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Factors Predicting Work Ability among Community Healthcare Providers in Yangon, Myanmar

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Abstract

Background: In healthcare organizations, a high level of work ability is necessary for workers to perform their tasks under different working conditions. This study aimed to describe the quality of work life, work environment, and work ability and examine predictors of the work ability of community healthcare providers.

Methods: A cross-sectional descriptive study was conducted from May 2020 to July 2020. The study enrolled 284 registered nurses and midwives from 38 public health departments in Yangon, Myanmar. Data were collected using the work-related quality of life scale (WRQoL) 2, work environment impact scale (WEIS-SR), and work ability index (WAI). The multiple regression method was used to analyze predictors of work ability.

Results: Overall, 71.13% of the participants were between 26 and 45 years old, and 99.30% were female. High WEIS-SR (61.98 ± 6.38), average WRQoL (106.10 ± 15.63), and good WAI (39.29 ± 4.99) scores were found (p = 0.05). WRQoL was found to be a predictor of the WAI of community healthcare providers (R2 = 0.140, B = 0.124) (p = 0.05).

Conclusions: Improving the quality of work life of community healthcare providers will also motivate them to perform their jobs better and thus satisfy their clients.

Keywords: community healthcare, healthcare providers, Myanmar, working conditions

INTRODUCTION

In healthcare organizations, a high level of work ability is necessary for workers to perform their tasks under different working conditions (e.g., high number of patients, high work pressure, etc.). Community healthcare providers include doctors, nurses, laboratory technicians, physiotherapists, and so on. Among them, nurses have significant and often untouched capability to help individuals and communities access high quality care, particularly in providing care for people in underserved rural and urban areas.[1] Poor work ability increases job stress and diminishes nurses' quality of work life (QWL).[2] Work-related stress can be detrimental to physical and mental health, which is associated with low productivity levels.[3] Work ability was found to be poorer among nurses than among other allied health professionals.[4]

Work ability is multifactorial and is linked to physical, mental, social, and health conditions rather than just a measurement of physical capacity.[5] Work ability was defined as the ability of a worker to perform his/her job, and the specific work demands, individual health condition, mental resources, and work life should also be considered.[6] It included individual, work-related, biological, and environmental factors.[7] Work ability was positively correlated with the QWL; thus, high work ability among nurses could also affect their QWL.[8] In addition, work ability varied among people depending on work-related factors such as shift work.[9]

Nurses have the ability, responsibility, and authority to carry out nursing services/care at various levels, and their lives are influenced by their QWL, which is attributable to dynamic changes in their work environment.[10] A high QWL is essential for healthcare facilities requiring qualified, dedicated, and inspired staff.[11] The QWL covers various factors ranging from work to nonwork life domains.[12] The QWL is a broad multidimensional construct that captures the perception of an individual on work experience, which incorporates work-based satisfaction factors, life satisfaction, and general feelings of well-being.[13]

The work environment can be an unhealthy workplace for nurses, as persistent stress and physical strain can lead to unqualified and unsafe patient care.[14] Work well-being can be abstracted in several ways, such as focusing on the qualitative aspects of work ability.[15] Regarding the work environment, practical nurses' work ability index (WAI) was found to be significantly lower than that of managers and senior officers as the reference group. Some white-collar occupations have work ability problems because of the work environment or physical load.[16] The work environment refers to the environment in which people work.[11] In a previous study, 44.5% of the respondents

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perceived their nursing work environment as positive;[16] 44% of nurses perceived their work environment at an average level, whereas 31% reported a high level of work environment. The needs related to the work environment and job satisfaction for community health nurses (CHNs) are increasing as healthcare reform for the care of people with chronic illness in institutions is shifting to primary care.[17]

In Myanmar, the rural population accounts for 70% of its total population, and its health system currently faces many challenges: failure to meet the Millennium Development Goals; the health status of the general population remains poor, for example, the life expectancy at birth is 67 years old, which is the lowest in the region; disease burdens such as tuberculosis, human immunodeficiency virus, and noncommunicable diseases; and shortage of human resources, with 1.33 health workforce (doctors, nurses and midwives) per 1,000 population, which is far below the WHO minimum recommended threshold of 2.3 to ensure access to quality care.[18] Moreover, the statistical data related to tertiary hospitals showed that the in-hospital death rate (3.2%) is the highest in Yangon, followed by Rakhine (2.3%) and Nay Pyi Taw (1.6%). In addition, there was a shortage of nurses, and nurses at Yangon General Hospital (YGH) experienced a heavy workload.[19]

Human resources are a critical input in the healthcare system to ensure access to quality care.[19] Quality is as important as an available, accessible, and responsible workforce in primary healthcare (PHC) for health system effectiveness and sustainable development.[18] Thus, investing in PHC and workforce-strengthening policies are important for coverage and sustainability of development. Quality PHC enhances self-care of clients, primary care, continuity of care, service utilization, coverage of care for all in the community, and cost-effective institutional care.[20]

Work ability, QWL, and work environments are essential for community healthcare providers given the rising incidence of chronic health problems and the challenging healthcare context. Some studies have examined the QWL and work environments among nurses; however, no study has assessed work ability and its influencing factors among community healthcare providers. Thus, activities in promoting the work ability of community healthcare providers in the health department, their work environment, and QWL must be supported and strengthened. This study aimed to identify the levels of QWL, work environment, and work ability and examine the predictive factors of work ability among community healthcare providers in the Yangon region in Myanmar.

METHODS

The study was conducted after receiving approval from the Research and Ethics Committee of the University of Nursing, Yangon (ID. 33/2020), and permission from the authorities of the Yangon Regional Public Health Department. This cross-sectional descriptive study was conducted in 2020 among community healthcare providers in 38 township public health departments instituted in central, peri-urban, and primary areas of Yangon region in Myanmar, namely, Ahlon, Sanchaung, Kamayut, Hlaing, Pabedan, Dagon, Kyautada, Mayangon, Kyimyindaing, Bahan, Pazundaung, Dawbon, Thaketa, Mingala Taungnyunt, South Okklapa, North Okklapa, Thingangyun, Yankin, Insein, Mingaladon, Hlaingthaya, Shwepyitha, North Dagon, South Dagon, East Dagon, Dagon Seikkan, Dala, Kon Chan Kone, Kyautan, Thonkwa, Kautmu, Thontay, Thanlyin, Seikkyi Kanaungto, Hlegu, Tikekyi, Htanbin, and Hmawbi.

Among the skill mix of community healthcare providers, 1127 registered nurses and midwives are working in the public health sector of Yangon region. The study included a total of 307 registered nurses and midwives according to the following inclusion criteria: at least 1 year of working experience and currently working in the township health public health department. The exclusion criteria were as follows: individuals who were on sick, maternity, or vacation leave during the study period. To obtain a higher representativeness of each level of community healthcare providers and an adequate number of nurses from each township public health department, the stratified random sampling method was used. The sample size was calculated according to Taro Yamane's (1973) formula with a 95% confidence level and p- value of 0.05.[21] Therefore, 14 township health nurses (THNs), 12 staff nurses, 20 trained nurses, 49 lady health visitors (LHVs), and 217 midwives were enrolled as participants.

The research instrument included four parts: (1) The demographic part included sex, age, marital status, educational level, job title, years of experience, and department; (2) The seven-item WAI scale (long version) of Tuomi *et al*. was used to measure work ability. The questionnaire consists of seven items, and each item is evaluated by different number of questions; therefore, the score ranges of items differ from each other. The scores range from 7 to 49, and a high score indicates an excellent level, whereas a low score indicates a poor level;[6] (3) The 15-item work environment impact scale (WEIS-SR) of Wästberg *et al*. was used to assess the work environment. The scores range from 0 to 75, and a high score indicates a high level, whereas a low score indicates a low level;[14] (4) The 32-item work-related quality of life-2 (WRQoL-2) of Van Laar *et al*. was used to measure the QWL.[12] The WRQoL-2 questionnaire assesses seven factors: control at work (CAW), employee engagement (EEG), general well-being (GWB), home–work interface (HWI), job and career

satisfaction (JCS), stress at work (SAW), and working conditions (WCS). Negative items were reversed before calculation. Easton and Van Laar mentioned that the overall WRQoL score and WRQoL 1 should not be included in the scoring. The score ranges from 31 to 155; a high score indicates a high level, whereas a low score indicates a low level.[13]

To obtain content validity, each questionnaire (Myanmar version) was tested by six nursing experts from Myanmar. The reliability of each questionnaire ranged from 0.80 to 0.95 on 20-pretest sample. The questionnaires were forward-translated into the Myanmar language by the researchers and back-translated into English by a bilingual Myanmar expert. To verify the accuracy and consistent meaning of the instruments, the back-translated questionnaires were checked by a native speaker.[22]

Data were collected from May 2020 to July 2020. After the participants received explanations about the study, informed consent was obtained, and the questionnaires were distributed to the participants. The completeness of the returned questionnaires (100%) was checked after 2 weeks. Of the 307 questionnaires, 284 completed questionnaires, gaining a response rate of 93%, were analyzed.

Descriptive statistics was used to analyze the demographic data, levels of WRQoL, work environment (WEIS-SR), and work ability (WAI). SPSS version 15 was used in the data analysis. After testing the assumption, regression analysis was used to analyze predictive factors on work ability. According to Burns and Grove, a correlation coefficient (R) of <0.30 demonstrated a weak linear relationship, 0.30 ≤ R ≤ 0.50 as moderate, and >0.50 as strong. A positive correlation indicated a direct relationship, whereas a negative relationship indicated an inverse relationship.[22]

RESULTS

Among the participants, 99.30% were female, and the remaining 0.70% were men. Of the 284 participants, 9.15% were <25 years old, 71.13% were 26–45 years old, and 19.72% were >45 years old. More than half of the participants were married (65.14%), and the remaining were single (34.86%). By designation, most participants were midwives (64.08%), followed by LHVs (17.61%), trained nurses (6.69%), staff nurses (4.23%), CHNs (1.76%), THNs (1.76%), and ward sisters (1.41%). By academic background, most of the participants (87.63%) received midwifery training: diploma (14.08%) and certificate (57.39%, including LHV certificate,15.90%). The remaining participants received nursing education: baccalaureate in nursing science (2.47%), diploma (9.54%), and others (0.35%). Regarding the duration of working experience, 30.63% of the participants had <5 years, 28.17% had 5–10 years, 20.42% had >10 years, and 20.77% had >20 years. According to the workplace, 77.11% of the participants worked in urban areas township public health department (37.68%), urban health center (UHC, 26.40%) and sub-UHC (13.03%), and the remaining 22.89% worked in the rural area: sub-rural health center (sub-RHC, 13.38%) and RHC (9.51%) (Table 1).

The mean WAI score was 39.29 (±4.99), indicating a good level of work ability. The mean WEIS-SR score was 61.98 (± 6.38), indicating a high level. The mean WRQoL-2 score was 106.10 (±15.63) at average level. The mean score of WRQoL factors were as follows: CAW, 14.16 ± 2.52; EEG, 11.17 ± 2.07; GWB, 21.03 ± 3.77; HWI, 13.51 ± 2.98; JCS, 22.62 ± 3.33; SAW, 9.59 ± 3.33; and WCS, 14.02 ± 2.62 (Table 2). The QWL weakly affected the work ability of the participants (R2 = 0.140, B = 0.124) (p = 0.05). The work environment has no significant effect on work ability (Table 3).

TABLE 1. Sociodemographic data of community healthcare providers in Yangon, Myanmar, from May to July 2020 (N = 1,127)

Variable	N	%
Gender		
Male	2	0.70
Female	282	99.30
Age		
≤25	26	9.15
26–45	202	71.13
>45	56	19.72
Marital status		
Single	99	34.86
Married	185	65.14
Education		
Midwifery certificate	163	57.39
Midwifery diploma	40	14.08
LHV certificate	45	15.85
Nursing diploma	27	9.50
Bachelor's Degree in Nursing Science	7	2.46
Other	2	0.70
Designation		
Midwife	182	64.08
LHV	50	17.61
Trained nurse	19	6.69
Staff nurse	12	4.23
Sister	4	1.41
Community health nurse	5	1.76
Township health nurse	5	1.76
Total services (in years)		
<5	87	30.63
5–10	80	28.17
10–20	58	20.42
>20	59	20.77
Departments		
Urban health center (UHC)	75	26.40
Sub-UHC	37	13.03
Rural health center (RHC)	27	9.51
Sub-RHC	38	13.38
Township public health department	107	37.68

TABLE 2. Levels of the quality of working life of community healthcare providers in Yangon, Myanmar, from May to July 2020

WRQoL-2	Mean	SD	Level
Overall	106.10	15.63	Average
Job and career satisfaction	22.62	3.33	Average
Control at work	14.16	2.52	Average
General well-being	21.03	3.77	Average
Stress at work	9.59	3.13	Average
Home–work interface	13.51	2.98	Average
Working conditions	14.02	2.62	Average
Employee engagement	11.17	2.07	Average

TABLE 3. Regression table

	B	Std. Error	Beta	Sig
(Constant)	28.193	2.837		0.000
Total WE	−0.033	0.047	−0.042	0.484
TWRQoL	0.124	0.019	0.388	0.000

DISCUSSION

The work ability of community healthcare providers in Yangon Region Public Health Department was found to be good; however, their work ability still needs support. The work ability of the healthcare providers can vary in relation to individual factors such as age and work experience.[8] In this study, 71.39% of participants were 26-45 years aged group which enhance the work ability to be good. Moreover, only 30.47% of participants had less than 5 year experiences and the remaining groups have longer work experience, which is important in essential care and can lead to recognition of good WAI for their commitment.[20] In addition, most participants (99.28%) were female, which was similar to the findings of a study on female Israeli nurses who had good WAI level (41.8 ± 5.2),[5] revealing that the good WAI level of the current female community healthcare providers is valuable for accessible quality care.[20] Work ability can vary in different settings, as a moderate level (36.9, range 7–49) was found among nurses in Iran.[8]

The work environment of community healthcare providers in Yangon Region Public Health Department was found to be high. The work environment of nurses and midwives in the PHC setting was found to be more favorable than that in other healthcare settings, where collaboration, community participation, and shared autonomy must be maintained for sustained development.[20] The finding of the study was not consistent with the previous study in Myanmar. Despite their perception of their work environment as nonsupportive, the participants perceived that they were working well with colleagues (81.69%) and recognized the importance of task engagement (73.94%), good communication, and having a certain level of self-esteem, which differed from the nurses in Mandalay General Hospital (MGH), where 53.8% reported satisfactory levels, 25.22% reported burnout, 43.01% expressed job satisfaction, 38.7% had intentions to leave,[23] and the perceived nursing practice environment as poor or non-supportive.[24] In this study, 81.69% of participants answered strongly agree to "I work well together with my colleagues" and 73.94% answered strongly agree to "What I do at work is important". The reason might be that they had good communication with their colleagues and fulfillment of their self-esteem needs while there was non-supportive environment.

The community healthcare providers perceived their QWL as average; nurses in tertiary hospitals, namely, YGH[25] and MGH,[26] reported to have reasonably well QWL, whereas those working in secondary hospitals, i.e., general hospitals in Yangon regions, had low QWL.[27] The levels of QWL vary depending on the context. The QWL levels must be considered regardless of how it relates to the context and culture of tertiary hospitals such as YGH and MGH in central cities, secondary hospitals such as general hospitals, and PHC settings in districts, townships, and urban and rural areas. The QWL in public health must be promoted for commitment toward organizational targets considering its effects on work ability and performance. Most nurses in Portugal had low QWL levels.[28] In addition, PHC nurses are satisfied with their QWL in general. However, some barriers affect the professional quality of life, such as educational status, monthly income, work unit, and the work environment.[11]

In this study, the QWL influences the work ability of community healthcare providers. The QWL positively and weakly affected the work ability of community healthcare providers in Yangon. The result of the present study confirmed previous findings of a correlation between work ability and quality of working life.[8] Improving QWL factors can increase individual performance and quality care in meeting population needs and promoting coverage to attain population health targets, particularly maternal and child health and disease controls.

The study population included community healthcare providers in the PHC setting in Yangon. Therefore, the results should not be generalized to other populations or settings. Further research is needed in other healthcare settings such as secondary and tertiary levels. Based on the findings, healthcare administrators should promote the work ability and QWL of community healthcare providers in PHC settings and maintain their work environment.

CONCLUSIONS

Based on the results of this study, community health and nursing administrators can promote a healthy work environment and QWL. This will improve the work ability of community healthcare providers and, thus, the provision of primary care and primary prevention.

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CONFLICT OF INTEREST

The authors report no conflict of interest.

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