

**SCHOOL OF PUBLIC HEALTH
COLLEGE OF HEALTH SCIENCES
UNIVERSITY OF GHANA**



**ASSESSING THE WELFARE ISSUES AFFECTING HEALTHCARE
PROVIDERS: A STUDY AT THE RIDGE HOSPITAL IN ACCRA, GHANA**

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DECLARATION

I hereby do declare that this submission is my own work towards the Master Of Public Health (MPH) degree and that except for references to other people's work which have been duly acknowledged, this piece of work is my own composition and neither in whole nor in part has this work been presented for the award of a degree in this University or elsewhere.

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DEDICATION

I dedicate this work to all who hold me dear.



ACKNOWLEDGEMENT

I wish to acknowledge significant individuals who in diverse ways supported and gave me the required guidance in ensuring the successful completion of my work.

I thank the almighty God for the gift of life, strength and resilience to enable me to complete this work successfully.

Secondly, my sincerest gratitude and heartfelt appreciation goes to my supervisor, Dr. Emilia Asuquo Udofia. Your directions, tolerance and commitment has led to the successful completion of this work.

It has really been a journey.



ABSTRACT

Introduction: Quality healthcare is one of the vital factors in how a country perceives its quality of life making it one of the most crucial measure of socioeconomic development of any country. Health institutions, particularly in developing countries however encounter several challenges in providing quality healthcare to patients. The most significant among these challenges is supporting the welfare of the medical staff. In recent times, there have also been several industrial unrests in the health sector due to issues related to the welfare of healthcare professionals.

Objective: The study aimed at identifying the welfare issues confronting healthcare providers at Ridge Hospital, Accra. It also examined the relationship between welfare issues and anxiety and depression.

Methodology: The study was conducted using the quantitative cross-sectional survey. The study made use of a calculated sample size of 400 including both doctors and nurses at Ridge Hospital. The instrument used in collection of data was a questionnaire. The data analysis was done using the Statistical Package for Social Sciences (SPSS) version 21 and results tabulated using frequency distributed tables. The relationship between variables were examined using the Chi-square test at the 95% confidence level.

Results: The results of the study revealed that the health workers at Ridge Hospital were not satisfied with health insurance provision for them and their families. Fifty-nine per cent (59%) of the health workers were satisfied with the shift system, 65% of the health workers were satisfied with study leave but 53% did not know off-duty allowance was a welfare issue. Most of the healthcare providers (53%) were not satisfied with the provision of health insurance to them and their families. a significant number of the healthcare providers were not satisfied. The study also revealed that the association between shift system, the health insurance, study leave, transportation

allowance and anxiety among health workers was statistically significant. The study also revealed that there is a relationship between the shift system, the health insurance, study leave, transportation allowance and depression among health workers.

Conclusion: The study recommended that the Ministry of Health, Ghana Medical Association (GMA), Nursing and Midwifery Council (NMC) should come up with a comprehensive health insurance package and address identified welfare issues for the health workers and their families so as to prevent anxiety and depression among health workers.

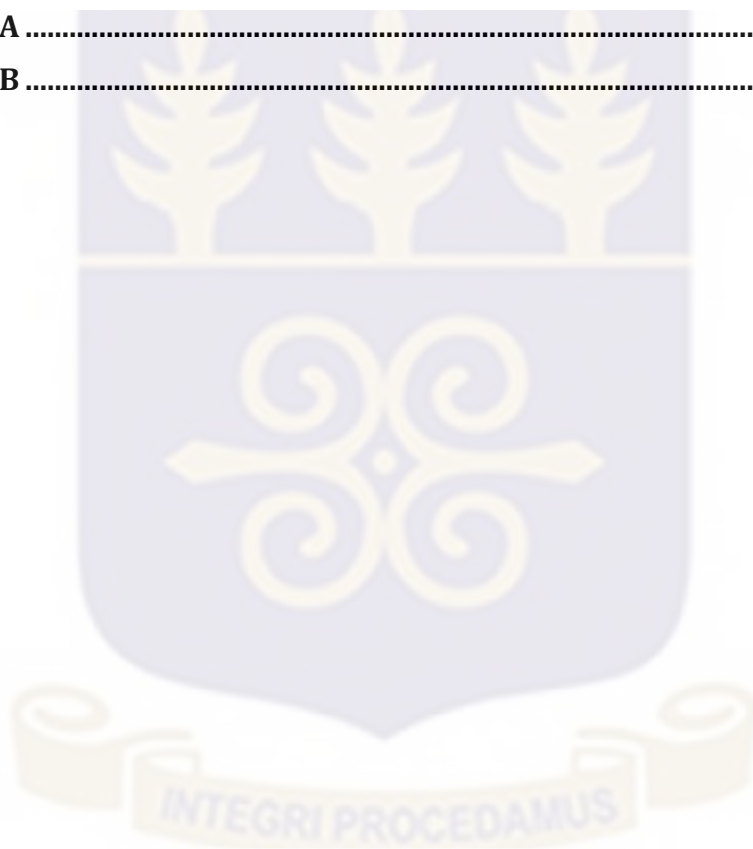


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LIST OF ABBREVIATIONS

GSS	Ghana Statistical Service
GMA	Ghana Medical Association
GHS	Ghana Health Service
NMC	Nursing and Midwifery Council
WHO	World Health Organisation



OPERATIONAL DEFINITION OF TERMINOLOGIES

- i. **Anxiety:** Refers to an emotion which is characterized by feelings like fear, apprehension, tension and worrying thoughts which results in physical changes like an increase in blood pressure, heartbeats and headaches.
- ii. **Depression:** Refers to a mood disorder that causes one to experience persistent feelings of sadness as well as a loss of interest in activities that were initially of interest.
- iii. **Health Insurance:** Health insurance according to the Insurance Association of America, is the coverage that provides for the payments of benefits as a result of sickness or injury. It is an insurance taken out to cover the cost of medical care.
- iv. **Healthcare Provider:** Refers to workers at the Ridge hospital who give curative, promotional or rehabilitative, preventive healthcare services in ways that follows a systematic order to people, families or communities.
- v. **Study Leave:** refers to an education, training or career development activity which requires the individual to have paid absence from their usual work duties in order to complete this.
- vi. **Welfare:** Refers to the statutory procedure or social effort designed to promote the basic physical and material well-being of people in the Ridge Hospital

CHAPTER ONE

1.0 INTRODUCTION

1.1 Background

The socio-economic development of each country depends largely on the productivity of its citizens. For this reason, developing countries, particularly those in sub-Saharan Africa and the Western Pacific regions, have worked hard over the past two decades to address the problem of developing and maintaining sufficient, responsive and competent health personnel to meet the health needs of their population (WHO, 2010). Quality healthcare is one of the vital factors in how a country perceives its quality of life making it one of the most crucial measure of socioeconomic development of that country, (Stone, Hughes & Dailey, 2008)

Health institutions, particularly in developing countries however encounter several challenges in providing quality healthcare to patients (Kasenga & Hurtig, 2014). The most significant among these challenges is supporting the welfare of the medical staff. This is because, as stated by Kasenga and Hurtig (2014), human resource is one of the most significant resources to any institution, including health institutions. Therefore it is essential to have policies that support the welfare of healthcare providers to ensure the sustenance of the healthcare industry.

Welfare, according to Adeloje, Rotimi, Olaogun, Auta, Adesokan et al. (2017), refers to the statutory procedure or social effort designed to promote the basic physical and material well-being of people. Similarly, healthcare providers are individuals whose activities are mainly dedicated to improving the well-being of people (Adeloje, et al., 2017). Notwithstanding their importance to the effectiveness of any country's health system and society at large, healthcare providers are affected by so many issues that

affect their welfare (Adeloye et al., 2017). Some of the issues affecting the welfare of healthcare providers include shift work, increased patients load, physical infrastructure, and shortage of staff, long working hours, and lack of resources (Manyisa and Aswegen, 2017). For instance, shift work and long working hours expose healthcare providers to health problems such as hypertension, cardiovascular diseases, fatigue, stress and depression, which tends to impact negatively on their sleeping patterns (Al-Momani, 2008; Geiger-Brown, Trinkoff & Rogers, 2011).

Other welfare issues confronting healthcare providers include the absence of health insurance for health workers and family, unavailability or inadequate transportation allowance to cover off-duty service, no condition of service, inadequate logistics and no laydown structure for sponsorship of education to enhance career (Mokoka, Ehlers & Oosthuizen, 2011).

Geiger-Brown, Trinkoff and Rogers (2011) carried out a study on how self-reported sleep among registered nurses was affected by work schedules, home, and work demands. According to the study, insufficient sleep was more frequent than restlessness. Precisely, 43.6% of the nurses did not have enough sleep for three (3) or more days. Further findings showed that insufficient sleep was frequent among night-shift workers. This consequently affects the welfare of the nursing staff since they could not get enough rest.

In another study, Mokoka, Ehlers and Oosthuizen (2011) identified the issues affecting the welfare of registered nurses in the Gauteng Province of South Africa. The results of the study revealed that factors including safety and security, medical equipment and supplies, staff and patients and finances affected the decisions of the registered nurses to stay at their workplace.

A study by Kommogldomo (2016) sought to establish the dangers of the healthcare profession and how there was no comprehensive health package available for the healthcare providers. Thus, the results of the study revealed that needle stick injuries occurred most at the 37 Military Hospital, followed by cuts and abrasions. Significantly, the study established that occupational hazards by means of needle stick or cuts affected the well-being of healthcare providers. Consequently, the unavailability of comprehensive health packages for the healthcare providers was an issue that affected the productivity of the healthcare providers. Ministries of health and their implementing partners are often overburdened by the operational aspects of personnel administration, governance, health financing and technology, leaving little attention to overall planning to ensure that human resources for health match the health needs of the citizens.

To this end, this study examined the issues affecting the welfare of healthcare providers using the Ridge Hospital as a case study.

1.2 Problem statement

The health system operations, especially in developing countries have been substandard and this is as a result of repeated problems in and outside the health sector (Singh & Sachs, 2013). In recent times, there have also been several industrial unrests in the health sector due to issues related to the welfare of healthcare professionals (Obour, 2015). These industrial unrests are mainly due to the fact that most health institutions in Ghana have no conditions of service which includes access to health insurance for health workers and family (Obour, 2015). Similarly, there is unavailability and inadequate transportation allowance to cover off-duty service, no condition of service for nursing staff, inadequate logistics and no structure for sponsorship of education to

enhance one's career. These situations generally have a tendency of generating anxiety and depression among healthcare professionals.

It is worth noting that anxiety inherent in healthcare negatively impacts healthcare professionals and the service they provide. This is because healthcare service involves taking care of other peoples' lives therefore mistakes or errors could be costly and sometimes irreversible. Thus, it is essential that healthcare workers are in a perfect state of mind devoid of morbid worries, depression and anxieties.

Issues affecting healthcare providers have been acknowledged as possibly the major challenge in the health sector (Dovlo, 2007). However, very few studies have been conducted to investigate how welfare issues contribute to anxiety and depression among healthcare practitioners. Segal and Bolton (2009) examined the issues affecting healthcare providers in Australia. The study specifically looked at the future of healthcare providers with emphasis on the aging population. Similarly, Odoom (2015) identified the intrinsic and extrinsic issues affecting the effectiveness, and subsequently the well-being of nurses at the Amasaman Municipal Hospital.

An examination of these empirical studies reviewed above, reveal that none of them focused specifically on the issues (relationship between welfare issues and anxiety and relationship between welfare issues and depression) which this current study is going to address. Even though Segal and Bolton (2009) aimed at identifying the issues affecting the welfare of healthcare providers, their study was restricted to the aging population and future of healthcare providers in Australia and did not examine how the welfare issues contribute to anxiety and depression. Again, the sample size of the study conducted by Odoom (2015) was small (20) and also failed to address welfare, anxiety and depression.

For these reasons, this study will focus on identifying the welfare issues confronting the healthcare provider and the relationship with anxiety and depression. The results of the study are expected to help bridge the literature gap identified.

1.3 Objectives of the study

1.3.1 General objectives

To assess welfare issues affecting the healthcare provider at Ridge Hospital, Accra.

1.3.2 Specific objectives

1. To identify the welfare issues confronting healthcare providers at Ridge Hospital
2. To examine the relationship between welfare issues and anxiety at Ridge Hospital.
3. To examine the relationship between welfare issues and depression at Ridge Hospital.

1.4 Research Questions

1. What are the welfare issues confronting healthcare providers at Ridge Hospital?
2. What is the relationship between welfare issues and anxiety at Ridge Hospital?
3. What is the relationship between welfare issues and depression at Ridge Hospital?

1.5 Justification of the study

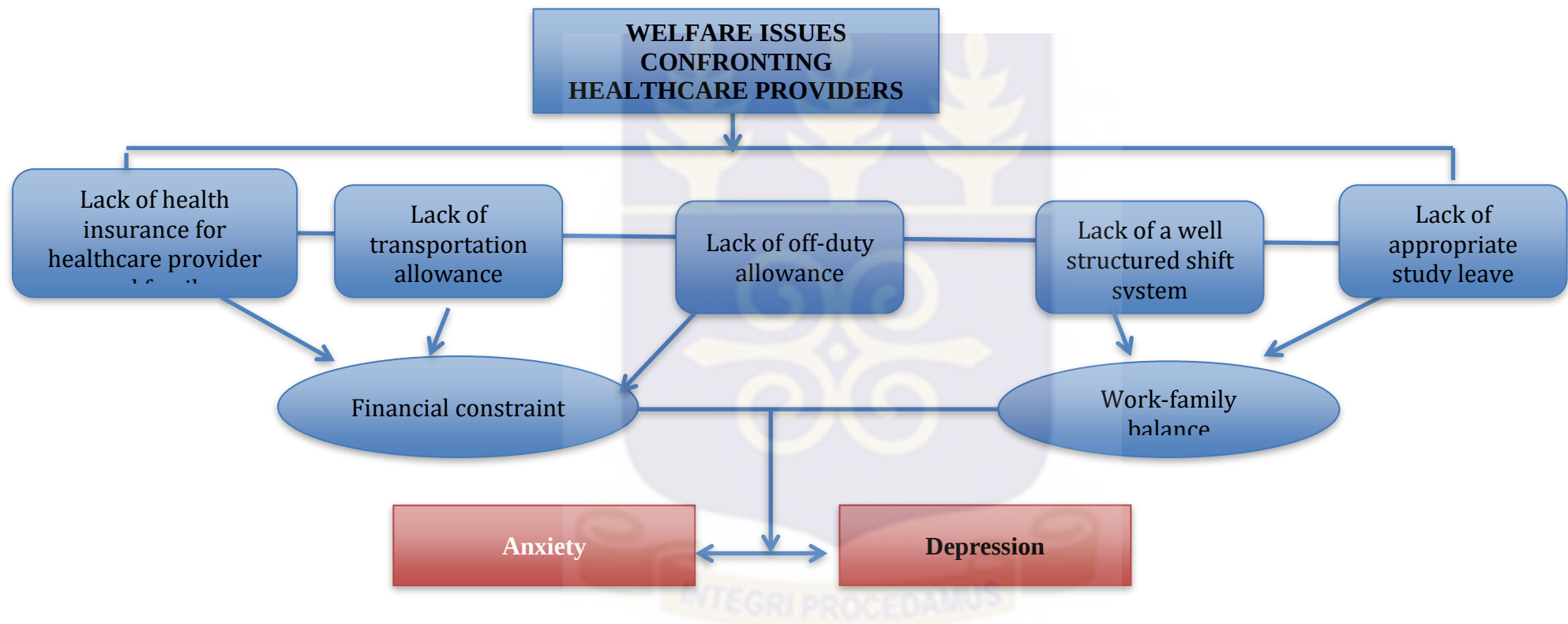
The results of the study is expected to outline the welfare issues confronting the healthcare providers to inform stakeholders and the government on the need to put policies in place to ensure that these welfare issues are dealt with appropriately.

Similarly, the results of the study will establish if there is a relationship between welfare issues, anxiety and depression to help put appropriate mechanisms in place to curb the incidence of anxiety and depression among healthcare providers. The results of the study will also act as a reference source for future research on this topic or related topics by students and researchers.



1.6 Conceptual Framework

Figure 1: Conceptual Framework



Source: Researcher's construct

Figure 1 shows that, welfare issues that confronts healthcare providers could lead to anxiety and depression. Most healthcare providers work under appalling conditions in order to save lives, yet matters that concern their welfare are left unattended (Manyisa and Aswegen, 2017). According to Harrington (2017), health workers engage in a shift system because of the shortage of staff. However, without a proper shift system, not only is the health of the healthcare provider at risk, but it also places their marriages, family and social life at risk. Without a well-structured shift system and appropriate study leave, work family balance may be affected. Love, Tatman and Chapman (2010) defines Work–family conflict as a situation when responsibilities at work interfere with family roles and responsibilities. Thus, working an 8-hour period without appropriate shift systems or having to combine work with schooling may imply cost of childcare for a female worker with an infant or young child. Unavailability of the healthcare worker at home to give his or her family the needed care and support may lead to failure to thrive, leading to guilt feelings and depression in the worker.

Other welfare issues confronting healthcare workers is lack of transportation allowance, lack of off-duty allowance and lack of health insurance for healthcare providers and family places financial constraints on the healthcare provider (Kasenga&Hurtig, 2014: Harrington, 2017). This situation makes the workers anxious about how to satisfy financial requirements confronting them and this eventually leads to depression (Al-Momani, 2008). According to Kasenga and Hurtig (2014), workers feel disrespected and treated unfairly when they do not get support for themselves and their families regarding health or personal difficulties and this might manifest as anxiety or depression.

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 Introduction

This chapter presents a review of related literature to the study. The chapter covers, the meaning of welfare, the welfare issues confronting the healthcare providers, the relationship between welfare issues and anxiety and the relationship between welfare issues and depression.

2.2 Definition of welfare

According to Kasenga and Hurtig, (2014) welfare refers to the provision of support, and contribution to the well-being of individuals, who need assistance (Kasenga&Hurtig, 2014). That is to say that, resources or capitals, as well as conditions required for healthy and comfortable living of individuals is defined as welfare. At the workplace, welfare ensures that the basic needs require by individuals to effectively carry out their duties to the optimum are met. Furthermore, Business dictionary (2017) defines welfare as the availability of resources and the presence of conditions that is required for comfortable, healthy, secure as well as reasonable living. The Oxford dictionary (2001) defines welfare as a well-being, happiness and prosperity of a person or community. Similarly, it is the financial support received from the state. Greve (2008) indicates that welfare can be based on a person's everyday life perspective as well as looking at it at the societal macro level. According to Dovlo (2007) issues affecting the well-being of healthcare providers have been acknowledged as a major challenge in the health system of any country.

2.3 Definition of Depression

Occasionally, everyone is expected to feel sad or blue yet this feeling is mostly short-lived and passes within few days. Yet one of the common and serious conditions that are experienced in most lives is depression (National Institute of Mental Health, 2015). According to Marcus, Yasamy, van Ommeren and Chisholm (2012) depression is a serious medical illness which is common that affects how one feels, think and act negatively. Similarly, MacGill (2017) described depression as a mood disorder that causes one to experience persistent feelings of sadness as well as a loss of interest in activities that were initially of interest. Likewise the American Psychiatric Association (2018) defines depression as a medical illness that is caused by a change in the brain chemistry of an individual.

The most common illness worldwide which also doubles as the leading cause of disability is depression. Similarly, depression affects 350 million people globally. According to the World Health Organisation (2008) also stated that depression is noted to be higher i.e. 50% among females than males, (WHO, 2008)

According to the National Institute of Mental Health (2015), there are several types of depressive disorders. These are major depression, psychotic depressions, postpartum depression, seasonal affective disorder, persistent depressive disorder and bipolar disorder. These types of depression affect people in different ways and as such there is a need to identify the causes of depression. The causes of depression are multiple and could be due to genetic factors, environmental factors, biochemistry, biological factors and psychosocial factors (MacGill, 2017). Other risk factors of depression are personality, abuse of recreational drugs, chronic pain syndromes, childhood trauma, life events like divorce, work issues, bereavement, acute stress and financial problems (Marcus, Yasamy, van Ommeren& Chisholm, 2012).

Thapar, Collishaw, Pine and Thapar (2012) indicated that adolescents who are mostly depressed feel sad, tearful, empty and hopeless. Other symptoms of depression are sleep disturbances, reduced appetite, anxiety, loss of interest or pleasure in most or all activities like hobbies or sex, trouble concentrating, slow in thinking body movement or speech and feeling guilty (Pillemer, Sutor, Pardo & Henderson, 2010).

In as much as depression is a common and serious mental disorder or problem, it can be treated (MacGill, 2017). One of the ways of treating depression is by taking medication. Schmidt (2005) further explains that antidepressants can be prescribed to help in the modification of one's brain chemistry. Other ways of treating depression are electroconvulsive therapy, psychotherapy and self-help and coping like regular exercise, eating healthy diet, getting enough quality sleep on regular basis and avoiding drugs and alcohol (Pillemer et al., 2010)

2.4 Definition of Anxiety

One of the most common psychological disorders is anxiety which is experienced by everyone at a point in time (Hoifodt, Strom, Kolstrup, Eisemann & Waterloo, 2011). According to Deb, Chatterjee and Walsh (2010) anxiety is a general term that is used in explaining the several disorders that are known to cause fear, apprehension, worrying and nervousness. Similarly, American Psychiatric Association (2018) defines anxiety as an emotion which is characterized by feelings like fear, apprehension, tension and worrying thoughts which results in physical changes like an increase in blood pressure, heartbeats and headaches. Craske, Rauch, Ursano, Prenoveau, Pine, and Zinbarg (2009) also describe anxiety as an emotion that is experienced by an individual at a time due to an unpleasant state of inner confusion. The feeling of anxiety is usually accompanied with nervous behaviors like heart beating at a faster rate, pacing back and forth or

having stomach upset or “butterflies in the stomach” (Craske et al., 2009). Other characteristics of anxiety are feeling dizzy or lightheaded, unreality or bright vision, tight or painful chest, sweating, heaving legs and cold or hot flashes (Jayakody, Gunadasa & Hosker, 2014).

Anxiety affects everyone be it young, old, male or female. Thus, according to the Mental Health Foundation report (2014) the anxiety level of women is higher than that of men. Similarly, people in their middle years i.e. 35 to 59 years have the highest level of anxiety as compared to the other age groups. Whereas it is noted that younger people are more likely to feel anxious about their personal relationships. The American Psychiatric Association (2018) also indicated that anxiety affects three parts of a human being, i.e. body, behaviour and thoughts.

Oathes, Squillante, Ray and Nitschke (2010) revealed that everyone gets anxious at a point in time but the state where one becomes consistently worried and afraid and is unable to carry on with his or her normal life makes it a disorder. According to Jayakody, Gunadasa and Hosker, (2014) there are types of anxiety disorder and they are separation anxiety disorder, social anxiety disorder or social phobia selective mutism, substance-medication-induced anxiety disorder, specific phobia, agoraphobia, generalized anxiety disorder and panic disorder. The World Health Organization states that health is a state of complete physical, mental, social and economic well-being of an individual and not simply an absence of infirmity (WHO, 2007).

Clearly, much more than the absence of diagnosed disease is involved. Basic human needs will be implicitly satisfied in a healthy individual. Thus, it is widely accepted today that the concept of health as a technical measure, in the absence of diagnosed disease, is insufficient in most cases.

Anxiety can be caused by the changes in one's brain, environmental stress and in some cases can be genetic (Oathes, Squillante, Ray & Nitschke, 2010).

2.5 Who is a Healthcare provider

Health is one of the delicate aspects of a human being. Therefore, people who handle the health of individuals in the society are expected to be of sound mind and well educated in the field. These people are called healthcare providers. According to Julliard, Klimenko and Jacobs (2006) a healthcare provider is one who has been charged to provide healthcare service to a person, groups of persons or a community. Also Sprangers and Aaronson (1992) described healthcare providers as individual, institution or an agency that provides health services to healthcare consumers. Similarly, Ray (2017) defines healthcare providers as people who give curative, promotional or rehabilitative, preventive healthcare services in ways that follows a systematic order to people, families or communities. Sneeuw, Sprangers and Sprangers and Aaronson (1992) stated that a healthcare provider is not necessarily restricted to a particular field. Therefore healthcare providers can operate in all fields like surgery, midwifery, pharmacy, nursing, dentistry or psychology.

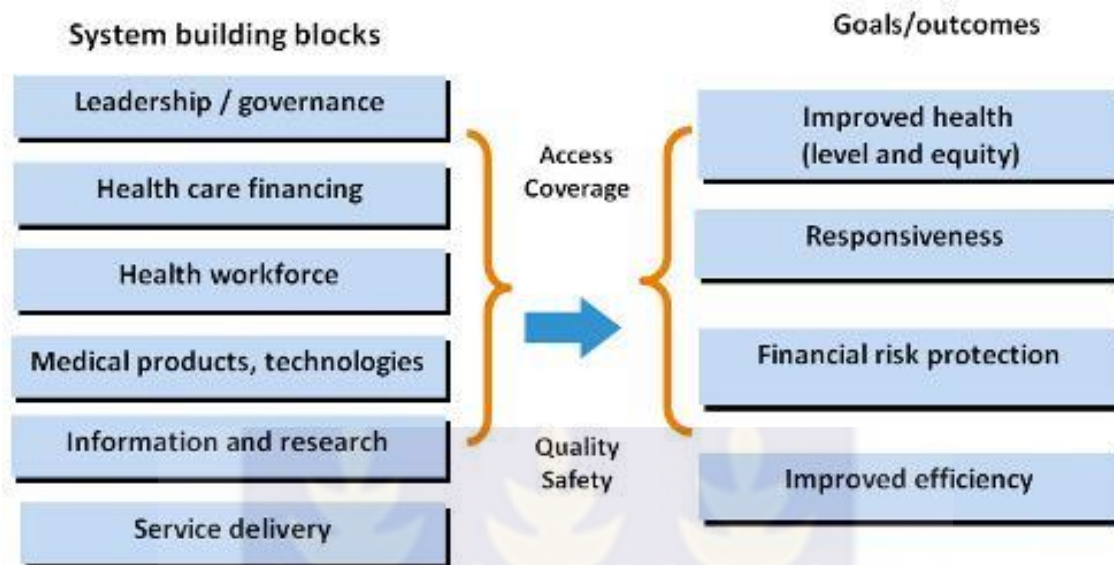
According to Ray (2017) there are types of healthcare providers. These include primary care provider, nursing care, drug therapy and specialty care. Crane and Moreno (2011) further explained that a primary care provider help in the management of the overall health of a patient. In other words a primary care provider is one that patient's may first see for health problems and checkups. A nursing care provider is one who has been licensed by a state to care for the sick. Also, the drug therapy is a licensed pharmacist who evaluates the health of patients and prescribes drugs for them accordingly whiles

specialty care is specialized care given to patients with special health cases like surgery, cancer treatment, disorders in the immune system, digestive system disorder etc.

A healthcare provider plays a very important role in the care of patients. Crane and Moreno (2011) indicated that the role of a healthcare provider is render expert medical advisory services as well as render medical treatment and services. According to Ray (2017), a healthcare provider evaluates, care, treat, prevent and administer healthcare services to patients. The Centre for Disease Control and Prevention (2017) also revealed that the roles of healthcare providers include diagnosing, counseling, coordinating care and supporting patients. Health professionals are at the heart of health systems that influence access to care, the quality of care and the cost of effective service delivery. Africa, including Ghana, has struggled over the years to meet this challenge. Despite the established importance of the healthcare provider, there is a global imbalance in health workforce across the world with developing countries at the disadvantaged end of it. The uncontrolled migration of labour from rural areas to urban areas and from poor to rich countries has disastrous consequences for the health of people living in abandoned communities. Welfare issues are said to be among the major reasons for migration of healthcare providers which has cost developing countries millions of Dollars over the past two decades (Dussault et al. 2009)

2.6 Health System Building Blocks

Figure 2: Health System Building Blocks



WHO, 2010.

A health system is primarily made up of all organizations, people and actions whose basic aim is to promote, restore and maintain health.

The World Health Organisation (WHO) has identified six basic building blocks which are essential for the effective and efficient management of every health system across the world. These six building blocks are:

- Leadership and Governance which ensure that availability of strategic policy framework exist with much focus on system design and accountability.
- Good health services are those which deliver effective, safe, quality personal and non-personal health interventions to those who need them, when and where needed, with minimum waste of resources.
- Essential medical products, vaccines and technologies of assured quality, efficacy, safety and cost effective.

- Health financing system in an effective health system ensure the raising of adequate funds for health in ways that do not end up impoverishing them
- Health information system is one that ensures the production, analysis, dissemination and use of reliable and timely information on health determinants, health systems performance and health status.
- Health Workforce is essentially one that works in a responsive way, effective and efficient ways to achieve the best health outcomes possible with the available resources and circumstances. The workforce should be in their sufficient numbers and required mix, fairly distributed, competent and very productive.

Strengthening human resources for strategic planning, implementation and monitoring of healthcare and alignment of high quality workforce education with health needs has been a major setback for developing countries (WHO, 2010).

2.7 Theoretical Framework of the Study

This section presents the theories that underpin the study. The theories used for the study includes the management theory and the Maslow's Hierarchy of needs.

2.7.1 Management theory

According to Hawthorne (2018) the use of management theory is to aid in increasing the productivity and service quality in the organisation as well as the relationship between management and staff. Hawthorne (2018) indicated that the management

theory focuses on how management relate the goals and objectives of the organisation to ways of implementing them effectively as well as motivating personnel to perform to the highest standard. In other words, management theory has to do with the measures management put in place in running the institution which includes motivating workers in any way to put in much effort to increase productivity. Relating this theory to the current study, managing the affairs in the health sector is very important as it is expected to be in line with the objective and goals of the institution. Therefore if the organization is handicapped in managing the operations in the organisation which includes appropriately handling the healthcare providers it can affect the work output of the organisation. This is because workers can become frustrated and depressed if what they need to make work easy and stress free

2.7.2 Maslow's Hierarchy of needs

The Maslow's Hierarchy of needs was propounded by Abraham Maslow in the year 1943. The theory explains that people are often motivated to attain certain needs even though some needs are most preferred over others (Burton, 2012). In other words, the theory explains human motivation. According to McLeod (2017) there are five needs within each human being which is in a form of a hierarchy. Consequently, every individual expects to achieve each need at each stage. The needs identified accordingly are physiological needs (basic needs like food, water, shelter and clothing), safety needs (environmental, emotional safety, physical safety and protection), social needs (affection, care, love friendship and belonging), esteem needs (recognition, status, respect, confidence) and self-actualization needs (need for growth, desire to gain more knowledge) (Burton, 2012). Relating Maslow theory of needs to the study, management is expected to provide the appropriate salaries needed to help the healthcare providers to acquire the basic necessities of life. In other words, workers can become anxious and

depressed if they are unable to meet their basic needs and that of their family if they have one. This in a long affects their productivity at work. Similarly, management appreciating their efforts and sacrifices makes them feel a part of the organisation.

2.8 Empirical Review

This section presents a review of the various empirical studies related to the study. The section covers the welfare issues confronting the healthcare providers, the relationship between welfare issues and anxiety and the relationship between welfare issues and depression.

2.8.1 The Welfare Issues confronting Healthcare Providers

Healthcare providers mostly work under appalling conditions either in a public or private Hospital in order to save lives yet their welfare is not taken into consideration (Manyisa and Aswegen, 2017). One of the welfare issues that confront healthcare providers is well- structured shift system. Shift systems involve a period of 6-12 hours' work at a time with shift members alternating on two, three or four shifts in any 24 hour period (Harrington, 2017). Health workers who are engaged in shift work or long hours of work experience disruptions of family and social activities. Similarly, marital responsibilities are severely disrupted as well as childcare, house work, shopping and even leaving a partner alone at night leads to marital strain and family dysfunction (Harrington, 2017). Also, there is a deleterious effect on the sleep pattern of health workers due to long hours of work as well as there is a high tendency of human error as shift and long hours affects the efficiency of work performance (Kasenga & Hurtig, 2014). Another welfare issue is the health insurance for workers and their families.

Health workers usually feel disrespected and treated unfairly when they miss support for themselves and their families regarding health or personal difficulties (Kasenga & Hurtig, 2014). The lack of opportunity to continue professional development (study leave) is another welfare issue that confronts health workers. The shortage of staff is seen as a major reason why health workers are not granted to opportunity to access study leave, join seminars or formal training. Due to this, some of the health workers tend to resign in order to acquire more knowledge in their field (Harrington, 2017). Similarly, off-duty allowance and transport allowance is also a welfare issue that confronts health workers. Reduction in allowances, allowances being revised or not paid on time is one of the issue confronting health workers. Transportation allowance, off-duty allowance, education assistance, call allowances and allowances accrued during holidays are not paid on time, revised or not paid on time thus it discourages health workers from executing their duties well because they are unmotivated (Kasenga & Hurtig, 2014).

According to Manyisa and Aswegen (2017) issues affecting the conditions of work in public Hospitals in South Africa include the amount of work done by healthcare workers, the prevalence of HIV/AIDS, long working hours, poor infrastructure, and shift work, lack of funds and shortage of staff. Similarly, Al-Momani (2008) revealed that issues affecting the well-being and working conditions of healthcare providers exposed them to health problems such as stress, hypertension, fatigue, depression and cardiovascular diseases.

A study conducted by Osain (2011) also revealed that the inadequate and functional surveillance systems in the health sector make it difficult for healthcare providers to control disease outbreak and bio-attack. This in a long run also affects their health because of their first-hand contact with patients. The aim of the study is to review the

state of Nigeria healthcare system as well as provide possible recommendations. Thus, a qualitative study design was adopted in achieving the study aim.

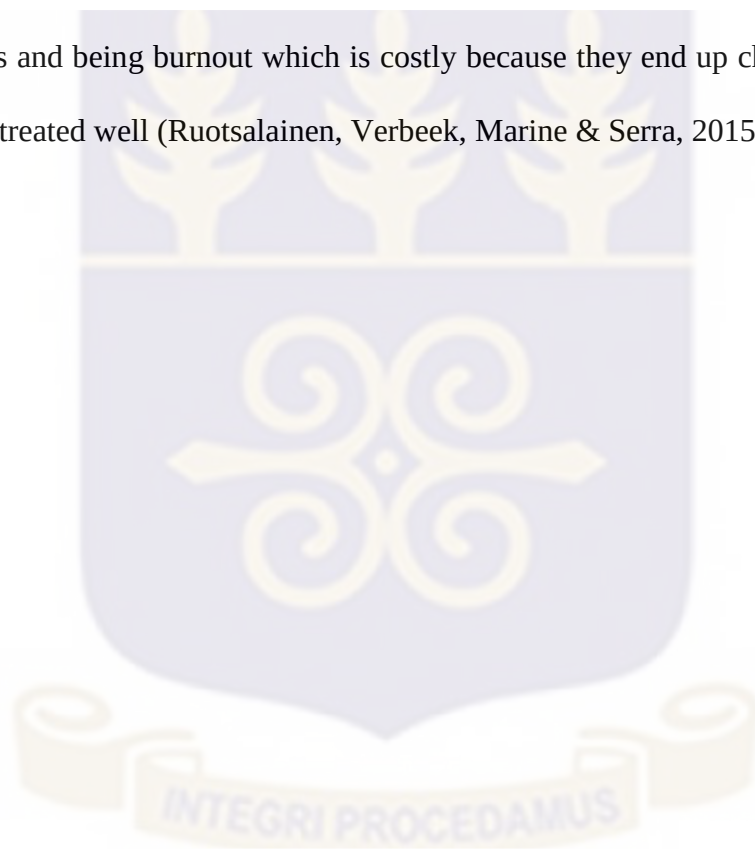
2.8.2 The relationship between welfare issues and anxiety

There is an estimate percentage between 20 and 30 of health workers who experience mental health problem yearly. Similarly, anxiety and stress conditions accounts for half of all days lost (Rolfe, Foreman & Tylee, ND). The physical symptoms of anxiety experience are tension, headaches, dizziness, breathlessness, diarrhea, cold clammy hands and sweating. Also, the psychological symptoms include feeling of threat, difficulty concentrating, early insomnia, panic attacks and intolerant (Shearer, 2007). Anxiety which is not clearly associated with identifiable stimuli can be defined as the discomfort, worry and strain which are caused by a danger prediction (Sonnentag & Fritz, 2014). Healthcare providers tend to be anxious if their needs are not met. This affects their work output as anxiety makes them tensed, panic attacks; difficulty in concentrating etc and it affects work output (Rolfe, Foreman & Tylee, ND). According to Kroenke, Spitzer, Williams et al., (2007), health workers may not identify their worries concerning welfare issues yet they tend to worry a lot which results in social or occupational situations and in the end it will lead to functional impairment.

2.8.3 The relationship between welfare issues and depression

Healthcare providers also suffer from occupational stress or work-related stress due to high expectations yet there are not enough time, social support, financial support, skills and human resource. The absence of these supports leads to severe distress, physical illness or burnout (Ruotsalainen, Verbeek, Marine & Serra, 2015). One of the health conditions that costs lives and affects the quality of life of individuals from all social

backgrounds and status is depression (Rolfe, Foreman & Tylee, ND). According to Biçkes, Çizmeci, Göver and Pomak (2017), depression is a mood disorder. In other words, one's mood can be normal, elevated and depressive. The loss of interest or pleasure, depressed mood and decreased in energy are the core features of depression. Some frequently seen symptoms of depression are feeling of guilty, pessimism, suicidal thoughts, sleep disturbance, lack of concentration, appetite change, loss of sex drive and sleep disturbance (Biçkes, et al., 2017). Health workers inability to access quality welfare policies that is needed to help them deliver quality of healthcare service may lead to stress and being burnout which is costly because they end up changing jobs if they are not treated well (Ruotsalainen, Verbeek, Marine & Serra, 2015).



CHAPTER THREE

3.0 METHODOLOGY

3.1 Introduction

This chapter presents the various methods that were adopted to achieve the objectives of the study. The chapter covers the study design, study setting, study variables, study population, inclusion and exclusion criteria, sample size and sampling techniques, data collection tools, data collection methods, quality control, data analysis procedure, ethical considerations, data management, data storage and usage and limitations of study.

3.2 Study design

The study design was a cross sectional survey that utilized quantitative methods for data collection and analysis. According to Zikmund (2009), descriptive surveys require asking respondents, for information, using either verbal or written questions. Quantitative research was used to describe more precisely the welfare issues and related factors presented in this study (Saunders, Lewis and Thornhill, 2003). Quantitative research methods are criticized for their deficiency in depth and insight as the responses on the questionnaires are often pre-coded (Creswell, 2009). In spite of this, the strength of quantitative research approaches lies in the capacity to measure and analyze data, enable easier establishment of statistical relationship between an independent and dependent variable and also improve the objectivity of the research findings (Creswell, 2009). To add, the goal of quantitative research is to identify the numeric data or the extent of some phenomenon in the form of number or figure (Creswell, 2009).

3.3 Study Area

Ridge Hospital is situated in the Osu Korley Klottey Sub-Metro, within Accra Metropolitan Assembly.

Figure 2: Map of Osu Korley Klottey Sub-Metro



The Hospital is one of the leading healthcare providers located in the center of Accra with a current capacity of 191 beds but undergoing major expansion to a 600 bed capacity. The Ridge Hospital was built in 1929 to provide healthcare for British Colonials during the pre-colonial era. Since its inception in 1930, the Hospital has provided quality healthcare to the general populace of the region. The study area was chosen because the Hospital is a secondary Hospital serving as a referral center to the Greater Accra catchment area but it also receives referrals from other parts of the country. Also, the Department of Obstetrics and Gynecology provides service to an average of 15,600 births a year. The Hospital provides antenatal services to an average

of 1000 patient per week. The Hospital is suitable for the study owing to the antenatal services it renders to pregnant women and the fact that it is a secondary level government Hospital supporting the leading referral center in Accra, KBTH. Accra itself has a population of at least 4 million and most referrals are distributed to KBTH, Ridge Hospital and 37 Military Hospital which positions it favorably as the study setting (Ridge Hospital, 2011).

3.4 Study Variables

i. Dependent variables

Anxiety

Depression

ii. Independent variables

Proxy variables for Welfare from earlier studies include leave duration, health insurance for self and family, safety logistics, study leave, off-duty allowance, transportation allowance, well-structured shift system, well-structured conditions of service (Al-Momani, 2008; Geiger-Brown, Trinkoff & Rogers, 2011; Mokoka, Ehlers & Oosthuizen, 2011)

3.5 Study Population

Doctors and nurses at the Ridge Hospital constituted the population of the study.

Currently, there are about 280 doctors and 520 nurses at the Ridge Hospital.

3.6 Inclusion and exclusion criteria

3.6.1 Inclusion criteria

- i. Doctors employed as permanent staff of the Ridge Hospital
- ii. Nurses employed as permanent staff of the Ridge Hospital

3.6.2 Exclusion criteria

- i. Staff on study, casual or annual leave from the Hospital

3.7 Sample size and sampling techniques

The sample size for the study was obtained as shown in the Table 1.

Table 3.1: Sample size

Respondents	Population (N)	Sample ($n = N/(1+N[e^2])$)
Doctors	280	165
Nurses	572	235
Total	852	400

As shown in the formula in Table 1, n is the sample size, N is the population size, and e is the level of precision (0.05). The formula for calculating the sample size was taken from Source: Solvin (1960).

The systematic sampling method was used to select the respondents at the ridge Hospital. The staff list was used as the sampling frame. The sample interval for the study was given by the population of health workers divided by the sample size considered ($852/400=2.1$) for the study.

3.8 Data collection tools

A questionnaire was the main instrument that was used for the collection of data for this study. The questionnaire contained closed ended questions. The questionnaire was divided into sections. The first section contained the bio-data of the respondents and the subsequent sections each contained questions aimed at answering each objective of the study. The subsequent questions on anxiety and depression were developed using the Hamilton Rating Scale for Anxiety and Beck's Depression Inventory respectively.

3.9 Data collection methods

The questionnaire was administered to the respondents in the Hospital during their lunch break or at their own time of convenience. The distribution of the questionnaires was done solely by the researcher. A period of twenty-eight (28) days was estimated for the data collection process.

3.10 Quality control

A three days training was given to two data collections assistants who assisted with the data collection. During this period the study instruments and good ethical principles were explained to the data collectors. The data collectors were degree holders who have prior experience in data collection. Periodic visits with the research assistants or data

collectors was done to ensure that ethical principles are duly observed and dealt with any practical issues during data collection.

3.11 Data analysis procedure

Inferential and descriptive statistics were generated. The descriptive statistics addressed the bio-data and identification of the welfare issues confronting the healthcare providers at the Ridge Hospital. The relationship between variables was expressed using Pearson's chi-square test and logistic regression analysis. The Pearson's chi-square test was used to show a relationship between the welfare variables and level of anxiety and depression.

The instrument had satisfaction with welfare (measured on 5 variables) and depression or anxiety (also measured on a ranked scale). So for the chi-square analysis, the variables for 'satisfaction with welfare' were re-group to be three where satisfied (very satisfied & satisfied as one group), neutral and not satisfied. Then anxiety was also grouped as mild – moderate (mild plus mild to moderate as one group) and severe – extreme (severe plus extreme as one group).

Thus, the anxiety among healthcare providers was measured using the Hamilton Anxiety Rating Scale (HAM-A) where a score of less 17 was classified under mild severity, a score of 18-24 was classified under mild to moderate severity, a score of 25-30 was classified under moderate to severe and a score of 30 and above was classified as extreme anxiety. Again, the depression among healthcare providers was measure using the Beck's Depression Inventory where a score of 1 to 16 is mild mood depression, 17 to 20 is borderline clinical depression, 21 to 40 to moderate to severe depression and above 40 is extreme depression.

3.12 Ethical considerations

i. Ghana Health Services Ethical Approval

Before the commencement of the study, ethical approval for the study was sought from the Ghana Health Service Ethical Review Committee of the Research and Development Division of the Ghana Health Services.

ii. Approval to conduct the study

Prior to the commencement of the study, approval to conduct the study was obtained from the management of Ridge Hospital.

iii. Informed consent from individual healthcare staff

Consent form was given to respondents to state their willingness to partake in the study. Their right to opt out of the study was also stated in the consent form.

iv. Potential risks/benefits compensation

This study is expected to be beneficial to the government, health facilities and individuals. The welfare issues confronting healthcare professionals were outlined. Thus, this is aimed at guiding policy makers when designing policies affecting manpower in the healthcare industry. There was a minimal potential risk posed by this study to the respondents. The minimal risks were attributed to healthcare professionals not being comfortable with some questions. In such cases, the study participants were informed about his/her right to decline a response as part of informed consent.

v. Privacy/confidentiality

Their rights were explained to them and they were assured of confidentiality and anonymity. Respondents were not required to write their names on the questionnaire. The questionnaire were also self-administered since all the respondents could read and write

3.13 Data management

Similarly, all questionnaire collected were checked to ensure that all entries have been appropriately filled. Data gathered from the respondents were coded. The data were subsequently keyed into the database of Statistical Package for Social Sciences (SPSS) to help process the data.

3.14 Data storage and usage

The principal invigilator was solely responsible for the storage of the data. The questionnaires collected each day were cross checked coded and put under lock and key. Similarly, during the data processing stage all the computers used had a password only known to the principal invigilator. Similarly, a soft copy of the entered data was stored on a pen drive and CD as backup and it was kept by the principal investigator. The data was stored for 3 to 5 years to allow for publication. Identifying information was excluded from published reports.



CHAPTER FOUR

4.0 RESULTS OF THE STUDY

4.1 Introduction

The first section of this chapter presents the biodata of respondents and the subsequent sections present the results according to the study objectives. In each section, the corresponding table follows the text.

4.2 Demography of respondents

Table 4.1 indicates that out of 400 respondents, 210 (52.5%) respondents were females and 190 (47.5%) were males. The mean age of the respondents was 29.5 ± 2.34 years. Majority of the respondents were Christians, 236 (59.0%), had obtained a degree, 260 (65.0%) and had not been in a marital union, 212 (53.0%).

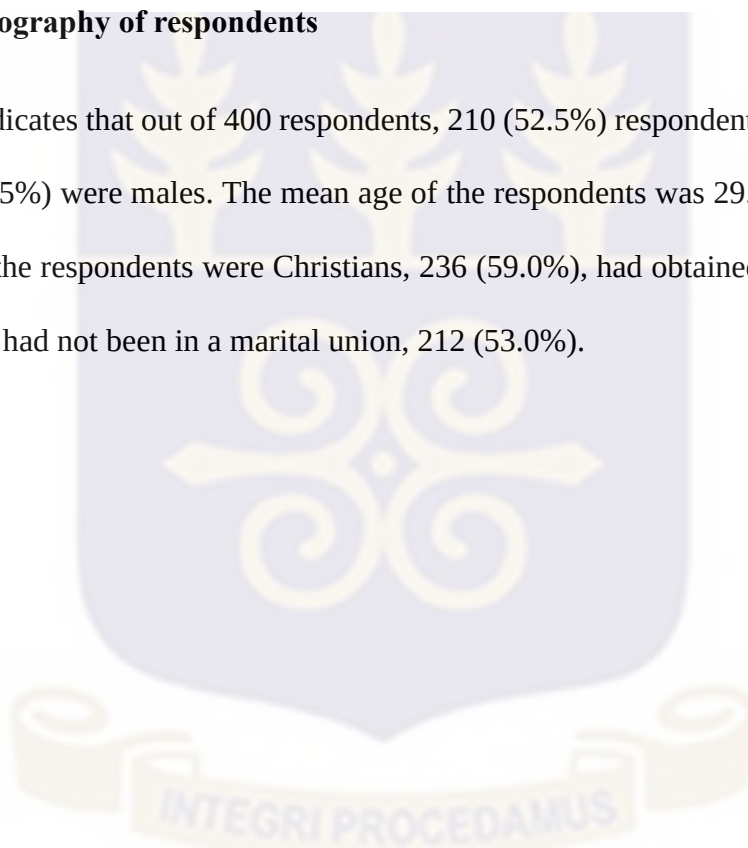


Table 4.1: Demographic profile of respondents

	Frequency	Percentage
Gender		
Male	190	47.5
Female	210	52.5
Total	400	100.0
Age		
21-28 Years	142	35.5
29-36 Years	118	29.5
37-44 Years	48	12.0
45 Years and Above	92	23.0
Total	400	100.0
Religious background		
Christian	236	59.0
Islam	94	23.5
Traditional	22	5.5
No Religion	48	12.0
Total	400	100.0
Level of education		
Diploma	140	35.0
Degree	260	65.0
Total	400	100.0
Marital status		
Single	212	53.0
Married	94	23.5
Separated	0	0.0
Divorced	46	11.5
Widowed	48	12.0
Total	400	100.0

Source: Field Data, 2018.

4.3 The welfare issues confronting the healthcare providers

Table 4.2 below indicates that fifty-nine per cent of respondents said they were satisfied with the shift system of the Hospital. Apart from 70 (17.5%) respondents who were uncertain, others were unsatisfied.

Furthermore, more than half of the respondents (53%) were not satisfied with the provisions available to them and their families under the National Health Insurance Scheme (NHIS). However, 118 (29.5%) respondents were satisfied and 70 (17.5%) respondents were neutral.

Sixty-five per cent of the respondents were satisfied with a study leave while 23.5% respondents were not satisfied with study leave.

One hundred and ninety respondents were satisfied with the transport allowance (47.5%) while 116 (29.0%) respondents were not satisfied and 94 (23.5%) respondents were uncertain.

Thirty-five point five per cent satisfied with off-duty allowance while more than half of the respondents (53%) were uncertain of their satisfaction with the off-duty allowance.

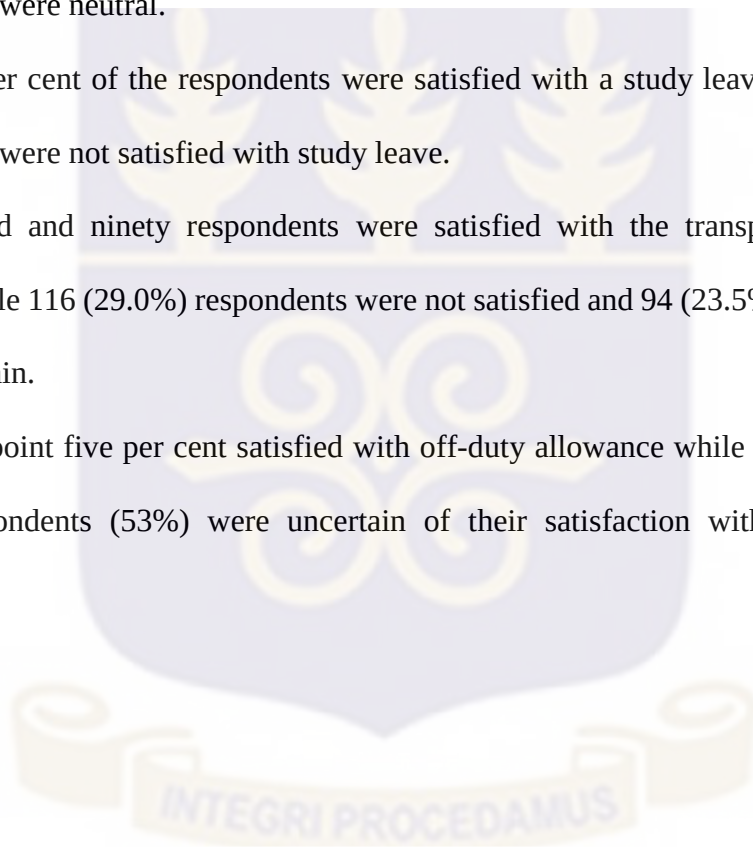


Table 4.2: Respondents satisfaction with welfare provision

Variables	Satisfied N (%)	Neutral N (%)	Not satisfied N (%)	Total N (%)
Well-structured shift system	236 (59.0)	70 (17.5)	94 (23.5)	400 (100.0)
Health insurance of healthcare providers and families	118 (29.5)	70 (17.5)	212 (53.0)	400 (100.0)
Study leave	269 (65.0)	46 (11.5)	94 (23.5)	400 (100.0)
Transportation allowance	190 (47.5)	94 (23.5)	116 (29.0)	400 (100.0)
Off-duty allowance	142 (35.5)	212 (53.0)	46 (11.5)	400 (100.0)

N = frequency, % = percentage

Source: Field Data, 2018.

4.6 The relationship between welfare issues and anxiety at the Ridge Hospital

As shown in Table 4.3, out of 236 respondents who were satisfied with the shift system, most (80.5%) respondents had mild to moderate anxiety, while 46 (19.5%) respondents had severe to extreme anxiety. However, all respondents (94) who were not satisfied with the shift system had severe to extreme anxiety. The association between shift system and anxiety was statistically significant ($\chi^2 = 183.714$; $df = 2$; $p < 0.01$)

Table 4.3:: Association between shift system and anxiety among healthcare professionals

	Mid to Moderate anxiety		Severe to extreme anxiety		Total	
	N	%	N	%	N	%
Well Structured shift system						
Satisfied	190	80.5	46	19.5	236	100
Neutral	48	68.6	22	31.4	70	100
Not satisfied	0	0.0%	94	100	94	100
Total	238	59.5	162	40.5	400	100

($\chi^2 = 183.714$; $df = 2$; $p < 0.01$)

Mild to moderate = scores less 25, severe to extreme = scores ≥ 25 ; N = frequency; % = percentage within variable

Table 4.4 shows that, out of 118 respondents who were satisfied with the NHIS membership, most (79.7%) respondents had mild to moderate anxiety, while 24 (20.3%) respondents had severe to extreme anxiety. Also, out of the 212 respondents who were not satisfied with the shift system, 120 (56.6%) had mild to moderate while 92 (43.4%) had severe to extreme anxiety. The relationship between health insurance system and anxiety was statistically significant ($\chi^2 = 39.110$; $df = 2$; $p < 0.01$)

Table 4.4: Association between health insurance system and anxiety among healthcare professionals

	Mid to Moderate		Severe to extreme		Total	
	N	%	N	%	N	%
Health insurance of healthcare providers and families						
Satisfied	94	79.7	24	20.3	118	100
Neutral	24	34.3	46	65.7	70	100
Not satisfied	120	56.6	92	43.4	212	100
Total	238	59.5	162	40.5	400	100

($\chi^2 = 39.110$; df = 2; $p < 0.01$)

Mild to moderate = scores less 25, severe to extreme = scores ≥ 25 ; N = frequency; % = percentage within variable

Out of 260 respondents who were satisfied with the study leave system, most 238 (91.5%) respondents had mild to moderate anxiety, while 22 (8.5%) respondents had severe to extreme anxiety (Table 4.5). Also, out of the 94 respondents who were not satisfied with the study leave system, all (100%) had severe to extreme anxiety. The relationship between health insurance system and anxiety was statistically significant ($\chi^2 = 316.429^a$ df = 2; $p < 0.01$)

Table 4.5 : Association between study leave and anxiety among healthcare professionals

Study Leave	Mild to Moderate anxiety		Severe to extreme anxiety		Total	
	N	%	N	%	N	%
Satisfied	238	91.5	22	8.5	260	100
Neutral	0	0.0	46	100	46	100
Not satisfied	0	0.0	94	94	94	100
Total	238	59.5	162	40.5	400	100

($\chi^2 = 316.429^a$ df = 2; $p < 0.01$)

Mild to moderate = scores less 25, severe to extreme = scores ≥ 25 ; N = frequency; % = percentage within variable

As shown in Table 4.6, all respondents (190) who were satisfied with the transportation allowance, had mild to moderate anxiety. Similarly, all the 116 respondents who were not satisfied with the transportation allowance had severe to extreme anxiety. The relationship between transportation allowance and anxiety was statistically significant

($\chi^2 = 302.524$; df = 2; $p < 0.01$)

Table 4.6: Association between transportation allowance and anxiety among healthcare professionals

Transportation Allowance	Mild to Moderate anxiety		Severe to extreme anxiety		Total	
	N	%	N	%	N	%
Satisfied	190	100.0	0	0.0	260	100
Neutral	48	51.1	46	48.9	46	100
Not satisfied	0	0.0	116	100.0	94	100
Total	238	59.5	162	40.5	400	100

($\chi^2 = 302.524$; df = 2; $p = p < 0.01$)

Mild to moderate = scores less 25, severe to extreme = scores ≥ 25 ; N = frequency; % = percentage within variable

All respondents (142) who were satisfied with the off-duty allowance had mild to moderate anxiety (Table 4.7). Similarly, all respondents (46) who were not satisfied with the off-duty allowance had severe to extreme anxiety.

The relationship between off-duty allowance and anxiety was statistically significant ($\chi^2 = 182.018$; $df = 2$; $p < 0.01$)

Table 4.7: Association between off-duty allowance and anxiety among healthcare professionals

Off-duty allowance	Mild to Moderate anxiety		Severe to extreme anxiety		Total	
	N	%	N	%	N	%
Satisfied	142	100.0	0	0.0	142	100
Neutral	96	45.3	116	54.7	212	100
Not satisfied	0	0.0	46	100.0	46	100
Total	238	59.5	162	40.5	400	100

($\chi^2 = 182.018$; $df = 2$; $p < 0.01$)

Mild to moderate = scores less 25, severe to extreme = scores ≥ 25 ; N = frequency; % = percentage within variable

4.7 The relationship between welfare issues and depression at Ridge Hospital.

Table 4.8 shows that all respondents (236) who were satisfied with the shift system structure had mild to moderate depression. Likewise, all respondents (94) who were not satisfied with the shift system had severe to extreme anxiety.

The association between shift system and depression was statically significant

($\chi^2 = 328.238$; $df = 2$; $p < 0.01$)

Table 4.8: Association between shift system and depression among healthcare professionals

Well structured shift system	Mild to Moderate Depression		Severe to extreme Depression		Total	
	N	%	N	%	N	%
Satisfied	236	100.0	0	0.0	236	100
Neutral	49	70.0	21	30.0	70	100
Not satisfied	0	0.0	94	100.0	94	100
Total	285	71.3	115	28.7	400	100

($\chi^2 = 328.238$; $df = 2$; $p < 0.01$)

Mild to moderate = scores less 25, severe to extreme = scores ≥ 25 ; N = frequency; % = percentage within variable

All respondents (118) who were satisfied with the NHIS membership had mild to moderate depression (Table 4.9). However, out of the 212 respondents who were not satisfied with the shift system, most (57.1%) respondents had mild to moderate depression while 91(42.9%) had severe to extreme depression. The association between NHIS membership and depression was statistically significant ($\chi^2=69.455$; $df=2$; $p<0.01$)

Table 4.9: Association between health insurance membership and depression among healthcare professionals

Health insurance of healthcare providers and families	Mild to Moderate Depression		Severe to extreme Depression		Total	
	N	%	N	%	N	%
Satisfied	118	100.0	0	0.0	118	100
Neutral	46	65.7	24	34.3	70	100
Not satisfied	121	57.1	91	42.9	212	100
Total	285	71.3	115	28.7	400	100

($\chi^2 = 69.455$; $df = 2$; $p < 0.01$)

Mild to moderate = scores less 25, severe to extreme = scores ≥ 25 ; N = frequency; % = percentage within variable

Among 260 respondents who were satisfied with the study leave system, 239 (91.9%) respondents had mild to moderate depression while 21 (8.1%) respondents had severe to extreme depression (Table 4.10). However, all respondents (94) who were not satisfied with the study leave system had severe to extreme depression. Thus the association between study leave and depression was statistically significant ($\chi^2=305.763$; $df=2$; $p<0.01$)

Table 4.10: Association between study leave system and depression among healthcare professionals

Study leave	Mild to Moderate Depression		Severe to extreme Depression		Total	
	N	%	N	%	N	%
Satisfied	239	91.9	21	8.1	260	100
Neutral	46	100.0	0	0.0	46	100
Not satisfied	0	0.0	94	100.0	94	100
Total	285	71.3	115	28.7	400	100

($\chi^2= 305.763$; $df = 2$; $p < 0.01$)

Mild to moderate = scores less 25, severe to extreme = scores ≥ 25 ; N = frequency; % = percentage within variable

All respondents (190) who were satisfied with the transportation allowance had mild to moderate depression (Table 4.11). However, out of the 116 respondents who were not satisfied with the transportation allowance, 115 (99.1%) had severe to extreme depression. The association between transportation allowance and depression was statistically significant ($\chi^2= 395.160$; $df = 2$; $p < 0.01$)

Table 4.11: Association between transportation allowance and depression among healthcare professionals

transportation allowance	Mild to Moderate Depression		Severe to extreme Depression		Total	
	N	%	N	%	N	%
Satisfied	190	100.0	0	0.0	190	100
Neutral	94	100.0	0	0.0	94	100
Not satisfied	1	0.9	115	99.1	116	100
Total	285	71.3	115	28.7	400	100

($\chi^2 = 395.160$; df = 2; $p < 0.01$)

Mild to moderate = scores less 25, severe to extreme = scores ≥ 25 ; N = frequency; % = percentage within variable

All respondents who were satisfied with the off-duty allowance had mild to moderate depression (Table 4.12). Similarly, all 46 respondents who were not satisfied with the transportation allowance had severe to extreme depression. The association between off-duty allowance and depression was statistically significant ($\chi^2 = 172.790$; df = 2; $p < 0.01$)

Table 4.12: Association between off-duty allowance and depression among healthcare professionals

Off-duty allowance	Mild to Moderate Depression		Severe to extreme Depression		Total	
	N	%	N	%	N	%
Satisfied	142	100.0	0	0.0	142	100
Neutral	143	67.5	69	32.5	212	100
Not satisfied	0	0.0	46	100.0	46	100
Total	285	71.3	115	28.7	400	100

($\chi^2 = 172.790$; df = 2; $p < 0.01$)

Mild to moderate = scores less 25, severe to extreme = scores ≥ 25 ; N = frequency; % = percentage within variable

CHAPTER FIVE

5.0 DISCUSSION OF RESULTS

5.1 Introduction

The study aimed at assessing the welfare issues affecting the healthcare provider at Ridge Hospital, Accra. The results are discussed in the sections following.

5.2 The welfare issues confronting the healthcare providers

The result of the present study revealed that 59% of the health workers were satisfied with the shift system of the Hospital. On the contrary a study done by Harrington, (2017) revealed that health workers were not satisfied with their shift system. Manyisa and Aswegen, (2017) further explained that healthcare providers mostly work under appalling conditions either in a public or private Hospital in order to save lives, yet their welfare is not taken into consideration. This in a long run affects their relationship with the outside world including their families. In other words, their shift systems were not well structured and this affects their family and social lives. Harrington (2017) further explained that the shift system engaged in by health workers disrupt their family and social activities. Clearly, not only are their family and social activities disrupted, their sleep pattern is affected as they work for long hours. This can ultimately result in a long run can lead to human errors and low work output. Furthermore, the present study revealed that a little more than half (53.0%) of the health workers were not satisfied with the health insurance of the healthcare providers and their families. This result agrees with Kasenga and Hurtig (2014) who reported that healthcare workers felt disrespected and unfairly treated with regards to the welfare of their families. Clearly healthcare workers are not only interested in their well-being but that of their families

and as such will feel they have not been treated well if their families are not treated well. Due to the long hours healthcare providers spend in the hospital and the possibility of getting infected with a communicable disease from the work environment, they expect that their healthcare needs and that of their immediate families will be a priority for their employers. Therefore neglect of their family healthcare needs affects their commitment level to their job as they do not see why they should invest their time in a job that does not care for the health of their family members.

The results suggest that 65% of respondents were satisfied with the Hospital's system of addressing their study leave 47.5% of respondents indicated the same level of satisfaction for provision of transportation allowance. The situation is different in some other study settings. In Harrington's (2017) study, it was found that healthcare providers were not happy about the leave system and allowances. Burton (2012), explained that in the health sector, the higher your level of education, the higher your salary and better working condition. Most health workers therefore want to enhance their career yet the lack of management making room for study leave affects them. Consequently, they are unable to improve their living standards.

Although 53% of the health workers were uncertain if off-duty allowance has a welfare issue confronting healthcare provider in the present study. On the contrary, Kasenga and Hurtig (2014) revealed that off-duty allowance was one of the welfare issues being faced by healthcare providers in Malawi. Harrington (2017), further explained that not being paid on time affects healthcare workers as there are wants and needs that must be met. Therefore, neglecting transportation allowance, off-duty allowance, education assistance, call allowances and allowances accrued during holidays discourages health workers from executing their duties well because they are unmotivated (Kasenga & Hurtig, 2014).

5.3 The relationship between welfare issues and anxiety at Ridge Hospital

Anxiety among health workers may be due to various factors. Significant among them are issues related to welfare (Kasenga and Hurtig, 2014). The study results revealed that the association between the shift system and anxiety among health workers was significant ($\chi^2 = 183.714$; $df = 2$; $p < 0.01$) as shown in Table 4.3. In other words, shift system has an effect on anxiety among health workers. Management therefore cannot neglect the need design a shift system that favors health workers since it can affect their level of anxiety and may eventually affect their work output.

Furthermore, a significant relationship was found between transportation allowance, off-duty allowance and anxiety among health workers. The results also indicate that there is a relationship between anxiety and other welfare issues such as study leave and health insurance. In related studies conducted by Rolfe, Foreman and Tylee (ND), Sonnentag and Fritz, (2014) and Shearer, (2007) workers become anxious if issues related to their welfare are not dealt with. Consequently, Kroenke, et al., (2007), explained that health workers may not identify their worries concerning welfare issues, yet they tend to worry a lot which results in social or occupational situations and in the end it will lead to functional impairment. Kroenke, et al., (2007), also indicated that healthcare providers tend to be anxious if their needs are not met. This affects their work output as anxiety makes them tense, experience panic attacks, difficulty in concentrating and it affects work output. The results suggest that welfare issues that are not met contributes to anxiety among healthcare workers.

5.4 The relationship between welfare issues and depression at Ridge Hospital

The shift system enables workers to plan their routines in life, this includes in and outside work. Appropriate shift system has the tendency of helping workers to balance their family life with work and this in the long run helps to reduce depression levels. In other words, the lack of appropriate shift system can lead to healthcare workers being depressed and this can eventually result in sub-optimal output when undertaking their duties.

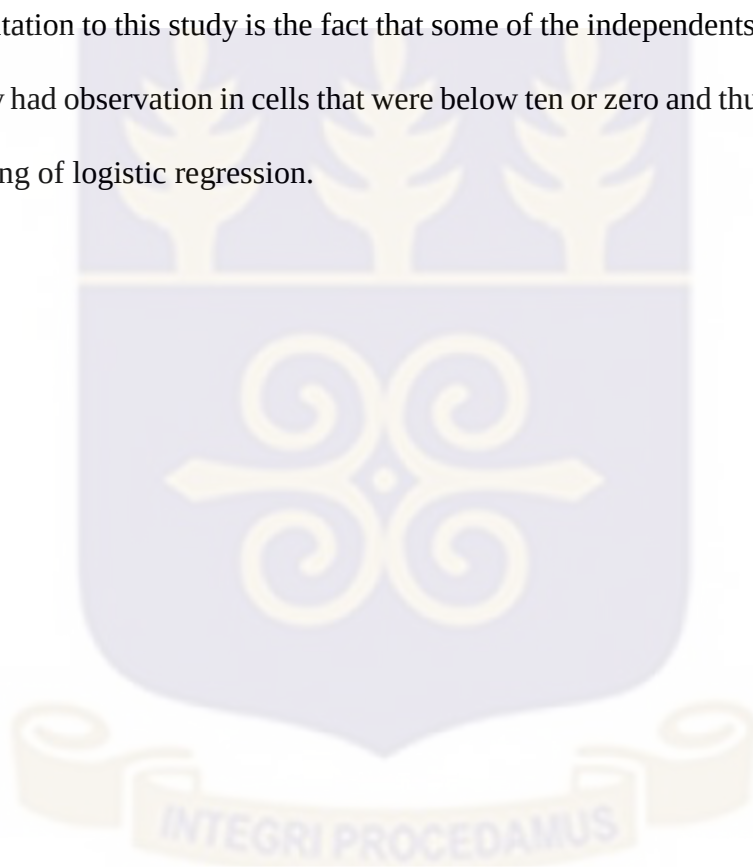
The absence of a shift system or a well-structured system can affect the mood of workers as the present study revealed that there is a significant relationship between shift system and depression among health workers ($\chi^2 = 328.238$; $df = 2$; $p < 0.01$) as shown in Table 4.8. Biçkes, et al. (2017) further explained that a depressed health worker is likely to show signs of guilty, pessimism, suicidal thoughts, sleep disturbance, lack of concentration, appetite change, loss of sex drive and sleep disturbance and this tend to affect their work output.

Similarly, the results revealed that there is a significant relationship between health insurance, study leave, transportation allowance, off-duty allowance and depression among health workers. Studies conducted by Ruotsalainen, Verbeek, Marine and Serra, (2015) and Biçkes, Çizmeçi, Göver and Pomak, (2017) revealed that workers become depressed when their welfare issues are ignored, clearly indicates a relationship between the variables and depression.

5.5 Limitations of the study

The main limitation of the current study is the fact that the study did not investigate the relationship between social demographic factors and the outcomes and this is basically because this has been studied previously (Metin , Aynur , Emel, Fatih and Artuner, 2015: Khodadadi, Hosseinzadeh, Azimzadeh, & Fooladi, 2016). However, future studies may wish to investigate how sociodemographic factors may influence the relationship between welfare issues, anxiety and depression.

Another limitation to this study is the fact that some of the independents variables used for this study had observation in cells that were below ten or zero and thus did not allow for the running of logistic regression.



CHAPTER SIX

6.0 CONCLUSION AND RECOMMENDATION

6.1 Introduction

This chapter provides conclusions of the study, as well as recommendation on the management of welfare of healthcare providers.

6.2 Conclusion

In conclusion, well-structured shift system, health insurance, study leave, transportation allowance and off-duty allowance were welfare issues confronting healthcare providers in Ridge Hospital. Health insurance for them and their families was the most significant among the welfare issues identified to be confronting the healthcare workers at Ridge Hospital. Welfare issues were significant causes of anxiety and depression among healthcare workers at the Ridge Hospital.

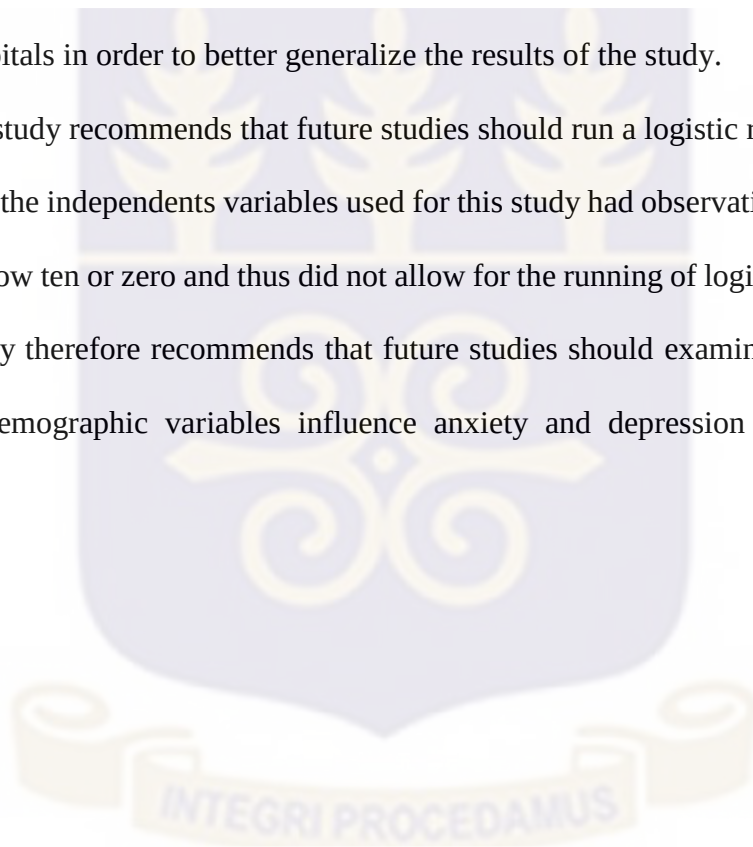
6.3 Recommendations

Based on the finding of the study, the following recommendations are made:

- i. The results of the study revealed that the respondents were not satisfied with health insurance provision for themselves and their families. The study recommends that the Ministry of Health, Ghana Medical Association (GMA), Nurses and Midwifery Council (NMC) must come up with a health insurance policy that will cater for health workers and their families so as to improve the anxiety and depression levels of these health workers. The Ghana Medical Association and the Nurses and Midwifery Council should therefore prioritize

a comprehensive health packages system when negotiating conditions of service with the Government

- ii. The results of the study showed that although most of the respondents were satisfied with the transportation allowance offered them, quite an appreciable number were not. The study recommends that a well-structured allowance system should be developed to address transportation allowances at the health facilities.
- iii. The study recommends that future studies on this topic should include other Hospitals in order to better generalize the results of the study.
- iv. The study recommends that future studies should run a logistic regression
Some of the independents variables used for this study had observation in cells that were below ten or zero and thus did not allow for the running of logistic regression. The study therefore recommends that future studies should examine the extent to which demographic variables influence anxiety and depression among health workers.



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APPENDIX A**QUESTIONNAIRE**

Dear Respondent, this questionnaire is designed to help the researcher to conduct a survey as part of research in assessing, “**ASSESSING THE WELFARE ISSUES AFFECTING THE HEALTHCARE PROVIDER**”. Be assured that information provided in this questionnaire is purely for academic purpose and therefore would be treated with utmost **CONFIDENTIALITY**.

Please tick or choose in the statements what clearly reflects your view, you can also express your views where necessary. Thank you

Section A: Demography

Q#	QUESTIONS	ANSWERS	CODE
1.	Gender	a) Male [] b) Female []	GENDER
2.	Age	a) 20 years and below [] b) 21-28 years [] c) 29-36 years [] d) 37-44 years [] e) 45 years and above []	AGE
3.	Religious background	a) Christian [] b) Islam [] c) Traditional/Spiritualist [] d) No Religion [] e) Other (Specify)	RELBAC
4.	Level of education	a) Diploma [] b) Degree [] c) Other (Specify)	EDUBAC
5.	Marital Status	a) Single [] b) Married [] c) Separated [] d) Divorced [] e) Widowed []	MARITAL

Section B: The welfare issues confronting the healthcare providers

Please indicate your level of satisfaction to the following welfare issues confronting you as a health worker

Q#	QUESTIONS	ANSWERS	CODE
6.	Well-structured shift system	a) Very satisfied [] b) Satisfied [] c) Neutral [] d) Not Satisfied []	WTSS

7.	Health insurance of healthcare providers and families	a) Very satisfied [] b) Satisfied [] c) Neutral [] d) Not Satisfied []	HIHCP
8.	Study leave	a) Very satisfied [] b) Satisfied [] c) Neutral [] d) Not Satisfied []	STULV
9.	Transportation allowance	a) Very satisfied [] b) Satisfied [] c) Neutral [] d) Not Satisfied []	TRAPN
10.	Off-duty allowance	a) Very satisfied [] b) Satisfied [] c) Neutral [] d) Not Satisfied []	ODALL

Section C: Anxiety among healthcare professionals.

Hamilton Rating Scale for Anxiety

Instructions: This checklist is to assist in evaluating respondent's degree of anxiety.

Please fill in the appropriate rating:

NONE = 0 MILD = 1 MODERATE = 2 SEVERE = 3 SEVERE, GROSSLY DISABLING = 4

Item

s/n	Item		Rating
1.	Anxious	Worries, anticipation of the worst, fearful anticipation, irritability	
2.	Tension	Feelings of tension, fatigability, startle response, moved to tears easily, trembling, feelings of restlessness, inability to relax	
3.	Fears	Of dark, of strangers, of being left alone, of animals, of traffic, of crowds	
4.	Insomnia	Difficulty in falling asleep, broken sleep, unsatisfying sleep and fatigue on waking, dreams, nightmares, night-terrors	
5.	Intellectual (cognitive)	Difficulty in concentration, poor memory	
6.	Depressed	Loss of interest, lack of pleasure in hobbies, depression, early waking, diurnal swing	
7.	Mood	Pains and aches, twitching, stiffness, myoclonic jerks, grinding of teeth, unsteady voice, increased muscular tone	

8.	Somatic (muscular)	Tinnitus, blurring of vision, hot and cold flushes, feelings of weakness, pricking sensation	
9.	Somatic (sensory)	Tachycardia, palpitations, pain in chest, throbbing of vessels, fainting feelings, missing beat	
10.	Cardiovascular Symptoms	Pressure or constriction in chest, choking feelings, sighing, dyspnea	
11.	Respiratory Symptoms	Difficulty in swallowing, wind, abdominal pain, burning sensations, abdominal fullness, nausea, vomiting, borborygmi, looseness of bowels, loss of weight, constipation	
12.	Gastrointestinal Symptoms	Frequency of micturition, urgency of micturition, amenorrhea, menorrhagia, development of frigidity, premature ejaculation, loss of libido, impotence	
13.	Genitourinary Symptoms	Dry mouth, flushing, pallor, tendency to sweat, giddiness, tension headache, raising of hair	
14.	Autonomic Symptoms	Fidgeting, restlessness or pacing, tremor of hands, furrowed brow, strained face, sighing or rapid respiration, facial pallor, swallowing, belching, brisk tendon jerks, dilated pupils, exophthalmos	
Total			

Section D: Depression among healthcare professionals.

Beck's Depression Inventory

Please indicate how you feel by ticking any of the items presented below in items 1 to 21

1.
 - 0 I do not feel sad
 - 1 I feel sad
 - 2 I am sad all the time and I can't snap out of it.
 - 3 I am so sad and unhappy that I can't stand it.
2.
 - 0 I am not particularly discouraged about the future.
 - 1 I feel discouraged about the future.

- 2 I feel I have nothing to look forward to.
- 3 I feel the future is hopeless and that things cannot improve.
- 3.
- 0 I do not feel like a failure.
- 1 I feel I have failed more than the average person.
- 2 As I look back on my life, all I can see is a lot of failures.
- 3 I feel I am a complete failure as a person.
- 4.
- 0 I get as much satisfaction out of things as I used to.
- 1 I don't enjoy things the way I used to.
- 2 I don't get real satisfaction out of anything anymore.
- 3 I am dissatisfied or bored with everything.
- 5.
- 0 I don't feel particularly guilty
- 1 I feel guilty a good part of the time.
- 2 I feel quite guilty most of the time.
- 3 I feel guilty all of the time.
- 6.
- 0 I don't feel I am being punished.
- 1 I feel I may be punished.
- 2 I expect to be punished.
- 3 I feel I am being punished.
- 7.
- 0 I don't feel disappointed in myself.
- 1 I am disappointed in myself.

2 I am disgusted with myself.

3 I hate myself.

8.

0 I don't feel I am any worse than anybody else.

1 I am critical of myself for my weaknesses or mistakes.

2 I blame myself all the time for my faults.

3 I blame myself for everything bad that happens.

9.

0 I don't have any thoughts of killing myself.

1 I have thoughts of killing myself, but I would not carry them out.

2 I would like to kill myself.

3 I would kill myself if I had the chance.

10.

0 I don't cry any more than usual.

1 I cry more now than I used to.

2 I cry all the time now.

3 I used to be able to cry, but now I can't cry even though I want to.

11.

0 I am no more irritated by things than I ever was.

1 I am slightly more irritated now than usual.

2 I am quite annoyed or irritated a good deal of the time.

3 I feel irritated all the time.

12

0 I have not lost interest in other people.

1 I am less interested in other people than I used to be.

2 I have lost most of my interest in other people.

3 I have lost all of my interest in other people.

13.

0 I make decisions about as well as I ever could.

1 I put off making decisions more than I used to.

2 I have greater difficulty in making decisions more than I used to.

3 I can't make decisions at all anymore.

14.

0 I don't feel that I look any worse than I used to.

1 I am worried that I am looking old or unattractive.

2 I feel there are permanent changes in my appearance that make me look unattractive

3 I believe that I look ugly.

15.

0 I can work about as well as before.

1 It takes an extra effort to get started at doing something.

2 I have to push myself very hard to do anything.

3 I can't do any work at all.

16.

0 I can sleep as well as usual.

1 I don't sleep as well as I used to.

2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.

3 I wake up several hours earlier than I used to and cannot get back to sleep.

17.

- 0 I don't get more tired than usual.
- 1 I get tired more easily than I used to.
- 2 I get tired from doing almost anything.
- 3 I am too tired to do anything.

18.

- 0 My appetite is no worse than usual.
- 1 My appetite is not as good as it used to be.
- 2 My appetite is much worse now.
- 3 I have no appetite at all anymore.

19.

- 0 I haven't lost much weight, if any, lately.
- 1 I have lost more than five pounds.
- 2 I have lost more than ten pounds.
- 3 I have lost more than fifteen pounds.

20.

- 0 I am no more worried about my health than usual.
- 1 I am worried about physical problems like aches, pains, upset stomach, or constipation.
- 2 I am very worried about physical problems and it's hard to think of much else.
- 3 I am so worried about my physical problems that I cannot think of anything else.

21.

- 0 I have not noticed any recent change in my interest in sex.
- 1 I am less interested in sex than I used to be.
- 2 I have almost no interest in sex.
- 3 I have lost interest in sex completely.

*Total Score*_____ *Levels of Depression*

APPENDIX B

CONSENT FORM

Introduction

I am Peter KwakuTitiati of University of Ghana Public Health School. This questionnaire is for a survey to acquire data for my MPH research on the topic: **“ASSESSING THE WELFARE ISSUES AFFECTING THE HEALTHCARE PROVIDER”**. The study has been approved by the Ethical Review Committee of Ghana Health Service. Information obtained would be used for purely academic purposes and treated with absolute confidentiality. Please tick what is appropriate.

Privacy/ Confidentiality

Also to ensure anonymity and confidentiality, respondents will not be required to write their names. Also, one the principal researcher and supervisor will have access to the information

Data Storage and Usage

The questionnaire used by the study will be under the care of the principal investigator. The hard copy will be coded into the data base of statistical software. The hard copy of the data will be under lock whiles the soft copy will be saved on a computer under a password known only to the principal investigator. A back up of the soft copy will also be kept on a pen drive and kept under lock by the principal investigator.

Voluntary Withdrawal

Participation in this study is strictly voluntary. Thus, you are at liberty to withdraw from the study at any time. However, your answers are greatly needed to help this research meet its objectives.

Compensation

There will be no pressure on individuals to participate as respondents and no incentives will be provided to respondents.

Clarifications

Please do you have any questions you wish to ask about the study? Yes/No

If yes, please, indicate below

.....
.....

If you have any questions later please, contact Peter KwakuTitiati (+233) 243376560.

I agree to participate in the study having fully understood the information provided.

Signature

Date