Journal of International Relations, Security and Economic Studies (JIRSES), Vol. 2, No 4, 2023. Available online at http://journals.rcmss.com/index.php/jirses. Covered in Scopedatabase- https://sdbindex.com/Sourceid/00000434, google scholar, etc. **ISSN: 2756-522X**
Ejeheri, Victor Idowu, 2023, 2 (4):10-26

Learning Opportunities/Self-Acquisition of New Skills and Job Performance in Medical and Health Workers Unions of Nigeria (2010-2020)

Ejeheri, Victor Idowu
Doctoral Student, Department of Public Administration, Faculty of Management Sciences, University of Calabar, Calabar, Nigeria

Abstract
In almost all low- and middle-income countries, national health systems have been functioning sub-optimally due to recurring challenges within and external to the health sector, with this particularly affecting the delivery of accessible and affordable healthcare services. For the health care system to function optimally, it requires a strong body or union to ensure the performance of the workforce. In Nigeria, it requires significant increase in the number of additional health workers to achieve desired population coverage. The establishment of Medical and Health Workers Union was targeted at learning and offering training skills for effective services delivery as well as fight the lingering crisis for medical and health workers. This paper provided insights on the activities of Medical and health workers union in the Nigerian health sector from 2010 to 2016. Furthermore, the paper provided an understanding of key underlying causes of poor performance of medical and health workers with feasible recommendations toward preventing and/or managing potential future occurrences in the country from 2010 to 2016. To boost the moral or workers, two theories of training and reward were employed-Human Capital Theory and Goal-Freedom Alertness Theory. The theories emphasis was on how staff training and goal setting from 2010 to 2016 has improved medical and health union. It was recommended amongst others that, there is a need to design a contextually adaptable framework for interprofessional education and collaborative practice in the health sector as recommended by the WHO, to further facilitate successful cooperation, communication and teamwork in health service delivery and ensure a health workforce that is better prepared to respond to local health needs. It was concluded that, the prevailing crises in the health workforce and service delivery may continue if unions or trade union organization refuses to intervene through policies that will better the worker environment.

Keywords: *Learning Opportunities, Health Sector, Self-Acquisition, New Skills, Job Performance, Medical and Health Workers Union of Nigeria*

1.1 Introduction

In almost all low- and middle-income countries (LMICs), national health systems have been functioning sub-optimally due to recurring challenges within and external to the health sector, with this particularly affecting the delivery of accessible and affordable healthcare services (Sieben Thomas, 2005). The health system, in most cases, is synonymous to publicly owned health facilities with several important private and non-state actors being downplayed. The functional capacities of the health system in these settings have gradually weakened, having failed to recognize and maximize efforts of all organizations, institutions, structures and resources primarily devoted to improving health. The health workforce—all persons involved in activities primarily devoted to enhancing health—is an essential block of any functioning health system in any country, in the absence of which clinical and public health services cannot be delivered to the population (Sieben Thomas, 2005). Health governance is the administrative umbrella of the health system primarily concerned with policymaker- or government-led steering and rule-making functions targeted at achieving national

health policy objectives for effective delivery of health services and attainment of universal health coverage.

Experts have actually shown direct links between efficient health system governance and promising health workers outputs, which ultimately have positive effects on overall health outcomes (WHO, 2006). However, poor administration and continued underinvestment in health, even with the spread of HIV/AIDS, re-emerging diseases and persistent violent conflicts, have contributed greatly to the fragile health systems in many African states (WHO, 2006). While there have been calls for concerted efforts—social, economic, environmental and multisectoral—toward health system strengthening in sub-Saharan Africa (sSA) (Ria, Anis & Oci, 2012), human resources' crises in the health sector have continued to be a major challenge (Reid, 2004). The governments of many African countries have reported challenges in training, funding, employment, capacity building and efficient deployment of the health workforce (Reid, 2004).

Consequently, the Africa has continued to experience a rapidly progressive health workforce migration to high-income settings in search of better opportunities (Reid, 2004). Crises within the health workforce have been reported as perhaps the biggest constraint towards global health system development and sustenance, particularly in Africa (Garcia Prado & Chawla, 2006). According to the 2006 World Health Report, 57 countries were in severe health workforce crises, with 37 of these in sSA—a region with only 3% of global health workforce, despite contributing about a quarter to the global disease burden (Aiken et al., 2002). Nigeria, the most populous African country, possibly contributes even more to these crises in the region. Increasing annual rates of population growth, as observed in Nigeria, has been adjudged a major factor in countries with severe health workforce crises (Buchan, 2002).

Nigeria obviously requires significant increase in the number of additional health workers to achieve desired population coverage. However, beyond the shortfall in health workforce, the Nigerian health sector has particularly experienced a number of other lingering crises in recent times. There are growing concerns locally and internationally over these issues, with this linked to the overall poor states of health governance in the country (Buchan, 2002). This paper therefore provides insights the activities of Medical and health workers union learning programs and skill for effective services delivery and worker welfare. The paper examined some major health workforce crises in the Nigerian health sector in recent years (2010–2016), to understand key underlying causes and provide feasible recommendations toward preventing and/or managing potential future occurrences in the country.

1.2 Learning opportunities/self-Acquisition of new Skills and performance of Medical Health Workers Union of Nigeria (2010-2020)

Established in 1975, the Medical and Health Workers' Union of Nigeria (MHWUN) provide a conducive work environment for health workers in Nigeria. Her function as an umbrella labour organization, the organization offers worker a learning opportunity to provide efficient services to medical and health care workers. These opportunities and learning environment has continued to be to confirm that one's life has no finite skill in organizational performance. However, in every organization, be it health, production or manufacturing organizations, employers of labour design or create opportunities for employees to learn new skill that will improve the general performance of the organization. In the health sector, these training or learning skills is to help in the provision of timely and quality health care services. Like in among medical and health workers union, effective training organized by individual establishment helps in data collection, processing and reporting for policy formulation where necessary These skills by Medical and Health Workers Union in general could come to achieve the following result:

1. **Capital improvement**. At this point, health institution or organizations tend to spend millions of money on upgrading their services provision, yet little on upgrading their human capital. Employees are an asset to the organization but employers are more concerned about reaching deadlines and profit maximization rather than employees skills development, without which employee performance could be hampered. Although the organization still achieves productivity, the focus should also be on the dedication, commitment and loyalty of employees. If employees do not receive ongoing training, up-to-date equipment will not be used optimally.
2. **Morale improvement**. Among health workers, employees who continuously upgrade their job skills will also improve their productivity. Developing employee skills not only plays a role in the workplace, but in the external world as well. It contributes to the full personal development of each employee and the socio-economic development of the nation at large; therefore, happy employees may be productive, but more productive employees are happier.
3. **Ability to adapt to change.** The more skilled the workforce is, the easier it will be for the entire organization to adapt to changes that may arise in the domestic and global market place in the demand of its products and services. Sometimes employees are reluctant to adapt to change because of the uncertainty involved, but one of the objectives of the Skills Development Act 97 of 1998 is to develop the skills of the South African workforce as well as increasing levels of investment in education and training in the labour market.

1.3 History of Medical and Health Workers' Union of Nigeria

The MHWUN is a union that represents medical workers in Nigeria. It was established in 1978 and became a member of the Nigeria Labour Congress. In 1988, the union had 41,000 members, which increased to 100,000 by 1995. However, in 2005, the membership fell back to 45,000. The union was founded in 1978, when the Government of Nigeria merged the following 17 unions:

- Animal Health Workers' Union of Nigeria
- Association of Public Health Inspectors of Nigeria
- Catholic Hospital Workers' Union
- Dispensary Overseers Workers' Union
- Eastern Region Nigeria Union of Rural Health Workers' Union
- Government Health Department D/P Workers' Union of Northern Nigeria
- Medical and Health Department Workers' Union of Nigeria
- Medical Technical Workers' Union
- Nigerian Baptist Mission Medical and General Workers' Union
- Nigerian Medical Records Workers' Union
- Nigerian Union of Dispensing Attendants
- Nursing and Health Auxiliary Staff Association
- Orthopaedic Limb Workers' Union of Western Nigeria
- Sacred Heart Hospital General Workers' Union of Nigeria
- Tuberculosis Preventive Staff Association
- Tse-Tse and Trypanosomiasis Staff Association, Federation of Nigeria
- Uromi Catholic Hospital Workers' Union

Presidents

1978: Pa A. A. Akinbola

1980: Y. O. Ozigi
1990: Emeka Okwonkwo
1996: Godwin Wokeh
2000: Mohammed Erena
2004: Ayuba Wabba
2016: Biobelemoye Josiah till date

General Secretaries

1978: J. A. Alajo
1984: J. A. Mbah
1998: S. O. Joshua
2000: J. A. Ogunseyin
2003: Marcus Omokhuale
2016: Kabiru Ado Sani

1.4 Aims and Objectives of Medical and Health Workers Union

The aims and objectives of the union are presented below:

1. Organizing and registering workers in the Medical and Health services, whether in public or private sectors.
2. To ensure fair and just relationships between workers and employers, and establish proper work hours, pay rates, and humane working conditions.
3. o providing adequate retirement and pension benefits to our workers.
4. Establishment and maintenance of just and proper hours of work, adequate rates of pay, humane conditions of labour and adequate retirement/pension benefits.
5. establishment and maintenance of high standards of workmanship and professional practices
6. Ensuring advancement of workers' education
7. Furthering the interest, welfare and wellbeing of members and their families
8. Encouragement of participation of workers in policy making in the health industry
9. Provision of legal or other assistance, when necessary, in matters pertaining to interest of members who may suffers by accident or through unjust treatment arising from dispute between employers and members
10. Ensuring cording intercede relationship among members
11. Ensuring cooperative and other welfare activities for activities for the benefit of workers generally

1.5 Learning opportunities/self-Acquisition of new Skills for data collection among Medical Health Workers Union of Nigeria

The medical records of patients' also known as case notes contain the medical history of patients which the health record officer must ensure confidentiality while handling patient information or data. They are the hand-written files or computerized files that record that health practitioners compose and build up containing information about a patient. In Nigeria, where a large majority of patient records are in hard copies in the form of files, the standard practice is that patients are not authorized to look into or handle their personal record at any stage of their treatment. On the body of the 'case note' itself there is often a caveat precluding the patient or any other unauthorized

persons within the medical institution from handling the case file. If patients cannot handle their own medical record, it is assumed that they do not have ownership in them.

The general practice is that a patient's medical record in form of a file is opened on a patient's first visit to a health facility with the patient's details including his name, age, height, the receipts of payment made and the like. It often includes the patient's contact details, the clinical findings on the patient, the patient's medical history, his family medical history. Either paramedics, auxiliary staff or clerks open the file. The medical records supply other information such as the drugs and other medication prescribed or used, medical processes adopted, decisions made, actions agreed and sometimes where there is disagreement, who is taking decisions and who is agreeing to the decisions, who is recording the history. The records include the progress or lack of progress of the patient or reports from each visit, details of any telephone consultations, and any diagnosis including hand notes, computer records, any correspondence between health professionals, reports of laboratory tests, x-rays, print outs from equipment used to examine the patient. The records are kept in the health facility and cover of the files often bear words that suggest that the records are not to be handled by the patient neither are they to be removed from the health facility. It is not unusual for medical facilities to have only paper form of medical records. Aiken et al., (2002) showed that medical record keeping in paper form in Nigeria often have ineligible handwriting, incomprehensible and confusing abbreviations 'and inappropriate request could limit the value of medical requests.

There is a low-level of archiving, protecting and keeping of patient's medical records in many of the public tertiary teaching hospitals in Nigeria. This would be disadvantageous to the patients themselves especially where a referral care is needed. Since 2003, many private hospitals in Nigeria have largely adopted one form of electronic record-keeping method or the other. Though, majority of Nigerian medical institutions and facilities have paper based medical record keeping methods, there is a slow but steady change to computerize medical record keeping especially in private hospitals. A number of computer developers such as Garcia Prado & Chawla (2006) have also embarked on putting in place a culturally viable computerized electronic medical keeping record medical records not in electronic forms are open to abuse, misrepresentation and misinformation by those responsible for putting recording the information in the medical record in electronic form. It is most certainly not the medical doctor(s) who wrote in the medical records who will be responsible for typing the information. Usually, it will be the medical doctor's secretary or Medical Record staff. This in itself leads to the fear of the patient's confidentiality being compromised in the course of putting the medical record's content in electronic form.

1.6 Other roles of Medical and Health Workers Union

Other dual roles of Medical and Health workers Union include:

Ensuring accountability: Health service providers (both public and private) might not adhere to standard guidelines for diagnosis, treatment and communication with patients, and may engage in harmful practices in consequence of a lack of accountability mechanisms. Health worker/patient relationships can be severely disrupted as a result of health worker attitudes (Modiba et al., 2002; Wood & Jewkes, 2006). Occurrence of inadequate behaviour towards patients is possible when staff members are not held personally responsible for their performance towards clients, managers or peers. Various reasons form a foundation for these practices, such as a lack of knowledge, equipment and supplies, economic incentives, lack of rules and regulations, a lack of supervision and follow-up, patient perspectives and characteristics, etc. (Chalker et al., 2000; Chakraborty & Frick, 2002; Nshuti et al., 2001). Many staff in the public sector adopt a coping strategy to deal with the low income earned from their public-sector job. Examples include requesting informal payments,

pilfering drugs, referrals to their own private service, or forms of mismanagement and corruption by health managers (Mc Pake et al., 1999; Ferrinho et al., 2004; Homedes & Ugalde, 2005; Israr et al., 2000). The Union is to ensure that health workers comply to set standards and ensure that services are provided as at when due and timely.

Ensure good working conditions: Good performance by staff is enabled via a supportive working environment with support from the medical and health workers union. This encompasses more than just having sufficient equipment and supplies. It also includes systems issues, such as decision-making and information-exchange processes, and capacity issues such as workload, support services and infrastructure (Potter & Brough, 2004). Protection from HIV/AIDS at work has become a very important issue in countries with a high HIV prevalence. A lack of protective measures increases fear of infection and limits quality of services due to stress and delegation of tasks to non-qualified staff (KIT/CHAZ, 2005; Dovlo, 2005). Although it is logical to link poor performance to poor working conditions, there is limited documentation showing how poor working conditions influence health provider productivity and responsiveness.

Development of interventions: In essence, this shows that strong government support and involvement and commitment from all stakeholders are important determinants for the success of interventions. This is facilitated by the union use of clear communication and implementation guidelines. Obviously, a comprehensive approach for enhancing performance will require additional and substantial financial resources, particularly for major improvements in basic working and living conditions such as equipment, supplies and infrastructure and increased payment of health workers. Effective collaboration between government and funding agencies for major increases in resources for HRD plans is a critical factor for success, as can be seen in the Malawi case study. Overall, the case studies often lacked a clear (description of an) analysis of factors at local level, which made it difficult to assess whether the priorities of local health workers were taken into consideration when interventions were designed

Monitoring and evaluation: In each case, indicators for process, outputs, effects or outcome are developed by the union, which differed among the cases with respect to the type of indicator, measurement tool, technique and use. Adequate monitoring and evaluation frameworks often were not developed, making it a difficult task to link the interventions with the objectives and outcome but since the inception of the union, this has been in place. As there is no international framework for analysis, the lack of a common framework impedes a comparative analysis of the interventions. In addition, most interventions were evaluated shortly after their implementation and would need to be revisited to assess sustainability. Since hardly any documents were found that described an evaluation after a number of years, no conclusions can be drawn about their sustainability.

1.7 Medical and health workers union and health workers situation in Nigeria (poor Health workers retention)

Staff shortages limit accessibility to health services and programmes, which in turn affect health outcomes. This explains why there is so much health workers turnover in Nigeria. This section identifies factors that influence staff shortage and retention, based on the available literature. Due to the limited documentation on retention in low-income countries (LICs), literature on high-income countries (HICs) has also been included to explore whether lessons could be learnt from experiences in them. Retention of health workers, particularly in rural areas of LICs, is high on the agenda, due to the severe staff shortages that hamper the attainment of the MDGs. As there are fewer health workers in rural areas, loss of health workers in these areas will severely contribute to accessibility

problems (Salafsky et al., 2005). Studies have shown that at hospital level, lower nurse-to-patient ratios lead to more complications and poorer patient outcomes (Aiken in Duffield & O'Brien-Pallas, 2003). In addition, staff shortages negatively affect the motivation of the remaining staff as they create increased workload, causing extra stress and the risk of more staff leaving or being absent from work. Migration to HICs is currently having a significant effect on the staffing situation, particularly in sub–Saharan Africa.

As HICs face an increasing demand for health care due to an ageing population, an ageing workforce and an increase in staff shortages (Buchan, 2002), more staff are required than are available locally, creating opportunities for health workers from LICs to migrate. Although various initiatives are under way to address recruitment by facilities in HICs, this trend will be difficult to change as long as the salaries offered in HICs are much higher than those in LICs, and working conditions and career opportunities are better. It is well known that migration to other countries stimulates internal migration from rural to urban areas, creating a "hierarchy of migration flows" (Padarath et al., 2003) and depleting remote rural areas of staff. Rural-to-urban migration also occurs in HICs, but they can better cope with the shortage as they have telemedicine or air services (Dussault & Franceschini, 2006). Various theoretical models explain mobility of staff, briefly described by Lehmann et al. (2005) and Dussault & Franceschini (2006). Economic models are often used, such as the neoclassical wage theory, which states that workforce mobility is related mainly to labour market demand/supply issues and that workers move for financial and economic reasons.

As finances are only one of the many factors influencing staff choices for practice location, behaviour models are also used. The main behavioural models used to explain job satisfaction are based on Maslow and Herzberg, who explain workforce mobility by looking at the complex process of making decisions according to needs. They distinguish between work satisfiers and dissatisfies. Studies have shown a clear relationship between job satisfaction7 and retention (Lu et al., 2005). The equity theory or the theory of organizational justice (Hughes et al., 2002) is also used to explain job satisfaction. Other publications explore workforce mobility by describing "push" and "pull" factors, with push factors being reasons to leave a certain workplace and pull factors being reasons to move to a certain location (among others, Padarath et al., 2003; Zurn et al., 2004). Examples of push factors include low salaries, difficult working and living conditions and limited career opportunities, while examples of pull factors include higher remuneration, improved living conditions, a better working environment (WHO, 2006; various authors cited in Buchan et al., 2005).

Main elements influencing staff retention

As mentioned above, various factors can influence staff retention and limit staff mobility. Combining the categories proposed by Lehmann et al. (2005) and Dussault & Franceschini (2006), the following factors can be distinguished:

1. personal and lifestyle-related factors, including living circumstances, e.g. living in conflict areas, areas with a poor infrastructure or with high AIDS levels
2. work-related factors:
    i. relating to preparation for work during pre-service education, such as medical education for rural areas;
    ii. relating to health systems, such as human resources policy and planning;
    iii. job satisfaction, influenced by health facility factors, such as financial considerations, working conditions, management capacity and styles, professional advancement and safety at work.

The influence of these factors on health providers depends on the overall context: the political, socioeconomic and cultural environment. The main conclusion by Lehmann et al. (2005) and Dussault & Franceschini (2006) is that health workers leave for many reasons and that financial reasons are often neither the only, or main, reasons. The aforementioned factors are also likely to be interrelated. For instance, poor and remote areas often lack infrastructure such as roads, schools and electricity, which has an impact on personal decisions to leave such locations, whereas health care facilities in these areas often are poorly managed and lack equipment and supplies, which then has an impact on work-related factors for departure. There is considerable literature available on the reasons for departure, but it focuses mainly on high-income countries. But most pronounce in Nigeria is poor condition of services which Union has strived over the years to ensure that there is stability and good condition of services for medical and health workers through training and skill development

Personal and lifestyle-related factors

Examples of individual factors are personal background, values and beliefs and gender-related factors, to name but a few. Lehmann et al. (2005) conclude that the evidence on leaving due to a personal situation is inconclusive and comes mainly from high-income settings. The authors report some studies showing that family reasons (children and spouse) certainly influence decisions, but more so for women than for men. Other influencing factors mentioned were lack of housing and health care services (Lehmann et al., 2005). Having a rural background seems important when it comes to workers' being willing to work in rural areas (British Columbia Medical Association in Dussault & Franceschini, 2006; Brooks and others in Lehmann et al., 2005).

Female professional workers have specific needs to be able to work, particularly due to security at work, their traditional role as family caretaker and their reproductive role (Mumtaz et al., 2003; Standing & Baume, 2003). Because women form a large part of the workforce in most countries, their needs must be understood and translated into workplace policies in order to better address staffing needs in rural areas, particularly in those places where women are not allowed to consult male providers on their health concerns (Dussault & Franceschini, 2006). Individual factors may vary according to a person's life cycle and career stage, and these changing needs must be taken into consideration when developing retention strategies. A number of studies in HICs have tried to map these needs in different life cycles in order to develop strategies to attract and retain staff (for instance Shields & Ward, 2001). Reid (2004) demonstrated that in South Africa financial incentives were perceived as being more important to experienced professionals in rural areas, whereas younger professionals considered educational opportunities to be more important.

Work-related factors

Preparation for employment

Pre-service training can have an impact when selecting a practice location after graduation. Many medical pre-service training courses are curative-oriented and urban-based. Students will often feel more comfortable starting their career in urban areas or in secondary or tertiary facilities, as these are where they have been prepared for their jobs. School location is also an influencing factor, as schools in rural areas are able to offer rural practice, thus better preparing and possibly motivating students to opt for practice in rural areas upon graduation (Dussault & Franceschini, 2006; Brooks in Lehmann et al., 2005).

Health systems-related factors

Various system-related factors have an indirect impact on staff retention, as they contribute to staff shortages and increased workload for existing staff. For instance, inappropriate policy and planning at national level lead to delays and limitations in recruitment and deployment of staff, and inadequate staffing deployment policies lead to the bad distribution of staff, leaving rural areas depleted (Dussault & Franceschini, 2006; Buchan, 2002; Hongoro & Normand, 2006). Other factors include inadequate information systems, which lead to ghost workers occupying posts (Dovlo, 2005), and a lack of coordination with the educational sector, leading to a mismatch between numbers produced and numbers required, as well as the trained skills and skills required (Buchan, 2002). Lastly, when posts in rural areas are perceived as punishments and rural posts are not made attractive, staff members are likely to ask for transfers or simply to refuse postings in rural areas.

Job satisfaction

Substantial research has been conducted on factors that influence job satisfaction in high-income countries and has shown a clear link between job satisfaction and the intention to leave a post. Financial benefits are an important factor, particularly in settings where salaries are extremely low, but they are not the only reason (Hongoro & Normand, 2006; Dussault & Franceschini, 2006). Evidence on the impact of financial benefits is inconclusive (Lehmann et al., 2005). Organizational and professional support, control over medical practice and working life, career opportunities and professional development have proven to be even more important, at least in rich countries (Joyce et al., 2003; Shields & Ward, 2001; Aiken et al., 2002; Lynn & Redman, 2005; Duffield & O'Brien-Pallas, 2003; Shen et al., 2004). Lu et al. (2005)summarized the following factors that influence job satisfaction: physical working conditions, relationships with fellow workers and managers, pay, promotion, job security, responsibility, recognition from managers and hours of work.

The authors acknowledge that while determinants for job satisfaction might be similar across countries, socio-cultural and labour-market issues will influence priorities in these factors among service providers. It is not clear whether findings from studies in HICs can also be applied to health workers in LICs, as wage levels and working conditions differ substantially between LICs and HICs. Health workers from LICs receive an income that is often insufficient to pay basic living costs (Zurn et al., 2005). However, limited research on factors relating to job satisfaction has been conducted in LICs8. These studies confirm the factors identified in the literature in HICs, although factors differ in priority depending on the context. Additionally, with the advent of AIDS, working conditions and safety at work have become very important to staff, as Lehmann et al. (2005) report from various studies.

1.8 Concept of health workers performance

Poor performance of service providers leads to inaccessibility of care and inappropriate care, which thus contribute to reduced health outcomes as people are not using services or are mistreated due to harmful practices. The final report of the Joint Learning Initiative clearly outlines the importance of the workforce in performing services by stating that health workers' number, quality and type of professionalism determine output and productivity, that they manage the other resources, that a large part of the health budget is spent on health workers and that they greatly influence progress (JLI, 2004). A number of articles and documents have reported problems relating to service provision due to poor performance of health workers (including JLI, 2004; WHO, 2006; Van Lerberghe et al., 2003; Rowe et al., 2005; Garcia Prado & Chawla, 2006).

Poor performance results from too few staff, or from workers not providing care according to standards and not being responsive to the needs of patients and the community. As Hughes et al. state: "Most performance problems can be attributed to unclear expectations, skills deficit, resource or equipment shortages or a lack of motivation" (Hughes et al., 2002). These causes are rooted in a failing health system, low salaries, difficult working and living conditions and inappropriate training.

The framework shows that determinants of health workers' behaviour (in the workplace) are rooted in factors relating to:

1. macro level, or the overall health system, such as resources allocation, planning and deployment of health workers, current regulatory framework, communication and decision-making processes, and accountability mechanisms. These can be influenced by policy-makers and planners in the health sector, as well as other stakeholders at national level, such as the ministry of finance, ministry of education, professional associations, civil society groups and funding agencies (health systems level).
2. micro level, or the workplace itself (district or facility, etc.), such as availability of equipment, drugs and supplies, teamwork and human resources management activities. In principle these can be influenced by local managers, colleagues, patients and other local partners (health facility level) individual characteristics and living circumstances, such as living in conflict areas or being a woman or a newly graduated professional. These require specific group strategies and can be developed locally by managers or nationally by policy-makers and planners together with other stakeholders (individual level).

Interventions by the union are designed based on an analysis of the determinants that influence health workers' performance. Implementation of these interventions (inputs and process) provides outputs (expected results) in terms of improved working conditions, improved motivation, improved staff retention, etc. These, in turn, result in the effects of the intervention in terms of measurable improvements on availability, productivity, competence and/or responsiveness of health workers. The effects positively influence performance, i.e. the outcome of the intervention, for which the intervention is not totally accountable. Improved performance in turn contributes to improved health status. There is no linear relationship between determinants and outputs, between outputs and effects, and between effects and outcomes.

Health worker performance is a complex issue to address, as a variety of determinants influence staff behaviour at different levels. Various authors have regrouped the determinants (Rowe et al., 2005; Hongoro & Normand, 2006; WHO, 2006), suggesting four main areas:

1. health worker characteristics (individual level) • health system and facility characteristics (macro and micro levels)
2. characteristics of the wider political and socioeconomic environment (contextual factors)
3. community/population characteristics (contextual factors). This report focuses on strategies implemented at individual, micro or macro level, but at the same time the authors make an effort to describe the contextual factors.

Determinants of poor performance can be influenced in a variety of ways, using various methods at different levels in the health system. The 2006 World health report describes three levers to influence workforce performance: job-related interventions that focus on individual occupations, support-system related interventions and interventions that create an enabling environment and focus on managerial culture and organizational arrangements (WHO, 2006). Using these levers, a further refinement can be made (at micro, macro and individual levels), to link these interventions to the determinants of poor performance. This distinction allows policy-makers, planners and managers to select appropriate interventions to address the determinants identified at each level. Understanding which contextual factors contributed to the success or failure of certain interventions will help to

assess their applicability in other countries, or the chances of replicating these successes in other regions (Rowe et al., 2005).

Chalker provides clear examples with respect to the application of one intervention in Thailand and in Viet Nam, with differing success rates due to the different contexts in which they were applied (Chalker et al., 2005). Where possible, the wider environment and the community characteristics are described when analyzing interventions that influence staff performance

Improved performance is assessed by looking at the availability of staff, as well as their competences, productivity and responsiveness. Indicators should be of a quantitative and qualitative nature. Monitoring and evaluation should also not be limited to indicators at the level of effects and outputs of interventions. It is equally important to monitor and evaluate the process of implementation and the financial and technical inputs, as both determine the success of an intervention. At all these levels, lessons can be learnt by health care policy-makers, planners and managers. Indicators and a framework for monitoring and evaluating HRD interventions are often not defined prior to interventions, and inadequate HR information systems make it extremely difficult to determine (retrospectively) the success of HR strategies. Monitoring and evaluation of HRH need more attention (WHO, 2006).

1.9 Employees training and health workers performance

Employee performance has been described in many ways; ability to achieve targets, realize goals, attain benchmarks. Most commonly people immediately talked of job performance as what a person did at work. Different stages of job as well the complexity of a job also affected the overall performance of the jobholder. This could mean that job performance as a construct could be defined in different ways depending on the different stages and complexities of the job (June, 2011). Sarmiento and Beale (2007) noted job performance resulted from two elements, abilities and skills (natural or acquired) that an employee possessed, and motivation to use them in order to perform a better job. The performance of an employee is measured actually by the output the individual produces in relation to productivity. At corporate level, productivity is affected by many factors such as employees, technology and objectives of the organization.

It is also dependent on the physical environment and its effect on health and employees' performance. Other factors include employees applying the skills they learnt during training programs once they return to their workplace. Tending to the structural and interpersonal aspects of each of these factors enables employees to apply the required skills in a consistent and habitual way (Knight, 2005). Crucial to an employee's performance is the extent of exposure to health and safety training and education. In most accidents, managers and supervisors almost instantaneously point fingers at human efforts and unsafe actions as the ultimate cause without probing deeper into the root cause of the accident. Such incidents occur due to multifaceted factors. Human errors and unsafe actions caused by illiteracy, lack of training, poor supervision, technical flaws relating to design, layout, machine guarding and arrangement of work (Krishnan, 1999). Workplace health and safety raises the question of economic costs. Ensuring occupational health and safety in the workplace has both advantages and disadvantages for an organization. While protecting employees from workplace hazards is important, it may sometimes clash with the management's goal of reducing production costs. Implementing effective health and safety policies can benefit both employees and the organization. By preventing accidents, disabilities, absenteeism, and illnesses, companies can save on costs related to these issues. In addition, work-related accidents can result in indirect costs such as overtime payments to make up for lost production, expenses associated with hiring and training replacement employees, and lost revenue from cancelled or lost orders. These accidents can also negatively affect employee morale and lead to a decline in work quality (Rousseau, 1998).

A company's appreciation of the employees is observed in the careful attention it pays to their health and the opportunities it gives for their personal development. The training activities planned to cause employees to have the appropriate attitudes, also serve to keep their safety and health. Regular training is considered as a function which serves both to increase employees' knowledge, skills and performance and to protect their physical and spiritual health (Sari, 2009). Investment in safety prevention will lead to a significant decrease in occupational accidents and diseases which will also help save lives, prevent enormous human suffering and financial resources through employee absenteeism.

1.10 Health and Safety Training by MHWU and Employee Performance

A good occupational health and safety program fosters a sense of security and comfort and increases job satisfaction which every union must strive to support and archive (Ria, Anis & Oci, 2012). Furthermore, Mamoria and Gankar (2011) argue that a comprehensive health program not only ensures good health of employees but also leads to a lowering rate of absenteeism and health insurance costs resulting in higher productivity and improved morale. For instance, a wellness program boosts employee morale and increases job satisfaction since it promotes employee health by providing education on health issues and healthy lifestyles. Safety training programs are developed with an aim of enabling workers acquire attitudes, knowledge and skills which helps them reduce the perceived risk of their jobs. Most workplace hazards are caused by incomplete or absent training and if an employee is not trained to their job properly in order to avoid falling victim to hazards, they are likely to become frustrated.

When trained correctly on health and safety measures, an employee is likely to feel much less stress and more satisfied with their job. Sieben (2005) found that job satisfaction tended to be higher where there is access to workplace training Studies conducted in different sectors on the influence of health and safety practices on job satisfaction reported a positive relationship between the variables. For instance, Gyekye (2005) found a positive association between job satisfaction and safety climate. Workers who expressed more satisfaction at their posts had positive perceptions of safety climate and displayed greater emotional attachment, involvement and expressed stronger feelings of allegiance and loyalty to their organization.Cole (2002) asserted that among the key factors that affect employees' productivity and performance include management driven factors which include the development of organization plans, shift-working, health and safety policies, including the provision of training, development of safe working practices and the adequate supply of protective clothing and equipment.

1.11 Theoretical Framework

Human Capital Theory

The proponent of this theory can be traced to Adam Smith in the 18th Century. The theory was popularized by Becker in 1964, a noble laureate from the University of Chicago. The basic assumption of the theory is that, it emphasizes on how education increase the productivity and efficiency of workers by increasing the productivity of workers, increasing the level of cognitive stock of economically productive human capital which is a product of innate abilities and investment in human being. The Human capital theory suggests that the abilities and knowledge acquired by individuals are likely to be rewarded with higher earnings in the labor market (Becker, 1964). Education and work experience are the two forms of human capital individuals are most likely to acquire during their careers (Myers, Griffeth, Daugherty, & Lusch, 2004; Singer & Bruhns, 1991; Strober, 1990).

It should be noted, though, that in numerous cases educational level and amount of work experience are likely to be negatively correlated. Those who spend more years in school will have less time available in which to accumulate work experience, whereas those who enter the labor market early typically accumulate less formal education. There has been mounting research evidence indicating the career benefits of human capital investments. For instance, in one of the earliest studies of the effect of education on salary, Mincer (1974) found that an additional year of schooling yielded a net increase of 11.5% in annual earnings. A meta-analysis conducted by Quinones, Ford and Teachout (1995) ˜ showed that work experience was positively related to job performance at 27. Furthermore, the positive effects of human capital investments (e.g., in schooling) in early career on subsequent earnings are large (Sweetland, 1996).

Thus, human capital theory is particularly useful for explaining income dispersion across social and occupational groups like in the health care sectors, for identifying the rate of return on educational expenditures, and for explaining national differences in economic growth. That is, if staff have the relevant skill and are sound in what they do, there will be positive result and patient satisfaction of services provided by health organizations.

Goal-Freedom Alertness Theory

The Goal-Freedom Alertness Theory was developed by Kerr (1950) and it states that safe work performance is the result of psychologically rewarding work environment. Under this theory, accidents are viewed as low-quality work behaviour occurring in an unrewarding psychological climate. This contributes to a lower level of alertness. According to this theory also, a rewarding psychological climate is one where workers are encouraged to participate, set sustainable goals and choose methods or safety programmes to attain those safety and health goals. They must be allowed to participate in raising and solving problems.

Goal-Freedom Alertness Theory essentially states that management should let workers have well defined goals and freedom to pursue those goals. The result is a higher level of alertness and a focus on the tasks at hand. The theory suggests that managers and supervisors should try and make work more rewarding for workers. They may use a variety of managerial techniques including positive reinforcements, goal setting participative management and clear work assignments.

Heinrich, Peterson & Roos (1980) supported this theory by stating that workers will be safe in a positive work environment. They argue farther that safe performance is compromised by a climate that diverts the attention of workers. They confirm that hazards divert the workers attention during work hours, and thus the diversion increases susceptibility to injury. Heinrich et. al (1980) suggests that manager's stakeholders, unions and supervisors can actively work to alleviate hazards in the work environment. Reaction of workers to unsafe conditions depends on the fact that whether the worker identifies the unsafe condition.

1.12 Conclusion

Good governance is needed to achieve a sound national health system, especially with regard to human resources for health. The Nigerian health system is lacking full capacity in leadership and governance, with this reflecting in the health workforce crises and poor health service delivery in recent years. Although the Nigerian government can be responsive to population health needs, without a driving, visionary, systemic and structural change in health governance, the prevailing crises in the health workforce and service delivery may continue if unions or trade union organization refuses to intervene through policies that will better the worker environment. Our aim in this paper is to encourage productive discussions and actions regarding the health workforce and governance

in Nigeria. We believe that by doing so, we can improve the quality of healthcare services provided in the country.

1.13 Way forward

Based on our findings, it is evident that health workforce crises in Nigeria have continued to deteriorate due to some specific factors, mostly related to poor health leadership. The following solutions have been suggested to help addresses issues raised in this paper.

1. The public needs to clearly understand the grievances of the health workers, especially towards the government. No doubt, the health workers directly benefit from government's interventions, but the public benefits even more when health service delivery is optimal.
2. To build sustainable leadership, it is important the national health system has a solid administrative policy foundation that allows alignment, coordination and coherence of priorities and partnerships in the health workforce and among various stakeholders
3. The mutual distrust, tension and supremacy challenge among the health workforce need to stop as a matter of priority. The focus of health service delivery should be on teamwork, rather than factional or individual strengths. Many have argued that this is perhaps the single most important factor in Nigeria, and until agreeable solutions are found across various professional groups, the Nigerian health system may continue to suffer from repeated and avoidable disruption of health service delivery
4. To address the challenges in medical training and academic appointments, it has been suggested that current residency programmes (postgraduate medical training) in Nigeria be structured and upgraded to allow for both academic and clinical training as observed in some other countries, such that residents are awarded Masters or Ph.Ds., along with their respective Fellowships, on completing their training
5. Moreover, there is a need to design a contextually adaptable framework for inter-professional education and collaborative practice in the health sector as recommended by the WHO, to further facilitate successful cooperation, communication and teamwork in health service delivery and ensure a health workforce that is better prepared to respond to local health needs
6. The goal of the health system is to ensure delivery of affordable, accessible, equitable and safe health services to the population, and in achieving this, every health worker has an important role to play. Lack of funds, inadequate welfare and poor state of health facilities have been major factors affecting workers' motivation. While these need to be addressed urgently, there is also the need to strategically adopt broader range of motivational factors.

References

Aitken JM, Kemp J (2003). HIV/AIDS, equity and health sector personnel in southern Africa. Regional Network for Equity in Health in Southern Africa and Oxfam (http://www.equinetafrica.org/bibl/docs/hivpersonnel.pdf/, accessed 12 March 2006).

Becker H (1964). Formalising under-the-table payments to control out-of-pocket expenditures: creating a sustainable financing scheme in Cambodia. Health Policy and Planning, 19(4):199–208.

Buchan J (2002). Nursing shortages and evidence-based interventions: a case study from Scotland. International Nursing Review, 49:209–218.

Buchan J, Kingma M, Elegardo-Lorenzo FM (2005). International migration of nurses: trends and policy implications. International Council of Nursing (http://www.icn.ch/global/Issue5migration.pdf, accessed 12 June 2006.

Chakraborty S, Frick K (2002). Factors influencing private health providers' technical quality of care for acute respiratory infections among under-five children in rural West Bengal, India. Social Science and Medicine, 55(9):1579–1587.

Chalker J, Chuc NT, Falkenberg T, Do NT, Tomson G (2000). STD management by private pharmacies in Hanoi: practice and knowledge of drug sellers. Sexually Transmitted Infections, 76(4):299–302. Improving health worker performance: in search of promising practices • Page 60

Chalker J, Ratanawijitrasin S, Chuc NTK, Petzold M, Tomson G (2005). Effectiveness of a multi-component intervention on dispensing practices at private pharmacies in Vietnam and Thailand: a randomised controlled trial. Social Science and Medicine, 60:131–141.

Cole, E. A. (2002). Personnel and human resource management, 5th edition. London: Biddles Limited

Dovlo D (2005). Wastage in the health workforce: some perspectives from African countries. Human Resources for Health, 3:6.

Duffield C, O'Brien-Pallas L (2003). The causes and consequences of nursing shortages: a helicopter view of the research. Australian Health Review, 26(1):186–193.

Dussault G, Dubois CA (2003). Human resources for health policies: a critical component in health policies. Human Resources for Health, 1:1.

Dussault G, Franceschini MC (2006). Not enough there, too many here: understanding geographical imbalances in the distribution of the health workforce. Human Resources for Health, 4:12 (http://www.human-resourceshealth.com/content/4/1/12, accessed 22 August 2006).

Ferrinho P, Omar MC, De Jesus Fernandes M, Blaise P, Bugalho AM, Van Lerberghe W (2004). Pilfering for survival: how health workers use access to drugs as a coping strategy. Human Resources for Health, 2:4.

García-Peña C, Reyes-Frausto S, Reyes-Lagunes I, Muñoz-Hernández O (2000). Family physician job satisfaction in different medical care organization models. Family Practice, 17(4):309–313.

Heinrich, H.W., Peterson D. &Roos, N. (1980). Industrial accident prevention. New York: McGraw-Hill. Kaplan, R. S. & Norton D.P., (1996). The balanced scorecard: Translating strategy into action. Boston, Ma, Harvard Business School Press.

Homedes N, Ugalde A (2005). Human resources: the Cinderella of health-sector reform in Latin America. Human Resources for Health, 3:1.

Hongoro C, Normand C (2006). Health workers: building and motivating the workforce. In: Jamison DT et al., eds. Disease control priorities in developing countries, 2nd edition. Washington, DC, The World Bank Group:1309– 1322.

Hughes RL, Ginnett RC, Curphy GJ (2002). Leadership, enhancing the lessons of experience. New York, McGraw-Hill/Irwin.

Israr SM, Razum O, Ndiforchu V, Martiny P (2000). Coping strategies of health personnel during economic crisis: a case study from Cameroon. Tropical Medicine and International Health, 5(4):288–292.

JOHESU press release on the NMA strike and the imminent crisis in the health sector [cited 2016 September 09]; Available from: http://www. medicalworldnigeria.com/2014/07/johesu-press-release-on-the-nma-strikeand-the-imminent-crisis-in-the-health-sector#.V86VjpgrLIU.

Joint Learning Initiative (2004). Human resources for health: overcoming the crisis. Cambridge, Global Equity Initiative/ Harvard University Press (http://www.globalhealthtrust.org/report/, accessed 7 June 2006).

Joyce C, Veitch C, Crossland L (2003). Professional and social support networks of rural general practitioners. Australian Journal of Rural Health, 11:7–14.

Kerr, J.H., &Vos, M.C. (1993). Employee fitness programs, absenteeism and general wellbeing. Work Stress, 7, 179-190.

KIT/CHAZ (2005). Coping with the impact of HIV/AIDS on health workers in Zambia: a pilot study in two districts, Amsterdam, Royal Tropical Institute.

Krishnan, N. V. (1999). Safety management in industry, 3rd edition. Mumbai: Jaico Publishing House, 406.

Lehmann U, Martineau T, Dieleman M, Lexombooon D, Matwa P (2005). The staffing of remote rural health services in low-income countries: a literature review of issues and options affecting attraction and retention. 3rd Improving health worker performance: in search of promising practices Making Health Systems Work, Midrand, South Africa, 15–17 May 2006. Unpublished report.

Lu H, While AE, Barriball KL (2005). Job satisfaction among nurses: a literature review. International Journal of Nursing Studies, 42:211–227.

Lynn MR, Redman R (2005). Faces of the nursing shortage: influences on staff nurses' intentions to leave their positions or nursing. Journal of Nursing Administration, 35(5):264–270.

Mamoria, C. &Gankar, S (2011). Personnel management. Mumbai: Himalaya Publishing House PVT Ltd.

McPake B, Asiimwe D, Mwesigye F, Ofumbi M, Ortenblad L, Streefland P, Turindi A (1999). Informal economic activities of public health workers in Uganda: implications for quality and accessibility of care. Social Science and Medicine, 49:849–865.

Modiba P, Schneider H, Weiner R, Blaauw D, Gilson L, Zondi T, Kunene X, and Brown K (2002). The integration of HIV/AIDS care and support into primary health care in Gauteng province. Johannesburg, University of Witwatersrand.

Mumtaz Z, Salway S, Waseem M, Umer N (2003). Gender-based barriers to primary health care provision in Pakistan: the experience of female providers. Health Policy and planning, 18(3):261–269.

Nshuti L, Neuhauser D, Johnson JL, Adatu F, Whalen CC (2001). Public and private providers' quality of care for tuberculosis patients in Kampala, Uganda. International Journal of Tuberculosis and Lung Disease, 5(11):1006– 1012.

Padarath A, Chamberlain C, McCoy D, Ntuli A, Rowson M, Loewenson R (2003). Health personnel in Southern Africa: confronting maldistribution and brain drain. EQUINET Discussion Paper no. 3. Harare, EQUINET.

Potter C, Brough R (2004). Systemic capacity building: a hierarchy of needs. Health Policy and Planning, 19(5):336–345.

Reid S, Conco D (1999). Monitoring the implementation of community service. South African Health Review. Durban, Health Systems Trust:233–248 (http://www.hst.org.za/uploads/files/chapter17_99.pdf#search=%22Monitoring%20the%20implementation%20of %20community%20service%22, accessed 22 August 2006).

Ria, M.Y., Anis, E., & ,Oci, N.S. (2012). The influence of occupational safety and health on performance with job satisfaction as intervening variables (study on the production employees in PT. MahakaryaRotanindo, Gresik). American Journal of EconomicsSpecial Issue: 136-140

Rousseau, D., (1988). Quantitative assessment of organisational culture, the case for multiple measures. London: Chapman & Hall.

Salafsky B, Glasser M, Ha J (2005). Addressing issues of maldistribution of health care workers. Annals of the Academy of Medicine of Singapore, 34:520–525.

Sari, F.O. (2009). Effects of employee trainings on the occupational safety and health in accommodation sector. Procedia Social and Behavioral Sciences, 1, 1865–1870.

Sarmiento, R., & Beale, J. (2007). Determinants of performance amongst shop-floor employees. Management Research News, 30 (12), 915- 927.

Shen J, Cox A, McBride A (2004). Factors influencing turnover and retention of midwives and consultants: a literature review. Health Services Management Research, 17(4):249–262.

Shields MA, Ward M (2001). Improving nurse retention in the National Health Service in England: the impact of job satisfaction on intentions to quit. Journal of Health Economics, 20:677–701.

Sieben-Thomas, F. (2005). Job quality in European labour markets. New York: Palgrave Macmillan.

Singh P, Sachs JD. 1 million community health workers in sub-Saharan Africa by 2015. Lancet. 2013;382(9889):363–5.

Standing H, Baume E (2003). Equity, equal opportunities, gender and organisation performance. In: Ferrinho P, Dal Poz MR, eds. Towards a global health workforce strategy. Antwerp, ITGPress:301–326.

Van Lerberghe W, Conceição C, Van Damme W, Ferrinho P (2003). When staff is underpaid. Dealing with the individual coping strategies of health personnel. In: Ferrinho P, Dal Poz MR, eds. Towards a global health workforce strategy. Antwerp, ITGPress:411–420.

WHO (2006). World health report 2006. Working together for health. Geneva, World Health Organization (http://www.who.int/whr/2006/en/, accessed 25 April 2006).

Zurn P, Dal Poz MR, Stilwell B, Adams O (2004). Imbalance in the health workforce. Human Resources for Health, 2:13.

Zurn P, Dolea C, Stilwell B (2005). Nurse retention and recruitment: developing a motivated workforce. Geneva, World Health Organization.