

The Role of the Psychological Contract on Health Care Workers' Commitment in Public Health Sector in Uganda: A Case Study of Medical Doctors in Mulago National Referral Hospital (MNRH)

S. S. Najjuma¹, J. C. Okiria², R. C. Nanyonga³

^{1,2} International Health Sciences University, Kampala-Uganda

Abstract: *This study assessed the role of the psychological contract on the commitment of health care workers in public health care facilities of Uganda, with specific reference to medical doctors in Mulago National Referral Hospital. Specifically, the study sought to assess the effect of the transactional factors; relational factors and organizational support, towards health care workers' commitment and establish whether there is an association between health workers' commitment and the quality of healthcare service delivery. A cross sectional research design was used, adopting both qualitative and quantitative approaches of data collection and analysis. A sample of 146 respondents was identified, and out of these, 112 dully completed and returned the questionnaires, while 04 responded to the interviews. Overall, the response rate was 79.4%. Quantitative data was analyzed using descriptive statistics, factor analysis, One-sample test, Pearson correlation and regression analysis techniques, while qualitative data was summarized and presented using verbatim statements. The findings showed that; the transactional factors accounted for 40.1% of the variation in health workers' commitment; the relational factors were positively related to health workers' commitment by 31%, while organizational support was also cited to play a significant role towards health care workers' commitment, indicating a correlation coefficient of .489**. Notably still, 53% of the doctors who participated in the study indicated that they preferred working in NGOs, compared to 26% who preferred working with Government. Among the factors explaining the transactional aspects, poor pay and rewards was key in influencing health care service delivery in public health care facilities, with 61% of the respondents attesting to it. From the relational factors, 42% cited poor work environment as having very high influence on the quality of health care service delivery, while 45% pointed at lack of support from the employer as a major factor influencing the quality of health care service delivery. Further, using the One-sample Test, it was noted that poor pay and rewards registered the highest mean difference of 4.223, implying that it had the greatest effect on health workers' commitment and the quality of public health care service delivery, followed by lack of employer support and poor work environment. The study thus recommends that Ministry of Health should come up with a competitive compensation package, especially for the medical doctors; management of MNRH should develop transparent strategies for career growth of the doctors and devise means such PPP to ensure the work environment is safe and conducive to her staff. Lastly, management of MNRH together with the planning and Human Resource departments should devise means to improve staff welfare.*

Keywords: Psychological Contract, Commitment, Transactional factors, Organizational support, Reward.

1. Introduction

A modern health system that can provide high quality care has a trickle – down effect on the quality of life of the individual, the citizens in general and the overall economic development of a country (Nketiah-Amponsah, 2009). This study was conducted to investigate whether the psychological contract had an effect on health workers' commitment and subsequently, the quality of healthcare service delivery in public healthcare facilities in Uganda, with particular focus on Mulago National Referral Hospital (MNRH) doctors. Quality of healthcare services is about the way services are perceived in terms of accessibility, timeliness, appropriateness and responsiveness to the needs of the customers.

The government of Uganda constructed health centres at various levels in different parts of the country. However, empirical evidence shows that a good number of these centres either did not have consistent supply of drugs or they had inadequate staff. This state of affairs has implications on the quality of health care service delivery. A psychological contract is one of the intangible salient aspects in the employees' level of commitment.

The concept of the psychological contract started in the 1960s, with the writings of Argyris (1960) and is used in reference to the relationship between the employer and employee in the work context, with reference to the covert expectations of each party from the other. The Psychological Contract thus refers to the relationship between an employer and its employees, and specifically concerns mutual expectations of inputs and outcomes and covers aspects such as respect, compassion, trust, empathy, fairness, among others (Rousseau, 2003). In an employment relationship, the psychological contract refers to the perceived fairness or balance between how the employee is treated by the employer and what the employee puts into the job. Thomas, *et al.*, (2003) defined the psychological contract as an unwritten agreement between the individual and the organization, about the terms of employment. Parks, Kidder and Gallagher (1998) further defined the psychological contract as the employees' perception of reality that shapes their expectations, attitudes and behaviors. Therefore, to understand employee attitudes and behaviors, it is necessary to understand their perceptions of reality.

The psychological contract is psychological and exists in the minds of the employees. Rousseau, (1989) looked at the psychological contract as a set of beliefs held by the

employees about the organization's obligations to them, adding that psychological contracts are subjective, dynamic and subject to change over time. In line with the same, (Rousseau, 1995) defines the psychological contract as the beliefs of an individual as shaped by the organization in respect to the terms of agreement between them (individuals) and the organization. Rousseau (ibid) adds that in the event that the employees perceive that their psychological contract has been violated, there is likelihood of increased staff turnover, reduced employee commitment and motivation; this may have negative effects on the quality of healthcare service delivery. Violation of the psychological contract invokes responses of disappointment, frustration and distress.

2. Theoretical Framework

The concept of the psychological contract can be explained through various theories, such as Rousseau's psychological contract theory, the Iceberg model, the Agency theory and motivational theories, among others. This study about the psychological contract and health workers' commitment in public health care facilities was largely underpinned by Rousseau's (1995) psychological contract theory.

Statement of the problem

One of the major issues highlighted as facing the health workforce in Uganda is dissatisfaction, as a result of perceived low salaries and allowances (Matsiko 2005). Further, MoH (2009) observed that the inability of systems to recruit and retain sufficient numbers of health professionals, especially skilled workers, is one of the biggest challenges for the health sector in Uganda. The poor work conditions do not help matters in attracting staff or even motivate them to stay, contributing to the high staff turnover. The low morale further results into poor attitude of the health workers towards the patients (clients), increased absenteeism and low productivity (Matsiko 2010). Consequently, as MoH (2009) observed, the quality of healthcare provided is perceived as poor by clients and patients, leading to low utilization of health services, most especially in the public sector.

In 2008, the MoH came up with what were thought to be initiatives towards quality healthcare service delivery in Uganda. In the human resource motivation and retention strategy, the following aspects were highlighted as underlying causes of human resources for health (HRH) problems: HRH management systems, leadership, policy, finance, education, partnership and other health systems, with specific focus on; salaries and benefits, leadership and management, conducive and safe working environment, professional values and ethical practices, health worker incentives, performance management and Continuing Professional Development. However, despite such initiatives, not much significance improvement has been registered in terms of improved quality of healthcare service delivery. It was therefore necessary to investigate the role of the psychological contract in influencing the health workers commitment hence quality of health care services delivered in the public health sector in Uganda.

Main objective

The main objective of this study was to assess the role of the psychological contract on health workers' commitment in public health sector in Uganda.

Specific Objectives

- i. To assess the effect of the transactional factors on health workers' commitment in MNRH
- ii. To assess the effect of relational factors towards health workers' commitment in MNRH
- iii. To assess the effect of organizational support on health workers' commitment in MNRH
- iv. To establish whether there is an association between health workers' commitment and quality of healthcare service delivery in MNRH

Methodology

Research design

This study used a cross sectional research design, adopting both qualitative and quantitative approaches of data collection and analysis. Questionnaires and key informant interviews were used to collect data. While the cross sectional design cannot be used to establish cause – effect relationship, it can look at the relationship or association between the two factors. It was therefore effective in examining the role of the psychological contract towards health workers commitment and quality of healthcare service delivery.

This particular study adopted a two-pronged approach of quantitative and qualitative approaches. The quantitative approach was used to test hypotheses on the lines of the classic hypothetical-deductive model, while the qualitative approach was used to explain the findings and processes at work that rest behind statistical relationships (Reynolds, 1991). Consequently, quantitative methods led to the generalization of results while qualitative methods facilitated a deeper understanding of the problem from the perspectives of the respondents.

Target Population

The target population included all medical doctors in public hospitals in Uganda.

Study population

The study considered the population of doctors in MNRH, including, consultants, senior consultants, physicians, surgeons, medical officers and Heads of departments (who were also medical doctors). Overall, a population frame of 230 doctors was identified and a sample size of 146 used. This selection was based on the premise that related research had shown that they had the highest intention to quit their jobs, with a significant number of them having left for greener pastures elsewhere. This could be an indication of reduced commitment, which could in turn affect the quality of healthcare service delivery.

Sampling procedure

The proportionate stratified sampling technique was first done by level of appointment of the doctors, followed by simple random sampling. On the other hand, the non-probability method of purposive sampling was used to select key informants who included; heads of department, senior consultants and physicians.

Study unit

The study unit considered for this research was the medical doctor at MNRH

Study Variables and their indicators

The independent variables of the study were; transactional contract, relational contract, and organizational support,

while the dependent variable was health workers' commitment. The transactional factors included; remuneration (pay and rewards), benefits and compensation, while the relational factors included the work environment, career development and job security. Organizational support entailed facilitation with transport, essential items for practice and support supervision. Commitment was discussed from the perspective of affective, normative and continuance commitment, as explained in the conceptual framework in chapter one of this study. Finally, quality of healthcare service delivery was measured in terms of responsiveness, accessibility, competence, timeliness, appropriateness and effectiveness of health care services. (Table 1)

Table 1: Study variables

Objective	Variable	Indicators	Data source	Data collection method
1. To assess the effect of the transactional factors on health workers' commitment in MNRH	Transactional factors of the psychological contract	<ul style="list-style-type: none"> • Remuneration • Benefits • Compensation 	<ul style="list-style-type: none"> • Secondary data • Primary data 	<ul style="list-style-type: none"> • Questionnaires • Key informant interviews • Document review
2. To assess the effect of relational factors towards health workers' commitment in MNRH	Relational factors of the psychological contract	<ul style="list-style-type: none"> • Work environment • Career development • Job security 	<ul style="list-style-type: none"> • Primary data 	<ul style="list-style-type: none"> • Questionnaires • Key informant interviews • Observation
3. To assess the effect of organizational support on health workers' commitment in MNRH	Organizational support	<ul style="list-style-type: none"> • Transport facilitation • Provision of essential items • Support supervision 	<ul style="list-style-type: none"> • Secondary data • Primary data 	<ul style="list-style-type: none"> • Questionnaires • Key informant interviews • Document review

Data collection techniques and instruments

A triangulation of methods was used to collect qualitative and quantitative data. Quantitative data was collected using a close ended structured questionnaire, which was arranged along a five-point likert scale, for ease of collection and analysis. This kind of questionnaire was preferred because of its ability to generate more data from a large sample. Semi-structured interview guides were used to collect qualitative data from the key informants.

Data analysis techniques and presentation

Quantitative data was converted into numerical codes and fed into epi-data, after which it was exported to SPSS data processor to generate both descriptive and inferential statistics. The quantitative data was organised and presented in form of tables indicating univariate, bivariate and multivariate analysis, as well as the demographic factors. After the bivariate analysis, the significant variables were further analysed using multivariate analysis. For qualitative data, interviews were reviewed, transcribed, sorted and classified into themes and categories. Patterns and trends were established and the information was reported verbatim or paraphrased where necessary.

Data quality control

The study tools were pretested in two health Center IIIs for better and unbiased results. The tools were reviewed for any unclear issues and to minimize respondents' and interviewer errors.

Validity

Content validity of the instruments was found to be 0.87 since it focuses on the extent to which the content of an instrument corresponds to the content of the theoretical concept it is designed to measure (Amin, 2005).

Amin (ibid) notes that for an instrument to be accepted as valid, the average index should be 0.7 or above. Thus, a validity of .870 as noted above was considered adequate.

Reliability

This was ensured through a test –retest procedure of the questionnaire, which involves administering the same tool twice to the same group of individuals, after a certain time interval has elapsed. The responses were then compared by computing the Cronbach's alpha. Alpha values that were closer to 1 were an indication of stronger internal consistency.

Table 2: Reliability Statistics

Cronbach's Alpha	N of Items
.839	26

The reliability statistics shown in table 2 reflect high reliability coefficients which indicated that all sub areas had been included in their correct proportions. The Cronbach's alpha statistics of .839 is above 0.7, as recommended by Amin (2005). Therefore, the instrument was adopted, since the test had shown that it would yield consistent results over time.

3. Results

Response rate

The response rate was 79.4%. In line with the views put forward by Sekaran (2003) that a response rate of 50% and above is considered acceptable, the response rate of 79.4% was considered adequate to allow for generalization of the study findings.

Background characteristics of the respondents

The background characteristics of the respondents which were considered for this study included; age categories, gender categories, marital status and duration of work in MNRH, as further discussed below;

Table 3: Respondents' age categories

Age range	Frequency (n)	Percentage (%)
20-29	32	28.7%
30-39	53	47.4%
40-49	20	18%
>50	02	1.8%

The mean age of the respondents, seen from the histogram below was 32 years (31.7). This shows that most of the respondents who took part in the study were in their most productive age group. The needs of people in such age group differ much from those who are older; many of such are just starting their families, with many demands of life. As such, they are easily swayed by opportunities that may seem more attractive than the current one; where they cannot achieve that, they may tend to take on more jobs, which can also compromise the quality of their work.

Table 4: Sex categories of the respondents

Sex	Frequency (n)	Percent (%)
Male	74	66.1
Female	35	31.2
Non response	3	2.7
Total	112	100.0

Majority 74 (66.1%) were Males and 35 (31.2%) were female

Table 5: Duration of work in MNRH

Duration of work in MNRH	Frequency (n)	Percent (%)
Less than 1 year	30	26.8
1-2 years	34	30.4
2-5 years	16	14.3
5-10 years	20	17.9
Over 10 years	10	8.9
None response	2	1.8
Total	112	100.0

The results in table 5 show that majority of the study participants (30.4%) had worked for MNRH for a period of 1 – 2 years, followed by 26.8% who had worked there for less than a year. The doctors who had worked for more than 10 years were least represented at 8.9%, implying that most of them were unavailable to take part in the study. The researcher further established that most of the senior doctors were irregular at the hospital facility, since most of such were busy attending to their private clinics and hospitals. This could be an indication of reduced commitment.

Empirical results

Results presented in this section are in line with the specific objectives of the study. The results are presented in terms of descriptive statistics and inferential statistics, at univariate, bivariate and multivariate levels. At the univariate level, the frequency counts and mean scores were used, while correlations were used at bivariate analysis to explain the variable relationships. Finally, the multivariate level comprised of the regression analysis which was done to confirm the correlation results in instances where they were significant, and to show the variation in the dependent variable that was attributable to the independent variable. The regression analysis was also used to show how the independent variables affected the variations of the dependent variable, using the R-square.

Health workers' commitment

Commitment of health workers was measured in terms of affective commitment, continuance commitment and normative commitment. In order to measure health workers' commitment, 07 questionnaire items were presented to the respondents to express their opinions on the same. The results in table 6 show the frequency counts and percentages, as well as the mean responses against each of the items that were arranged on a five-point likert scale of 1-5, where 1 represented strong disagreement, while 5 represented strong agreement. The mean scores above 3.0 were an indication of agreement, while those below 2.5 showed that majority of the respondents disagreed to a given questionnaire item.

Table 6: Health workers' commitment

Health workers' Commitment	Percentage Response (%)					Mean
	SA (5)	A (4)	N (3)	D (2)	SD (1)	
I always look forward to improving the quality of work I am assigned	40 (35.7%)	58 (51.8%)	7 (6.2%)	2 (1.8%)	5 (4.5%)	4.12
I fully understand the patients' needs	30 (26.8%)	54 (48.2%)	19 (17%)	3 (2.7%)	4 (3.6%)	3.94
I think MNRH encourages physical and mental wellbeing of her staff	5 (4.5%)	10 (8.9%)	20 (17.9%)	55 (49.1%)	19 (17%)	2.33
I can easily leave MNRH when I get another opportunity	55 (49.1%)	30 (26.8%)	15 (13.4%)	7 (6.2%)	2 (1.8%)	4.18
MNRH takes steps to retain her employees	6 (5.4%)	3 (2.7%)	21 (18.8%)	47 (42%)	33 (29.5%)	2.11
I feel emotionally attached to MNRH	3 (2.7%)	10 (8.9%)	50 (44.6%)	28 (25%)	18 (16.1%)	2.56
I believe in the mission of MNRH	15 (13.4%)	26 (23.2%)	38 (33.9%)	22 (19.6%)	10 (8.9%)	3.13

Key: SA – Strongly agree; A – Agree; N – Not sure; D – Disagree; SD – Strongly Disagree

Results on commitment of health workers as indicated in table 6, showed that majority of them (87%; M=4.12) always looked forward to improving the quality of work

assigned. However, a significant proportion of them (76%; M=4.18) still indicated that they could easily leave Mulago hospital when and if they got another opportunity. This

shows that while a significant number of them may be working, they may not exactly be fully committed and the only trace of commitment demonstrated is as a result of not having an option (continuance commitment). Further, majority (75%; $M=3.94$) indicated that they fully understood the needs of their patients, which implies that the existing service quality gaps cannot be attributed to inadequacy in skills.

Concerning whether Mulago encourages physical and mental wellbeing of its staff, majority (74%) negated the statement. This shows that there is a general perception of being neglected and that management seems detached from the needs of the health workers; this can result into reduced commitment, which may eventually affect the quality of health care service delivery. Similarly, 72% ($M=2.11$) negated the statement that Mulago takes steps to retain her employees; this indirectly shows that most of the health care workers felt that they had been neglected and the management was not doing enough to deserve their commitment. Such overtones of dissatisfaction among the health care workers could result into reduced commitment and hence affect the quality of health care service delivery.

Overall, the results from the descriptive statistics showed that majority of the health workers who participated in the study exhibited continuance commitment, while affective and normative commitment were rather lacking. This was noted from the majority who indicated that they would easily leave Mulago if they got a better opportunity; implying that their loyalty is only because they do not yet have an option, rather than a felt moral obligation to work with the hospital or an emotional attachment to the hospital. In addition, the absence of affective commitment could be noted from the results which showed that only 11% indicated that they felt emotionally attached to Mulago.

The effect of transactional factors on health workers' commitment in MNRH

The purpose of this theme was to establish the effect of transactional factors on the commitment of health care workers. The transactional factors were construed in terms of; remuneration (pay and rewards) and provision of other benefits, and was measured using five items, as presented in the descriptive statistics in table 7. Further, the correlation and regression analyses were computed, in order to further analyse the nature of the relationship between the two variables.

Table 7: Showing descriptive statistics on transactional factors and health workers' commitment

Transactional factors	Percentage Response (%)					Mean
	SA (5)	A (4)	N (3)	D (2)	SD (1)	
I get fair pay for the responsibilities in my job	0	6 (5.4%)	20 (17.9%)	23 (20.5%)	59 (52.7%)	1.75
My pay is an adequate reflection of my performance	2 (1.8%)	6 (5.4%)	11 (9.8%)	34 (30.4%)	56 (50%)	1.75
I get support when I want to learn new skills	10 (8.9%)	32 (28.6%)	22 (19.6%)	24 (21.4%)	22 (19.6%)	2.85
We have enough equipment to do our job	0	7 (6.2%)	11 (9.8%)	31 (27.7%)	62 (55.4%)	1.67
Staff in MNRH are motivated and inspired	2 (1.8%)	2 (1.8%)	18 (16.1%)	34 (30.4%)	50 (44.6%)	1.88

Key: SA – Strongly agree; A – Agree; N – Not sure; D – Disagree; SD – Strongly Disagree

Seen from the descriptive statistics in table 7, majority of the respondents (73%) perceived their pay as low, when compared to the responsibilities of their job. As such, it was noted that many of the doctors had to get jobs in several health care institutions to supplement their income, while others would be physically present in the hospital but do their other business. Further, results showed that over 80% of the respondents did not consider their pay to be an adequate reflection of their performance. This perception of unfairness could explain the lapses in the commitment of some of the health care workers, further affecting the quality of health care service delivery.

In addition, 82% of the respondents indicated that they did not have enough equipment to do their work. In situations where someone may not be in position to improvise, owing to the nature of a given health condition, that may not be short of demoralizing, which can affect one's commitment. For instance, when one feels that the tools required to do the job are not available, they may not find it necessary to show up at work. In this case, the quality of health care service delivery, in terms of accessibility, responsiveness and effectiveness may be affected.

It was further noted that 75% of the respondents held the view that staff in MNRH were not motivated and inspired. This means that to such, work was simply a routine which

they had to go through, which presents a challenge in line with the quality of services delivered.

Table 8: Correlations for transactional factors and health workers' commitment

Transactional factors	Pearson Correlation	Health workers' commitment
		.639**
	Sig. (2-tailed)	.000
	N	111

***.* Correlation is significant at the 0.01 level (2-tailed).

Of the three independent variables that were used to explain the psychological contract, transactional factors registered the highest correlation results, implying a stronger relationship with health workers' commitment. Seen from table 8 above, the Pearson correlation corresponding to transactional factors was .639**, with a P-value of .000, implying a strong positive correlation between the two variables. By implication, the correlation shows that there was a positive relationship between the two variables and thus, with an alteration in transactional factors, there was likely to be a change in health workers' commitment.

Further, the coefficient of determination was computed to show the variation in health workers' commitment which could be attributed to transactional factors – R^2 (.639x.639 =.408 or40.8%). It emerged that transactional factors were

accountable for 40.8% of the variation in health workers' commitment.

Table 9: Regression analysis for transactional factors and health workers' commitment in MNRH

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	2.199	.121		18.153	.000
	Transactional factors	.506	.058	.639	8.675	.000
Model	R	R Square	Adjusted R Square	Std. Error of the Estimate		
1	.639 ^a	.408	.403	.38061		

a. Predictors: (Constant), Transactional factors; Dependent Variable: Health workers' Commitment

From the 9 table above, the regression model shows a significance value of 0.000, which confirms that the relationship between transactional factors and health workers' commitment is significant, since the P-value of .000 is less than 0.05. The results also indicate that the adjusted R square (R^2) = .403 or 40.3% (R^2 tells how the independent variable explains variations of the dependent variable). This means that the transactional factors account for 40.3% of the variations in health workers' commitment in MNRH; the rest could be attributed to other factors, other than transactional factors.

Further, the results also revealed that the standardized coefficient of transactional factors was positive (.639). This

suggests that holding other variables constant, improvement of transactional factors would result into an enhancement in health workers' commitment by a magnitude of 0.639 units. This finding confirms what the earlier correlation result showed and thus, the hypothesis that; 'transactional relations do not have an effect on health workers commitment' was rejected.

The effect of relational factors towards health workers commitment in MNRH

A total of 07 questionnaire items were used to measure the variable 'relational factors'. Results are explained in tables 10, 11, 12 and 13, depicting the descriptive and inferential statistics.

Table 10: Descriptive statistics for relational factors and health workers' commitment

Statements on relational factors	Percentage Response (%)					Mean
	SA (5)	A (4)	N (3)	D (2)	SD (1)	
Good performance is acknowledged in MNRH	8(7.1%)	19 (17%)	28 (25%)	30 (26.8%)	26 (23.2%)	2.58
MNRH and government in general, show concern for the medical doctors	0	12 (10.7%)	12 (10.7%)	43 (38.4%)	45 (40.2%)	1.92
MNRH and government care about the wellbeing of medical officers	0	8 (7.1%)	18 (16.1%)	43 (38.4%)	41 (36.6%)	1.94
My presence and efforts frequently pass unnoticed	11 (9.8%)	36 (32.1%)	40 (35.7%)	16 (14.3%)	9 (8%)	3.21
I like working in MNRH because I am respected as an employee	11 (9.8%)	16 (14.3%)	37 (33%)	26 (23.2%)	20 (17.9%)	2.75
I have a challenging and interesting job	28 (25%)	55 (49.1%)	16 (14.3%)	10 (8.9%)	3(2.7%)	3.85
I am generally satisfied with my work	13(11.6%)	29 (25.9)	27 (24.1%)	24 (21.4%)	19 (17%)	2.94

Key: SA – Strongly agree; A – Agree; N – Not sure; D – Disagree; SD – Strongly Disagree

Results in table 10 showed that majority of the respondents, (74%; M=3.85) considered their job to be challenging and interesting. However, to the contrary 41% did not really like working with MNRH, while 33% were uncertain as to whether they really liked to work with MNRH. This situation points at other factors rather than the job itself, which could explain the challenges associated with health workers' commitment.

Furthermore, 42% of the respondents opined that their presence and efforts did not always pass unnoticed, though 75% were of the view that MNRH and government in general, did not care about the wellbeing of the medical doctors, a situation which can lead to reduced commitment. Finally, concerning whether good performance was acknowledged in MNRH, majority of the respondents (50%) held the view that there was no acknowledgement of their efforts. This perception that their efforts are not appreciated as they deserve can invariably affect the commitment of the health workers and as a result, the quality of health care service delivery can be compromised.

Factor analysis

The questionnaire items measuring relational factors were subjected to factor analysis, so as to identify those that were the strongest predictors of health workers' commitment. Emerging results are presented in table 11;

Table 11: Component factor analysis for relational factors

	Component factor	Factor loading
1	Good performance is acknowledged in MNRH	.526
2	MNRH and government in general, show concern for the medical doctors	.725
3	MNRH and government care about the wellbeing of medical officers	.572
4	I like working in MNRH because I am respected as an employee	.583
5	We have enough equipment to do our job	.514
6	Lack of fairness	.624
7	Poor work environment	.799

From the factor analysis in table 11 above, poor work environment (.799), lack of concern for the medical doctors by both government and Mulago as a hospital (.725) and

lack of fairness (.624) emerged as the strongest relational aspects, which could most significantly affect the commitment of health workers and resultantly, the quality of health care service delivery in Mulago National Referral Hospital. The working environment was outstanding, registering the highest factor loading. This means that within the relational factors of the psychological contract, the work environment had the greatest effect on health care workers' commitment and the quality of health care service delivery in MNRH.

		commitment
Relational factors	Pearson Correlation	.563**
	Sig. (2-tailed)	.000
	N	112

** Correlation is significant at the 0.01 level (2-tailed).

Table 12: Correlations for relational factors and health workers' commitment

	Health workers'
--	-----------------

Table 13: Regression Coefficients for relational factors and health workers' commitment in MNRH

Model		Unstandardized Coefficients		Standardized Coefficients	T	Sig.
		B	Std. Error	Beta		
1	(Constant)	1.944	.180		10.782	.000
	Relational factors	.458	.064	.563	7.136	.000
Model	R	R Square	Adjusted R Square	Std. Error of the Estimate		
1	.563 ^a	.316	.310	.40731		

a. Predictors: (Constant), Relational factors; Dependent Variable: Health workers' Commitment

The results of the regression coefficients as shown in table 13 above further confirm the correlation results in table 12, where it was found that relational factors had a significant relationship with health workers' commitment ($r=.563^{**}$; $P=.000<0.05$). From the regression results, the adjusted R square is .310, implying that relational factors affect the variations in health workers' commitment by 31%. Further,

the standardised coefficient for relational factors is .563, significant at .000, which means that relational factors significantly affect health workers' commitment in public health care facilities.

The effect of organizational support on health workers' commitment in MNRH

Table 14: Descriptive statistics for organizational support

Organizational support	Frequency and Percentage Response (%)					Mean
	SA (5)	A (4)	N (3)	D (2)	SD (1)	
MNRH has sufficient drug supplies and other necessary equipment for our work	0	5 (4.5%)	13 (11.6%)	45 (40.2%)	49 (43.8%)	1.77
MNRH ensures that we work in an environment which is safe and hygienic, which enhances our commitment	1 (0.9%)	23 (20.5%)	17 (15.2%)	41 (36.6%)	30 (26.8%)	2.32
The state of MNRH as a health facility is acceptable and conducive for our work	0	8 (7.1%)	24 (21.4%)	51 (45.5%)	27 (24.1%)	2.12
I perceive the kind of support I get from MNRH to be sufficient	0	7 (6.2%)	34 (30.4%)	39 (34.8%)	32 (28.6%)	2.14
We have adequate support supervision in the course of our work	7 (6.2%)	26 (23.2%)	26 (23.2%)	28 (25%)	24 (21.4%)	2.68
Provision of suitable accommodation enhances commitment of health workers	32 (28.6%)	27 (24.1%)	27 (24.1%)	13 (11.6%)	11 (9.8%)	3.51
Provision of health care for the family enhances commitment of health workers	30 (26.8%)	25 (22.3%)	27 (24.1%)	15 (13.4%)	12 (10.7%)	3.42

Key: SA – Strongly agree; A – Agree; N – Not sure; D – Disagree; SD – Strongly Disagree

Results of the descriptive statistics as seen from table 14, show that majority of the respondents (53%; $M=3.51$) held the view that provision of suitable accommodation could enhance the commitment of health workers. In addition, 49% ($M=3.42$) indicated that provision of health care for the family enhances commitment of health workers. This shows that the health workers appreciate that with the modest pay that government pays, such additions could help them to make ends meet and hence enhance their commitment.

Concerning whether MNRH has sufficient drug supplies and adequate equipment, it was established that majority of the respondents (84%; $M=1.77$), did not consider such to be adequate. In addition, 70%; $M=2.12$ did not consider the state of the facility to be conducive and acceptable for their work. Such concerns can greatly affect the commitment of the health workers, and thus the quality of health care service delivery can be compromised. Further, 63% did not

consider the kind of support they got to be adequate. However, some of the doctors expressed dissatisfaction with some senior doctors who they reported to be delegating their work to the lower cadres. Lastly, 63% considered the work environment to be unsafe and thus could not enhance their commitment. These views showed that there were gaps in respect to organizational support, which affected the health workers' commitment.

In order to identify the factors related to organizational support that had a key role in respect to the health workers' commitment, factor analysis was done and results are shown in the table 16;

Table 15: Factor analysis for organizational support

	<i>Organizational support factors</i>	<i>Factor loading</i>
1	I perceive the kind of support I get from MNRH to be sufficient	.511
2	We have adequate support supervision in the course of our work	.569
3	Provision of suitable accommodation enhances commitment of health workers	.811
4	Provision of health care for the family enhances commitment of health workers	.731

From the results in table 15, it can be noted that four variables measuring organizational support were identified as having the highest factor loading and thus likely to be the strongest predictors of health workers' commitment. Provision of suitable accommodation stood out as one factor which was most likely to enhance the health workers'

commitment, followed by provision of health care for the family. This shows that doctors perceived provision of suitable accommodation and health care for the family as an indication of support from the organisation, which would induce their commitment. Further, adequate support supervision was cited as a factor that could positively impact on the health care workers' commitment; support supervision helps to give guidance amidst challenging work situations which are bound to happen in a health facility such as Mulago.

Table 16: Correlation between organizational support and health workers' commitment

		Health workers' commitment
Organizational Support	Pearson Correlation	.489**
	Sig. (2-tailed)	.000
	N	112
** Correlation is significant at the 0.01 level (2-tailed).		

Table 16 shows that the Pearson correlation for organizational support was positive and significant. The $r=.489$ indicated a moderately strong positive relationship between the two variables. In addition, $p=.000 < 0.05$ showed that the relationship between the two variables was statistically significant, implying that an improvement in organizational support would result into a significant improvement in the commitment of health workers. To further confirm the correlation results, a regression analysis was done, as demonstrated in table 18 below;

Table 17: Coefficients for organizational support and health workers' commitment in MNRH

Model		Unstandardized Coefficients		Standardized Coefficients	T	Sig.
		B	Std. Error	Beta		
1	(Constant)	2.246	.167		13.424	.000
	Organizational support	.373	.063	.489	5.886	.000
Model	R	R Square	Adjusted R Square	Std. Error of the Estimate		
1	.489 ^a	.239	.233	.42962		

a. Predictors: (Constant), Organizational Support; Health workers' commitment

From the regression analysis results as shown in table 17, it can be noted that the standardized coefficient Beta was .489, implying that an alteration in organizational support would contribute to .489 units of change in health workers' commitment. In addition, the corresponding significance value is $.000 < 0.05$, implying that the result is statistically significant. Further, the adjusted R square was .233, implying that 23.3% of the variation in health workers' commitment could be attributed to organizational support. By implication, the results of the regression analysis show that if the health workers perceive the kind of support they get from MNRH to be insufficient, they may instead psychologically withdraw their commitment, which can eventually affect the quality of health care service delivery in terms of competence, timeliness, appropriateness and effectiveness of the services delivered.

The relationship between the psychological contract and health workers' commitment in MNRH

Table 18: Transactional factors, relational factors and organizational support on health workers' commitment

Model Summary				
Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.713 ^a	.508	.494	.35045

a. Predictors: (Constant), organizational support, relational factors, transactional factors

Analysis of Variance (ANOVA)

ANOVA ^b						
Model		Sum of Squares	Df	Mean Square	F	Sig.
1	Regression	13.552	3	4.517	36.781	.000 ^a
	Residual	13.142	107	.123		
	Total	26.694	110			

a. Predictors: (Constant), support, relational, transactional
 b. Dependent Variable: commitment

Coefficients

Coefficients^a

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	1.569	.176		8.896	.000
	Relational factors	.246	.065	.301	3.800	.000
	Transactional factors	.318	.068	.402	4.649	.000
	Organizational Support	.127	.063	.165	2.037	.044
a. Dependent Variable: Health workers' commitment						

Results of the regression model summary in table 18 show that the R-square for all the three dimensions of the psychological contract (transactional factors, relational factors and organizational support) was .494 or 49.4%. This means that nearly 50% of the variations in respect to the commitment of medical doctors in MNRH can be attributed to the psychological contract. This is fairly a large proportion, which if not addressed, can invariably affect the quality of health care service delivery.

From the analysis of variance results show, the degree of freedom (df) is 3, given the three dimensions of the psychological contract and health workers' commitment as the dependent variable. Further, the 'F' = 36.781, significant at .000 < .05, means that the model is significant, thus implying that the psychological contract significantly explains the variations in health workers' commitment in MNRH.

The regression coefficients of .301, .402 and .165 respectively, showed that the psychological contract (transactional factors, relational factors and organizational support) had an effect on health workers' commitment in MNRH. This was further explained through the p-values, (P=.000, .000, .044<0.05), which all showed that the dimensions of the psychological contract had a significant effect on the commitment of health care workers. This therefore means that the psychological contract significantly affects health workers' commitment in public health care facilities. However, it was also noted that of the three dimensions under investigation, the transactional factors had a greater effect on the commitment of health care workers,

when compared to relational factors and organizational support.

Table 19: Preferred place of work

Place of work	Frequency (n)	Percent (%)
NGO	53	47.3
Government	26	23.2
FBO	2	1.8
Private institution	24	21.4
Total	112	100.0

To the question of where they would prefer to work, results in table 19 show that most of the respondents (47%) indicated that they preferred working with NGOs, followed by 23% who preferred working with Government, while 21% preferred working with private institutions and 2% had preference for working with Faith Based Organisations (FBOs). The preference for working with NGOs could be attributed to the many benefits they offer, besides giving a better salary. It should be noted that within Mulago, there are quite a number of NGOs where some of the doctors who left MNRH work.

The relationship between health workers commitment and quality of healthcare service delivery in MNRH

Descriptive statistics for health workers commitment and quality of health care service delivery

Respondents were asked to rank the statements, showing which of them had the highest influence on the quality of health care service delivery. Results are presented in table 20.

Table 20: Level of influence of health workers' commitment on the quality of health care service delivery

Health worker commitment factors influencing quality of health care service delivery	Levels of influence				
	No influence	Low influence	Moderate influence	High influence	Very high influence
Poor pay and rewards	5 (4.5%)	8(7.1%)	7 (6.2%)	22 (19.6%)	61 (54.5%)
Lack of opportunities for further training	7(6.2%)	11 (9.8%)	31 (27.7%)	25 (22.3%)	31 (27.7%)
Lack of fairness	5 (4.5%)	11 (9.8%)	22 (19.6%)	30 (26.8%)	37 (33%)
Poor work environment	6 (5.4%)	8 (7.1%)	16 (14.3%)	32 (28.6%)	42 (37.5%)
Lack of support from employer	6 (5.4%)	8 (7.1%)	21 (18.8%)	25 (22.3%)	45 (40.2%)

Results in table 20 showed that poor pay and rewards was noted to have the highest influence on the quality of health care service delivery, as evidenced through 55% of the respondents. This was followed by 'lack of support from employer', as ranked by 40% of the respondents; 'poor work environment' which was ranked highest by 38% of the respondents, while 33% highly ranked 'lack of fairness' and 28% ranked 'lack of opportunities for further training'. To confirm these further, One-sample test was used, as explained in the following sub-section.

One-Sample Test for health workers' commitment and quality of health care services delivery

Respondents were asked to give their opinions on how each of the following factors related to health workers' commitment affected the quality of health care service delivery. The one-sample test was used to assess whether the responses were significant, as shown in the table 22 below;

Table 22: One-sample Test

	Test Value = 0					
	T	Df	Sig. (2-tailed)	Mean Difference	95% Confidence Interval of the Difference	
					Lower	Upper
Poor pay and rewards	36.603	102	.000	4.223	3.99	4.45
Lack of opportunities for further training	30.494	104	.000	3.590	3.36	3.82
Lack of fairness	33.078	104	.000	3.790	3.56	4.02
Poor work environment	33.649	104	.000	3.905	3.67	4.13
Lack of support from employer	33.201	104	.000	3.905	3.67	4.14

The mean difference of 4.223 and .000 significance, at 95% confidence interval as shown in table 22, was an indication that poor pay and rewards had an effect on health workers' commitment and quality of health care service delivery in MNRH. Since 4.223 was the largest mean difference, it thus shows that poor pay and rewards given to the health care workers were likely to have the greatest effect on their commitment and the quality of health care service delivery.

Further, poor work environment and lack of support from the employer both registered a mean difference of 3.905, which was also statistically significant at 95% confidence interval. In the same breath, the significant result on the perceived lack of support from the employer could work against the commitment of the health workers to the effect that some would absent themselves or simply show up at the hospital facility without engaging in active work – a situation of 'presenteeism'.

Lack of fairness as a variable testing health workers' commitment and whether that could affect the quality of health care service delivery also registered a significant mean difference of 3.790, significant at 95% confidence interval. This showed that among the medical doctors, there was a perception of unfairness in that they considered the treatment they received as not in tandem with their skills and efforts.

Finally, there was a mean difference of 3.590, significant at 95% confidence interval in respect to the issue of lack of opportunities for further training. This factor was noted by a significant proportion of respondents as affecting their commitment, with a further possibility that it could affect the overall quality of health care service delivery. It was established that some doctors who had been denied leave for study had resorted to studying during the day and working at night, with no rest for most of the time. This kind of approach to work is likely to make the health care worker more prone to error and thus affecting the quality of health care service delivery.

Presentation of qualitative data

The researcher further interviewed key respondents who included senior consultants and Heads of departments to give their opinion on the study subject. The various responses from the key informants are presented here below, in line with the study objectives and variables.

Levels of health workers' commitment

When asked to share his views about the issue of health workers' (doctors') commitment in MNRH, one key respondent shared thus;

"The issue of commitment is really serious here in Mulago. In the past, they used to complain that doctors were leaving, but these days, they don't leave; they stay but do their business...."

This clearly implies that there are instances where some doctors just keep around the hospital facility without engaging in any official work. One other informant shared that such a situation is especially true with senior doctors who have complained and actually given up. The informant shared that in the Out Patient Department (OPD), while they are meant to have a specialist at least once every week, such is hard to come by. This pertains to issues of motivation, which translate into reduced commitment and thus affecting the quality of health care service delivery.

Transactional factors

Among the transactional factors that were studied were; remuneration, rewards, benefits and compensation. The qualitative results did not differ from the quantitative ones earlier discussed. To most of the respondents, their pay was considered unfair and yet the benefits that come with their work were either erratic or in some cases totally missing. One of the doctors interviewed shared thus;

"When I asked for study Leave, management refused to grant it, yet I really needed to go for further studies when I am still young and energetic. At the same time, I do not have any kind of scholarship, so I have to raise my own fees. The salary Mulago pays me cannot meet my too many family obligations, so I had to look for other jobs to supplement my income. It gets to be very complicated, but I really have no alternative, my situation requires that I work day and night to make ends meet"

From this response, it is evident that the concerns in line with the transactional factors are not totally independent of the relational aspects, which possibly explains why the quantitative data showed that it had the strongest effect on health workers' commitment. The meagre pay in the face of the many demands of life forces some doctors to take on more jobs, a situation that could compromise the quality of services rendered.

Several views of the key informants further underscored the role of pay and rewards. For instance, one doctor shared thus;

"I am not motivated; that is why I come in the morning and leave at noon. I don't care about the

patients and how I leave them; if the government does not care about me, I will not care about the patients”

Relational factors

Considered under relational factors were; work environment, career development and job security. Similar to what was noted through the quantitative results, the qualitative data also showed that there were serious concerns pertaining the work environment and career advancement. To a number of respondents, the work environment was considered uncondusive, in fact one shared; *“This kind of environment is not even safe for us the doctors; our health is at a risk”*

Similarly, another key informant lamented thus, in regard to the work environment;

“There is no respect for patients’ privacy in the wards. The beds are meant to be separated with curtains, but that is not the case here, with all the congestion in the wards. The hygiene is so poor and not exactly healthy even for us who work here”.

Such views show that there were cases of dissatisfaction with the work environment, a factor that could diminish the health workers’ commitment and hence affecting the quality of health care service delivery. The researcher’s own observation showed that many wards in the hospital were very congested, with some patients pushed to the corridors and whichever other tiny space was still available.

Organizational support

Organization support was assessed in terms of facilitation with transportation, provision of essential items for practice and support supervision. Commenting on the issue of organizational support, one senior physician responded thus in an interview;

“You can imagine, in the past, we used to have regular meetings with the management of the hospital, where we could share our views but that is no more. The administrators are so inaccessible; some of them actually have body guards - the situation is rather so demoralizing.”

Such sentiments showed that in some instances, the health care workers did not feel motivated. Such a feeling would compel some doctors to withhold their commitment, consequently affecting the quality of health care service delivery.

A number of respondents highlighted the fact that there were insufficient supplies of drugs and other necessary equipment for one to do their work. One shared; *“You can imagine sometimes even gloves are not enough but if I fail to attend to an emergency case because of that, I will be accused of negligence”* Another respondent shared; *“There are insufficient drugs and supplies and as a result, patients are instead given what the hospital can afford, rather than what could cure them”* Such a situation implied that even where doctors would wish to do their best, some situations made it difficult for them to practice their work as they ought to. This can result into frustration and reduced commitment.

Still commenting on the issue or organizational support, one informant noted thus;

“You can imagine a situation where a doctor who treats others can find it so hard to secure medical treatment for him or herself, or even for any of their family member.....doctors here do not have the luxury of health insurance which our colleagues in the private sector or those in NGOs enjoy; and yet the salary is rather too meagre to allow someone to access care in any decent health facility”.

From this comment, it can be noted that while the doctors endeavored to do their best, there was a general feeling that the support they received from the organization was not adequate.

Further elaborating on the issue of organizational support, one key informant revealed that there is a perception of inequitable treatment of the doctors;

“There is lots of disparity; some people have houses, while others don’t and they are not even given housing allowances. Awards and promotions are also political; though they are there, they are not genuine. When you want to go back for further studies, getting study Leave is such a hustle; one doctor had to resign his job in order to go for further studies.”

Such views showed perceived lack of support from the organisation, which could affect the commitment of some of the doctors, hence affecting the quality of health care service delivery.

4. Summary of Key Findings

Results showed that the three independent variables; transactional factors, relational factors and organizational support, had an effect on health workers’ commitment. Overall, transactional factors (remuneration, benefits and compensation) had the strongest effect on the commitment of health workers in MNRH. In addition, poor pay and rewards, lack of support from the employer and poor work environment were noted as key factors that were likely to affect health workers’ commitment and hence affect the quality of health care service delivery. It was further noted that the form of commitment that most doctors exhibited in MNRH was continuance commitment – where many of them kept at their jobs for lack of a better opportunity; instances of affective and normative commitment were very scanty.

5. Recommendations

Transactional factors

The Ministry of Health in Uganda should come up with competitive compensation packages for health staff, particularly doctors, in order to enhance their commitment and induce them to stay in the public health care facilities. These packages should include family health care and be reviewed and revised regularly in order to address rapidly changing needs and circumstances over time.

Relational factors

There is need for the Ministry of Health and management of MNRH to come up with clear strategies for career growth and promotion, especially for the higher cadre of health workers, such as doctors. In addition, MNRH should come

up with strategies where the career development opportunities are distributed equitably and fairly to all concerned staff. This might entail revisiting the existing human resource policies concerning career growth and promotion of staff.

It was noted that the working environment in MNRH had a negative effect on the commitment of health care workers. Therefore, there is serious need by the management of MNRH to improve the working conditions. As a measure towards enhancing the relational factors, management of MNRH, through the human resources and planning departments, should come up with strategies to ensure that specialised services and specialists are fully recognised and compensated accordingly.

Organizational support

Management of MNRH should come up with measures to ensure that the essential drugs and equipment needed in patient care are available at all times. This will necessitate close monitoring of the inventories to avoid drug stock-outs, in addition to developing measures that ensure safety of all supplies delivered to the hospital facility. In addition, equipment should be updated and research should be supported; basic equipment, laboratory and drugs should be maintained and sustained at all times.

Management of MNRH should come up with incentives to improve staff welfare, such as provision of health insurance, accommodation, savings and retirement packages, among others. Such incentives can help to ensure that the doctors do not have to incur a lot of expenses with their already small salary.

References

- [1] Abuosi, A. A and Atinga, R. A,(2013), Service quality in healthcare institutions: establishing the gaps for policy action, *International Journal of Health Care Quality Assurance*, Vol. 26 pp. 481 – 492
- [2] Amin, E.M. (2005), Social Science Research, Conception, Methodology and Analysis, Makerere University Printery.
- [3] Beheshtifar, M. and Zare, E. (2012), The effect of perceived organizational support on employees' attitudes toward work, *Science series data report*, Vol 4, No. 9;Sep 2012
- [4] Buchan, J., Thompson, M., O'May F. (2000), Issues in Health service delivery; Health workforce incentive and remuneration, Department of Organization of Health Services Delivery, *World Health Organisation*, Geneva
- [5] Carney, M., (2011), Influence of organizational culture on quality healthcare delivery, *International Journal of Health Care Quality Assurance*, Vol. 24 7 pp. 523 – 539
- [6] Chapman, B. (2000), Organizational infidelity: how violations of trust affect the employee employer relationship, *The Academy of Management Executive*, 11, pp. 94-96.
- [7] Cohen, A. (2011), Values and psychological contracts in their relationship to commitment in the workplace, *Career Development International*, Vol. 16 pp. 646 – 667
- [8] Coyle- Shappiro, J and Kessler, I, (2000). Consequences of the psychological contract for the employment relationship: A large scale survey, *Journal of Management Studies*, 37 (7), 904 - 930
- [9] Eisenhardt, K. M. (2009). Agency theory: An assessment and review, *Academic Management Review* 14(1), 57–74.
- [10] Eisenberger R, Armeli S, Rexwinkel B, Lynch PD, Rhoades L. (2001). Reciprocation of perceived organizational support, *Journal of Applied Psychology*, pp. 86:42–51
- [11] Gorgi, *et al.*, (2014), Perceived organizational support and job involvement in the Iranian health care system: A case study of emergency room nurses in general hospitals, *Journal of Educational Health Promotion* 2014; 3: 58
- [12] Hakanen, P. M. (2010). Psychological contract and its motivational and Health enhancing properties, *Journal of Managerial Psychology*, Vol. 25 pp. 4 – 21
- [13] Jaffe, R. *et al.*, (2006), Healthcare transparency: opportunity or mirage, *Journal of Management Development*, Vol. 25 10 pp. 981 – 995
- [14] Kaija, D. and Okiira –Okwii, P.,(2004). Quality and Demand for Health Care in Rural Uganda: Evidence from 2002/03 Household Survey
- [15] Kaše, R and Zupan, N. (2007). Psychological contracts and employee outcomes in transition to market economy: a comparison of two Slovenian companies, *Problems and Perspectives in Management*, Volume 5, 2007
- [16] Makanjee CR, Hartzler YF, Uys IL (2006). The effect of perceived organizational support on Organizational Commitment of diagnostic Imaging radiographers. *Radiography*. 2006;12:118–26.
- [17] Matsiko, C. W, (2010). Positive Practice Environments in Uganda: Enhancing health worker and health system performance.
- [18] McGoldrick, J.P, (2003). The impact of psychological contract violation on employee attitudes and behaviour, *Employee Relations*, Vol. 25 6 pp. 557 – 573
- [19] Meyer, J.P. and Allen, N.J. (1991). A Three-Component Conceptualization of Organizational Commitment. *Human Resources Management Review*, 1, 61-89. [http://dx.doi.org/10.1016/1053-4822\(91\)90011-Z](http://dx.doi.org/10.1016/1053-4822(91)90011-Z)
- [20] Middlemiss, S., (2011). The psychological contract and implied contractual terms, *International Journal of Law and Management*, Vol. 53 Issue 1 pp. 32 – 50
- [21] Ministry of Health Uganda (2009c), Health Sector Strategic Plan III 2010/11-2014/15.
- [22] Mosadeghrad, M. A, (2013). Healthcare service quality: towards a broad definition, *International Journal of Health Care Quality Assurance*, Vol. 26 3 pp. 203 – 219
- [23] Narang, R., (2011) Determining quality of public health care services in rural India, *Clinical Governance: An International Journal*, Vol. 16 1 pp. 35 – 49
- [24] Paauwe, M. S, (2011) Balancing HRM: the psychological contract of employees, *Personnel Review*, Vol. 40 pp. 664 – 683

- [25] Robinson, L. S., and Rousseau, D. M, (1995) Violating the Psychological Contract: Not the Exception but the Norm, *Journal of Organizational Behavior*, Vol. 15, No. 3 (May, 1994), pp. 245-259
- [26] Rousseau, D, (1989). Psychological and implied contracts in organisations
- [27] Rousseau, D. M. (1995) *Psychological contracts in organisations: Understanding written and unwritten agreements*, Thousand Oaks, CA: Sage.
- [28] Rousseau, D.M, (2003). Extending the psychology of the psychological contract: A reply to 'Putting psychology back into psychological contracts', *Journal of Management Inquiry*
- [29] Sekaran, U. (2003). *Research Methods for Business: A skill Building Approach* Fourth Edition, John Wiley & Sons, Inc.South Illinois.
- [30] Shore, L.M., Barksdale, W.K. and Shore, T.H. (1998) Managerial perceptions of employee commitment to the organization, *Academy of Management Journal*, Vol. 38, pp. 1593-615.
- [31] Streefland, P., (2005)., Public health care under pressure in sub-Saharan Africa, *Health Policy*, 71: 375-382. Vol. 12 No. 3, pp. 229-38.
- [32] Thomas, *et al.*, (2003) Changes in Newcomers' Psychological Contracts during Organizational Socialization: A Study of recruits entering the British Army. *Journal of Organizational Behavior* Vol 19, pp 745-767.
- [33] Zaki M. A. (2006), The study and measurement of organizational support *Faculty of Admin sciences and Econ Journal*, Vol. 18, University of Isfahan; pp. 103–23.