Motivation and Retention of Health Workers in Ministry of Health Facilities in Four Governorates in Jordan

Findings from a Mixed Methods Study

HRH2030: Human Resources for Health in 2030

December 1, 2016

This publication was produced for review by the United States Agency for International Development. It was prepared by members of the HRH2030 consortium.
Acknowledgements

This research was conducted by the HRH2030 consortium through the generous support of the United States Agency for International Development (USAID). The research consortium consists of the Royal Tropical Institute, Mindset, Chemonics International, University Research Co., and the Palladium Group.

The research team is thankful for the support and the contributions of the Ministry of Health, including H.E. Dr. Ali Hyasat and H.E. Dr. Mahmoud Al-Sheyyab, the former and current Ministers of Health, respectively. The research team also recognizes the contributions made by the HRH2030 Technical Working Group, including Mr. Ghaleb Al-Qawasmeh of the Personnel Directorate, Dr. Rania Al-Jilani of the Planning Administration, Dr. Khaled Al-Odwan and Dr. Ahmad Qteitat of the Health Directorates Administration, and Dr. Ali Al-Saad of the Hospital Administration, as well the Health Directors of the subject health Directorates, Dr. Lail Al-Fayez (Amman), Dr. Ahmad Al-Shouqran (Irbid), Dr. Turki Al-Kharabsheh (Zarqa), and Dr. Tayseer Kreshan (Ma’an). The team is especially indebted to Dr. Mohammad Al-Tarawneh, Director of the Primary Health Care Administration, for his leadership, continuous support, and valuable feedback during all stages of this research.

The team also appreciates the inputs provided by colleagues at the Civil Service Bureau, including H.E. Mr. Sameh Al-Naser and Ms. Reem Hoseh, the High Health Council, including H.E. Dr. Hani Brosk Al-Kurdi and Dr. Raghad Hadidi, the Jordan Nursing Council, including Dr. Muntaha Gharraibeh, and the Jordan Medical Council.

Disclaimer

The views expressed in this research publication including its interpretation of findings and recommendations are entirely those of the research team and do not necessarily reflect the views of the Ministry of Health, USAID or the United States government.
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Acronyms

CHC  Comprehensive Health Centers
CSB  Civil Service Bureau
FGD  Focus Group Discussion
HR  Human Resources
HRH  Human Resources for Health
HRH2030  Human Resources for Health in 2030
HRM  Human Resources Management
JD  Jordanian Dinar
KIT  Royal Tropical Institute
MENA  Middle East and North Africa
MOH  Ministry of Health
NGO  Non-Governmental Organization
PHC  Primary Health Centers
RMS  Royal Medical Services
SD  Standard Deviation
SSI  Semi-Structured Interview
USAID  United States Agency for International Development
WHO  World Health Organization
Executive Summary

This report provides an overview of research conducted on the motivation and retention of doctors, nurses, and midwives in Ministry of Health (MOH) facilities in Jordan. Through support from the U.S. Agency for International Development (USAID), this research has been initiated by the Human Resources for Health in 2030 (HRH2030) activity to support the MOH in developing a specific human resources for health policy to improve retention of the MOH workforce. The results of this research will drive USAID and MOH interventions to improve Jordan’s health workforce in line with mission and ministry objectives.

This research used an exploratory, mixed methods design combining both quantitative and qualitative data collection techniques. Research tools included questionnaires, semi-structured interviews and focus group discussions. The survey sample included 1,032 health workers and 67 managers in Amman, Zarqa, Irbid, and Ma’an. For the quantitative data, responses to individual questions were described and analyzed by means of frequency distributions, mean and median scores, as well as multi-variate regression analysis. For the qualitative data, responses were analyzed per group of respondents and by research question, using a framework approach based on the research questions and main issues in the topic guides. Quantitative data were disaggregated by gender, and gender balance was considered in the recruitment of subjects for the semi-structured interviews and focus group discussions.

Overall, the main findings showed that there is relatively high retention in the MOH, with relatively low turnover and a low number of vacancies reported in sampled facilities. Two-thirds of all health workers intend to stay within the MOH sector for the next two years, and one-third of health workers reported they are actively seeking a position outside of the MOH. Additionally, the study found that health workers’ motivation is neutral to slightly positive, with doctors, men, younger employees, and health workers with fewer years of experience less motivated and having a higher intention to leave. Health workers are most satisfied with the value that their work brings to society, interpersonal relations, team work and some working arrangements; their biggest sources of dissatisfaction included incentives, supplies and infrastructure, opportunities for professional and career development, and some working arrangements. These findings conflict with the MOH’s general perception of the health workforce, which identifies the distribution of doctors and nurses, combined with high turnover and poor retention, as a key challenge.

This study resulted in clear recommendations for improving the motivation and retention of the health workforce in the MOH. These recommendations include:

▪ Critically assessing the actual workload, facility staffing and efficiency in relation to current requirements at facility level
▪ Reviewing and reforming, if needed, the deployment and transfer process jointly with the MOH and Civil Service Bureau (CSB)
▪ Introducing more defined career paths (offering specialization) or performance-related incentives to improve motivation of younger staff
▪ Improving implementation of human resources management (HRM) practices, including leadership, team building, coaching, support and supervision and communication
▪ Building capacity of managers in conflict management to support staff in dealing with conflicts, aggression and abuse
▪ Supporting decentralizing decision-making, particularly as it relates to HRM practices, the directorate and facility levels
▪ Providing frequent and equitable opportunities for continuing professional development for staff to regularly update their knowledge and skills
▪ Introducing systematic and productive channels for patient feedback and appreciation

In addition to the above recommendations, there are clear areas of further study that emerge from this research. First and foremost, a similar study among university, Royal Medical Services (RMS) and
the private health workforce is recommended to ensure a complete and comparative understanding of motivation and retention in Jordan’s health sector. Additionally, there is a need to better understand the barriers that affect women’s ability to access and assume management positions in the MOH, in light of their being underrepresented at the decision-making level within the ministry. There was also an identified gap in understanding the impact of the current refugee crisis on the MOH and the broader health sector; while the study did not reveal a strong burden on the health sector due to refugees, a better and more nuanced understanding of the situation is warranted. Finally, while researchers reported qualitative references to harassment and aggression at the workplace, and its impact on motivation, it is important to measure and better understand the magnitude of this problem.
Introduction

Research purpose

According to policymakers and health professionals, the motivation and retention of health workers in Ministry of Health (MOH) facilities is one of the most prominent health sector challenges in Jordan. MOH officials identified the distribution of doctors and nurses, combined with high turnover and poor retention, as particularly challenging.1 In its Strategic Plan 2013-2017, the MOH cited the retention of both technical and administrative staff and attracting new talent into the system as two of its biggest challenges. This research has been initiated by the Human Resources for Health 2030 (HRH2030) Activity to support the MOH developing a specific HRH policy to improve retention of the MOH workforce. More specifically, it aims to assess retention and to identify factors influencing retention, job satisfaction and motivation among doctors, nurses and midwives within MOH primary and comprehensive health facilities and make an inventory of experiences with current HRM practices. It also will provide insights about why staff leave the MOH health workforce.

USAID’s goal for Jordan from 2013 to 2017 is to improve prosperity, accountability and equality for a stable, democratic Jordan. Improving the standard of living in Jordan is critical to stability, and is dependent on the government's ability to strengthen the delivery and quality of essential services, including health. Going forward, USAID’s strategy will focus on supporting the government of Jordan’s efforts to address the demands of citizens for increased employment opportunities in key sectors of the economy. Emphasis will be placed on gender equality and female empowerment to foster inclusive development.

USAID/Jordan’s Development Objective Number Three, Social Sector Quality Improved, recognizes that the government’s ability to provide equitable high-quality social sector services strengthens the governments’ credibility, the nation’s stability, the elimination of opportunities for corruption and the likelihood that citizens will build better lives for themselves and their children. Intermediate Result Number One under this development objective is Health Status Improved. Through the HRH2030 Activity, USAID is assisting the government of Jordan and the MOH to strengthen its health workforce through optimized performance, productivity and efficiency of human resources for health (HRH); increased competency, distribution and number of health workers; and improved public sector leadership in health. The results of this research will drive USAID and MOH interventions to improve its health workforce in line with mission and ministry objectives.

Country context

Jordan is classified as an upper-middle income country and has a population of 9.5 million persons across 12 governorates. Almost 67% (6.4 million) of the population lives in urban areas. Over the past ten years, Jordan has successfully implemented a number of structural reforms in education and health, as well as economic reforms. Adverse regional developments, in particular crises in neighboring Syria and Iraq, remain the biggest shock affecting Jordan, as reflected in the large refugee influx, disrupted trade routes, lower tourism inflows and a high unemployment rate of 12-14%.2

Jordan spends 7.7% of its gross domestic product on health. The MOH provides approximately 38% of the country’s health services through 377 primary care centers (PHCs), 98 comprehensive health centers (CHCs), 202 peripheral health centers and 31 hospitals. The Royal Medical Services (RMS), university hospitals and the private sector provide 18%, 9% and 34% of health services, respectively. The MOH provides care to 3.8 million people, including 614,000 refugees, most of whom are Syrians living in Irbid, Mafraq, Zarqa and Amman governorates.3

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1 Trip report, KIT, March 2016
2 World Bank, 2016
3 Mapping the Health Workforce within Jordan’s Ministry of Health, internal HRH2030 document, 2016
The influx of refugees and their dependence on public services have caused an immense burden to the Jordanian health system. After several policy changes since the start of the crisis in 2011, refugees can no longer access care for free (with the exception of maternal and child health services), and are now required to pay out-of-pocket. This has reduced the use of services by refugees tremendously and lifted some of the burden on the system.

Through several national and private universities, Jordan has a robust educational system for physicians, nurses, dentists, pharmacists and allied health sciences. There are three levels of education that supply the health sector: community college and associate degree programs (two years after secondary school), university/undergraduate (four to six years after secondary school) and post-graduate (one to four years after university degree). Many reports, while anecdotal, suggest that universities and other institutions that supply the health work force to the MOH and other service providers produce technically proficient workers. Additionally, for the moment, the number produced is sufficient to meet the needs of the system.

The High Education Council sets education policies and regulations, including for health workers, which are then implemented by the Ministry of Higher Education and Scientific Research through their oversight of medical, nursing and other health sciences schools. The MOH is not directly involved in policy formulation or decisions related to pre-service training and education at public or private universities and colleges. However, the MOH has a mechanism to coordinate with medical universities to adjust existing curricula to address the current and future needs of the health sector.

As of 2014, there were 19,655 physicians working in Jordan, approximately 21% of whom work in the MOH system, and 18,454 registered nurses, 25% of whom work in MOH facilities. Overall, across the public and private sectors, Jordan has 29.4 doctors and 27.6 registered nurses per 10,000 residents. Geographically, human resources are unevenly distributed: MOH facilities in six governorates (Amman, Balqa, Zarqa, Irbid, Mafraq and Aqaba) have fewer doctors and registered nurses than the national level ratios.

MOH staff members are part of the civil service staff in Jordan. The Jordanian Civil Service System follows a centralized decision-making approach that sets rules for the recruitment, appointment, compensation, promotion and distribution of the health workforce. The Civil Service Bureau (CSB) coordinates the health workforce deployment and recruitment for the MOH sector.

The MOH Strategic Plan 2013-2017 suggests that 2.7% of MOH doctors and 6.8% of MOH nurses leave the country every year. Some sources suggest that the number of health workers leaving the country is increasing; the lack of an accurate tracking system makes it difficult to confirm. Women account for more than 50% of the health workforce, but the gender representation by cadre is skewed, with most women working as nurses, pharmacists, and lab and dental technicians. Men predominate the physician, dentist, pharmacy assistant and environmental health worker cadres. A steady increase in the percentage of women graduating from medical universities is reported, but there is a discrepancy between the number of women graduating and the number deployed in the health care system.

Jordan’s health workforce includes various cadres. This report focuses on doctors, nurses and midwives as the largest key cadres within the MOH. Doctors are composed of general practitioners and specialists and nurses can be subdivided into registered, associate and assistant nurses. Among nurses, registered nurses have the highest level of education, followed by associate nurses and assistant nurses.

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4 Doocy et al. 2016
Knowledge gap on motivation and retention at the MOH

Previous workforce studies conducted in Jordan provide indications on factors influencing retention and motivation. However, these studies are either outdated or limited in that they only investigate one profession.\(^5\) Therefore, the extent of the problem is not clear, nor are the current reasons motivating people to stay or leave the MOH. Also, a better understanding is needed if and how workforce motivation and retention is influenced by the refugee situation in certain governorates. In addition, these studies do not assess the relationship between retention, motivation and/or satisfaction and experiences with HRM practices, which would enable policymakers to identify workplace interventions for change.

Factors influencing retention and motivation in the Middle East and North Africa region and HRM improvement strategies

Various factors influencing retention, satisfaction and motivation are reported in the literature on Jordan and the Middle East and Northern Africa (MENA) region.\(^6\) These include individual/personal level factors like gender, age, employment contract, family circumstances or personal goals. Work-related factors include financial reasons, career development, organizational leadership and supportive work environment, and equipment and infrastructure. Macro-level and environmental factors include the safety, security, political and economic situation in country, the available health budget and health sector reforms. For example, relocation is often done when opportunities for children of health workers are considered inadequate in an area.

There is only limited evidence on effective HRM interventions to improve motivation, satisfaction and retention.\(^7\) HRM strategies (or HRM practices) that are reported in the literature to improve retention and motivation include provision of financial incentives, regulation of scope of practice, compulsory service, recruitment from and deployment to an area of origin, matching training to practice in the field, providing professional development opportunities and improving management practices at a facility level, such as providing clear job descriptions, supportive supervision, conducting performance appraisals, improving communication and team work and providing sufficient equipment and medication. Bundled interventions (for instance, combining training, supportive supervision and guidelines) have shown to be more effective than single interventions.\(^8\) Effective HRM interventions need to be sensitive to the context, have commitment from policymakers and implementers and the support and involvement of stakeholders.\(^9\)

Methodology

Research objective

The objective of this research is to identify factors influencing retention, job satisfaction, and motivation of doctors, nurses and midwives within MOH health centers in Jordan, in order to inform HRH policy development and strategies to improve retention of the MOH workforce.

Conceptual framework and definitions

Based on the research objective, the following conceptual framework was developed to guide the study (Figure 1), which is structured around the concepts of motivation and satisfaction. These concepts are explained differently in various theories\(^10\) and may not be easy to distinguish in practice. In fact, the terms are often used interchangeably by managers and health workers. What is understood

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\(^7\) WHO, 2010; Kroezen et al, 2015
\(^8\) WHO, 2010; Kroezen e al, 2015
\(^9\) Gomes, 2015; Kian et al, 2014

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is that they are determined by individual- and organizational-level factors situated in the larger political, social, economic, cultural and community context, and that they mutually influence each other.

**Figure 1. Conceptual framework**

In this study, the key concepts are defined as follows:

**Retention rate** relates to the extent to which an employer retains its employees, and may be measured as the proportion of employees with a specified length of service (typically one year or more) expressed as a percentage of overall workforce numbers. The researchers did not have access to data on the length of employment for the total number of staff in selected facilities; rather, turnover rate is used as a proxy for retention rate.

**Employee turnover** refers to the proportion of employees who leave an organization over a set period (often on a year-on-year basis), expressed as a percentage of total workforce numbers. This research assesses turnover through the number of people who left a facility in the past 12 months, reported by facility managers (as a proxy for actual turnover).

**Motivation** is an individual’s willingness to exert and maintain an effort toward organizational goals and is the result of interactions between health workers, their work environment and the wider context. The following constructs of motivation were used: general motivation, burnout, job satisfaction, intrinsic job satisfaction, organizational commitment and timeliness.

**Job satisfaction** is the perceived relationship between what one expects and obtains from one’s job and how much importance or value is attributed to the job. This consists of the feelings individuals have about their jobs overall and the extent of individuals’ satisfaction with particular aspects of their jobs, such as pay, pension arrangements, working hours, etc.

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12 Kanfer, 1999
13 As developed by Mbndyo et al, 2009
14 Explained as satisfied to use abilities, to value the health facility and to accomplish something worthwhile (Mbndyo et al, 2009)
Health workers are all people engaged in actions whose primary intent is to enhance health. This study’s focus is doctors (specialists and general practitioners), nurses (registered, associate and assistant), midwives and managers as key providers. Managers of MOH facilities in the context of Jordan may have dual clinical and managerial roles.

**Study design**

An exploratory, mixed methods design combining both quantitative and qualitative data collection techniques was used (Table 1).

**Table 1. Overview of research questions and related respondents and data collection tools**

<table>
<thead>
<tr>
<th>Theme/Research questions</th>
<th>Respondents</th>
<th>Data collection tools</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health workforce flow</td>
<td>N/A</td>
<td>Document analysis</td>
</tr>
<tr>
<td>1. What is the current and past (ten years) health workforce flow at entry and exit levels in the MOH system?</td>
<td>MOH health workers*</td>
<td>Quantitative: Questionnaire Qualitative: Semi-structured interviews and FGDs</td>
</tr>
<tr>
<td>HRM practices</td>
<td>MOH managers</td>
<td>Quantitative: Questionnaire</td>
</tr>
<tr>
<td>2. What are current incentives and HRM practices to motivate and retain health workers in the MOH sector? How are these valued and how can they be improved?</td>
<td>Key informants</td>
<td>Qualitative: Semi-structured interviews</td>
</tr>
<tr>
<td>3. What motivates doctors, nurses and midwives to work in the MOH sector?</td>
<td>MOH health workers*</td>
<td>Quantitative: Questionnaire Qualitative: Semi-structured interviews and FGDs</td>
</tr>
<tr>
<td>Leavers</td>
<td>Leavers</td>
<td>Qualitative: Semi-structured interviews</td>
</tr>
<tr>
<td>4. What are factors that made health workers decide to join the MOH system?</td>
<td>Leavers</td>
<td>Qualitative: Semi-structured interviews</td>
</tr>
<tr>
<td>5. How do health workers that have left the MOH sector perceive their current motivation, incentives and HRM practices?</td>
<td>Leavers</td>
<td>Qualitative: Semi-structured interviews</td>
</tr>
</tbody>
</table>

* MOH health workers include doctors (general practitioners and specialists), nurses (registered, associate and assistant nurses) and midwives

N/A = not applicable

**Sampling**

Four governorates were selected by the HRH2030 team in coordination with MOH: Irbid, Ma’an, Zarqa and Amman (Figure 2). This selection was done based on level of population, refugee concentration, urban/rural and types of HRH concerns. Table 2 provides an overview of the different MOH health facilities and population under MOH coverage in the selected governorates. The sample included three governorates that are mainly urban (Amman, Zarqa and Irbid) and one rural governorate (Ma’an).

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15 WHO
Table 2. Overview of the population under MOH coverage and the number of MOH health facilities in the four selected governorates

<table>
<thead>
<tr>
<th>Governorate</th>
<th>Population</th>
<th>% of total Syrian refugees (out of 1.4 million)</th>
<th>Number of MOH health facilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>7,278,083</td>
<td>59.5%</td>
<td>206</td>
</tr>
<tr>
<td>Zarqa</td>
<td>1,364,000</td>
<td>454,108 8.50%</td>
<td>29 9 2</td>
</tr>
<tr>
<td>Ma’an</td>
<td>144,083</td>
<td>61,786  N/A</td>
<td>20 5 1</td>
</tr>
<tr>
<td>Irbid</td>
<td>1,770,000</td>
<td>674,526 23.30%</td>
<td>90 11 8</td>
</tr>
<tr>
<td>Amman</td>
<td>4,000,000</td>
<td>1,761,292 27.70%</td>
<td>67 18 2</td>
</tr>
</tbody>
</table>

Quantitative data collection (questionnaire)
A sufficient number of facilities and respondents were needed for this study to allow for meaningful analysis stratified by a number of factors such as gender, cadre, facility type, and governorate.

Facilities. For practical reasons, a facility was selected as a sampling unit and the number of people working at each facility was assumed based on the MOH’s 2015 Statistic Book. According to sample size calculations applying clustered sampling techniques at 50% variability, 95% confidence level and 5% margin of error, 30% of PHCs and 70% of CHCs were randomly selected for this study, totaling 67 PHCs and 31 CHCs. Additionally, one hospital in Zarqa, Ma’an and Amman and two hospitals in Irbid were selected, for a total of five hospitals. Table 3 presents the number of health facilities and health workers randomly selected for the study.

Health workers. All doctors, registered, associate and assistant nurses, and midwives at the selected PHCs and CHCs and up to 10 professionals of each cadre in hospitals from those who were present.
at the moment of the visit were approached for inclusion in the study. Residents, dentists, dentistry nurses and community and environmental physicians were excluded. The overall response rate was 84% (1,032 out of 1,228 approached health workers). Managers from the same facilities were also included in the study. From 103 managers, 67 agreed to participate and filled out the questionnaire (response rate of 65%).

Participants were asked to identify their gender, and quantitative data was disaggregated by gender.

Table 3. Number of MOH facilities and MOH health workers selected for questionnaire

<table>
<thead>
<tr>
<th>Governorate</th>
<th>Primary Health Centers</th>
<th>Comprehensive Health Centers</th>
<th>Hospitals</th>
<th>Estimated number of health workers to be approached</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zarqa</td>
<td>10</td>
<td>6</td>
<td>1</td>
<td>290</td>
</tr>
<tr>
<td>Ma’an</td>
<td>7</td>
<td>4</td>
<td>1</td>
<td>215</td>
</tr>
<tr>
<td>Irbid</td>
<td>30</td>
<td>8</td>
<td>2</td>
<td>510</td>
</tr>
<tr>
<td>Amman</td>
<td>20</td>
<td>13</td>
<td>1</td>
<td>550</td>
</tr>
<tr>
<td>Total</td>
<td>67</td>
<td>31</td>
<td>5</td>
<td>1,565</td>
</tr>
</tbody>
</table>

* Five health workers were assumed to be available at the PHC level, 30 at the CHC level and 60 at each hospital, thus the total number of health workers was estimated at 1,565 people.

Health workers = Doctors (general practitioners and specialists), nurses (registered, associate and assistant nurses) and midwives

Qualitative data collection (semi-structured interviews and focus group discussions)

Health workers from facilities selected for the quantitative survey were purposively sampled for semi-structured interviews (SSIs). In each governorate, one general practitioner, specialist, registered nurse, associate nurse and midwife was approached. In Zarqa, seven health workers agreed to be interviewed, in Ma’an five, in Irbid six and in Amman seven. The number of interviewees by cadre, gender, governorate and facility type is displayed in Table 4.

In total, eight focus group discussions (FGDs) were organized, two in each governorate. In Zarqa, one FGD was held with seven nurses from hospitals and one with nine nurses from PHC and CHC clinics. In Ma’an, one was held with ten doctors from hospitals and one with nine nurses and midwives from CHCs and PHCs. In Irbid, one FGD was held with ten doctors from a hospital and six nurses from CHCs and PHCs. In Amman, one was held with eight nurses from hospitals and one with nine doctors from CHCs and PHCs.

SSIs enquiring about motivation and satisfaction were also held with doctors and nurses who have left the public sector in the last three years (called “leavers”) based on convenience sampling. Respondents were contacted through professional councils, facility registers and suggestions provided by the MOH. Snowballing was also used to identify additional respondents. Of the 15 health workers who were approached, 12 agreed to be interviewed: 4 doctors, 7 nurses and 1 midwife.

Fifteen key informants were approached for SSIs: 12 MOH facility managers, 1 person at the governorate level (the Director of the Amman Directorate), 1 at MOH central level (Human Resources [HR] Director of HR department) and 1 at national level (Secretary General of Jordan Nursing Council). One MOH facility manager refused to participate in this study.
Gender balance was considered in the recruitment of subjects for the semi-structured interviews and focus group discussions.

**Table 4. Descriptive characteristics of respondents participating in interviews and focus group discussions**

<table>
<thead>
<tr>
<th></th>
<th>Sex</th>
<th>Governorate</th>
<th>Facility Type</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>Amman</td>
<td>Irbid</td>
</tr>
<tr>
<td>SSIs</td>
<td>4</td>
<td>12</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Doctors</td>
<td>9</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Managers</td>
<td>10</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Leavers</td>
<td>9</td>
<td>3</td>
<td>11</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>32</td>
<td>19</td>
<td>20</td>
<td>11</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>FGDs</th>
<th>Nurses</th>
<th>Doctors</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurses</td>
<td>15</td>
<td>24</td>
<td>8</td>
<td>16</td>
</tr>
<tr>
<td>Doctors</td>
<td>19</td>
<td>10</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>Total</td>
<td>34</td>
<td>34</td>
<td>17</td>
<td>16</td>
</tr>
</tbody>
</table>

* N/A = Not applicable.
** For FGDs: health worker from PHC and CHC were combined.

Leavers includes both nurses and doctors, and they currently work in different types of facilities such as NGOs (4), RMS (2), private clinics (3) and private hospitals (3). These categories do not fit the MOH categories defined in the table.

### Quantitative and qualitative data collection tools

Two quantitative tools (i.e. questionnaires) were developed by the research team separately for managers and non-managerial employees. Both tools contained the following sets of variables: 1) personal information, 2) working arrangements, 3) HRM practices, 4) most satisfying and dissatisfying aspects of current work, and 5) motivation (see Annex A for detailed description of the tools). Managers were additionally asked to provide general statistical information on their facility (for example, catchment population, number of employed health workers, number of vacancies, etc.).

To measure motivation, we have used the validated tool. Motivation was assessed through 23 statements that addressed:
- General motivation
- Burnout
- General job satisfaction
- Intrinsic job satisfaction
- Organizational commitments
- Conscientiousness
- Timeliness and attendance

Respondents rated their agreement with each statement on a scale from 1 (strongly disagree) to 5 (strongly agree); the scale for negatively worded questions was reverted i.e. 1 = strongly agree and 5 = strongly disagree. The maximum motivation score for all 23 items combined was 115 points.

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16 Mbindyo et al, 2009
The most satisfying and dissatisfying aspects of current work were assessed through a series of factors developed and evaluated by the research team based on the scoping review and discussions with key stakeholders. These factors were grouped into six constructs:

- **Value of work to society** (including aspects as appreciation from patients, results of work i.e. patients get better, the work helps society, serving refugee population)
- **Working arrangements** (including flexible working hours, short working day, ease in taking leave, early finishing hours, how work is organized in this facility, night shifts, facility is near my home, workload, rotations to other health facilities)
- **Work environment, interpersonal relations and team work** (appreciation from colleagues, appreciation from manager, friendly relationship with colleagues, freedom to take decisions, working as a team with colleagues, manager easily approachable for work-related issues)
- **Supplies and infrastructure** (supply of equipment and materials, sufficient space)
- **Professional & career development** (opportunities for career growth, opportunities for continuous education)
- **Incentives** (financial incentives, non-financial incentives)

Respondents were asked to mark five most satisfying and five most dissatisfying aspects of their work.

Topic guides for semi-structured interviews were developed by the research team separately for non-managerial health workers and for key informants. For non-managerial health workers, these questions covered perceptions about current job and experiences with HRM practices. Key informants were asked questions regarding the following issues: 1) perceptions regarding staff in facility/governorate, 2) general management, and 3) HRM practices and tools.

For the focus group discussions, a topic guide was developed covering: 1) perceptions on working at a MOH facility, 2) perceptions on geographical position, 3) support environment, and 4) future.

All tools were developed in English, translated into Arabic and then pre-tested in non-sampled facilities prior to conducting data collection. Changes based on pre-test were discussed within the research team.

**Data processing and analysis**

*Quantitative data analysis.* Responses to individual questions were described and analyzed by means of frequency distributions, mean and median scores. For the motivation scale, factor analysis was used to confirm latent factors using principal component analysis extraction method with varimax rotation and Kaiser normalization technique. Seventeen items had a coefficient value of more than 0.4, which was used as a cut off point for further analysis. This cut-off means that each item has a shared variance of at least 16% with the factor under consideration. Using this criterion, seven dimensions were confirmed from factor analysis. The 23-items index of motivation had a Cronbach’s $\alpha$ of 0.75. The overall scores were calculated by the sum of all sub-scores of the latent factors described. Multivariable regression analysis was performed to test the association and contribution of different factors to motivation and satisfaction. Data were disaggregated by cadre (e.g. doctor, nurse, midwife), facility type, governorate and gender. Due to similarities in the results for registered nurses and midwives, these two cadres were often grouped in the analysis. Similarly, due to similarities in results, findings for associate and assistant nurses are presented together.

*Qualitative data.* Responses were analyzed per group of respondents and by research question, using a framework approach based on the research questions and main issues in the topic guides. New issues emerging from the interviews or FGDs were added. Answers between and within groups were compared and contrasted, with special attention paid to differences between cadres and genders.
Quality assurance

Several measures were taken to assure quality of the research and credibility of the data. Firstly, both quantitative tools and the topic guides for the interviews and FGDs were pre-tested. Secondly, the research was conducted by a Jordanian firm (Mindset) and international firm (Royal Tropical Institute - KIT) with support from the HRH2030 team. This assured a combination of knowledge about the local environment including the health system, research skills and language. Tools and data collection instruments were jointly discussed and developed by the entire team. Thirdly, data collectors received two days of training, which was conducted separately for personnel collecting quantitative and qualitative data regarding data collection. Fourthly, when possible, interviews were conducted in a place where respondents were comfortable. SSIs and FGDs were recorded to avoid data loss. Finally, results were triangulated by asking the same questions to various respondent groups (e.g. physicians, nurses and managers) and by asking the same questions using different methods (e.g. SSIs and FGDs).

Ethical approval

Ethical approval was obtained from the Ministry of Health’s Ethical Review Board. For each interview and FGD, consent to conduct the interview and to record the answers was obtained. The privacy and confidentiality of each respondent was guaranteed by assigning codes to each interview, by not recording the names of the participants, by interviewing in a private location and by storing the data in a safe location to which only the principal investigator and the senior researchers will have access.

Strengths and limitations of the study methodology

The strengths of the study design were its mixed methods approach and the inclusion of different levels in the MOH health system (primary and secondary level), as well as inclusion of health workers and their managers. Data analysis included a workshop during which Mindset and KIT discussed quantitative and qualitative data per research objective, which allowed for better incorporation of local contextual factors.

The main limitations of the study design were that the tools only allowed the assessment of reported practices and the reported staffing situation and not actual practices nor actual staffing situation. Actual staffing data were not accessible. Data on reported practices were validated through triangulation, by asking the same questions to managers and health workers and through different methods (focus groups discussions and interviews). Reported practices on HRM and the reported outcomes for motivation and satisfaction were not linked to service delivery outcomes and patient satisfaction, as this was beyond the scope of this study. There was also an assumption that improved motivation and satisfaction contributes to improved service delivery. In addition, contextualization of our data is limited: staff from the private sector, RMS or university hospitals were not included in the study, and data on the MOH staff were only available to a limited extent. The study, therefore, was not able to assess distribution within the MOH. The study’s focus was on MOH staff, the inclusion of current employees and a limited number of leavers might give a biased reflection on MOH experiences. Lastly, the study used a tool to assess motivation that could not be validated in Jordan due to time and resource constraints.
Findings

Description of respondents

The survey sample included 1,032 health workers and 67 managers in four governorates. The descriptive characteristics of the respondents are presented in Table 5.

Table 5. Descriptive characteristics of survey sample population

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Health workers</th>
<th>Managers</th>
<th>Health worker professions</th>
<th>Health workers</th>
<th>Managers</th>
<th>Health worker professions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N*</td>
<td>%</td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>Total Sample</td>
<td>1,032</td>
<td>67</td>
<td>226</td>
<td>21.9</td>
<td>496</td>
<td>48.1</td>
</tr>
<tr>
<td>Governorate</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amman</td>
<td>437</td>
<td>42.3</td>
<td>25</td>
<td>37.3</td>
<td>121</td>
<td>53.5</td>
</tr>
<tr>
<td>Irbid</td>
<td>315</td>
<td>30.5</td>
<td>25</td>
<td>37.3</td>
<td>43</td>
<td>19.0</td>
</tr>
<tr>
<td>Ma’an</td>
<td>80</td>
<td>7.8</td>
<td>6</td>
<td>9.0</td>
<td>10</td>
<td>4.4</td>
</tr>
<tr>
<td>Zarqa</td>
<td>200</td>
<td>19.4</td>
<td>11</td>
<td>16.4</td>
<td>52</td>
<td>23.0</td>
</tr>
<tr>
<td>Type of health facility</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHC</td>
<td>280</td>
<td>27.1</td>
<td>23</td>
<td>34.3</td>
<td>81</td>
<td>35.8</td>
</tr>
<tr>
<td>PHC</td>
<td>319</td>
<td>30.9</td>
<td>61</td>
<td>11.2</td>
<td>66</td>
<td>29.2</td>
</tr>
<tr>
<td>Hospital</td>
<td>433</td>
<td>42.0</td>
<td>3</td>
<td>4.5</td>
<td>79</td>
<td>35.0</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>327</td>
<td>31.7</td>
<td>60</td>
<td>89.6</td>
<td>151</td>
<td>66.8</td>
</tr>
<tr>
<td>Female</td>
<td>705</td>
<td>68.3</td>
<td>7</td>
<td>10.4</td>
<td>75</td>
<td>33.2</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;30</td>
<td>255</td>
<td>24.7</td>
<td>9</td>
<td>13.4</td>
<td>53</td>
<td>23.5</td>
</tr>
<tr>
<td>30-39</td>
<td>445</td>
<td>43.1</td>
<td>14</td>
<td>22.4</td>
<td>81</td>
<td>35.8</td>
</tr>
<tr>
<td>40+</td>
<td>332</td>
<td>32.2</td>
<td>44</td>
<td>65.7</td>
<td>92</td>
<td>40.7</td>
</tr>
<tr>
<td>Years working in current position</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;5</td>
<td>259</td>
<td>25.1</td>
<td>46</td>
<td>68.7</td>
<td>100</td>
<td>44.3</td>
</tr>
<tr>
<td>5-9</td>
<td>249</td>
<td>24.1</td>
<td>7</td>
<td>10.5</td>
<td>40</td>
<td>17.7</td>
</tr>
<tr>
<td>10-14</td>
<td>205</td>
<td>19.9</td>
<td>3</td>
<td>4.5</td>
<td>22</td>
<td>9.7</td>
</tr>
<tr>
<td>15+</td>
<td>319</td>
<td>30.9</td>
<td>11</td>
<td>16.4</td>
<td>64</td>
<td>28.3</td>
</tr>
<tr>
<td>Years working in current facility</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;5</td>
<td>457</td>
<td>44.3</td>
<td>36</td>
<td>53.7</td>
<td>145</td>
<td>64.2</td>
</tr>
<tr>
<td>5-9</td>
<td>265</td>
<td>25.7</td>
<td>15</td>
<td>22.4</td>
<td>41</td>
<td>18.1</td>
</tr>
<tr>
<td>10-14</td>
<td>176</td>
<td>17.1</td>
<td>6</td>
<td>9.0</td>
<td>22</td>
<td>9.7</td>
</tr>
<tr>
<td>15+</td>
<td>134</td>
<td>13.0</td>
<td>10</td>
<td>6.0</td>
<td>18</td>
<td>7.9</td>
</tr>
</tbody>
</table>

* N = Absolute value
All within characteristic differences are statistically significant at P-value <0.05.
Nurses and midwives made up the largest proportion of the total sample of health workers (78.1%). More than 68% of the respondents were women, but the gender distribution varied substantially between professions: almost 90% of managers and two-thirds of doctors were men, while almost 80% of nurses were women. Nearly 75% of respondents came from Amman and Irbid. Doctors and managers tended to be older (41% and 66% aged 40+, respectively) than nurses, however, they had significantly fewer years of experience in their position and were relatively new to the facility where they were working compared to nurses.

Ninety-six health workers agreed to provide an interview or participate in a FGD. Of them, 41 were doctors and 55 were nurses and midwives. In addition, 11 managers and 3 policymakers were interviewed. The age of nurses participating in interviews ranged between 24 and 49 years and the age of doctors ranged between 27 and 65 years. Seventy-five percent of nurses were women, while 75% of doctors were men. Out of the 11 managers, 10 were men.

Furthermore, 12 leavers were interviewed: 9 men and 3 women. Of these 12 leavers, 3 left MOH to start their own private clinic, 3 moved to a private hospital (1 man and 2 women), 4 work for an (international) non-governmental organization and 2 moved to the RMS.

Retention

**Key findings:**

- Overall, there are indications of high retention in the MOH sector, with relatively low turnover and a low number of vacancies reported in sampled facilities.
- Nearly half of health workers worked elsewhere in the past five years, of which 64% worked in another MOH facility.
- Two-thirds of all health workers intend to stay within the MOH sector for the next two years, and one-third of health workers reported they are actively seeking a position outside of the MOH.
- Working close to home is important to health workers.
- Staff reported variations in length of time of deployment by the MOH.
- There is a perceived lack of transparency in the deployment process.

**Turnover and vacancy rates in sampled facilities**

At the time of the study, there were a total of 81 vacancies at 66\(^{17}\) facilities that employ a total of 2,287 clinical and administrative employees, which indicates a reported vacancy rate of 3.5% in the sampled facilities. Sixty percent of facilities in Amman reported to have at least one vacancy, whereas only 36% of facilities in Zarqa reported a vacant position. On average, each facility had 1.2 vacancies; half of them were for clinical staff and half for administrative staff. The two most cited vacancies were for physicians (25 out of total 81 vacancies from the total of 426 available positions) and nurses (19 out of 81 vacancies from the total 664 available registered nurse’s positions). The reported mean time required to fill a vacancy was 3.5 months, but managers indicated that some positions required more time, for example specialists (6.3 months).

Around 45% of managers reported that at least one member their staff had vacated their position in the last 12 months. Sixty-six percent of managers reported that at least one position has been filled in their facility over this same time period. In total, 84 staff left and 195 clinical and administrative staff joined the facilities in the last 12 months. This results in a turnover rate between 3.7%-8.5%.\(^{18}\) Of these, 46% (or 39) of staff who left were general physicians and specialists and 20% (or 17) were nurses. Most departures occurred because the health worker retired or went to another MOH facility

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17 One facility was excluded due to missing data.
18 Turnover is calculated as the number of staff that left in the past 12 months per total number of staff. Considering that many more people have joined staff in the past 12 months than left, it is plausible that the reported number of staff left is slightly underestimated. The researchers therefore calculated a turnover range, including reported staff departures (3.7%) and reported staff arrivals (8.5%). Staff arrivals was calculated as the number of staff that recently joined over the total number of staff.
About 19% of vacancies resulted from health worker going to work in one of the Gulf States or moving to the private sector.

**Five-year mobility of staff and intention to leave in the next two years**

Almost 46% of all respondents had worked at another health facility in the previous five years. Most health workers had previously worked at another MOH facility (64%) or in the private sector (47%). Mobility was higher among doctors (59%) than among nurses and midwives (42%) and among respondents from Zarqa (52%) compared to other governorates, with the lowest mobility reported in the rural governorate of Ma’an (39%). Analysis by cadre revealed that doctors had most frequently worked in a different facility and/or sector in the previous five years (55%), while associate and assistant nurses reported the lowest mobility (23%).

Two-thirds (66%) of all health workers intend to stay within the MOH sector for the next two years. More than half of all employees (51%) reported no intention to leave their current MOH workplace, and over one-third (36%) are actively seeking to transfer to another MOH facility (Figure 3). Additionally, one-third (34%) of all health workers reported they are actively seeking a position outside of the MOH sector, including the Gulf States, the private sector, university hospitals/RMS, or another sector. Men and doctors were most interested in leaving their current workplace compared to women and other cadres. Men were also the ones most interested in moving to the private sector. Thirty-five percent of all doctors (n=111) had been in their current post for less than three years.

Movement between MOH facilities was most common: two-thirds of employees, especially nurses and midwives that worked elsewhere in the past five years, had worked at another MOH facility. Additionally, the highest proportion of employees planning to leave were seeking employment at another MOH facility.

**Figure 3. Intention to leave with the next two years**

SSIs and FGDs revealed that intention to leave seemed related to:
- Desire for higher salaries and bonuses to attain private goals (get married, buy a car or house, maintain an acceptable standard of living and education for children, etc.). Young doctors were more likely to say they were seeking better financial opportunities in the private sector or abroad, whereas older doctors tended to stay in the MOH sector because they had earned respect and status in their current positions and in order to receive retirement benefits.
▪ Frustration with management, working procedures and workload, which causes stress and demotivation.
▪ Intention to specialize and pursue employment abroad. Some doctors reported being required to work for a minimum number of years with the MOH. Although several doctors (mainly specialists) reported an aspiration to have a private practice, they tended to stay at the MOH because of a lack of the financial resources needed to open a private practice.

A multivariable logistic regression revealed a clear association between motivation levels and intention to leave. The odds of intending to stay at one’s current job increase by four percent with each increasing score of motivation (OR=1.04, p<0.01) when controlling for sex, governorate, position and facility type.

Deployment within MOH sector and geographic preferences

Graduating nurses and doctors seeking employment with the MOH first apply to the CSB, after which those who pass are added to a waiting list. The CSB assigns applicants based on available positions and proximity to residence. The waiting period for a response from the CSB varied from one respondent to another, from a few months to several years. A number of respondents felt the process lacked transparency and was compromised by nepotism (“wasta,” Table 6).

Among all respondents, 63% were working in their governorate of origin. Registered nurses and midwives (66.5%) and associate and assistant nurses (71.3%) were more likely to be working within their governorate of origin than doctors (44.7%). The percentage of employees originating from and currently working in Irbid and Ma’an was especially high (on average 70%). One reason for staying at the MOH and in Jordan was reported to be staying close to one’s family and community.

According to the respondents and key informants at the CSB, requests for transfers between MOH facilities and between governorates were common for both doctors and nurses. Transfer requests were described by staff as lengthy and a source of frustration (Table 6).

Table 6. Main issues related to deployment from interviews and FGDs

<table>
<thead>
<tr>
<th>Main issues</th>
<th>Illustrative quotes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geographical preference</td>
<td>“The reason that makes people stay is the need to stay close to family and community. For me, I got chances [to leave Jordan] in the past, when I was at the beginning of my career. I did not take them because I didn’t want to be far from my family. Living in a foreign country [away from your wife and children] is difficult; the children need care and attention. So I preferred to stay here despite the lack of adequate financial compensation.” (Manager, male, PHC, Zarqa)</td>
</tr>
<tr>
<td>Lengthy deployment and transfer processes</td>
<td>“When I was in Mafraq, I didn’t work in only one center; I worked all over Mafraq. It took three years of being transferred from one place to another until I was finally assigned to my current facility, which is closest my home.” (Nurse, female, PHC, Irbid)</td>
</tr>
<tr>
<td>Lack of transparency</td>
<td>“I applied to the Civil Service Bureau. The process did not take long when compared to others. It took around two years after I registered at the Bureau.” (Doctor, male, PHC, Zarqa)</td>
</tr>
<tr>
<td></td>
<td>“Wasta and favoritism play a role. There’s no transparency in appointment. When you see someone who graduated in 2006 and is not working yet, while another one graduated in 2010 and is working, you realize that there’s no transparency at all.” (Nurse, male, Hospital, Irbid)</td>
</tr>
</tbody>
</table>

Leavers’ perspective: Reasons to depart from the MOH sector

The respondents who had left the MOH and were working outside it cited a variety of reasons for their departure, such as starting their own practice to improve their income and lifestyle (doctors), moving to the private sectors as it offers more opportunities for career advancement, and having temporary contracts with the MOH.
Motivation and satisfaction

Key findings:
▪ Health workers’ motivation is neutral to slightly positive with some variations between cadres, type of facilities and governorates.
▪ Doctors, men, younger employees and health workers with fewer years of experience are less motivated and have a higher intention to leave.
▪ Health workers are most satisfied with the value that their work brings to society, interpersonal relations and team work and some working arrangements.
▪ The biggest sources of dissatisfaction included incentives, supplies and infrastructure, opportunities for professional and career development, and some working arrangements.
▪ Health workers reported occurrences of aggression on the work floor among staff and between staff and patients.

Motivation

Overall, health care workers were neutral to slightly positive when rating their motivation (Figure 4 and Table 7). There were small but significant differences between groups:
▪ Managers and associate and assistant nurses show higher levels of motivation compared to registered nurses and midwives.
▪ Women were significantly more motivated compared to men.
▪ Older health workers and those with more years of experience were significantly more motivated compared to younger health workers.
▪ Health workers from PHCs and CHCs reported higher overall motivation compared to their colleagues from hospitals.

Figure 4. Total 23-item motivation scores by selected descriptive characteristics
(minimum score=23, maximum score 115)

* Statistically significant differences at 95% confidence level
Age was positively associated with motivation: the mean total motivation score increased significantly with increasing age, by 0.15 points with each one-year increase in age, while controlling for sex, governorate, profession and facility type (p<0.01). Older employees and those who have served in their current position for more than 15 years reported having less burnout and higher general job satisfaction, intrinsic job satisfaction and organizational commitment. This finding was confirmed through the FGDs and qualitative interviews, where younger doctors and nurses expressed more frustration with their work than older staff.

Table 7. Motivation scores by cadre

<table>
<thead>
<tr>
<th></th>
<th>Managers (n=67)</th>
<th>Doctors (n=226)</th>
<th>Registered nurses &amp; Midwives (n=496)</th>
<th>Associate &amp; Assistant nurses (n=310)</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1: General motivation</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>These days, I feel motivated to work as hard as I can</td>
<td>3.4</td>
<td>1.1</td>
<td>3.5</td>
<td>1.1</td>
<td>3.3</td>
</tr>
<tr>
<td>I only do this job so that I get paid at the end of the month*</td>
<td>3.3</td>
<td>1.4</td>
<td>3.3</td>
<td>1.2</td>
<td>3.2</td>
</tr>
<tr>
<td>I do this job as it provides long-term security for me</td>
<td>3.6</td>
<td>1.2</td>
<td>3.7</td>
<td>1.0</td>
<td>4.0</td>
</tr>
<tr>
<td><strong>2: Burnout</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel emotionally drained at the end of every day*</td>
<td>2.4</td>
<td>1.2</td>
<td>2.3</td>
<td>1.1</td>
<td>2.3</td>
</tr>
<tr>
<td>Sometimes when I get up in the morning, I dread having to face another day at work*</td>
<td>3.4</td>
<td>1.4</td>
<td>3.0</td>
<td>1.2</td>
<td>2.8</td>
</tr>
<tr>
<td><strong>3: General job satisfaction</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall, I am very satisfied with my job</td>
<td>3.5</td>
<td>1.2</td>
<td>3.7</td>
<td>1.0</td>
<td>3.6</td>
</tr>
<tr>
<td>I am not satisfied with my colleagues at this facility*</td>
<td>3.7</td>
<td>1.4</td>
<td>3.9</td>
<td>1.1</td>
<td>3.6</td>
</tr>
<tr>
<td>I am satisfied with my supervisor</td>
<td>3.7</td>
<td>1.0</td>
<td>3.8</td>
<td>0.9</td>
<td>3.7</td>
</tr>
<tr>
<td><strong>4: Intrinsic job satisfaction</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am satisfied with the opportunity to use my abilities in my job</td>
<td>3.7</td>
<td>1.1</td>
<td>3.5</td>
<td>1.2</td>
<td>3.6</td>
</tr>
<tr>
<td>I am satisfied that I accomplish something worthwhile in this job</td>
<td>4.1</td>
<td>0.9</td>
<td>4.1</td>
<td>0.7</td>
<td>4.0</td>
</tr>
<tr>
<td>I do not think that my work in the health facility is valuable these days*</td>
<td>4.0</td>
<td>1.2</td>
<td>3.7</td>
<td>1.2</td>
<td>3.6</td>
</tr>
<tr>
<td><strong>5: Organizational commitment</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am proud to be working for this health facility</td>
<td>3.9</td>
<td>1.0</td>
<td>3.6</td>
<td>1.1</td>
<td>3.7</td>
</tr>
<tr>
<td>I find that my values and this health facility’s values are very similar</td>
<td>3.6</td>
<td>1.0</td>
<td>3.4</td>
<td>1.0</td>
<td>3.5</td>
</tr>
<tr>
<td>I am glad that I work for this facility rather than other facilities in the country</td>
<td>3.6</td>
<td>1.1</td>
<td>3.4</td>
<td>1.1</td>
<td>3.5</td>
</tr>
<tr>
<td>I feel very little commitment to this health facility*</td>
<td>3.5</td>
<td>1.3</td>
<td>3.3</td>
<td>1.2</td>
<td>3.2</td>
</tr>
<tr>
<td>This health facility really inspires me to do my very best on the job</td>
<td>3.8</td>
<td>1.1</td>
<td>3.5</td>
<td>1.0</td>
<td>3.5</td>
</tr>
<tr>
<td><strong>6: Conscientiousness</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I cannot be relied on by my colleagues at work*</td>
<td>4.6</td>
<td>0.9</td>
<td>4.4</td>
<td>0.9</td>
<td>4.3</td>
</tr>
</tbody>
</table>
MOTIVATION AND RETENTION OF HEALTH WORKERS IN MINISTRY OF HEALTH FACILITIES IN FOUR GOVERNORATES IN JORDAN: FINDINGS FROM A MIXED METHODS STUDY |

Managers (n=67)  | Doctors (n=226)  | Registered nurses & Midwives (n=496)  | Associate & Assistant nurses (n=310)  | P-value
---|---|---|---|---
Mean | SD | Mean | SD | Mean | SD | Mean | SD | Mean | SD |

**I always complete my tasks efficiently and correctly**  
Mean: 4.3  
SD: 0.8  

**I am a hard worker**  
Mean: 4.4  
SD: 0.7  

**I do things that need doing without being asked or told**  
Mean: 4.4  
SD: 0.7  

7: **Timeliness and attendance**  

I am punctual about coming to work  
Mean: 4.3  
SD: 0.8  

I am often absent from work*  
Mean: 4.2  
SD: 1.3  

It is not a problem if I sometimes come late to work*  
Mean: 3.7  
SD: 1.2  

The minimum score is 1 and the maximum score is 5. A higher score indicates higher levels of motivation and job satisfaction.  

* The scale for negatively worded questions was reversed i.e. 1=strongly agree and 5=strongly disagree. Thus, a high score shows disagreement with a negative statement and is therefore suggestive of higher motivation.  

** Significant at 95% confidence level.  

Factor analysis was used to confirm latent factors using principal component analysis extraction method with varimax rotation and Kaiser normalization technique. Explained variance was 62%. The 23-items index of motivation had a Cronbach’s α of 0.75.

---

**Figure 5A. Characteristics of staff by motivation level**

- **Intend to stay**
  - Women: 31.2%
  - Men: 22.9%
  - <5 years of experience: 30.5%
  - ≥5 years of experience: 25.5%
  - <30 years old: 29.2%
  - ≥30 years old: 24.3%
  - Zarqa: 24.1%
  - Ma’an: 21.5%
  - Irbid: 24.1%
  - Amman: 26.3%

- **Intend to leave**
  - Women: 27.2%
  - Men: 22.9%
  - <5 years of experience: 30.5%
  - ≥5 years of experience: 25.5%
  - <30 years old: 29.2%
  - ≥30 years old: 24.3%
  - Zarqa: 24.1%
  - Ma’an: 21.5%
  - Irbid: 24.1%
  - Amman: 26.3%

- **Associate & Assistant nurses**
  - Registered nurses & Midwives: 29%
  - Doctors: 26.2%
  - CHC: 22.9%
  - PHC: 31%
  - Hospital: 24%

- **25% Least motivated staff**
- **Average motivated staff**
- **25% Most motivated staff**
Figure 5B. Characteristics of staff by motivation level and intention to leave

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Least motivated &amp; intend to leave</th>
<th>More motivated &amp; intend to stay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women</td>
<td>20.4%</td>
<td>35.5%</td>
</tr>
<tr>
<td>Men</td>
<td>35.8%</td>
<td>22.9%</td>
</tr>
<tr>
<td>20+ years of experience</td>
<td>9.7%</td>
<td>47.2%</td>
</tr>
<tr>
<td>&lt;5 years of experience</td>
<td>34%</td>
<td>23.2%</td>
</tr>
<tr>
<td>40+ years old</td>
<td>14.8%</td>
<td>42.5%</td>
</tr>
<tr>
<td>30-39 years old</td>
<td>29%</td>
<td>27%</td>
</tr>
<tr>
<td>&lt;30 years old</td>
<td>32.5%</td>
<td>25.1%</td>
</tr>
<tr>
<td>Zarqa</td>
<td>23.5%</td>
<td>36.5%</td>
</tr>
<tr>
<td>Ma’an</td>
<td>21.3%</td>
<td>33.8%</td>
</tr>
<tr>
<td>Irbid</td>
<td>23.2%</td>
<td>31.8%</td>
</tr>
<tr>
<td>Amman</td>
<td>28.4%</td>
<td>28.6%</td>
</tr>
<tr>
<td>Associate &amp; Assistant nurses</td>
<td>14.8%</td>
<td>38.7%</td>
</tr>
<tr>
<td>Registered nurses &amp; Midwives</td>
<td>25.8%</td>
<td>29.2%</td>
</tr>
<tr>
<td>Doctors</td>
<td>38.5%</td>
<td>26.6%</td>
</tr>
<tr>
<td>CHC</td>
<td>27.3%</td>
<td>28.6%</td>
</tr>
<tr>
<td>PHC</td>
<td>22.3%</td>
<td>33.5%</td>
</tr>
<tr>
<td>Hospital</td>
<td>25.7%</td>
<td>32.5%</td>
</tr>
</tbody>
</table>

Note: Less motivated = < 50th percentile of motivation score.

Identifying characteristics of least motivated health workers with highest intention to leave

Contrasting the most motivated health workers with the least motivated confirms the above findings (Figure 5A and 5B): doctors, men, younger employees, and those with less than five years of experience were less motivated and expressed a greater intention to leave compared to their colleagues. Additionally, health workers who intended to leave were substantially less motivated compared to people who expressed an intention to stay. Notable is the lowest proportion of least motivated people in Ma’an, the only rural governorate in the sample.

Satisfying and dissatisfying factors

Respondents were asked to indicate the five most satisfying and dissatisfying factors in their work. These factors were grouped into six groups: intrinsic factors (value of work to society), working arrangements, work environment, supplies and infrastructure, professional career development and incentives.

Tables 8 and 9 depict the top ten most satisfying and dissatisfying factors as reported by health workers. Most-often mentioned factors were similar across cadres, genders, facility types and governorates, although the ranking of these factors had some variations. For example, women, especially associate and assistant nurses, expressed more satisfaction with working arrangements compared to men. Almost two times as many women indicated satisfaction with flexible working hours, short working day and early finishing hours. Health workers from Ma’an valued appreciation from their manager less (36%) than colleagues from other governorates (on average 55%). Registered nurses and midwives reported lower satisfaction with manager appreciation but higher satisfaction with perceived value to society compared to other cadres. Health workers working in hospitals expressed less satisfaction with manager appreciation, while PHC workers were more satisfied with most working conditions than colleagues from hospitals.
By far, the most frequently mentioned dissatisfying factor was the level of financial incentives (76%) (Table 9). Women and health workers from PHCs perceived higher dissatisfaction with opportunities for continuous education compared to their counterparts. Dissatisfaction with the workload was also much higher at CHCs and hospitals compared to PHCs (on average 43% vs. 33%). According to self-reported questionnaires, the mean number of patients seen on average by a doctor was 58, significantly more than the mean reported by nurses (36 patients/day) and midwives (27 patients/day). This translates to 6.8 minutes per patient for doctors and 10.3 minutes per patient for nurses. There was no particular correlation pattern between dissatisfying factors and the level of motivation, for example, 24% of those most dissatisfied with financial incentives indicated to be least motivated. This was also the case for 23% of those who did not mention financial incentives as one of five most dissatisfying factors. This points to a complex non-linear relationship between satisfying/dissatisfying factors, general satisfaction and motivation.

In line with the quantitative data, qualitative findings show that interpersonal relations and sentiments were the highest contributors to employee motivation, with appreciation from patients and management the most mentioned reasons for satisfaction among health workers (Table 10). Feeling appreciated served as a motivator for better performance and drove job satisfaction. Working at the MOH was generally considered comfortable because of job security, shorter working days and less stringent management, especially when compared to the private sector. These working conditions were more appealing for married females (both nurses and doctors) at PHCs especially, where there are no night shifts. There was a higher sense of comfort from working near one’s home and helping one’s community, which was more likely at PHCs, especially in facilities outside of Amman.

<table>
<thead>
<tr>
<th>Table 8. Top ten most satisfying factors for health workers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Group</strong></td>
</tr>
<tr>
<td>-----------</td>
</tr>
<tr>
<td>Intrinsic factors (value of work to society)</td>
</tr>
<tr>
<td>Work environment (interpersonal relations and team work)</td>
</tr>
<tr>
<td>Work environment (interpersonal relations and team work)</td>
</tr>
<tr>
<td>Work environment (interpersonal relations and team work)</td>
</tr>
<tr>
<td>Intrinsic factors (value of work to society)</td>
</tr>
<tr>
<td>Intrinsic factors (value of work to society)</td>
</tr>
<tr>
<td>Working arrangements</td>
</tr>
<tr>
<td>Working arrangements</td>
</tr>
<tr>
<td>Work environment (interpersonal relations and team work)</td>
</tr>
<tr>
<td>Working arrangements</td>
</tr>
</tbody>
</table>

* Absolute number (N) and percent (%) of the total population mentioning each specific factor as one of the five most satisfying. N/A = not applicable
Table 9. Top ten most dissatisfying factors for health workers

<table>
<thead>
<tr>
<th>Group</th>
<th>Dissatisfying factors</th>
<th>N(%)*</th>
<th>Rank order</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>All</td>
</tr>
<tr>
<td>Incentives</td>
<td>Financial incentives</td>
<td>784 (76.0)</td>
<td>1</td>
</tr>
<tr>
<td>Supplies and infrastructure</td>
<td>Supply of equipment and materials</td>
<td>456 (44.2)</td>
<td>2</td>
</tr>
<tr>
<td>Professional and career development</td>
<td>Opportunities for continuous education</td>
<td>449 (43.5)</td>
<td>3</td>
</tr>
<tr>
<td>Working arrangements</td>
<td>Work load</td>
<td>410 (39.7)</td>
<td>4</td>
</tr>
<tr>
<td>Professional and career development</td>
<td>Opportunities for career growth</td>
<td>409 (39.6)</td>
<td>5</td>
</tr>
<tr>
<td>Work environment (interpersonal relations and team work)</td>
<td>Freedom to make decisions</td>
<td>245 (23.7)</td>
<td>6</td>
</tr>
<tr>
<td>Incentives</td>
<td>Non-financial incentives</td>
<td>244 (23.6)</td>
<td>7</td>
</tr>
<tr>
<td>Working arrangements</td>
<td>How work is organized in this facility</td>
<td>225 (21.8)</td>
<td>8</td>
</tr>
<tr>
<td>Working arrangements</td>
<td>Flexible working hours</td>
<td>215 (20.8)</td>
<td>9</td>
</tr>
<tr>
<td>Working arrangements</td>
<td>Easy to take leave</td>
<td>207 (20.1)</td>
<td>10</td>
</tr>
</tbody>
</table>

* Absolute number (N) and percent (%) of the total population mentioning each specific factor as one of the five most dissatisfying. N/A = not applicable

While some doctors and nurses reported a good relationship with their managers, others reported conflicts and tensions. The working environment was especially less collaborative in Zarqa and Amman hospitals. Several health workers, particularly nurses, reported that their relationship with managers and colleagues determined workload, exposure to learning and training opportunities and affected evaluation and career progression. Some nurses said that managers would give more work to subordinates they did not like or assign them to sections with fewer learning opportunities, while some doctors said that they felt personal relationships with managers affected their chances of being nominated for training opportunities and the outcome of performance evaluations. Such events fostered a negative environment, with staff holding grudges against managers and colleagues.

A recurrent issue reported by numerous respondents, in particular nurses, was aggression and conflicts on the work floor that regularly occurred in the form of rude and aggressive language, verbal and physical abuse, threats, and harassment, and was reported between staff and patients, management and staff and between peers. Although patient appreciation was one of the highest satisfying factors, on average 13% of staff rated patient appreciation as one of the top five dissatisfying factors. Fifty-five percent of the respondents who did not feel appreciated by their manager were less motivated than those who were appreciated by their manager (43%). Health workers felt that patients sometimes acted aggressively because of long waiting times or because they believed their case deserved priority. According to staff, there is no clear or safe system or procedure to report aggression and harassment from patients or staff. In addition, staff, especially nurses, felt that there will be no repercussions for offending doctors, even if they are reported. Interestingly, none of the leavers mentioned any incidents of violence or harassment.
Motivation and satisfaction of leavers

Motivation and satisfaction were interchangeably used by the leavers. MOH leavers expressed satisfaction with their current job and reported to be motivated. All respondents indicated that their financial compensation had significantly improved.

Other factors for motivation and satisfaction among leavers varied per type of work they had chosen:

- Those having their own private practice reported that passion and financial compensation is rewarding and that they enjoy being independent and being able to focus on their specialty.
- Those working for international development organizations reported that dealing with different cultures, appreciation from patients and colleagues and supervisors, the friendly environment and the financial compensation and experience are rewarding and motivating.
- Those who are now working in the private sector said that the experience gained in current work and the impact on patients are what motivates them to work.
- Respondents who currently work at RMS reported that passion for work, impact on patients and the abilities to choose a facility near home were reasons for motivation and satisfaction.

A number of factors negatively affecting motivation and satisfaction of leavers in their current job were also mentioned. These differed among respondents and included long working hours and shifts, heavy workload, having many responsibilities and perceived unfairness in salaries and other benefits, such as perceived unfair overtime calculations.

Table 10. Illustrative quotes related to satisfaction and dissatisfaction

<table>
<thead>
<tr>
<th>Issues</th>
<th>Illustrative quotes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Satisfying factors</strong></td>
<td></td>
</tr>
<tr>
<td>Contribution to the wellbeing of society, help people in need and save lives</td>
<td>“When people come here, they give you a push. When the patient comes holding his son and he’s happy that I will examine him like I did last time, it gives me a morale boost. Even if one patient does this, he gives me motivation for the rest of the day because I feel comfortable and happy. The community around me motivates me.” (Nurse, Female, PHC, Ma’an)</td>
</tr>
<tr>
<td>Individual appreciation and recognition valued as high as financial incentive</td>
<td>“We make a better society. If you follow up on a pregnant woman until she gives birth and follow up on the baby until they are five years old, we will produce a healthier society.” (Nurse, Female, CHC, Zarqa)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Issues</th>
<th>Illustrative quotes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comfort</td>
<td>“In a private hospital there’s no specific system. But in the MOH we have insurance, social security. This gives you security and makes you comfortable.” (Nurse, Female, PHC, Ma’an)</td>
</tr>
<tr>
<td>Support from managers</td>
<td>“I cannot provide any financial incentive, because I am an employee just like them. I can only support them morally. I tell them that we are serving our families, our loved ones, our relatives, our friends and poor people. Really poor people.” (Manager, Male, PHC, Zarqa)</td>
</tr>
<tr>
<td>Teamwork and a supportive work environment</td>
<td>“They [colleagues] help me out emotionally during the day, and to be honest there are a couple of colleagues here that are the reason I come to work here, because they mean a lot to me” (Manager, Male, PHC, Zarqa)</td>
</tr>
<tr>
<td></td>
<td>“...we work as a group, when we get a heavy workload we distribute it amongst us, we might bring in the midwives to do some nursing work, we’re adapting, if one of the clinics is having a shortage, we help in covering that shortage, so we work as a group, we adapt to the circumstances that arrive” (Female, Nurse, CHC, Irbid)</td>
</tr>
<tr>
<td>Shorter working days and flexibility</td>
<td>“Sometimes I give them a day off without them signing for a vacation.” (Manager, Male, PHC, Ma’an)</td>
</tr>
</tbody>
</table>

Motivation and Retention of Health Workers in Ministry of Health Facilities in Four Governorates in Jordan: Findings from a Mixed Methods Study
<table>
<thead>
<tr>
<th>Issues</th>
<th>Illustrative quotes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Working near home</td>
<td>“Well, before marriage, I loved to work at Al-Basheer hospital, it has more incentives than the health centers, but once you marry and have kids, you always choose to be near your children and your home.” (Midwife, Female, CHC, Amman)</td>
</tr>
<tr>
<td>Dissatisfying factors</td>
<td></td>
</tr>
<tr>
<td>Lack of recognition and appreciation from management</td>
<td>“No incentives, bonuses or rewards! No thank you letters!” (Nurse, Female, Zarqa, PHC)</td>
</tr>
<tr>
<td>Transparency and fairness</td>
<td>“Here, we asked for clear technical classification and it got rejected. While doctors asked for the same and they got it, blatant discrimination. A doctor enters, get incentives let’s say 1,000 JD, 500 JD, nurses with 23 years of experience get 180-170 JD and every now and then they cut off more. So you feel yourself nothing. And eventually your performance goes down too! I personally feel my work declined. There’s a huge difference” (FGD, Female, Zarqa, Nurse)</td>
</tr>
<tr>
<td>Low salaries</td>
<td>“The salaries of some employees are not enough and they have to find another job, driving a taxi for example or cooking and baking in order to educate their children for example. Someone who is running a household on 300 JD is obliged to take another job. At the end, they come and tell you if we find out that you are working in another place, we will fire you. Ok, if you do not want me to work somewhere else then give me a good salary and I can come to my job satisfied.” (Nurse, Female, PHC, Zarqa)</td>
</tr>
<tr>
<td>Lack of training opportunities for staff and managers</td>
<td>“We need good training opportunities. In the past, the MOH used to send doctors to the medical city, University Hospital, even out of the country to the USA and U.K. for a year to get a certificate. Now there’s nothing. No scholarships for current doctors to do a subspecialty. No courses, no conferences… even internal conferences… they say we have 500, but in reality we have 5.” (Doctor, Female, Hospital, Amman)</td>
</tr>
<tr>
<td>Lack of autonomy and limited decision-making space for managers</td>
<td>“Here we have issues with the maintenance section. The maintenance here is so difficult. Every district has a maintenance department who know all the equipment. So when the dental equipment or any other equipment stop working, the maintenance come from the Ministry in Amman. This takes one week to 10 days, based on their conditions. There is a slack.” (Male, PHC, Manager, Ma’an)</td>
</tr>
<tr>
<td>Heavy workload</td>
<td>“If I didn’t follow up with the periodic test, I can’t track the patient’s health properly. With this number of patients I see, I just cannot follow up with 100% of them.” (Doctor, Male, CHC, Amman)</td>
</tr>
<tr>
<td>Bad infrastructure and lack of equipment</td>
<td>“This center covers a large area from Al-Nu’uheh to Bireen… big number of visitors! The infrastructure is worn out… the sewage and water pipes are old… we have a problem with the water every month. This affects our work. When there is no water in the clinic, the dentist can’t do his work. When there is no water in the W.C., how can the patient give samples for the lab? We ask the MOH for help continuously. The center has several problems; the directorate addresses the ministry, but the ministry takes time to respond. For the past eight years, we have been promised that they will build another center in Bireen District on a land that belongs to the MOH. The same promises each year, but nothing yet.” (Manager, PHC, Zarqa)</td>
</tr>
<tr>
<td>Disruptive patient-provider interaction and interaction with peers</td>
<td>“Some doctors make nurses feel uncomfortable. I heard some girls moving from one center to another because their doctor made them feel uncomfortable. They asked to be moved because they couldn’t report him and their voice was never heard. An investigation team came and he was found innocent! Not all nurses have the courage, they’re afraid.” (FGD of nurses, Female, Zarqa)</td>
</tr>
<tr>
<td></td>
<td>“We had a young doctor who used to harass us, and we complained. Not only once, but ten times and more… clear sexual harassment! The nurse would be taking a patient’s pressure and he would pass next to her and touch her on purpose. He wanted to do the same thing to me; I told him to go play somewhere else!” (Nurse, Female, PHC, Zarqa)</td>
</tr>
<tr>
<td></td>
<td>“People come and verbally abuse you. I serve you, it’s true… but I am an employee and I should be respected. You should respect me and treat me well. I think some people disrespect the Ministry of Health staff because the ministry itself does not offer them any support.” (Nurse, Female, PHC, Zarqa)</td>
</tr>
<tr>
<td></td>
<td>“Until one o’clock I’m stressed because out of 50 patients, three will have a fight with you and ruin your day. Maybe not the patient himself, but his/her escort.” (Doctor, Male, CHC, Amman)</td>
</tr>
</tbody>
</table>
Human resource management practices

Key messages:
- Managers in sampled facilities implement most HRM activities, although often poorly.
- Opportunities for professional development are limited.
- Several HRM practices affect motivation, including job descriptions, coaching and support, performance appraisals and participation in decision-making.

Overall, most HRM activities were implemented in the majority of sampled facilities: job descriptions were reported to be largely available, tasks were in line with job descriptions and training, performance appraisals were common and done on a regular basis, and meetings were regularly organized (Table 12). However, staff felt HRM activities were often poorly executed. For instance, staff members did not know how to access their job descriptions, they felt that performance appraisals were not useful, staff did not feel heard and needed more coaching and support, especially in Ma’an. Health workers who reported discussing performance appraisal with the manager were more motivated (32% in the highest motivation quartile) compared to those who did not discuss their performance appraisal (24% in the highest motivation quartile). Opportunities for professional development through in-service training and conference attendance were limited and the selection process was not transparent. Staff who reported to have less opportunities for training were also less motivated: 19% of health workers who felt they had opportunities for training were least motivated compared to 30% of health workers who felt they lacked such opportunity. Managers also struggled with opportunities for training: only one-third of managers received HRM training and about half felt they lacked opportunities for additional training to upgrade managerial skills.

Multivariable regression where motivation was an independent variable and various HRM practices were used as dependent variables revealed a negative and statistically significant association between motivation and average time spent on administrative tasks, and between motivation and working nights, weekends and holidays. The following HRM aspects were positively associated with motivation:
- Having a clear job description and relevance of one’s job to training and scope of work.
- Availability of in-service trainings and having attended in-service training or conference; motivation scores slightly increase when attendance was more recent.
- Ability to voice one’s opinion during clinical and non-clinical meetings.
- Level of comfort in discussing problems and errors with managers.
- Receiving enough support at the start of employment as well as ongoing support from managers.

Experiences with HRM practices at current job among leavers

All leavers reported receiving more and better supervision compared to MOH, with regular feedback from supervisors and sometimes from patients (in the private sector). Leavers running private practices maintained their own standards for quality of service. Leavers reported performance evaluations regularly being done, at least once per year. Performance evaluations were included in the employment contracts with clear evaluation criteria and the results of evaluation were openly discussed. Most leavers reported having more training opportunities compared to the MOH.
| Table 12. Summary of HRM practices as reported in questionnaires and during interviews and FGDs |
|--------------------------------------------------|--------------------------------------------------|
| **Results from questionnaires** | **Issues emerging from SSIs and FGDs** |
| Availability of job descriptions | |
| ▪ 90% have a clear job description. | ▪ Uncertainty about location of and access to the job description. |
| ▪ 84% (of 90%) agreed that their tasks are in line with job description. | ▪ Job descriptions are generic. |
| ▪ 81% perform tasks in line with their training and education. | ▪ Staff perform tasks that are not in their descriptions due to heavy workload and staff shortages. |
| ▪ 85% of managers have their own job description. | |
| Performance appraisals | |
| ▪ 85% of employees had formal performance appraisals in the past 12 months. | ▪ Performance appraisal focuses too much on attendance and dress code and pays little attention to performance and results. |
| ▪ 31% discussed the results of the appraisal with their managers. | ▪ Results of performance have little impact on career progression. |
| ▪ Uncertainty about location of and access to the job description. | ▪ The process is not transparent. |
| ▪ Job descriptions are generic. | |
| ▪ Staff perform tasks that are not in their descriptions due to heavy workload and staff shortages. | |
| Support and supervision | |
| ▪ Almost 70% of health workers reported receiving supervision regularly or occasionally. | ▪ More support required in form of answers to questions, advice and constructive feedback. |
| ▪ 73% felt that more coaching and support was needed. | ▪ Disproportionate importance given to dress code and attendance, as opposed to skills and performance. |
| ▪ More support required in form of answers to questions, advice and constructive feedback. | ▪ Managers admitted being more focused on their medical tasks. |
| Continuous medical education and professional development | |
| ▪ 76% reported to have received training in the past two years. | ▪ Scarcity of training opportunities. |
| ▪ 28% reported attending a national or international medical conference. | ▪ Nomination process for training opportunities is not transparent. |
| ▪ 50% felt that their facility provides them with opportunity to receive training to upgrade skills. | |
| ▪ 63% of reported that they upgrade their own clinical skills and knowledge. | |
| ▪ 34% of managers reported receiving management or human resources training | |
| Participation in meetings, reporting errors and discussing problems | |
| ▪ 52% have clinical and/or organizational staff meetings. | ▪ Few staff meetings. |
| ▪ 20% have them weekly or more frequently. | ▪ Staff is rarely included in the decision-making process. |
| ▪ 96% are able to always or sometimes voice their opinions. | ▪ Meetings mostly administrative in nature intended to inform staff of decisions rather than involve them. |
| ▪ 87% feel to be able easily report errors and discuss problems or complaints with their managers. | |
| ▪ 88% of doctors and 76% of nurses are very or somewhat comfortable in discussing errors and problems with their managers. | |
Discussion and recommendations

Reflection on findings

Our study set out to identify factors influencing retention, motivation and job satisfaction of health workers in the MOH sector. We focused on people who are currently working for the MOH; since they may have deliberately chosen to work for the MOH, this might have created a bias. That said, the study nonetheless provides interesting insights in the perceptions and experiences of MOH health workers.

Retention

The concern of stakeholders regarding high turnover and poor retention was not confirmed in our sampled facilities, neither in the urban governorates of Amman, Irbid and Zarqa nor in the rural governorate of Ma'an. On the contrary, the reported turnover rate of staff working in the selected facilities was relatively low, 3.7 - 8.5%. There are no international nor regional benchmarks for turnover rates. Data from the United States report (voluntary) turnover rates for health care staff of 14.2% in 2015.

Turnover of National Health Services staff in the United Kingdom as reported to be 11.3% in 2015. Although these data are not fully comparable due to differences in health systems, working conditions, organizational culture and societal values, they offer an indication that the turnover rate in Jordan is actually quite low. Low turnover means high retention, and therefore our data indicate a relatively high retention of health workers currently working for the MOH. These findings on retention need to be further contextualized with the following factors in mind:

- Relating our findings to national MOH data on in- and outflows, current turnover and vacancy rates and trends over time, and comparing to data from other sectors was not possible. The scope of this study was limited to MOH staff, with no access to national data for MOH or other sectors.
- Relating our findings to the goals of the MOH was not possible, as retention targets need to be more clearly defined by MOH. The data show that 46% of staff have changed their place of work in the past five years. It is unclear whether 46% mobility is high within the Jordanian’s MOH context: is the aim to retain staff at least five years, or is three years acceptable? Is the aim for the ministry to retain their staff in the MOH-sector or at facility level?
- Relating the findings to previous studies about turnover in Jordan is challenging as these studies addressed retention and turnover either among nurses or doctors, focused on specific types of facilities or geographic areas, used different instruments and/or measured turnover in different ways. Hayajneh et al (2009) assessed nurse turnover in 21 Jordanian hospitals in the period 2006-2007, using the same approach to turnover as in our study. They found an overall reported turnover rate of 36.2% with public hospitals having a significantly lower turnover rate (29.5%) compared to private (66.7%) and university hospitals (33.0%). The study did not investigate factors influencing the turnover rate. The reported high turnover rate was not confirmed by our study. As details of data collection were not provided, it is unclear why the difference between the two studies is so high. One reason could be that Hayajneh et al only looked at hospitals, whereas our sample included more PHCs and CHCs than hospitals. Additionally, both studies used reported turnover rates, and there might be, respectively, over- and underreporting, as well as challenges in the availability and quality of data. Four studies assessed turnover through intention to stay or intention to leave. Our findings corroborate these studies regarding the importance of social and professional support, working near one’s place of residence, as well as remuneration levels on intention to stay or leave.

21 AbuAlRub et al, 2009; Jardali et al, 2013
22 Alhamwan et al 2015; Khatabeh et al, 2015
Motivation

Doctors and nurses in our study were overall neutral to positive regarding their motivation, with a mean score of 3.48. Reported motivation and satisfaction levels in this study are similar to the levels that were assessed by Miller et al in two public hospitals in Jordan in 2000. This study reported an average general satisfaction of 3.39 and a cognitive motivation of 3.09. Even though the statements used for rating in the two studies were not identical, the findings indicate that the motivation of health staff working in the MOH over time has remained relatively neutral to positive. These data do not match the assumptions made by stakeholders that poor motivation and satisfaction is an issue. In other motivation and satisfaction studies in the public and the private health sector in Jordan and elsewhere that used Likert scales, relatively positive ratings were also reported: in Jordan, staff of an NGO for family planning were overall quite satisfied and scored between 3.5 and 4 on most statements related to job satisfaction (on a scale from 1-5); in Saudi-Arabia, nurses scored an average of 3.75 for job satisfaction, in Ghana, motivation and satisfaction among several staff categories scored on a scale from 1-5 respectively 3.65 and 3.15; and in Kenya, staff in district hospitals scored a mean 10-item score for motivation of 3.69.

Due to complexity of motivation as a concept and the tendency of respondents to rate positively, it is better to use the data to examine the significant differences between groups in relation to the average motivation and satisfaction levels instead of drawing conclusions on the basis of the absolute level of motivation. This allows policymakers and managers to better match HR strategies with workers' preferences so as to address the bottlenecks to enter and stay in the MOH.

Satisfaction

Most satisfying and dissatisfying factors were similar across respondents and as reported in the international literature. Satisfying factors were mentioned in three areas: intrinsic factors (value to society), work environment (interpersonal relations and team work) and working arrangements. The most reported satisfying factors were patient appreciation (71.1%), appreciation from colleagues and manager (69.5 and 53.8%) and interpersonal relations with colleagues (49.2%). The most reported dissatisfying factors were financial incentives (76%), supplies and infrastructure (44.2%), continuous education (43.5%) and workload (39.7). Leavers, now working in their own private clinics, hospitals, NGOs or the RMS reported overall to be satisfied with their current salaries and incentives. Dissatisfaction with financial incentives and salaries is commonly reported in the international literature, also in other countries in the MENA region. Although better aligning the remuneration packages (including financial and non-financial incentives) across health sectors in Jordan could improve satisfaction and reduce the intention to leave, particularly for doctors, the MOH is likely to face budgetary challenges to match salary and incentive levels with those in other health sectors and those abroad. Additionally, in interviews health workers reported that appreciation by management is just as important as financial incentives. Registered nurses and midwives, and health workers in hospitals reported in our study lower satisfaction with appreciation from managers. A large majority of all health workers (73%) reported the need for more coaching and support, particularly in Ma’an. AbuAlRub et al (2009) showed that nurses are more satisfied when they have support from their peers and supervisors and this, in turn, decreases their intention to leave. These findings suggest that emphasis should be placed on improving HRM practices, reported by our respondents to influence their motivation and satisfaction levels.

Although the number of refugees in Jordan has grown substantially in the past ten years, our study did not confirm the impact of refugees on health workers’ satisfaction and motivation, as expected by

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23 Mean satisfaction score was not calculated. Source: SHOPS, 2011
24 Elasmari, 2012
25 Bonenberger et al, 2014
26 Mbndiyo et al, 2009
27 Kian et al, 2014; Gomes and Proença, 2015
28 Eljardali, 2009;
stakeholders. Refugee care does not seem to be a source of dissatisfaction for health providers. However, this factor needs further exploration as the situation evolves.

HRM practices

A recent review of the evidence suggests that HRM practices have a large impact on intrinsic motivation, in particular through performance management. Receiving respect, appreciation and rewards, as well as having supervision, managerial and social support, autonomy and teamwork, communication and receiving feedback all influence intrinsic motivation. On the other hand, extrinsic motivation can be stimulated through improved working arrangements, financial incentives and supplies and infrastructure. When HRM strategies and working arrangements better address health workers’ motivational factors, intention to leave will reduce. In addition, such improvements are likely to affect health worker performance. We specifically assessed working arrangements and HRM activities related to performance management such as availability of job descriptions, interactions with managers, colleagues and patients, and support, supervision, appraisals at work and opportunities for professional development. Overall, managers implemented most HRM activities in the majority of sampled facilities, although often poorly. Improving HRM practices is important as the study has shown that a number of HRM practices that are currently poorly implemented have an impact on motivation. Examples are job descriptions, support and coaching and offering training opportunities.

Working for the MOH

As an employer, the MOH has a number of characteristics that distinguish it from other employers in the health sector. Although salaries in other public institutions, the private sector and, even more so, in Gulf States are reported to be two to five times higher, the MOH has other advantages. For instance, the MOH tries as much as possible to place its personnel close to their homes and working arrangements are more flexible. This is of particular interest for nurses and women, for whom the MOH is therefore an attractive employer.

Challenges to enter and stay in the MOH

Among the respondents, we identified specific groups that were the least motivated and most likely to leave MOH: doctors (38.5%), men (35.8%), younger workers (32.5%) and workers with less than five years of experience (34%). For these groups, the conditions the MOH offers did not seem of sufficient interest to stay. The findings seem to say that the main reason for this group, and in particular for young doctors, to work for the MOH was to gain experience and then to move on to another MOH facility, the private sector or abroad. Reasons to leave mentioned by younger workers were better financial opportunities to attain private goals such as starting a family or more opportunities for specialization. A high level of intention to leave among doctors in Jordan is also reported by Khatatbeh et al (2015).

Although working for the MOH has important advantages for staff, the relatively high number of respondents (34%) who reported they are actively seeking a position outside of the MOH sector within the next two years is of concern. Additionally, while more than half of all employees (51%) reported no intention to leave their current MOH workplace, over one-third (36%) are actively seeking to transfer to another MOH facility. The most important reasons emerging from the findings that might influence intention to leave MOH facilities are:

- **Geographical preferences.** In principle, MOH staff is as much as possible placed in their areas of origin, and this is an advantage. Still, 37% of the MOH workforce does not work in their governorate of origin. A number of these health workers will try to transfer so as to gain employment close to home. Working close to home is important for the MOH as it will facilitate recruitment and retention of staff in rural areas. For instance, among respondents in the rural governorate of Ma’an, 77% of nurses and midwives originated from there. This might explain the stability in the facilities in this rural governorate and makes a case to continue focusing on deployment to areas of origin. The importance of proximity of residence among nurses in Jordan

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29 Okello and Gilson, 2015
is also reported by Hayajneh (2009). The World Health Organization (WHO) (2010) reports the success of posting in areas of origin in other countries in improving retention. If it is important to keep staff in the MOH facilities they are currently working in, even more efforts have to be made to place staff to their areas of origin.

- **Heavy workload.** Doctors and nurses in hospitals and CHCs reported a heavy workload as an important source of dissatisfaction. Although the study did not assess actual workload, doctors reported less than seven minutes for each patient consultation, which seems relatively short: in the Netherlands, physicians at the primary level have a maximum consultation time of 20 minutes per patient; consultation time for primary care physicians varied in Germany, the United Kingdom and United States between 16-32 minutes for new patients and 6-18 minutes for routine visits. It might be that the short working day has its downside as more patients need to be seen in less time. It might, however, also be that gains can be made in repartition of tasks. This requires more insight in current work processes.

- **Limited opportunities for continuous education.** Health workers were dissatisfied with the limited number of opportunities for professional development and what they perceive to be an unclear selection process. Dissatisfaction was strengthened by constant comparison with other sectors (university hospitals/RMS and private health facilities) where a lot of attention and resources are allegedly invested in continuing medical education. MOH health workers felt that they have outdated medical knowledge compared to their colleagues in other public and private sectors, which they felt affected the quality of their work. Training needs particular attention in Ma'an: although Ma'an governorate has a particularly large need for training given the number of assistant and associate nurses and younger less experienced doctors, respondents reported the lowest number of in-service training opportunities available amongst all governorates.

Other emerging findings that have an impact on motivation and satisfaction, and that require attention and improvement, include:

- **No regular feedback from patients.** Patient satisfaction was reported to be the biggest driver of motivation, with more than 70% of health workers reporting patient satisfaction as one of their top five satisfying factors. In most facilities, there is currently no systematic collection of patients’ perspectives on the provided care, nor is patient feedback discussed in meetings to inform debates on health worker performance and quality improvement processes within facilities. However, this situation is changing with the recently introduced accreditation process: facilities that are accredited are required to conduct bi-annual patient feedback surveys.

- **Limited HRM capacities of facility managers.** Improving HRM also requires improving capacities of managers. However, HRM in the MOH is challenging: about 25% of health facility managers reported not being trained in management, and often health facility managers stated preferring their clinical duties over their management duties and having limited decision-making space. Research on factors influencing motivation and performance of health workers has identified the importance of the role of health facility managers. How they perform their HRM tasks, that is, how they support health workers, facilitate team work, manage conflicts and negotiate with their superiors and other stakeholders, is likely to affect health worker motivation and performance. Their ability to act depends on their leadership and management competencies, decision-making space (autonomy) and tools and support they have to manage their staff, amongst other factors.

- **Aggression at the workplace.** Although appreciation from patients and managers as well as relations with colleagues were the biggest motivating factors in this study, about 13% of health workers

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31 Konrad et al, 2010
32 Asiri et al, 2016; Okello and Gilson, 2015; Fritzen, 2007
33 Fritzen, 2007
reported appreciation from managers and patients as one of the most dissatisfying factors. Several times in interviews and FGDs, health workers reported gender- and position-related cases of harassment. Additionally, aggression and verbal and physical abuse and threats directed from patients toward staff were reported. The study did not assess the magnitude of occurrence of aggression on the work floor but violence toward health personnel, especially nurses, in Jordan has repeatedly been described in the literature. Furthermore, interviews and FGDs identified lack of clear or safe procedures to report violence and harassment from patients or staff, and nurses felt that there were no sanctions for violator. Further assessment is required.

- Deployment/transfer. Although the study did not investigate the deployment process, an emerging issue from the interviews that requires further exploration is the way requests for transfers were handled, as these were perceived as lengthy and frustrating.

Recommendations

Below we provide a number of recommendations. It is imperative to further discuss and validate these recommendations with the MOH.

1. This study has shown that, while the reported turnover rate among MOH staff is relatively low, the MOH faces a challenge in the intention of staff to leave their current positions in the coming years. The cadres that have the highest intention to leave are doctors and registered nurses. These were the cadres that also were highly dissatisfied with a heavy workload. Given the limited number of vacancies and the reported short working days, this raises questions regarding current staffing norms and efficiency. It is, therefore, important to critically assess the actual workload, facility staffing and efficiency in relation to current requirements at facility level. The Workload Indicator Staffing Needs is one of the tools that can be used to help identify actual workload and staffing needs. In addition, task division and patient flow can be reviewed to address any inefficiencies.

2. Distinguishing characteristics of the MOH as an employer attract a certain profile of health workers, such as starting doctors and women, as MOH facilities are perceived to allow women to combine work with family life, and health workers to live close to their place of employment. Given that 37% of staff is not working in their area of origin, it is important to identify how to respond even better to health workers’ geographic preference in the deployment process, especially among doctors, as it is likely to decrease intention to leave. This includes a review of the CSB’s deployment and transfer process.

3. The MOH should review how to make it more attractive for younger staff to stay, possibly through a more defined career path (offering specialization) or performance-related incentives, as these were important reasons for younger workers to leave.

4. This study identified that the implementation of HRM practices should be improved. According to international literature, improved HRM practices such as appreciation, support and offering training, would positively affect motivation and satisfaction of health employees. Facility managers can play a crucial role, but most managers reported clinical work as a priority and managerial tasks were more often regarded as a nuisance that distracted them from their main clinical tasks. Investments in capacity building of facility managers is needed. Areas that would need to be included are leadership, team building, coaching, support and supervision and communication. Additionally, capacity needs to be strengthened to improve managers’ skills related to conflict management to support staff in dealing with conflicts, aggression and abuse. Apart from knowledge and skills, managers need to have dedicated time for management.

34 Al-Awawdeh et al, 2007; Al-Omari, 2015; Albashtawy, 2013; El Rayan et al, 2016
35 Okello and Gilson, 2015
5. Further, the current decision-making space for managers is limited, as most HRM decisions are centralized. In order to be effective, health workers need to have space to voice their concerns and preferences. This will allow managers to align HRH strategies with staff preferences. Facility managers need to have enough decision-making space to be able to adapt HR strategies to the needs of their own staff. Given that management is currently heavily dominated by men, it would be important to attract more women to management positions, especially because the majority of the workforce is female.

6. It is important to provide opportunities for continuing professional development for staff to regularly update their knowledge and skills. Offering these opportunities remotely and individually, without the need to attend training courses, may prove more cost-effective and less disruptive to facilities.

7. Patients’ appreciation was highly valued by health workers. Giving patients a voice by systematically collecting their perceptions might further boost health worker motivation, contribute to quality improvement activities, and improve patient-provider interactions. International literature provides solid evidence of the positive effect of patient involvement, for instance by introducing social accountability mechanisms.

8. Aggression, harassment and abusive behavior in the workplace was often reported, but health workers were not familiar with any formal process to report cases of abuse and violence. Furthermore, mainly female nurses lacked confidence that a formal process would result in fair outcomes. This calls for clear and well-communicated plan and procedures to report harassment and aggression at the workplace.

9. We could not validate our data with data from the MOH at national level and with the other sectors on vacancy- and turnover rates, as we could not access these data. In addition, turnover rates and vacancy rates in our study are reported by managers and facility data were not accessible. For planning and strategy development purposes, these data are essential. Furthermore, more clearly defining retention and making retention expectations within MOH more explicit will allow for the development of better retention strategies.

10. Suggestions for further research:
    a. A similar study among university/RMS and the private sector is recommended to have a complete picture of retention and motivation in the health sector in Jordan. This will allow comparison of turnover, motivation and satisfaction between different employers in the health sector.
    b. A second study area is the current refugee impact on the health sector. Our study did not reveal a strong burden on health services due to the influx of refugees, in spite of the large number of refugees currently residing in Jordan. Better understanding of the impact on health facilities after the changes in payment system is warranted. In addition, it is important to monitor whether the health needs of refugees are adequately met.
    c. A third area is the barriers for women to access and assume management position in the MOH, as women are largely underrepresented at decision-making level in the health sector.
    d. A final area that emerged from this study is harassment and aggression at workplace. It is important to measure and better understand the magnitude of this problem, which cadres and gender are most affected, and what type and circumstances in order to determine most appropriate strategy to address it.

Additionally, a secondary analysis of this study’s data set should be conducted to answer additional questions not included in the original research proposal, including generating additional gender-disaggregated data tables.
Bibliography


Annex A. Data Collection Tools

Questionnaire for health facility employees

Number HRM_EMP________

Human resource management practices at health facilities

Governorate: ______________________
Name of Facility: ___________________
Type of Facility: ____________________
Interviewer: _______________________

We are conducting research to support the Ministry of Health (MOH) to develop strategies to motivate and retain staff working in health sector. We are investigating what currently motivates and demotivates health workers and would like to ask you a few questions related to your experience. Participation is voluntary and we would very much appreciate your collaboration. Completing this questionnaire will take you about 20 minutes. This questionnaire is anonymous; all results will be summarized in a report from all the facilities.

Do you agree to participate?
   a. Yes \( \Rightarrow \) Thank you! Please, proceed to question 1.
   b. No \( \Rightarrow \) Thank you for your consideration. Please still complete question 1-3.

Section I. Personal information

1. Gender:
   a. Man
   b. Woman

2. Year of birth: __________

3. What is your highest obtained education and where did you obtain it?
   a. Medical Doctor, obtained from ________ University and residency in ______________
   b. Registered nurse, obtained in __________________________
   c. Associate nurse, obtained in __________________________
   d. Midwife, obtained in __________________________
   e. Other, namely __________________________

4. What is your current marital status?
   a. Married
   b. Single
   c. Other __________

5. What is your place of birth (place and governorate)? _______________________

6. What is your current position at this institution?
   a. Manager
   b. Manager and practicing doctor
   c. Specialist, namely ______________
   d. General practitioner/Family doctor
   e. Registered nurse
   f. Nurse, other ______________
   g. Midwife
7. How many years of experience do you have in this position?
   a. ____________ full years

8. How long have you been working at this facility?
   a. ____________ full years

9. In addition to clinical tasks, do you also have additional tasks at this facility?
   a. Yes, namely ________________
   b. No, I only perform my clinical tasks

**Section II. Description of your work**

10. Please fill in your expected and actual working hours and days:

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<tr>
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<th><strong>Expected working hours</strong> (indicate starting and ending time according to contract)</th>
<th><strong>Actual working hours</strong> (indicate approximate actual starting and ending time)</th>
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<td>Saturday</td>
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11. How often are you working during nights, weekends and public holidays?

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<th>1=never 2=rarely 3=regularly</th>
<th>Is it your personal choice? Yes/No/Not applicable</th>
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<tbody>
<tr>
<td>Night shifts</td>
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<tr>
<td>Weekends</td>
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<tr>
<td>Public holidays (for example, list public holidays....)</td>
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12. How many days of holiday and/or vacation do you take each year on average?
   a. ____________ days/year

13. Can you easily take holidays at your own convenience?
   a. Yes
   b. No

14. How many patients do you attend on average in one full working day?
   a. Approximately ____________ patients per day
15. Do you have to do rotations to other health facilities?
   a. Yes, on average ___________ weeks/year
   b. No

16. How far was your last rotation from your home?
   a. Not applicable
   b. Approximately ___________ hours travel time from my home in one direction.

17. On an average day, how much time do you devote to clinical tasks (for example, attending to patients)?
   a. ___________ hours per day

18. On an average day, how much time do you devote to administrative tasks (for example, filling in the papers, data in the computer, collecting data, meetings, everything else not related to direct patient care)?
   a. ___________ hours per day

Section III. Human resource management practices

19. Do you have a job description where your tasks and responsibilities are outlined?
   a. Yes
   b. No

20. Are the tasks that you are now performing in line with the job description?
   a. Yes
   b. No
   c. I do not know

21. Are the tasks that you are now performing in line with your training? (In other words, do you do what you were trained for?)
   a. Yes
   b. No

22. Do you have staff meetings at your institution for clinical issues, where you discuss patient cases and clinical approaches?
   a. Yes
   b. No
   c. I do not know

23. How often on average are these clinical staff meetings?
   a. Weekly or more often
   b. Monthly
   c. Occasionally
   d. Never
   e. I do not know

24. Do you participate in these meetings?
   a. Yes, always
   b. Yes, sometimes
   c. Yes, rarely
   d. No

25. During these meetings, are you able to voice your opinion?
26. Do you have staff meetings at your institution for non-clinical issues, where you discuss administrative or organizational issues?
   a. Yes
   b. No
   c. I do not know

27. How often on average are these organizational staff meetings?
   a. Weekly or more often
   b. Monthly
   c. Occasionally
   d. Never

28. Do you participate in these organizational staff meetings?
   a. Yes, always
   b. Yes, sometimes
   c. Yes, rarely
   d. No

29. During these organizational staff meetings, are you able to voice your opinion?
   a. Always
   b. Sometimes
   c. Rarely
   d. Never

30. Do you receive minutes of these organizational staff meetings?
   a. Yes
   b. Sometimes
   c. Never

31. Does your health facility provide you with opportunity to receive formal training to upgrade your skills and knowledge?
   a. Yes, yearly
   b. Yes, once in 3-5 years
   c. No
   d. I do not know

32. On average, how many days per year you spend on additional in-service formal training to upgrade your knowledge and skills?
   a. ________________days

33. When was the last time you attended an in-service training (after graduation from college/university)?
   a. I never attended such training
   b. I attended a clinical in-service training in ________ year
   c. I do not remember

34. When was your last time you attended a national or international conference in your working domain?
   a. I never attended a conference
b. In ______________ (year)
c. I do not remember

35. Apart from training, on average how many hours per month you spend upgrading your clinical knowledge or skills?
a. ___________ hours/ month

b. I do not upgrade my skills because I do not have time/interest/access to information

36. What is the main source of information do you use for upgrading your knowledge?
a. Medical journals
b. Internet
c. Books from my study
d. Medical guidelines
e. Training sessions for medical students
f. Other, namely _____________

37. Have you in the past 5 years worked at (please, answer all questions):
a. Another MOH institution Yes/No If yes, for how long ______ years
b. Private institution Yes/No If yes, for how long ______ years
c. RMS institution Yes/No If yes, for how long ______ years
d. University hospital Yes/No If yes, for how long ______ years
e. Gulf States Yes/No If yes, for how long ______ years
f. Outside of Jordan, not in Gulf States Yes/No If yes, for how long ______ years
g. This is my first position

38. What are your aspirations for the next 2 years?
a. I am planning to get a higher position/career promotion
b. I will continue in my current position
c. I will stop working
d. Other, namely _____________

39. Are you actively pursuing a career change?
a. I am actively looking for a position in a different MOH facility
b. I am actively looking for a position in a different type of facility
c. I am actively looking for a position in private sector
d. I am actively looking for a position in RMS/University
e. I am actively looking for a position in the Gulf States
f. I am not actively pursuing a career change, but will consider other options may the opportunity arise
g. I will continue working at the same facility
h. I do not know/I am not actively looking

40. When was the last time you had a performance appraisal/evaluation?
a. <1 year
b. 1-2 years ago
c. > 2 years ago
d. Never

41. Did you discuss your performance appraisal and the results with your manager?
a. Yes
b. No
c. I do not know
42. When you started in this position did you receive support from your manager or peers to perform your tasks?
   a. Yes, I received enough support at the beginning to perform my tasks
   b. Yes, but too little support to perform my tasks
   c. No, I received no support at all at the beginning to perform my tasks and I did not need it
   d. No, I received no support at all at the beginning to perform my tasks and I really missed it

43. Do you receive support to improve your performance from your manager or supervisor?
   a. Yes, regularly (weekly or monthly)
   b. Yes, occasionally
   c. Yes, rarely
   d. No, never

44. Would you like to receive more coaching or support to improve your performance?
   a. No, I receive enough support
   b. No, this is not important to me
   c. Yes, I would like to receive more support to improve my performance
   d. I do not know/not sure

45. If you have a problem or a complain, can you easily discuss it with your manager?
   a. Yes
   b. No

46. If you make a mistake, do you feel comfortable discussing your mistake with your manager and peers?
   a. Yes
   b. No

47. Do you use medical guidelines and clinical pathways in treatment of the patients?
   a. Always
   b. Often
   c. Rarely
   d. Never
   e. We do not have guidelines/pathways

48. Which financial and non-financial incentives are you getting?

<table>
<thead>
<tr>
<th>Incentive</th>
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<td>Experience allowance</td>
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<tr>
<td>Hardship allowance</td>
<td>JD</td>
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<td>Overtime allowance</td>
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<td>Night shift allowance</td>
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<tr>
<td>Weekend allowance</td>
<td>JD</td>
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<tr>
<td>Public holiday allowance</td>
<td>JD</td>
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<tr>
<td>Education allowance</td>
<td>JD</td>
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<tr>
<td>Health insurance</td>
<td>JD</td>
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<tr>
<td>Maternity leave</td>
<td>JD</td>
</tr>
<tr>
<td>Pilgrimage/Hajj</td>
<td>JD</td>
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<tr>
<td>Allowance</td>
<td>JD</td>
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<td>JD</td>
</tr>
<tr>
<td>Paid leave</td>
<td>days</td>
</tr>
<tr>
<td>Possibility of unpaid leave with position retention</td>
<td>years</td>
</tr>
</tbody>
</table>

49. Which 5 aspects of your work are currently for you the most SATISFYING and the most DISSATISFYING?

<table>
<thead>
<tr>
<th>Please indicate maximum 5 the most SATISFYING aspects of your work</th>
<th>Please indicate maximum 5 the most DISSATISFYING aspects of your work</th>
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Section IV. Motivation

We would like to ask you some questions about your motivation in your work. Please rate from 1 to 5 to what extent you agree or disagree with the below statements.

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MOTIVATION AND RETENTION OF HEALTH WORKERS IN MINISTRY OF HEALTH FACILITIES IN FOUR GOVERNORATES IN JORDAN: FINDINGS FROM A MIXED METHODS STUDY | 44
These days, I feel motivated to work as hard as I can
I only do this job so that I get paid at the end of the month
I do this job as it provides long term security for me
I feel emotionally drained at the end of every day
Sometimes when I get up in the morning, I dread having to face another day at work

Overall, I am very satisfied with my job
I am not satisfied with my colleagues at this facility
I am satisfied with my supervisor
I am satisfied with the opportunity to use my abilities in my job
I am satisfied that I accomplish something worthwhile in this job
I do not think that my work in the health facility is valuable these days
I am proud to be working for this health facility
I find that my values and this health facility’s values are very similar
I am glad that I work for this facility rather than other facilities in the country
I feel very little commitment to this health facility

This health facility really inspires me to do my very best on the job
I cannot be relied on by my colleagues at work
I always complete my tasks efficiently and correctly
I am a hard worker
I do things that need doing without being asked or told
I am punctual about coming to work
I am often absent from work
It is not a problem if I sometimes come late to work
Questionnaire for health facility managers

Number HRM_MAN________

**Human resource management practices at health facilities in Jordan**

Governorate: _____________________
Name of Facility: __________________
Type of Facility: __________________
Interviewer: ______________________

We are conducting a research to support the Ministry of Health (MOH) to develop strategies to motivate and retain staff working in health in public sector. We are investigating what currently motivates and demotivates health workers in public sector and would like to ask you as a manager a few question related to your experience. Participation is voluntary and we would very much appreciate your collaboration. Completing this questionnaire will cost you about 15 minutes. This questionnaire is anonymous; all results will be summarized in a report from all the facilities. Do you agree to participate?

c. Yes→ Thank you! Please proceed to question 1.
d. No → Thank you for consideration. Please still complete questions 1-3.

**Section I. Personal information**
1. Gender:
   - a. Man
   - b. Woman

2. Year of birth: ___________

3. What is your highest obtained education and where did you obtain it?
   - f. Medical Doctor, obtained from ____________________University and residency in ________
   - g. Registered nurse, obtained in ___________________
   - h. Unregistered nurse, obtained in ___________________
   - i. Midwife, obtained in ____________________________
   - j. Other, namely _________________________________

4. What is your current marital status?
   - a. Married
   - b. Single
   - c. Other __________

5. What is your place of birth (place and governorate)? _____________________

6. What is your current position at this institution?
   - i. Manager only, I do not see patients
   - j. Manager and practicing doctor
   - k. Other, namely ________________

7. How long have you been working at this facility?
   - a. _______________ full years

8. How long have you been working as a manager?
   - a. _______________ full years
9. How many years of experience do you have in the health sector?
   a. ____________ full years

Section II. Description of this facility and your work
10. Please describe your facility in the table below, including staff that is listed/employed at the moment:

<table>
<thead>
<tr>
<th>What is the catchment population area (if applicable)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>How many beds do you have (if applicable)?</td>
</tr>
<tr>
<td>How many patients are seen/attended on average per day? (total number)</td>
</tr>
<tr>
<td>How many staff do you have in total?</td>
</tr>
<tr>
<td>How many specialist-doctors?</td>
</tr>
<tr>
<td>How many general practitioners?</td>
</tr>
<tr>
<td>How many registered nurses?</td>
</tr>
<tr>
<td>How many other (associate, assistant) nurses?</td>
</tr>
<tr>
<td>How many midwives?</td>
</tr>
<tr>
<td>How many technical and lab staff?</td>
</tr>
<tr>
<td>How many administrative staff?</td>
</tr>
<tr>
<td>Do you have pharmacy?</td>
</tr>
<tr>
<td>Do you also serve a refugee population?</td>
</tr>
<tr>
<td>How many refugee patients are seen/attended on average per day? (from the total number)</td>
</tr>
</tbody>
</table>

11. Please fill in your expected and actual working hours and days:

<table>
<thead>
<tr>
<th>Expected working hours (indicate starting and ending time according to contract)</th>
<th>Actual working hours (indicate approximate actual starting and ending time)</th>
</tr>
</thead>
<tbody>
<tr>
<td>From</td>
<td>Until</td>
</tr>
<tr>
<td>Sunday</td>
<td></td>
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<tr>
<td>Monday</td>
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<tr>
<td>Friday</td>
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<tr>
<td>Saturday</td>
<td></td>
</tr>
</tbody>
</table>

12. How many days of holiday and/or vacation do you take each year on average?
   a. ___________ days/year

13. Can you easily take holidays at your own convenience?
   a. Yes
   b. No

14. Are you practicing clinical medicine in addition to your managerial tasks?
   a. Yes, I am specialized in ___________
b. No

15. On an average day how much time do you devote to clinical tasks (for example, attending patients)?
   a. __________ hours per day
   b. I see on average __________ patients per day

16. On an average day how much time do you devote to managerial tasks?
   a. __________ hours per day

Section III. Human resource management practices

17. Please list all staff (limited to doctors, nurses and midwives) working at your facility

<table>
<thead>
<tr>
<th>Position of each staff member (only limited to doctors, nurses and midwives)</th>
<th>Number of years at this facility of each staff member</th>
<th>Present at the moment of questionnaire? Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

18. Do you have vacancies at this facility? Please list all vacant position and possible temporary solution for the vacancy if exists.

<table>
<thead>
<tr>
<th>Vacant position according to the budget</th>
<th>How long has the position been vacant?</th>
<th>Do you have a temporary solution?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

19. In the past 12 months how many staff left your facility and why (indicate reason according to code below? Reasons for leaving:
   a. Went to work in Gulf States
   b. Went to work in another MOH hospital
   c. Went to work in another MOH primary health facility
   d. Went to work in private sector
   e. Went to work in RSM/University hospital
   f. Stopped with working
   g. I do not know
   h. Other, namely ___________________
Position | Reason for leaving
-----|-------------------

20. Please list the positions of all new staff that have joined your facility in the past 12 months:

<table>
<thead>
<tr>
<th>Position</th>
<th>How many people</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
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</tbody>
</table>

21. How long does it take on average to fill in the vacancy?
   a. Doctor-specialist _______________ days
   b. Doctor-general practitioner _______________ days
   c. Registered Nurse _______________ days
   d. Associated/assistant nurse _______________ days
   e. Midwife _______________ days

22. Did you ever follow management training?
   a. Yes. If yes, how long? ________________
   b. No

23. Do you have a job description where your tasks and responsibilities are outlined?
   a. Yes
   b. No

24. Are the tasks you are now performing in line with the job description?
   a. Yes
   b. No
   c. I do not know

25. When you started as manager did you receive support from your manager or peer managers?
   a. Yes, I received enough support at the beginning
   b. No, I received very little support at the beginning
   c. No, I received no support at all at the beginning

26. Do you receive coaching or support to improve your performance from your manager or supervisor?
   a. Yes, regularly (weekly or monthly)
   b. Yes, occasionally
   c. Yes, rarely
   d. No, never

27. Do you organize performance appraisal for your staff?
   a. Yes
   b. No

28. If yes, how often do you conduct a performance appraisal?
   a. Once per year or more often
b. Once every two years
c. Rarely
d. Never

29. Do you discuss with each employee the results of the performance appraisal?
   a. Yes, always
   b. Yes, sometimes
   c. Yes, but only with selected staff
   d. Rarely
   e. Never

30. Do you yourself discuss your performance appraisal with your manager?
   a. Yes
   b. No

31. If yes, how often do you discuss your own performance appraisal?
   a. Once per year or more often
   b. Once every two years
   c. Rarely
   d. Never

32. Do you organize staff meetings to discuss administrative or organizational issues (not clinical) with your staff?
   a. Yes
   b. No
   c. I do not know

33. How often on average are these organizational staff meetings?
   a. Weekly or more often
   b. Monthly
   c. Occasionally
   d. Never

34. Do you make minutes of these organizational staff meetings?
   a. Yes
   b. Sometimes
   c. Never

35. Do you have staff meetings for managers (at governorate or national level) to discuss managerial issues?
   a. Yes
   b. No
   c. I do not know

36. How often are these meetings for managers?
   a. Weekly
   b. Monthly
   c. Rarely
   d. Never

37. Do you receive minutes of these organizational staff meetings?
   a. Yes
   b. Sometimes
38. Does your staff each have their own job description?
   a. Yes, all staff have their job description
   b. Not all staff have their job description
   c. I do not know

39. Are these job descriptions aligned with their actual tasks?
   a. Yes, all job descriptions are aligned with the actual tasks
   b. No, some job descriptions are generic and staff do additional not specified in the job
description tasks as requested
   c. I do not know

40. Do you offer additional training to upgrade skills and knowledge of staff?
   a. Yes, mostly for doctors
   b. Yes, mostly for nurses
   c. Yes, for doctors and for nurses
   d. I do not know

41. How many staff received additional training to upgrade skills in the past 2 years?
   a. Specialists: ____________ people
   b. Doctors (not specialists): _______________ people
   c. Registered Nurses: _______________ people
   d. Not registered nurses: _______________ people

42. How do you select staff for training?
   a. Anyone who asks for training receives it
   b. I select people according to my own priorities
   c. I discuss in staff meetings needs of staff
   d. I use performance evaluation results
   e. I do not know

43. Do you have clinical guidelines available in this facility?
   a. Yes
   b. No

44. If yes, where are they?
   a. I keep them in my office
   b. Staff each have their own clinical guidelines
   c. They are in a separate place where everyone can consult them when they want
   d. I do not know

45. When staff makes a clinical mistake what is done?
   a. They report the incident
   b. They report the incident and we discuss between the staff and the management who made the
mistake
   c. We discuss this at the ward level to see how this can be prevented next time
   d. We do nothing

46. Do you have opportunity to receive additional training to upgrade your managerial skills and
knowledge?
   a. Yes, yearly
   b. Yes, once in 3-5 years
c. No
d. I do not know

47. When was the last time you attended a training focusing on management?
   a. I never attended such training
   b. I attended a management training in _______ year
   c. I do not remember

48. Which financial and non-financial incentives are you getting?

<table>
<thead>
<tr>
<th>Incentive</th>
<th>JD</th>
<th>Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Salary</td>
<td></td>
<td></td>
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<tr>
<td>Transportation allowance</td>
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<tr>
<td>Remote area allowance</td>
<td>JD</td>
<td></td>
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<tr>
<td>Housing allowance</td>
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<td></td>
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<tr>
<td>position retention</td>
<td></td>
<td></td>
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</tbody>
</table>

49. Have you in the past 5 years worked at:
   a. Another MOH institution Yes/No If yes, for how long _______ years
   b. Private institution Yes/No If yes, for how long _______ years
   c. RMS institution Yes/No If yes, for how long _______ years
   d. University hospital Yes/No If yes, for how long _______ years
   e. Gulf States Yes/No If yes, for how long _______ years
   f. Outside of Jordan, not in Gulf States Yes/No If yes, for how long _______ years
   g. This is my first position

50. What are your aspirations for the next 2 years?
   a. I am planning to get a higher position
   b. I will continue in my current position
   c. I will stop working
   d. Other, namely ___________________

51. Are you actively pursuing a career change?
   a. I am actively looking for a position in a different MOH facility
   b. I am actively looking for a position in a different type of facility
   c. I am actively looking for a position in private sector
   d. I am actively looking for a position in RMS/University
   e. I am actively looking for a position in the Gulf States
   f. I am not actively pursuing a career change, but will consider other options may the
      opportunity arise
   g. I will continue working at the same facility
h. I do not know/I am not actively looking

52. Which 5 aspects of your work are the most SATISFYING and the most DISSATISFYING?

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<td>Other, namely ..........</td>
</tr>
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<th>4 = agree</th>
<th>5 = strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>These days, I feel motivated to work as hard as I can</td>
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<td>I only do this job so that I get paid at the end of the month</td>
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<td>Sometimes when I get up in the morning, I dread having to face another day at work</td>
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<td>Overall, I am very satisfied with my job</td>
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<td>I am not satisfied with my colleagues at this facility</td>
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<td>I am satisfied with my supervisor</td>
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<td>I am satisfied with the opportunity to use my abilities in my job</td>
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<td>I am satisfied that I accomplish something worthwhile in this job</td>
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<td>I do not think that my work in the health facility is valuable these days</td>
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<td>I am proud to be working for this health facility</td>
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<td>I find that my values and this health facility’s values are very similar</td>
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<td>I am glad that I work for this facility rather than other facilities in the country</td>
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<td>I feel very little commitment to this health facility</td>
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<td>This health facility really inspires me to do my very best on the job</td>
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<td>I cannot be relied on by my colleagues at work</td>
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<td>I always complete my tasks efficiently and correctly</td>
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<td>I am a hard worker</td>
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<td>I do things that need doing without being asked or told</td>
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<td>I am punctual about coming to work</td>
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<td>I am often absent from work</td>
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<td>It is not a problem if I sometimes come late to work</td>
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Informed Consent – Focus Group Discussions with Staff

Introduction

Good morning/afternoon, my name is ______ and I work for ______. We are researchers recruited by a project called Human Resources for Health 2030 (HRH2030), to assist the Ministry of Health in developing policies to support health workers in their work. We will be conducting interviews and focus group discussions with nurses, midwives and doctors, and with managers in health centers and hospitals in four different governorates. We are conducting these activities with the aim to find what staff think about their work and how motivated they are. The information of this study is intended to be used for policy making by the Ministry of Health. Before we continue, we would like to ask you to read the consent form and to tell us if you agree to participate.

We have invited you to participate in a discussion with several other people with similar experiences. This enables you to discuss your experiences with each other. Your participation is voluntary and it will have no consequences for your work or your situation in this facility. During the discussion you can stop any time, even if you agreed to participate at the start of the focus group discussion. We will organize these discussions in several facilities. In addition, we will ask these questions to nurses, midwives and doctors in different facilities and we have a form with questions for nurses, midwives and doctors that will be filled out.

We expect that this focus group discussion will last for about one and a half hour. During this time, we will start by making sure that you are comfortable and we can answer any questions you might have. We then will ask questions about work in this facility, how motivated staff is, how staff is supported in performing their tasks and what can be improved. We ask you to express yourself freely. No one else but the other people participating and us researchers will be present. We will not ask you to share your personal experiences and you do not have to share any information you feel not comfortable sharing. You do not have to give us a reason for your refusal.

We request that everyone in this group not to tell others outside this group what was said during the discussion and keep what was said in the group confidential. You should know, however, that we cannot stop or prevent participants who were in the group from sharing things that should be confidential.

This study will not directly benefit you, but your participation is likely to help us find out more about how health workers working in the Ministry of Health facilities can be better supported in performing their tasks.

The discussion is confidential and anonymous. We assure everyone that no one’s name can be linked to the research and that instead of names we will use numbers. These numbers are only known to us, the researcher, and we will lock that information up with a lock and key. With your approval, this discussion will be recorded, and we will also make sure that your name is not mentioned on the recorded discussion. The notes and the recorded discussion will only be accessed by the research team. These will be stored in a safe place that is only accessible to the researchers. The recorded discussion will be destroyed after September, when we have finalized our study.

The information you will give us today will not be shared with anyone outside the research team. When the results of the study are ready we will share a summary of the results with the facilities that participated. After this, the results will be made widely available to others, such as the Ministry of Health and the High Health Council.

Contact person
If you have any questions about the research you can contact (add contact information).
 Consent
 I have read the information about the study and how it is conducted as described above. I have had the opportunity to ask questions about it and any questions I have been asked have been answered to my satisfaction. I consent voluntarily to be a participant in this study.

 Print Name of Participant: __________________
 Signature of Participant: __________________
 Date: ___________________
     Day/month/year
Informed Consent – Interviews with Staff and Managers

Introduction

Good morning/afternoon, my name is ____ and I work for _____. We are researchers recruited by a project called Human Resources for Health 2030 (HRH2030) to assist the Ministry of Health in developing policies to support health workers in their work. We will be conducting interviews and focus group discussions with nurses, midwives and doctors, and with managers in health centers and hospitals in four different governorates. We are conducting these interviews with the aim to find what staff thinks about their work and how motivated they are. The information of this study is intended to be used for policy making by the Ministry of Health. Before we continue, we would like to ask you to read the consent form and to tell us if you agree to participate.

We have invited you to participate as we can learn a lot from your experiences. Your participation is voluntary and it will have no consequences for your work or your situation in this facility. During the interview you can stop any time, even if you agree to be interviewed at the start of the interview. We expect that our interview will last for about one hour and during this time, we will ask you questions about your work and what you like about it, how you are supported in performing your tasks, and what can be improved. We will ask these questions to nurses, midwives and doctors in different facilities. In addition, we have a questionnaire for nurses, midwives and doctors with questions that you can answer on a form and we will organize in some focus group discussions.

We ask you to be open and express yourself freely. No one else but the interviewer will be present unless you would like someone else to be there. If you feel that this environment is not private enough, we will look for another place, where you prefer to be interviewed. If you feel uncomfortable answering certain questions, you are free to refuse and we will continue the interview with the following questions.

The interview is confidential and anonymous. We assure that your name can not be linked to the research and instead of names we will use numbers. These numbers are only known to us, the researcher, and we will lock that information up with a lock and key. With your approval, the interviews will be recorded, and we will also make sure that your name is not mentioned on the recorded interview. The interview notes and the recorded interview will only be accessed by the research team. These will be stored in a safe place that is only accessible to the researchers. The recorded interview will be destroyed after September, when we have finalized our study.

This study will not directly benefit you, but your participation is likely to help us find out more about how health workers working in the Ministry of Health facilities can be better supported in performing their tasks.

The information you will give us today will not be shared with anyone outside the research team. We will review our notes after interview and when we are not sure if we understood your answers correctly we would like to ask your permission to come back and ask for clarification. When the results of the study are ready we will share a summary of the results with the facilities that participated. After this, the results will be made widely available to others, such as the Ministry of Health and the High Health Council.

Contact person
If you have any questions about the research you can contact (add contact).

Consent
I have read the information about the study and how it is conducted as described above. I have had the opportunity to ask questions about it and any questions I have been asked have been answered to my satisfaction. I consent voluntarily to be a participant in this study.
Introduction
Good morning/afternoon, my name is _____ and I work for _____. We are researchers recruited by a project called Human Resources for Health 2030 (HRH2030), to assist the Ministry of Health in developing policies to support staff in their work. We will be conducting interviews and focus group discussions with nurses and doctors, and with managers in health centers and hospitals in four different governorates. We conduct these interviews with the aim to find what staff thinks about their work. Each interview will last for about one hour. Before we continue, we would like to ask you to read the consent form and to tell us if you agree to participate.

HAND OUT CONSENT FORM, ASK STAFF TO SIGN AND RETURN IT TO YOU.

Thank you for your willingness to participate, we really appreciate it as we can learn a lot from your experiences. Let’s begin the interview:

We would like to start with some question about this group.

Focus Group Discussion characteristics:
Participants: Number of men: __________
Number of women: __________
Age range: __________
Range of total years of experience: __________
Range of number of years working in this facility: __________
Number of participants with rural origin: __________

Perceptions on working at a Ministry of Health facility
1. According to you, how do health workers normally get a position in a public or private facility?
   - Comment on formal and informal processes/ fairness and transparency/ comment on first posts and transfers
   - Probe if they know health workers who practice in the private sector in addition to their work at the MoH facility?

2. Why do health workers choose a Ministry of Health facility to work for?
   - Probe for advantages and disadvantages, in relation to other workplaces

3. And what are the reasons to work here (in this particular geographical area)?
   - Probe for details on remote areas and areas with refugees

4. What are the most important factors that motivate staff to work in this particular facility?
   - Have post-its or colored cards and write each reason participants give on a separate card-then ask participants to jointly rank these cards. Note and (if permitted) record the discussions about the ranking
   - During discussion probe for any differences between male and female staff

5. What are the most important management efforts to support you in your work?
   - Have post-its or colored cards and write each reason participants give on a separate card-then ask participants to jointly rank these cards. Note and (if permitted) record the discussions about the ranking

6. How are these put in practice at the moment?
   - Many people do not want to work in Ministry of Health facilities: why is this the case?
     What would be needed for them to work for the Ministry of Health?
   - Probe: if no more resources are available to increase pay, incentives or payment for housing etc., what else could be as innovative way tried out to keep health workers work in the public sector. What is the effect of these practices on colleagues and on patients?
Topic Guide – Semi-structured Interviews with Managers/Governorates

Cover sheet:
Interviewer:                      Date:
Governorate:                     Start time:
Type of center:                  End time:

Code of respondent:

Comments/observations about the interview:

Introduction
Good morning/afternoon, my name is _____ and I work for _____. We are researchers recruited by a project called Human Resources for Health 2030 (HRH2030), to assist the Ministry of Health in developing policies to support staff in their work. We will be conducting interviews and focus group discussions with nurses and doctors, and with managers in health centers and hospitals in four different governorates. We conduct these interviews with the aim to find what staff thinks about their
work. Each interview will last for about one hour. Before we continue, we would like to ask you to read the consent form and to tell us if you agree to participate.

HAND OUT CONSENT FORM, ASK STAFF TO SIGN AND RETURN IT TO YOU.

Thank you for your willingness to participate, we really appreciate it as we can learn a lot from your experiences. Let’s begin the interview:

We would like to start with some question about yourself.

**Personal characteristics**
Man/Woman: __________
Age: __________
Highest obtained education: __________
Place of highest education: __________
Current post: __________
Years in current post: __________
Previous post: __________
Place of origin: __________
Rural/urban: __________
Marital status: __________
Main income earner: Yes/No

**General information on perceptions regarding staff in facility/governorate**
We would like to continue with some question about staff in this facility/governorate:
1. How many staff work in this facility?
2. Why do physicians/ nurses and midwives work for MoH in this facility/governorate?
   - Probe for differences between nurses/physicians, men/women. Examples?
3. How long on average physicians/nurses and midwives remain in this facility/governorate? Why
   - Probe for differences between nurses/physicians, men/women. Examples?
4. How motivated do you think physicians and nurses are in this facility/governorate? Why?
   - Probe for differences between nurses/physicians, men/women. Examples?
   - Probe for governorate: do differences exist between governorates? Examples?
5. For those who stay for more than 2 years: what makes them stay?
   - Probe for differences between nurses/physicians, men/women. Examples?
   - Probe for governorate: do differences exist between governorates? Examples?
   - Ask specifically for rural areas and areas with refugees
6. What can facility management do to motivate staff?
   - Probe for examples in the facility, elsewhere, suggestions and ideas
7. What can governorate people do to motivate staff
   - Probe for examples in the facility, elsewhere, suggestions and ideas
8. Many people do not want to stay in Ministry of Health facilities: what would be needed to have doctors and nurses return and stay?
   - Probe for suggestions and ideas

**General management**
We would like to ask you questions about your management tasks:
1. What are your main tasks as a manager?
   - Probe for what management tasks take most time?

2. We understand that managers also provide care: can you estimate how much time you spend on management and on care provision?

3. How have you been prepared for this task governorate level: Do managers receive training in management?
   - Probe for training, reading books, no preparation
   - When training is mentioned- probe for: when, what topic and by who and how helpful this was for the tasks

Human resources management practices and tools
Now we would like to discuss your human resources management tasks:
1. Have you been trained in certain human resources tasks? Governorate level: Do managers receive training in human resources?
   - Probe for when, what topic and by who and how helpful this was for the tasks

2. Which tools do you use to manage your staff? Governorate level: Which tools managers use for human resources?
   - Probe for availability of job descriptions, checklist for supervision, forms for performance appraisals - can you show it to us?

3. What do you think about the equipment, infrastructure and supplies that staff require to do their job in this facility?
   - Probe for sufficiency, ease to ask for extra equipment, supplies and ask for specific examples

4. What do you do to support your staff in their work?
   - Probe for guidelines, working with other cadres, supervision, performance appraisals, identifying training needs, staff meetings, stimulating team work - ask for concrete examples
   - Probe: which is the most important support you can give them?

5. Do staff in this facility get an opportunity for in-service training? How are training needs identified? How do you select staff for training?

6. Can you tell us about supervision in this facility? What happens?
   - Probe for who supervises, how often and ask for concrete examples

7. Do you organize performance appraisals? When was the last time? What happens?
   - Probe for contents of performance appraisal, consequences/results, frequency - ask for concrete examples

8. When you face difficulties in your tasks what do you do? Governorate level: what do managers do when they face difficulties?
   - Probe for examples, ask peers, governorate level, central level, nothing. If nothing, ask why nothing is tried

9. Which support are you getting to perform your management tasks? Governorate level: what support do managers receive to perform their management tasks?
   - Probe for examples and if nothing is done: ask what should be done
Topic Guide – Semi-structured Interviews with Leavers

Cover sheet:
Interviewer: ___________________________ Date: ____________
Governorate: __________________________ Start time: ____________
Type of center: __________________________ End time: ____________

Code of respondent: _______________________

Comments/observations about the interview: ____________________________________________________________

Introduction
Good morning/afternoon, my name is _____ and I work for ____. We are researchers recruited by a project called Human Resources for Health 2030 (HRH2030), to assist the Ministry of Health in developing policies to support staff in their work. We will be conducting interviews and focus group discussions with nurses and doctors, and with managers in health centers and hospitals in four different governorates. We conduct these interviews with the aim to find what staff thinks about their
work. Each interview will last for about one hour. Before we continue, we would like to ask you to read the consent form and to tell us if you agree to participate.

HAND OUT CONSENT FORM, ASK STAFF TO SIGN AND RETURN IT TO YOU.

Thank you for your willingness to participate, we really appreciate it as we can learn a lot from your experiences. Let’s begin the interview:

We would like to start with some question about yourself.

**Personal characteristics**

Man/Woman: ____________
Age: ____________
Highest obtained education: ____________
Place of highest education: ____________
Current post: ____________
Years in current post: ____________
Previous post: ____________
Place of origin: ____________
Rural/urban: ____________
Marital status: ____________
Main income earner: Yes/No

**Information on past experiences with the Ministry of Health (MOH)**

1. Why did you choose in the past to work at an MOH facility?

2. What were your experiences working for the MOH?
   - Probe for positive and negative experiences
   - Probe for working conditions, prospects and management support

3. Why did you leave?
   - Probe for work and reasons in personal life (we do not need details on personal life if the respondent does not want to share this)
   - Probe for current work and future intentions

If the respondent is currently working in the health sector, please continue with the next questions. If not, please go to last question of this topic guide.

**General information on perceptions regarding the respondent’s current job**

We would like to continue with some question about your job:

1. How did you get this position?
   - Probe for: Was this the post you wanted to have? If so, why? If not, what happened?
   - Ask respondent to describe his/her recruitment process and time it took to get the job
   - Also probe for previous experience with MOH and reasons not to continue

2. What are your main tasks? What do you think about these tasks?
   - Probe for ease, workload, time between caring for patients and administrative tasks

3. Could you tell us about the results of your work? What do you think about these?
   - Probe for examples of results, also probe for views on appreciation by patients, colleagues or management, existence of patient satisfaction surveys or suggestion boxes and their use

4. Do results matter? If so, how? If not, why not?
5. In general, what do you think of your current job?
   - Probe for: What do you like about your work and why? What do you dislike and why?
   - Probe for: Is your job easy to combine with private life?

6. Why do you work here (in this particular geographical area)?
   - Probe for reasons, especially for remote areas and areas with refugees

7. How long do you intend to continue working in this facility? Why? What are your plans for the future?
   - Probe for: Do you intend to leave for another sector? If so, which one and why? What possibilities do you have? How will you go about this?
   - Or do you plan to work abroad – where and why? For how long? What possibilities do you have? How will you go about this?
   - Probe for: How common is it for health workers to make the decision you make? Do workers from your profession have similar ambitions/plans? Is there a difference between young and more experienced staff? Is there a difference between male and female staff with regard to career perspectives and choices?

8. Are you motivated to work in this facility? If yes, why? If not, why not?

9. What would you like to see changed? And who should do this?

**Experiences with human resources management practices**

We would like to ask you questions about your workplace and support that you receive from colleagues and from management:

1. Do you have a job description? Can you show it to us?

2. What do you think about the equipment, infrastructure and supplies that you require to do your job in this facility?
   - Probe for sufficiency, ease to ask for extra equipment, supplies and ask for specific examples

3. What support do you have to perform your tasks? What do you think about this support and why?
   - Probe for guidelines, working with other cadres and in teams, management support - ask for concrete examples

4. When you face difficulties in your tasks or when you want to make any changes e.g. in the way your work is organized, what do you do?
   - Probe for examples, ask about meetings among staff, between staff and management. If nothing, ask why nothing is tried

5. Have you ever made a mistake in the clinical care you provide in this facility? Or a colleague? What happened? How are mistakes dealt with in this facility?
   - Probe for problem analysis and mistakes being used to learn and better work together or solved at individual level

6. What opportunities exist in this facility to upgrade your skills and knowledge? Have you used any of these?
   - If so, ask for concrete examples: when, what, where, experiences of getting opportunities for training- fairness and transparency in opportunities for training. If not, why not?
7. Can you tell us about supervision in this facility? When was the last time someone came to supervise you? What happened? What did you think about the supervision?
   - Probe for who supervises, how often and ask for concrete examples

8. Have you had your performance appraised? When was the last time? What happened? What did you think about this?
   - Probe for contents of performance appraisal, consequences/results, frequency-ask concrete examples

9. What is your current salary and incentives? What do you think about this?
   - Probe for types and volume, most appreciated and why, least appreciated and why, fairness

10. What is for you the most important support you can think of to perform your tasks? How could this further be improved?

11. Overall: how satisfied are you with your current working conditions? Why?

Suggestions to motivate health workers to work for MOH
1. Many people do not want to work in Ministry of Health facilities, in particular in some areas. What would be needed to have other doctors and nurses to want to work for MOH facilities?
   - Probe for rotation, bonding, outsourcing, extra hardship allowance, preference choice in training
   - Probe for: Some areas do not have sufficient female health workers; do you think any specific measures should be introduced to retain female health workers?
**Introduction**

Good morning/afternoon, my name is _____ and I work for _____. We are researchers recruited by a project called Human Resources for Health 2030 (HRH2030), to assist the Ministry of Health in developing policies to support staff in their work. We will be conducting interviews and focus group discussions with nurses and doctors, and with managers in health centers and hospitals in four different governorates. We conduct these interviews with the aim to find what staff thinks about their work. Each interview will last for about one hour. Before we continue, we would like to ask you to read the consent form and to tell us if you agree to participate.
HAND OUT CONSENT FORM, ASK STAFF TO SIGN AND RETURN IT TO YOU.

Thank you for your willingness to participate, we really appreciate it as we can learn a lot from your experiences. Let’s begin the interview:

We would like to start with some question about yourself.

**Personal characteristics**

- Man/Woman: ____________
- Age: ____________
- Highest obtained education: ____________
- Place of highest education: ____________
- Current post: ____________
- Years in current post: ____________
- Previous post: ____________
- Place of origin: ____________
- Rural/urban: ____________
- Marital status: ____________
- Main income earner: Yes/ No

**General information on perceptions regarding the respondent’s job**

We would like to continue with some question about your job:

1. **How did you get this position?**
   - Probe for was this the post you wanted to have? If so, why? If not, what happened?
   - Ask respondent to describe his/her recruitment process and time it took to get the job

2. **What are your main tasks? What do you think about these tasks?**
   - Probe for ease, workload, time between caring for patients and administrative tasks

3. **Could you tell us about the results of your work? What do you think about these?**
   - Probe for examples of results, also probe for views on appreciation by patients, colleagues or management, existence of patient satisfaction surveys or suggestion boxes and their use

4. **Do results matter? If so, how? If not, why not?**

5. **In general, what do you think of your current job?**
   - Probe for what do you like about your work and why? What do you dislike and why?

6. **Why have you chosen a Ministry of Health facility to work for?**
   - And why do you work here (in this particular geographical area)?
   - Probe for reasons - especially for remote areas and areas with refugees

7. **How long do you intend to continue working in this facility? Why? What are your plans for the future?**
   - Probe for: Do you intend to leave for another sector-if so which one and why? What possibilities do you have? How will you go about this?
   - Or do you plan to work abroad – where and why? For how long? What possibilities do you have? How will you go about this?

8. **Are you motivated to work in this facility? If yes, why? If not, why not?**

9. **What would you like to see changed? And who should do this?**
- Probe: If health workers mention salary and incentives-ask: if it is not possible to increase finances - what else would make you stay?

10. How could you contribute to the changes you propose?

11. Many people do not want to work in Ministry of Health facilities, in particular in some areas: what would be needed to have other doctors and nurses join you?
   - Probe for: rotation, bonding, outsourcing, extra hardship allowance, preference choice in training

**Experiences with human resources management practices**

We would like to ask you questions about your workplace and support that you receive from colleagues and from management:

12. Do you have a job description? Can you show it to us?

13. What do you think about the equipment, infrastructure and supplies that you require to do your job in this facility?
   - Probe for sufficiency, ease to ask for extra equipment, supplies and ask for specific examples

14. What support to you have to perform your tasks? What do you think about this support and why?
   - Probe for guidelines, working with other cadres and in teams, management support- ask for concrete examples

15. When you face difficulties in your tasks or when you want to make any changes e.g. in the way your work is organized, what do you do?
   - Probe for examples, ask about meetings among staff, between staff and management. If nothing: ask why nothing is tried

16. Have you ever made a mistake in the clinical care you provide in this facility? Or a colleague? What happened? How are mistakes dealt with in this facility?
   - Probe for problem analysis and mistakes being used to learn and better work together or solved at individual level

17. What opportunities exist in this facility to upgrade your skills and knowledge? Have you used any of these?
   - If so, ask for concrete examples: when, what, where, experiences of getting opportunities for training- fairness and transparency in opportunities for training. If not, why not?

18. Can you tell us about supervision in this facility? When was the last time someone came to supervise you? What happened? What did you think about the supervision?
   - Probe for who supervises, how often and ask for concrete examples

19. Have you had your performance appraised? When was the last time? What happened? What did you think about this?
   - Probe for contents of performance appraisal, consequences/results, frequency-ask concrete examples

20. What is your current salary and incentives? What do you think about this?
   - Probe for types and volume, most appreciated and why, least appreciated and why, fairness
21. What is for you the most important support you can think of to perform your tasks? How could this further be improved?

22. Overall: how satisfied are you with your current working conditions? Why?
Research Proposal

Working Title: Motivation and Retention of Health Workers in Ministry of Health Facilities in Four Governorates in Jordan

I. Background

Country Context. The Government of Jordan has recognized the critical importance of having an accessible and high performing health workforce in order to achieve its universal health coverage objectives. The Ministry of Health (MOH) identified human resources for health (HRH) challenges as an important area of attention in its Strategic Plan 2013-2017. The MOH of Jordan is preparing a National HRH Policy to respond to the challenges outlined in the plan.

Currently, 38% of the health services are provided by the MOH, 34% are provided by the private sector, and 18% and 9% are provided by the Royal Medical Services and the University hospitals, respectively. Data on the private sector is not included in the MOH statistics. According to the annual statistical book of the MOH, the country has 29.4 doctors and 27.6 registered nurses per 10,000 people; of that number, 21% of the physicians and 25% of the registered nurses work for the MOH. Women make up 44% of the total workforce, and 70% of the registered nurses are female, whereas over 70% of physicians are men.

Health workforce retention has repeatedly been identified as a key challenge in Jordan, in particular as it relates to physicians (medical specialists) and registered nurses, specifically women. Jordan’s strategic health plan looks to address the HRH objective: “improve the process of attracting qualified and trained technical and administrative cadres to work in the Ministry of Health and keep them in the ministry” by focusing on the recruitment and retention of skilled physicians and registered nurses. Previous workforce studies conducted in Jordan provide indications on factors influencing retention and motivation. However, these studies are either outdated or limited in that they only investigate one profession. Therefore, the extent of the problem is not clear, nor are the reasons motivating people to stay or leave specific workforces.

An additional challenge for the health system, that needs further research, is the large influx of refugees from the Middle Eastern region - particularly Syrians - who live within the host communities and rely on public services, including health services. For example, workforce motivation and retention might be influenced by different factors in the governorates of Irbid, Mafraq, and Amman, where the majority of the refugees live.

II. Research Approach

This research has been initiated by the Human Resources for Health Activity (HRH2030) to assist the MOH in developing a specific HRH policy in Jordan. Consultation with key activity stakeholders (MOH, High Health Council [HHC], etc.) identified motivation and retention of health staff as one of the most prominent challenges in the health sector, particularly in rural areas and in the MOH facilities.

This study looks to assess why health workers are leaving the MOH system in Jordan’s health sector. Retention is assessed through turnover – defined as the number or percentage of health workers who leave an organization and are replaced by new employees annually. Retention is influenced by job satisfaction and motivation.

For the purpose of this study, motivation is defined as “an individual’s willingness to exert and maintain an effort towards organizational goals,” and is a result of interactions between health workers, their work environment, and the wider context (Kanfer, 1999). We use the construct of
motivation as developed by Mbindyo et al, consisting of level of burnout, job satisfaction, intrinsic motivation, organizational commitment, and timeliness.

*Job satisfaction* is defined as the “perceived relationship between what one expects and obtains from one’s job and how much importance or value is attributed to the job.” This consists of the emotional feelings individuals have about their jobs overall and the extent of individuals’ satisfaction with particular aspects of their jobs, such as pay, pension arrangements, working hours, etc. Job satisfaction and motivation are key considerations when looking at retention and performance issues. Poor job satisfaction and poor motivation lead to people leaving (or wanting to leave) their job and contribute to poor performance. An assessment of health worker performance is beyond the scope of this study.

**Research objectives.** The general objective this study is to identify factors influencing retention, job satisfaction, and motivation of physicians, nurses, and midwives within MOH health centers in Jordan, in order to inform HRH policy development and strategies to improve retention of the MOH workforce.

Specific research objectives:
1. To analyze the current health workforce flow at both the entry and exit levels of the MOH system, disaggregated by sex.
2. To identify current incentive mechanisms in the MOH system in Jordan, disaggregated by sex.
3. To identify and analyze factors contributing to job satisfaction among the different health cadres and levels within each in the MOH system, disaggregated by sex.
4. To identify and analyze motivational factors among the different health cadres and levels within each cadre to continue working in the MOH system and disaggregated by sex.

**Research questions.** The following are the five research questions guiding the study:

1. What is the current health workforce flow at entry and exit levels of the MOH system and what is the trend over the past 10 years?
   - This will be analyzed by reviewing existing and available documents and data within the MOH and Civil Service Bureau (CSB).
2. What incentives and human resources management (HRM) practices (such as performance appraisal systems, orientation packages, supportive supervision structures) are currently in place to motivate and retain MOH workers? How are these valued by the health workers and what suggestions for improvements can be made?
   - To address this question, we will ask managers and health care providers to share their current approach and experience with: supervision, performance appraisal, setting job expectations, incentives and rewards (expected and perceived), handling of staff's complaints and providing channels for sharing concerns, opportunities for training and career progression. We will also identify and describe experiences using existing strategies aimed at retaining health workers in the public sector.
3. What motivates physicians and nurses (including associate nurses and midwives) in MOH facilities and/or in rural areas?
   - To address this question, we intend to examine underlying issues related to turnover, motivation, and job satisfaction. We will assess overall motivation and motivation constructs including job satisfaction, burnout, staff commitment to their organization, conscientiousness, and timeliness that collectively measure overall levels of motivation.
4. What are/were the factors that have pushed certain providers to leave rural areas or to leave the MOH system?
   - To address this question, we will use convenient sampling to identify and ask respondents who used to work for the MOH facilities and who have left between 6 months and 5 years ago. We will ask them to list and expand upon their three most important reasons for leaving the MOH system.
5. How do those who have left perceive their current motivation, incentives and HRM practices?
   - To address this question, we will ask people who have left what their current work is and what motivates them at the moment, what their current incentives are, their experiences with HRM and what would be needed for them to return to a MOH facility.

**Organizational roles.** For this study, HRH2030 will access both international and local firms to provide international research and health systems expertise and an understanding of the local context. HRH2030 will partner with the Amsterdam-based Royal Tropical Institute (KIT) to provide technical expertise in health system strengthening research. In addition, HRH2030 will contract with a Jordanian research organization to conduct the on-the-ground data collection and analysis. KIT will oversee all technical aspects of the research activity, including providing technical oversight of the local firm’s work.

### III. Methodology

**Study design.** We will use an exploratory design, applying a mixed methods approach. This design is the most suitable in this context as it enables us to obtain information on the gamut of retention and motivation factors across cadres, map explanations of answers and gain insight on solutions provided by health workers and their managers. The mixed methods design will include an analysis of secondary data (documents and existing statistics) on the current workforce flows, and primary data including a survey among health professionals, and semi-structured interviews and focus group discussions (FGDs) among health professionals and managers. The use of a mixed methods approach will improve the validity of information by corroborating the findings of new and existing data, while taking a quantitative and qualitative approach.

**Research population.** For the study, we will sample two types of health workers: those who have left and those who currently work in MOH facilities. Comparing the two profiles and their perspectives will enable us to propose targeted strategies.

Health workers who have left the MOH system will provide insight and deepen our understanding of the profile of those who chose to leave, their reasons for departure and their current level of motivation, job satisfaction, and perspectives on incentives and other HRM practices. They will be identified and selected from private health facilities, and/or through professional associations and councils. A specific sampling strategy is not required for this group of respondents.

Those who continue working in the MOH system, will provide insight on their demographic profile, scope of their job, reasons for staying, and their current level of motivation, job satisfaction and perspectives on incentives and other HRM practices.

**Research location.** The research will take place in selected MOH primary health centers, comprehensive health centers and hospitals.

- **Survey** – We propose to sample governorates with specific characteristics: containing both rural and urban areas, areas with high concentrations of refugees, and areas known for high levels of MOH staff turnover. This will allow the survey to capture and describe a full picture of the underlying factors influencing motivation and retention in the MOH system.

- **Semi-structured interviews and FGDs** – Within each of the surveyed governorates we propose to select respondents working in rural areas considered to be ‘less attractive’ working environments. This will inform our understanding of the retention and motivation factors present in difficult environments, which will inform strategies to improve retention and motivation in more ‘desirable’ working environments.

From this criteria, four governorates were selected based on level of urbanity, refugee concentration, and areas of high turnover: Irbid, Ma’an, Zarqa, and Amman. This selection was discussed and confirmed with the MOH and the HRH2030 team.
The below table presents the total number of primary health centers, comprehensive health centers, and hospitals within the four targeted governorates. The quantitative sampling (as described in the next section) will select a sample of facilities from this pool.

<table>
<thead>
<tr>
<th>Governorate</th>
<th>Primary Health Centers</th>
<th>Comprehensive Health Centers</th>
<th>Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zarqa</td>
<td>29</td>
<td>9</td>
<td>2</td>
</tr>
<tr>
<td>Ma’an</td>
<td>20</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Irbid</td>
<td>90</td>
<td>11</td>
<td>8</td>
</tr>
<tr>
<td>Amman</td>
<td>67</td>
<td>18</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>206</strong></td>
<td><strong>43</strong></td>
<td><strong>13</strong></td>
</tr>
</tbody>
</table>

Sampling. We will target the following different sub-groups to address the above research questions:

1) Health workforce currently working in MOH facilities in Jordan

Within each selected primary health center, comprehensive health center and hospital we will include managers, physicians, registered and associate nurses, and midwives present at the moment of the survey. The following sub-groups will not be included in the survey sample:

a. Residents
b. Dentists and dentistry nurses
c. Community physicians
d. Environmental physicians

The below table presents the estimated number of people who will participate in the quantitative component of the study. This estimate is derived through a sample of the total number of facilities multiplied by the approximate number of targeted staff within each facility.

<table>
<thead>
<tr>
<th>Governorate</th>
<th>Primary Health Center</th>
<th>Comprehensive Health Center</th>
<th>Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zarqa</td>
<td>10x5=50</td>
<td>6x30=180</td>
<td>1x60=60</td>
</tr>
<tr>
<td>Ma’an</td>
<td>7x5=35</td>
<td>4x30=120</td>
<td>1x60=60</td>
</tr>
<tr>
<td>Irbid</td>
<td>30x5=150</td>
<td>8x30=240</td>
<td>2x60=120</td>
</tr>
<tr>
<td>Amman</td>
<td>20x5=100</td>
<td>13x30=390</td>
<td>1x60=60</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>67x5=335</strong></td>
<td><strong>31x30=930</strong></td>
<td><strong>5x60=300</strong></td>
</tr>
</tbody>
</table>

For the qualitative component, within each selected governorate we will purposively sample physicians - general practitioners and specialists (two interviews and one FGD), as well as registered and associated nurses and midwives (one interview and one FGD), who are present at each of the surveyed primary and comprehensive health centers and hospitals.

Recruitment of respondents for the survey and the interviews/FGDs will be done pending approval by both the MOH headquarters and facility management, and a public announcement in the facility – participation will always be voluntary and anonymous. Recruitment of staff for the semi-structured interviews will target two people (one man and one women) from each type of facility within a selected governorate, following maximum variation in terms of type of center and type of profession. The two professionals do not have to work in the same center. One FGD in any of the centers in the selected governorates will enable exchange on current factors for job satisfaction and motivation, on HRM practices, and suggestions for improvement. Recruitment for the FGD can take place in centers with sufficient doctors and nurses. Participants of the semi-structured interviews will not participate in the FGDs.

2) Health workforce who have recently (between 6 months and 5 years) left MOH facilities

36 In the MOH system, environmental physicians focus on water, sanitation, and hygiene.
37 Number of sampled facilities multiplied by the approximate number of people per facility.
We will use convenient sampling for this group, as tracing people who have left the MOH is very difficult. The respondent group will include physicians and nurses who have left the public sector in the last 3 years, who can be traced and are willing to be interviewed, either face-to-face or by phone. Identification of participants will be done through professional councils and the facility registers, and based on any additional leads provided by the MOH. Recruitment will be initially done by mail asking for consent to be interviewed. After permission has been granted, respondents will be interviewed over the phone or via an in-person visit.

**Data collection techniques.**

1) Secondary data analysis of the workflow

At the national level, we will attempt to obtain data on the current entry and exit rates of doctors and registered nurses, associate nurses and midwives and if possible, focusing specifically on the public sector. At the governorate level, we will collect data, to the extent possible, from the selected governorates on actual turnover rates among doctors and nurses in all facilities. We will also collect data on the current HRM tools and policies in place, both at the national level and in the selected facilities.

2) Quantitative data collection

We will use the existing tools to measure motivation and retention. We will use a structured questionnaire to collect quantitative data on motivation, job satisfaction, and turnover intention among all physicians, registered and associate nurses, and midwives in selected facilities. In order to measure turnover intention, we will ask whether they have intentions to leave their current health facility (dichotomous responses [yes/no]).

To measure motivation, we will treat it as a construct that includes 7 outcomes: ‘burnout’, ‘job satisfaction’, ‘intrinsic job satisfaction’, ‘organizational commitment’, ‘conscientiousness’, and ‘timeliness’. The instrument is composed of 23 5-point Likert-scale items, ranging from 1, fully disagree, to 5, fully agree, which are then grouped into 7 motivational outcome constructs, namely ‘general motivation’ (Mbindyo et al., 2009, Bennett et al., 2001, Kanfer, 1999).

We will translate and pre-test all tools, focusing particularly on the comprehensibility and relevance of the questions for all types of health workers included in the study. We will also add detailed questions on the profile and experiences of health workers with HRM practices such as supervision, performance appraisal, availability of job description, incentives, training received, etc.

3) Qualitative data collection

We will conduct face-to-face semi-structured interviews and FGDs with physicians, nurses, midwives, and key informants. More specifically, in each governorate, we intend to have 6 semi-structured interviews with health care professionals (see sampling) and 1 FGD with nurses (including midwives and associate nurses) and if feasible one FGD with doctors. Each FGD will have 6-8 participants. We will also conduct semi-structured interviews with key- informants at facility level (one manager and one head of ward in each governorate), at governorate level (one person from the Governorate Director of Health) and at MOH central (one person from HR department) and at national level (one person from the Jordan Nursing Council and one person from HHC). Selection criteria to be discussed with the local firm.

For each of the four governorates we will conduct 9 interviews and 2 FGDs with staff and stakeholders, and 3 interviews at national level: in total 39 interviews and 8 FGDs.

For those health workers who left the sector we intend to conduct a maximum of 15 semi-structured interviews.
Data processing and analysis.

1) Quantitative data processing analysis

Responses to individual questions will be examined by means of frequency distributions, mean and median scores and examining whether the direction of response is as anticipated and consistent with responses within and across constructs – especially for negatively worded questions. The relationships between responses to questions will be examined using Pearson’s and rank correlation (especially examining factors with coefficients above 0.5) and as a set using Cronbach’s alpha. The data will be disaggregated by type of health provider (doctor, nurse, midwife, etc.), origin and sex.

2) Qualitative data processing and analysis

We will analyze the data per group of respondents and by research question. Data processing and analysis will take place during data collection and at the end of every day in the field. The researchers will review and discuss the collected data and explore if any additional questions need to be asked in the following interviews. They will also discuss if the same answers are reoccurring and data saturation is achieved. If this is the case, the principal investigator will be contacted (if not present with the field based research teams) to determine the next steps. We will use a framework approach for the data analysis, based on the research questions and main issues in the topic guides and we will compare and contrast answers between and within groups. Special attention will be paid to differences between cadres and gender differences.

Secondary data will be inserted in a pre-developed sheet and this will be used to summarize the information per research question.

Quality assurance. In order to assure quality of the research and credibility of the data we will:

- Pre-test the tool for motivation, the structured questionnaires and the topic guides for the interviews and the FGDs. Testing of tools will be done during the scoping mission by organizing one FGD and some interviews to adapt and further develop existing instruments to ensure they are tailored to and appropriate for the situation in Jordan.
- The research will be conducted jointly by a local Jordanian firm and KIT with close involvement of the HRH2030 team: the tools and data collection instruments will be jointly discussed and developed and training will be provided as required, e.g. on HRH and the motivation and satisfaction tools. The data collection instruments will be translated into Arabic for use in the field and all information will be translated back into English.
- The interviews will be conducted in a place where respondents feel comfortable expressing themselves and the local team will receive guidance on how to perform the interviews in a way that in cognizant of local social norms. With permission, the semi-structured interviews and the FGDs will be recorded to avoid data loss.
- We will triangulate data asking the same questions to different groups of respondents (health workers working in the health sector, health workers who have left, managers) and by asking the same type of questions to the same groups using different methods (interviews and FGDs).
**Ethics.** Ethical approval for this study will be obtained in Jordan.

The study aims to provide insight into the reasons health workers stay (or leave) the MOH facilities so this information can be used to develop policies and practices to improve retention and motivation. If, for some reason, the interviews or FGDs trigger distress, the researchers will let the person express him/herself and ask if this person requires counselling. Before the start of the study, contacts will be made with a counsellor in each governorate, in case the need arises.

For each interview and FGD, consent to conduct the interview and to record the answers will be obtained. The privacy and confidentiality of each respondent will be guaranteed by assigning codes to each interview, by not recording the names of the participants, by interviewing in a private location and by storing the data in a safe location to which only the principal investigator and the senior researchers will have access.

**Dissemination of results.** It is important that the results of the study are validated and discussed. Ownership of the data by facility managers, health workers, governorate officials and the MOH at the national level is essential. To better assure this, there will be three stakeholders meetings organized at the national level, during which the governorate stakeholders will participate as well. One meeting to discuss the objectives, research location and population approach and timeline, will be held with different stakeholders individually before initiating the research study. A second meeting to report on the progress and preliminary findings will take place halfway through the study. The last meeting will take place during the final stage to validate and discuss the findings and how these findings could be used in the formulation of HRH Policy for Jordan. Summaries of the study results will be prepared in English and in Arabic for dissemination.

### IV. Work plan and timeframe

<table>
<thead>
<tr>
<th>Step</th>
<th>Location</th>
<th>Planning</th>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preparation/draft research design and draft tools, Collection of the documents on HRH in Jordan</td>
<td>Netherlands</td>
<td>January</td>
<td>HRH2030 and KIT</td>
</tr>
<tr>
<td>Meetings with partners, Interviews with stakeholders, Logistical arrangements for data collection</td>
<td>Jordan</td>
<td>15-23 February</td>
<td>HRH2030 and KIT</td>
</tr>
<tr>
<td>Finalizing trip report, Selection of local firm</td>
<td>Jordan/Netherlands</td>
<td>26 February - 11 March</td>
<td>HRH2030 and KIT</td>
</tr>
<tr>
<td>Obtaining Ethical approval, Jointly with local research team: finalization and translation and pre-test of the tools, Refinement of the methodology- and preparation of data collection and of analysis/reporting</td>
<td>Jordan</td>
<td>Final two weeks in March</td>
<td>HRH2030, KIT and local firm</td>
</tr>
<tr>
<td>Data collection and data processing (both quantitative and qualitative component)</td>
<td>Jordan</td>
<td>April</td>
<td>KIT and local firm</td>
</tr>
<tr>
<td>Preparation of data analysis and reporting</td>
<td>Jordan/Netherlands</td>
<td>May</td>
<td>KIT and local firm</td>
</tr>
<tr>
<td>Joint data analysis and interpretation, reporting, Presentation of preliminary results</td>
<td>Jordan</td>
<td>21-26 May</td>
<td>HRH 2030 Jordan, KIT and local firm</td>
</tr>
<tr>
<td>Step</td>
<td>Location</td>
<td>Planning</td>
<td>Responsibility</td>
</tr>
<tr>
<td>------</td>
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</tr>
<tr>
<td>Draft report</td>
<td>Jordan/Netherlands</td>
<td>June</td>
<td>KIT</td>
</tr>
<tr>
<td>Partner meeting, formulation of recommendations</td>
<td>Jordan</td>
<td>June</td>
<td>HRH2030, KIT and local firm</td>
</tr>
<tr>
<td>Final report</td>
<td>Netherlands</td>
<td>July</td>
<td>KIT</td>
</tr>
</tbody>
</table>

V. Documents consulted


Annex C. Ethical Review Board Approval

Ministry of Health

Ref: TK/12/HRH/158
Date: 20/4/2016

Director, Population & Health Office
USAID / Jordan

Dear Ms. Anna McCrerey

With reference to your correspondence dated March 16, 2016 concerning the USAID’s Human Resources for Health (HRH 2030) Activity plan to conduct a research study on motivation and retention factors among the Ministry of Health workforce in Jordan.

Kindly be informed that it’s our great pleasure to approve the abovementioned study. Please provide us with the final report of the study.

Your cooperation is highly appreciated.

Sincerely,

Minister of Health
Dr. Ali Al-Yassar

The Hashemite Kingdom of Jordan
Tel: +962 6 5221299  Fax: +962 6 569379  P.O. Box 36 Amman, Jordan  Postal Code 1118, Website: www.moh.gov.jo