

# Organizational Commitment of Health Professionals and Associated Factors in Government Health Facilities of Gurage Zone, South Ethiopia

Gebremariam Hailemichael Nima<sup>1</sup>, Mirkuzie Woldie Kerie<sup>2</sup>, Gebeyehu Tsega Nebeb<sup>2, \*</sup>

<sup>1</sup>Department of Public Health, Wolkite University, Wolkite, Ethiopia

<sup>2</sup>Department of Health Policies and Management, Jimma University, Jimma, Ethiopia

## Email address:

ghaile81@yahoo.com (G. H. Nima), mirkuzie@yahoo.com (M. W. Kerie), gebishtgmail.com (G. T. Nebeb)

\*Corresponding author

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**Abstract:** There is a general conviction that organizational commitment has a positive and significant impact upon business performance and reform process of health systems. However, to the best of the investigators knowledge, there are no studies examining organizational commitment in the health care setting of Ethiopia. Hence the objective of this study is to assess the level of organizational commitment and associated factors among health professionals in government health facilities of Gurage zone, south Ethiopia. A facility based cross sectional study was conducted in 30 health centers and one general hospital from March, 20/2014 to April, 12/2014 in Gurage zone, south Ethiopia. A total of 424 health professionals were included in this study. A self-administered questionnaire asking about socio-demographic and economic characteristics of the participants, organizational commitment, job satisfaction and perceived organizational support was used. Factor analysis was conducted to identify the measurement scales and factor scores were used in both binary and multiple linear regressions. The percentage mean score of organizational commitment for health professionals working in government health facilities of Gurage zone was 64.81%. This study found that perceived leadership style and training opportunity, perceived value and care for employee and perceived remuneration were predictors of organizational commitment. Moreover, perceived staff interaction and perceived resource availability and work setting were factors affecting organizational commitment in this study. The percentage mean score of organizational commitment for health professionals working in government health facilities of Gurage zone was comparable to those reported from other developing countries. Hence, health managers and policy makers has to work on designing human resources management system with arrangements for training opportunities, reasonable reward and recognition system and appropriate leadership approaches to promote commitment among health professionals.

**Keywords:** Health Professionals, Commitment, Organization, Satisfaction, Perceived Support

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## 1. Introduction

In addition to high competition health facilities confront for scarce resources, they are also severely challenged by the internal and external environments [1]. Health facilities must have committed health work force if they are to achieve their goals effectively and efficiently or even to survive. This point has been well recognized in the organizational behavior area,

where a considerable amount of research has been undertaken to understand organizational commitment and its correlates better [2, 3].

Organizational commitment has been defined as a multidimensional construct: "The relative strength of an individual's identification with and involvement in a particular organization. Conceptually, it can be characterized by: (a) a strong belief in and acceptance of the organization's goals and

values; (b) a willingness to exert considerable effort on behalf of the organization; and (c) strong desire to maintain membership in the organization” [4].

Meyer & Allen (1991) also defined organizational commitment based on a framework that was designed to measure three different types of it: (a) *Affective commitment* refers to employees’ emotional attachment, identification with, and involvement in the organization. (b) *Continuance commitment* refers to employees’ assessment of whether the costs of leaving the organization are greater than the costs of staying. (c) *Normative commitment* refers to employees’ feelings of obligation to the organization [5]. In arguing for their framework, the authors contended that affective, continuance, and normative commitments were components rather than types because employees could have varying degrees of all the three. [6].

Moreover, organizational commitment is characterized as a shared belief and acceptance of the values and goals of the organization. It is also manifested as the eagerness to go above and beyond the call of duty to enhance the organization's goals and values, as well as the desire to maintain membership with the organization [7].

Achieving an elevated level of employee organizational commitment is considered as one of the main goals of human resources management in many companies including those in the health sector. Indeed, there is a general conviction that organizational commitment has a positive impact upon business performance of an organization. [8].

Organizational commitment is an ongoing process through which organization’s members devote their effort for the organization and its continued success and well-being. So commitment represents one useful indicator of the effectiveness of an organization [3].

The quality of health systems critically depends on the size, skill mix and commitment of the health workforce. Commitment has a strong association with employee retention and job performance in health professions [9]. For the organization, the rewards of commitment can mean increased employee tenure, limited turnover and reduced costs. In addition it enhances greater employee job satisfaction, acceptance of organization’s demands, and the meeting of organization’s goals such as high quality of care [10, 11]. Further, there is an improvement in customer satisfaction because long-tenure employees have better knowledge of work practices, and customers like the familiarity of doing business with the same employees [12].

In Ethiopia the health system is facing many challenges related to shortage of health professionals in different disciplines and at all levels. Low density and low training output for key human resources for health (HRH) categories, poor HRH management, high attrition rates, and massive geographic imbalances are other problems of the health system [13].

Job turnover is typically high early in one’s career. About 52% of the nurses and 60% of the doctors in Ethiopia have stated that they planned to migrate abroad in the year 2009.

Those health care workers were serious about their intention to migrate. This is clear from the fact that more than 80% of them have applied for a lottery visa, or DV, which would allow them to leave the country [14]. The main causes for attrition were low salary followed by lack of educational opportunity, poor career structure and other benefits [13]. Given the lack of empirical evidence in relation to level and determinants of organizational commitment in the country, there is no choice but to assume that these factors have resulted in low level of commitment among health professionals in Ethiopia.

Cognizant of this lack of evidence we designed this study to assess the level of organizational commitment and associated factors among health professionals in government health facilities of Gurage zone, south Ethiopia. Hence, the questions we posed were: (1) What is the percentage mean score of organizational commitment of health professionals working in public health facilities of Gurage zone, south Ethiopia; (2) What individual and organizational factors predict organizational commitment score among the health professionals?

## 2. Methods and Participants

### 2.1. Study Area and Design

A facility based cross sectional was conducted from March, 20 to April, 12/2014 in Gurage zone which is located in the Southern nation’s nationalities and people’s regional state (SNNPR) of Ethiopia. During the conduct of this study there were 4 hospitals in the zone, among these only one; Butajira general hospital, was governmental and the remaining 3 were non-governmental. On the other hand, among the total 71 health centers those delivering health services in the zone, 64 were governmental and others (7) were owned by non-governmental organizations. About 397 rural health posts were fully functional. There were a total of 1066 health professionals working in the health facilities in the zone [15].

### 2.2. Participants

From a total of 13 woredas (districts) and 2 towns in Gurage zone 7 woredas and 1 town administration were randomly selected. Butajira general hospital and all health centers found in these woredas and the Butajira town were included in the study. Then, all health professionals working in these health facilities were targeted for the study. Consequently, a total of 424 health professionals (339 from health centers and 85 from Butajira general hospital) were interviewed. Health professionals who have served for at least six months before the date of data collection were eligible for this study.

### 2.3. Study Variables

The dependent variable in this study was *organizational commitment score*. The explanatory variables were socio-demographic and economic variables, perceived leadership style and professional training, perceived resource availability

and work setting, perceived promotion opportunity, perceived remuneration, perceived staff interaction, perceived concern for employee and perceived value and care for employee.

#### 2.4. Data Collection Technique

Data were collected using pre-tested self-administered structured questionnaire. The study population was invited to participate voluntarily by explaining the rationale of the study at the time of data collection. Trained data collectors were used to distribute questionnaires for the health professionals during their tea or lunch breaks and at the beginning or end of work hours. Written guideline was given to the administrators of the questionnaire to assure that each health professional receives the same direction and information.

#### 2.5. Study Tools

The tool consisted of four parts. Part one was on socio-demographic and economic data that comprised of 10 items. Part two had 23 items of 5-point Likert scale to measure job satisfaction [16]. Part three contained 8 items of 7-point Likert type scale to measure perceived organizational support [17]. And part four was made up of 9 items adapted from the Organizational Commitment Questionnaire used in earlier works [18, 19]. The response categories were 7-point Likert scales ranging from 1 strongly disagree to 7 strongly agree. After conducting factor analysis the following factors/scales emerged as part of the tools:

*Organizational commitment:* Only one factor with Eigen value greater than one was extracted. This scale explained 49.53% of the variability in organizational commitment among the respondents. This scale was reliable as evidenced by the Cronbach's alpha value of 0.869.

*Perceived organizational support:* Two factors with Eigen value greater than one were extracted. These two factors explained 55.03% of the variability in perceived organizational support among the respondents. Four items load on to each of the two factors and items which loaded on to factor one include: the organization fails to appreciate any extra effort from me; the organization would ignore any complaint from me; even if I did the best job possible, the organization would fail to notice and the organization shows very little concern for me. This scale was named as "*perceived appreciation of employee scale*". The second factor had four items: the organization values my contribution to its well-being; the organization really cares about my well-being; the organization cares about my general satisfaction at work and the organization takes pride in my accomplishments at work. This scale was named as "*perceived value and care for employee scale*". The reliability coefficients of perceived value and care for employee and, perceived appreciation of employee scales were 0.754 and 0.708, respectively.

*Job satisfaction:* Five factors with Eigen value greater than one were extracted. These five factors explained almost 61% of the variability in job satisfaction among the respondents.

Nine items including I receive recognition for tasks well

done; adequate consideration is given to my personal needs; I have enough freedom to decide how I do my work; I have support to be fully accountable for those decisions; I have the freedom to work alone on the job; the management does involve staff in decision making; there are training opportunities available to me; Training programs are appropriate to enhance my professional job performance; my organization gives training and orientation to new staffs well were load on to factor one. This factor was named as "*perceived leadership style and training opportunity scale*". This scale had a reliability coefficient of 0.808.

Three items, I have a good working relationship with my colleagues; there is a clear channel of communication at my workplace and I can depend on my colleagues for support load on to factor two and it was named as "*perceived staff interaction scale*". The reliability coefficient of this scale was 0.874.

I have enough support for continuing education; I have sufficient opportunity for professional growth and I get support for personal growth and development through education and training were the other three items load onto factor three. This scale was named as "*perceived promotion opportunity scale*". The reliability coefficient of this scale was 0.766.

The fourth factor comprised of four items including there is an atmosphere of co-operation between staff & management; my working environment encourage me to make adjustment in my professional practice to suit patient needs; I have sufficient time for each clients and I do not experience frustration in my work due to limited supply. This scale was named as "*perceived resource availability and work condition scale*" and had reliability coefficient of 0.722.

The last factor included three items: my income is a reflection of the work I do; I get compensation for working weekends and my job has more advantages than disadvantages. This scale was named as "*perceived remuneration scale*". The reliability coefficient of this scale was 0.766.

The item "adequate Consideration is given to my opinion and suggestion for change in the work setting" was deleted because it loaded on factor two and three equally. Only items having a communality of >0.4 on factor analysis were retained in this study.

#### 2.6. Data Processing and Analysis

Editing and sorting of the collected questionnaires was done manually every day to check for completeness. The completed questionnaire were coded and entered into a data entry template in EPI-DATA version 3.1. After double entry verification, the data were exported to SPSS version 16.00 for analysis. The negatively worded items were reverse scored.

All assumptions of multiple linear regressions were checked. Normality of distribution was checked by observing p-p plot and all the points were laid on the normality line. Linearity was checked by observing scatter plot and showed the proportional distribution of dependent and independent variables. Multicollinearity was checked by examining the variance

inflation factors (VIF) and all the values of VIF were less than ten which signals absence of Multicollinearity. Finally, homoscedasticity was checked by observing all residual and scatter plots. So, all plots and contained points were of the same width. This was also checked by observing the box plots.

In addition to this, all the assumptions of factor analysis were checked. Bartlett's Test of Sphericity was checked and it was significant at ( $p=0.001$ ). This indicated it was possible to conduct factor analysis. Sampling adequacy for factor analysis was checked with Kaiser-Meyer-Olkin Measure of Sampling Adequacy and all of the results in this measure were  $>0.5$ .

Raw means, standard deviations, mean scores, summary tables, and graphs were used for describing the data. Simple linear regression was conducted and significant variables at  $p$ -value  $<0.25$  were candidate for multiple linear regressions. T-test was used for comparing organizational commitment scores between health centers and the hospital.

Factors predicting organizational commitment were identified by using multiple linear regression analysis at a significance level of  $p$ -value  $< 0.05$ . The reduced model was constructed using backward model selection method.

### 2.7. Data Quality Control

The questionnaire initially prepared in English was translated into the local language (Amharic) and was back translated into English to ensure consistency. The study tools were pre-tested on 25 health professionals working in a nearby hospital, Hosanna Nigist Eleni hospital. Participants of the pre-test were contacted to give their general feelings, comments and problems encountered while responding to the questions. Based on this relevant modifications were made before the start of the actual data collection.

Four nurses (holding BSc. Degree) and one MPH holder were recruited as data collectors and research assistant, respectively.

Data collectors were trained for one day. During the training overviews regarding organizational commitment and its impact on health care delivery system was communicated. Effective data collection methods and ethical issue during data collection were discussed. Both the PI and the research assistant were responsible for supportive supervision and checking filled questionnaires on daily basis. Double entry verification was done to assure quality of the data.

### 2.8. Operational Definitions and Measurement

Job satisfaction is positive or pleasurable emotional state resulting from the appraisal of one's job or job experience. It was measured with five Likert type scales on five points where 1 implied very dissatisfied and 5 very satisfied. During analysis factor scores were generated for each of the scales and higher scores implied higher job satisfaction. Below are the definitions of each scale as used in this study.

*Perceived remuneration:* It includes wage, benefits and incentives or other payments in the organization.

*Perceived promotion opportunity:* It denotes both career

development and opportunity for further education upgrading in once organization.

*Perceived resource availability and work condition:* Refers to the situation in which the professionals work in and the presence of adequate supplies and time for each client.

*Perceived leadership style and professional training:* It refers to how the organization treats the health professionals and the presence of on the job or off the job training programs for the health professionals.

*Perceived staff interaction:* It is about relationship that is warm or bad with anyone in the organization.

*Perceived Organizational Support:* refers to the extent to which employees feel that the organization recognizes their contribution and cares about their well-being. It was measured using two scales each having 4 items. The responses of the professionals was obtained along a scale of 5 points where 1 was for strongly disagree and 7 for strongly agree. Scores were generated using factor analysis and higher scores implied higher level of perceived organizational support.

*Perceived value and care for employee:* It is about the degree to which the organization acknowledges the efforts of health professionals and care for their wellbeing.

*Perceived appreciation of employee:* It is the way how the organization is being open to the needs and questions of the health professionals.

*Organizational commitment:* is the relative strength of an individual's linkage to the organization. The scale for this variable had 9 items measuring along 7 points where 1 denoted strongly disagree and 7 strongly agree. Organizational commitment score was created and higher score indicated higher organizational commitment.

### 2.9. Ethical Consideration

Ethical approval was obtained from the Public Health and Medical Sciences Collage of Jimma University ethical clearance committee. Permission letter was obtained from the Gurage zone health department and respective woredas health offices. Written informed consent was obtained from each study participant.

Anonymity of the participant was kept by informing them not to write their name and individual's information was not disclosed to other person or party. Participants were told that they had full right to participate or refuse participation in the study.

## 3. Results

### 3.1. Characteristics of the Respondents

From a total of 424 questionnaires distributed, 408 (96.2%) questionnaires were returned. Eleven of these questionnaires were discarded due to incompleteness with the remaining 397 questionnaires fully completed. These yields a response rate of 93.6% (397/424). More than half (52.4%) of the respondents were males. Almost two third of the respondents (60.7%) were single. The average age of the participants was 26.31 (SD 5.802) year with a range of 18 to 56 years. The median year of

work experience at the current health facility was 2 (SD 3.48) years, ranging from six month to 31 years. Two hundred three (50.9%) were nurses with 280 (70.5%) of these having diploma level educational qualification. Three hundred twenty (80.6%) participants were from health centers and 243 (61.2%) of the participants live in urban areas. Forty eight (12.1%) of the participants were serving on a managerial position. The median net monthly salary was 1233Birr [SD 614.10 Birr], ranging from 1000.00 Birr to 5,000.00 Birr (1 US dollar=19.75 Ethiopian Birr during the data collection period) (Table 1).

**Table 1.** Sociodemographic and economic Characteristics of health professionals, Gurage zone, South Ethiopia, 2014 (n=397).

Variable	No (%)	
Sex	Female	189 (47.6)
	Male	208 (52.4)
Age	18-23	126 (31.7)
	24-29	199 (50.2)
	30-35	43 (10.8)
	36	29 (7.3)
Marital status	Single	241 (60.7)
	Married	149 (37.5)
Work experience	Widowed/divorced	7 (1.8)
	≤2	234 (58.9)
Qualification	2.01-5	115 (29.0)
	5.01-10	30 (7.6)
	>10	18 (4.5)
	Diploma	279 (70.2)
Residence	First-degree	114 (28.6)
	Postgraduate	4 (1.2)
	urban	243 (61.2)
Working institution	Rural	154 (38.8)
	Health center	320 (80.6)
Type of post	Hospital	77 (19.4)
	Managerial	48 (12.1)
Profession category	None managerial	349 (87.9)
	Nurse	202 (50.9)
	Midwifery	46 (11.6)
	Health officer	49 (12.3)
	Medical lab/ technicians	42 (10.6)
	Pharmacist/druggist	40 (10.1)
	Others <sup>1</sup>	18 (4.5)

<sup>1</sup>Othersmedical doctor, x-ray, optometrist and anesthesia

### 3.2. Level of Organizational Commitment

Percentages mean score of health professionals for organizational commitment who participated in this study was 64.81%. On the other hand, raw mean score for this scale was 43.99± 1.2.

### 3.3. Level of Perceived Organizational Support and Job Satisfaction

Perceived organizational support percentage mean score was 56.06% for perceived value and care score and 55.22% (Table

2) for perceived concern for employee score.

**Table 2.** Mean scores for perceived organizational support amongst health professionals, Gurage zone, South Ethiopia, 2014 (n=397).

Factors emerged (scales)	Mean raw score±SD	%SM
Perceived appreciation of employee	17.25±4.74	55.22
Perceived Value and care for employee	17.45±4.8	56.06

%SM is the Standardized score as the percentage of possible maximum scale score, and it lies between 0 and 100

For the job satisfaction part mean score was (66.1%) for perceived Promotion opportunity and (29.64%) for perceived remuneration (Table 3).

**Table 3.** Mean scores for job satisfaction among health professionals, Gurage zone, South Ethiopia, 2014 (n=397).

Factors emerged (scales)	Mean raw score±SD	%SM
Perceived leadership style and training opportunity	25.62±9.11	46.16
Perceived staff interaction	13.24±2.35	64.81
Perceived promotion opportunity	10.93±2.98	66.10
Perceived resource availability and work condition	13.88±3.98	61.78
Perceived remuneration	6.56±2.82	29.64

%SM is the Standardized score as the percentage of possible maximum scale score, and it lies between 0 and 100.

Predictors of organizational commitment.

### 3.4. Background Characteristics as Predictors of Organizational Commitment

In this model background variables such as age, gender, marital status, qualification, work experience, profession, type of working facility, type of post, area of residence and net monthly salary were entered. This model explained only 3.6% variability in organizational commitment among the participants (adjusted R square=0.036, p=0.152). Among these variables only sex of the respondent (p=0.242), marital status (p=0.216) and the type of health institution in which the respondents work (p=0.018) were a candidate for multiple linear regression. The result of independent t-test showed that organizational commitment mean score of health professionals were significantly different between hospitals (59.45%) and health centers (66.10%) (p=0.022).

### 3.5. Perceived Organizational Support as Predictor of Organizational Commitment

In this model, two factors related with organizational support were entered. Perceived appreciation of employee score had no statistically significant effect on the organizational commitment score (p=0.876). On the other hand, perceived value and care for employee score was a significant predictor of organizational commitment score (p<0.0001, B=0.524, 95%CI=0.440, 0.608). This model explained almost 27.0% (adjusted R square=0.271) of the variance in organizational commitment (Table 4).

**Table 4.** Perceived organizational support related predictors of organizational commitment of health professionals, Gurage zone, South Ethiopia, 2014 (n=397).

Perceived organizational support related factors	Unstandardized Coefficients	Standardized Coefficients	P value	95% CI for B	
	B	Beta		Lower	Upper
perceived concern for employee	-0.007	-0.007	0.876	-0.084	0.084
perceived Value and care for employee	0.524	0.524	0.000*	0.440	0.608

R=0.524, R Square=0.275, Adjusted R Square=0.271, \* significant at p value < 0.0001

### 3.6. Job Satisfaction as Predictor of Organizational Commitment

Five factors related with job satisfaction were entered in this model. Out of which four were significant predictors of organizational commitment. Perceived leadership style and training opportunity was the strongest predictor (B=0.363, 95%CI=.279, 0.446) followed by perceived remuneration (B=0.278, 95%CI=0.195, 0.362). The other two predictors

were perceived resource availability and work condition (B=0.219, 95%CI=0.136, 0.303) and perceived staff interaction (B=0.195, 95%CI=0.111, 0.278). On the other hand, perceived promotion opportunity had no statistically significant relation with organizational commitment score (p=0.586). Almost 29% of the variance in organizational commitment was explained by this model (adjusted R square=0.287, p<0.001) (Table 5).

**Table 5.** Job satisfaction related predictors of organizational commitment of health professionals, Gurage zone, South Ethiopia, 2014 (n=397).

Job satisfaction related predictors	Unstandardized Coefficients	Standardized Coefficients	P value	95% CI for B	
	B	Beta		Lower	Upper
Perceived leadership style and training opportunity	0.363	0.363	0.000**	0.279	0.446
Perceived staff interaction	0.195	0.195	0.000**	0.111	0.278
Perceived promotion opportunity	0.023	0.023	0.586	-0.060	0.107
Perceived resource availability and work condition	0.219	0.219	0.000**	0.136	0.303
Perceived remuneration	0.278	0.278	0.000**	0.195	0.362

R=0.544, R square=0.296, adjusted R square=0.287, \*\* significant at P value <0.0001

### 3.7. Independent Predictors of Organizational Commitment

Those variables which had statistical significant association with organizational commitment in the preceding three models were entered into the final model. This model explained almost 35% (Adjusted R Square=0.347) the variability in the organizational commitment. None of the background variables were significant predictors in the final model.

In this study a one unit increment in perceived value and care for employee score resulted in 0.304 unit increase in the organizational commitment score of health professionals (95%CI: 0.203,0.411). Similarly, there was positive relationship between perceived leadership style and training opportunity score and organizational commitment score.

So a unit increment in perceived leadership style and training opportunity score increased organizational

commitment score by 0.237 units (95%CI: 0.130,0.316).

The other predictor variable of organizational commitment was perceived staff interaction score. It was found that a unit increment in the perceived staff interaction score leads to an increment of organizational commitment score by 0.125 (95%CI=0.045, 0.211). It was also noted that one unit increment in the perceived remuneration score of the professionals increased their organizational commitment score by 0.207 (95% CI, 0.121, and 0.289).

Moreover, this study showed positive relationship between perceived resource availability and work condition score and organizational commitment score. Hence, a unit increase in the perceived resource availability and work setting score results in a change of 0.117 units in the organizational commitment score (95%CI=0.032, 0.207) ( Table 6).

**Table 6.** Independent predictors of organizational commitment of health professionals, Gurage zone, South Ethiopia, 2014 (n=397).

Variables	Unstandardized Coefficients	Standardized Coefficients	P value	95% CI for B	
	B	Beta		Lower	Upper
Perceived leadership style and training opportunity score	0.237	0.237	0.000**	0.130	0.316
Perceived staff interaction score	0.125	0.125	0.003*	0.045	0.211
Perceived value and care for employee score	0.304	0.304	0.000**	0.203	0.411
Perceived resource availability and work setting score	0.117	0.117	0.008*	0.032	0.207
Perceived remuneration score	0.205	0.205	0.000**	0.121	0.289
Sex of respondent	-0.143	-0.071	0.086	-0.306	0.021

R=0.597, R Square=0.357, Adjusted R Square=0.347, \* significant at p value <0.01 \*\*significant at p value <0.001

## 4. Discussion

The results of this study point out that Organizational Commitment percentage mean score of health professionals who participated in this study was 64.81 (%SM). This result was higher than the result of research done on nurses in Saud Arabia where the organizational commitments mean score of nurses was 57.43%. It was also better than the organizational commitment mean score of health workers in Nigeria which was 55.15% [19]. This may be due to the low reward system with mean score of 15.58% which was provided to the health care workers in the Nigerian case. On the contrary it was somewhat lower than the result of research done on nurses in Taiwan in which the organizational commitment mean score of nurses was 67% [20, 21]. This may be due to the benefits, including pension benefits, housing loan, car loan and medical benefits which were provided by the organization to the nurses in the case of Taiwan.

One of the determinant factors of organizational commitment in the present study was job satisfaction. Satisfaction in relation to perceived leadership style and training opportunity score, perceived staff interaction score, perceived resource availability and work condition score, and perceived remuneration score were found to be important predictors.

This finding is congruent with the findings of previous studies that showed some of the components of job satisfaction were influential in explaining organizational commitment among health professionals [22-28, 29].

This study demonstrated that perceived leadership style score have a significant influence on health professionals' organizational commitment score. This finding is similar with the result of two researches done on medical emergency employees and nurses in Iran [30, 27]. Hence, it shows that as the perceived style of leadership is welcoming and free of imposing force; their organizational commitment will stay stronger. It is clear that at the heart of each and every health system, the work force is central to advancing health. Hence, by exercising appropriate leadership style it is possible to create a more committed work force which sufficiently contributes to efforts of building effective and efficient health system.

Perceived training opportunity score was the other scale that affected the organizational commitment score of the participants. The same result was reported by research from Ekiti State of Nigeria on health care workers [19]. This can be explained as training can help health professionals to cope better with the requirements of their job. It can also enable them to take on more demanding duties and positions and to achieve personal goals of professional advancement.

On the other hand, perceived promotion opportunity score was not significantly associated with organizational commitment. This finding is in contradiction with the findings of researches done on employees of pharmaceutical organizations in England and nurses in Taiwan [31, 32]. This

may imply that health professionals in this study were more satisfied with short term benefits like professional training than educational opportunity or career structures which are beneficial only in the long run.

Perceived staff interaction score was the other predictor of organizational commitment in this study. This finding was consistent with studies which showed positive association between staff interaction and organizational commitment [27, 29]. These imply health professionals who were satisfied with the communication and interaction among staffs and the support they get from their staffs were more likely to be committed to their organizations. But contrary to these findings a study from Sultanate of Oman conducted among employees of the service industry concluded that level of staff interaction did not predict organizational commitment [24]. The similarity in the age of the health professionals in this study than the previous study may have contributed to the relationship picked in this study. This may encourage a positive interaction and a good team work among them. In turn this can create strong bonds and encourage teamwork as well as increasing the affection and sense of belongingness to the institution.

Another factor which was found to predict organizational commitment score of health professionals was perceived resource availability and work setting score. The working environment of the organization does not include only the physical infrastructure, but also the modern tool, technology and machinery available in the health facility. So the presence of adequate supplies and; the comfortability of work setting to make adjustment to suit patient needs affect organizational commitment positively.

Other researches did elsewhere support this fact [22, 26-33]. These results indicates that if health professionals have attractive work setting and get all needed resources on time to fulfill client needs they can be satisfied with their job and consequently become committed to their organization.

Perceived level of remuneration was also a predictor of organizational commitment in this study. This result was supported by findings of other researches [30, 24]. However, an earlier study among hospital nurses in Malaysia found no relationship between the perceived level of pays and benefits and organizational commitment [29]. The difference in this regard may relate to the amount of pays and benefits in different settings. In this study, mean scores for job satisfaction among health professionals related to perceived remuneration score was only 29.64%. If health goals are going to be achieved there should be highly committed health human power. So paying fair wage and incentives may be one of the means to create a committed health human power.

The other factor which affected organizational commitment of health professionals in this study was perceived organizational support. It showed that whether or not individual health professionals perceive valued and cared for by their organization matters in terms of building a committed work force. Studies done on radiographers in South Africa, on medical doctors in Chandigarh (North India) and others

elsewhere showed similar results [34-37]. So, it appears that health professionals with higher scores of perceived value and care are more likely to be committed to their organization. They may also be willing to engage in extra roles than those employees who feel that the organization does not value their effort and fail to care about them.

None of the background variables, like years of experience and age show any predictive effect on the organizational commitment score of the health professionals. However, several earlier studies including researches done on the health care sector in Iran found significant relationships between these variables and organizational commitment [23-24, 38, 39, 40]. These studies implied higher work experience or higher age might bring too much benefit such as high salary and position to the employee. The absence of significant association in this study might imply that benefits difference due to age or years of experience in this study setting may be little or none.

The main limitation of this study was respondent bias. This might occur because respondents may perceive the survey as an opportunity to voice their grievances in the hope of their complaints will be addressed.

## 5. Conclusions

Level of organizational commitment among health workers of government health facilities in Gurage zone was higher than those reported in several studies conducted elsewhere in the world. It was showed that job satisfaction is an important predictor of organizational commitment score. More specifically, perceived leadership style and training opportunity was an important predictor of organizational commitment of health professionals. According to the findings of this research the presence of strong perceived staff interaction and perceived availability of adequate resource in ones working health facility can lead to higher level of organizational commitment. Moreover, the perceived suitability of work setting and the perceived fair provision of remuneration were the other instruments to increase organizational commitment. Finally, from the findings of this study it can be concluded that organizational commitment is much more influenced by organizational factors than personal factors.

## Recommendation

This research Taking note of the findings in this study several measures could be recommended to positively affect organizational commitment among health professionals. At the organizational level, health managers should demonstrate practically that they appreciate the efforts of the employees in their organizations and they really care for every one under their supervision. This requires taking practical measures including public and individual appreciation of individual professionals. Moreover, health managers should adopt leadership styles which are suitable to the situational variables in their organization including the characteristics of the health professionals they manage. It also recommended that in-service

training opportunities are arranged and all the necessary resources are availed in the health facilities. On the other hand, factors such as perceived level of remuneration are amenable only to policy level intervention in the Ethiopian context since salaries and benefit packages should be revised to fairly satisfy the health professionals thereby affecting their organizational commitment.

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