVIEW FOR NURSES IN THE PUBLIC HEALTH SERVICES OF BOTSWANA