MENTORING AND ORGANISATIONAL CONSTRAINTS AS PREDICTORS OF ATTITUDES TO WORK IN THE NIGERIAN PUBLIC HEALTH SECTOR

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ABSTRACT

The present study examines work attitudes in the public health sector using the relative impact of mentoring and organisational constraints on job satisfaction and organisational commitment. Data was collected from 161 employees in a large government-owned hospital in south western Nigeria. Results of the hierarchical regression analysis (which controlled for the effects of relevant covariates) showed that when informal mentoring and perceived organisational constraints were entered in the second step, $R^2$ for organisational commitment and job satisfaction increased from .17 to .45 ($p < .001$), and from .15 to .49 ($p < .001$), respectively. These findings suggest that work attitudes in the public health sector can be improved by facilitating mentoring relationships and removing organisational obstacles. The implications of these findings for policy formulation and effective health care delivery are explained.

INTRODUCTION

Work attitudes are a widely studied human resource variable and continues to attract the attention of researchers because of the important practical implications it has for organisational activities and assigned roles in the workplace. Obviously, a vital human resource function of management in any organisation will be to foster positive attitudes that will lay the foundation for high performance. Negative attitudes lead to low levels of output and the tendency to avoid work, and sometimes the desire to quit
(George & Jones, 1996). Positive attitudes toward work have the effect of making employees more willing to put in the extra effort to meet deadlines and improve the standard of performance. In health care delivery workplaces, negative attitudes affect doctor-patient relationship, compromise quality care and may result in inappropriate prescribing patterns (Melville, 1980). These lead to lower levels of patient satisfaction and decreased patient compliance with prescribed medication (Linn, Brook, Clark et al. 1985). The importance of examining work attitudes is particularly underscored by the fact that peoples’ attitudes are very dynamic and the environment in which they operate is not static. Organisations, therefore, have to monitor employee attitudes to ensure organisational effectiveness.

As would be expected, many more studies on employee attitudes toward work in the private sector have been carried out, when compared to similar studies in the public sector (Ellickson, 2002). This has created a gap in the literature, more so when Vasu, Stewart, & Garson (1998) report that private and public employees do differ in their organisational behaviour and motivational profiles. Using the concepts of organisational commitment and job satisfaction, the present study therefore examined attitudes to work in the Nigerian public health sector. This is against the backdrop of continuing public complaints about poor attitudes to work of employees in government-owned health institutions. In Nigeria, documented empirical investigation of attitudes to work is concentrated in the private sector, without a corresponding focus on the public health sub-sector.

The dearth of studies in the public health sector is of particular concern in this study because employees in government-owned health institutions play a crucial role in governments’ ability to meet the health needs of the nation (Ting, 1997). The Nigerian health sector has been
undergoing dramatic reforms meant to reduce the country’s disease burden. It is expected that health care workers, especially those in government-owned health institutions, will play a vital role in providing good health care for all. The stock of the nation’s human resources for health care is one of the largest in Africa (Chankova, Nguyen, Chipanta, Kombe, Onoja & Ogungbemi, 2006) and is capable of meeting the challenge of the nation’s health burden. A major threat to the effective implementation of the health programmes of government is the negative attitudes to work among health care professionals. Health professionals such as doctors and nurses are key players in the quest to maintain the wellbeing of the citizenry. New policies such as the National Health Insurance Scheme, the workplace HIV/AIDS policy, the task of coping with additional responsibilities occasioned by the HIV/AIDS pandemic and a rising incidence of chronic health conditions such as tuberculosis, diabetes, and hypertension require skilled and committed health workers. Undoubtedly, changes in medical practice arising from new health issues require an investigation of work attitude (Baker & Cantor, 1993). Besides, the fact that most Nigerians are constrained by the economic situation in the country to use public health facilities, the industrial actions embarked upon by health workers in government-owned hospitals in recent years, and the general complaint about the poor attitudes towards work among health care professionals further underscore the need to examine the conditions which would promote positive work attitudes in the hospital setting.

Existing research on mentoring and organisational constraints in the public health sector in Nigerian are limited. Thus, this study examines how mentoring and organisational constraints affect attitudes toward work in a government-owned health institution, in order to enlighten management on areas in which changes could be made that will lead to an improved attitude toward work. Mentoring is
a potent human resource management tool which improves worker performance and job satisfaction (Stueart & Barbara, 1993; Johnson, Geroy & Griego, 1999; Steijn, 2004). The benefits of this practice will accrue to all stakeholders in the Nigerian health sector. The government gains from effective implementation of health policies, the health organisations gain from committed employees, employees gain from doing a satisfying job, and the public gains from receiving satisfying health care delivery.

Job satisfaction is an attitude that is based on a worker’s perception (positive or negative) of the job or work environment (Reilly, Chatman & Caldwell, 1991; Pool, 1997), while organisational commitment is also categorised as an attitude (Mathieu & Zajac, 1990) that fosters emotional attachment and feelings of obligation to remain with an organisation. Emotional attachment to an organisation correlates positively with job performance, promotability and employee potential (Meyer, Paunonen, Gellatly, Goffin & Jackson, 1989; Shore, Barksdale & Shore, 1995). Organisational commitment predicts outcomes such as turnover, absenteeism and work quality (Blau, 1986; Blau, G., and Boal, 1989; Randall, 1990). Research findings reveal that organisational commitment and job satisfaction are crucial to attitudinal dispositions that lead to better customer satisfaction (Aniftos, 2002). Individuals who are satisfied with their work become satisfied with life (Judge, Boudreau & Bretz, 1994) and do well in complex and autonomous tasks (Blau, 1999; Miller, 1980). They tend to be more productive and are more committed to their organisations (Judge, Thoresen, Bono & Patton, 2001).

Mentoring has been demonstrated to be an effective strategy for promoting a positive work attitude in organisations (Fagan & Walter, 1982; George, P. and Peace, 1997; Hill & Bahnink, 2000). The rationale for the acclaimed benefits of mentoring is usually based on a
developmental social learning theory which posits that behaviour is learned in interaction with others, especially when they serve as models (Sarason, Sarason, Piece, Shearin & Sayers, 1991; Baldwin, 1992). The social approach to the investigation of work attitude (DeVaney & Chen, 2003) posits that the social context of work, which includes relationships with superiors or supervisors, has a significant impact on a worker’s attitude and behaviour (Wharton & Baron, 1991; Marks, 1994). Empirical information suggests that the better the relationship the greater the level of job satisfaction (Sousa-poza & Sousa-poza, 2000).

Evidence of formal mentoring programmes in the Nigerian work environment is virtually absent in the literature (Okurame, 2007). It appears that mentoring occurrence is entirely informal (Okurame, 2008a). This form of the relationship necessarily thrives because the work setting is interpersonally flexible (Okurame, 2008a). Mentoring is foremost an interpersonal relationship that develops naturally from shared admiration, aspiration, values and interests (Kram, 1983, 1985; Kalbfleisch & Davies, 1993). Besides, mentoring is generally a voluntary relationship where the mentor works in the same organisation or field as the mentee (Dancer, 2003). For these reasons and because studies (e.g. Phillips-Jones, 1983; Chao, Walz, & Gardner, 1992; Dreher & Cox, 1996) show that traditionally mentoring relationships occur informally in organisations and are more beneficial than formal mentoring, this study focused on informal mentoring in the investigation of its role in work attitude among health care providers.

It has been argued that mentoring is a viable technique which is presently under-utilised to encourage positive attitudes (Appelbaum, Ritchie & Shapiro, 1994). Among health care professionals, the concept of mentoring has a general lack of clarity (Dancer, 2003) that has
hindered its utilisation. Mentoring is a form of induction activity that is different from the officially structured induction among health care professionals. It has a broader application than induction and the role of ‘expert’ is not the same as that of a mentor in the context of health care (Dancer, 2003). Beyond the basic idea of making expertise available for the acquisition of skills, mentors are experienced and trusted guides and advisers (Stephen, 1996). If all employees are mentored and the benefits of mentoring accrue to all of them, they should all feel equally motivated. It is common knowledge that this is not always the case. Though, health care professionals go through induction at one point or another, this may or may not lead to mentoring relationships. Dissatisfying informal mentoring relationships are no more effective than no mentoring at all. The perception of inequity by employees who do not receive mentoring support results in resentment and jealousy because of perceived distributive injustice (Scandura, 1998; Bauer, 1999). Even marginally satisfying formal or informal relationships negatively impacts on work and career attitude (Ragins, Cotton & Miller, 2000). Good mentoring is therefore the only means through which employees could profit from the relationship.

Mentoring is especially valuable for the transmission of invaluable information on the mission and philosophy of the organisation, making it possible for employees to cope with career stress, giving employees a proper orientation towards work place values and bringing about the transfer of skills which mentees can apply in diverse professional and personal circumstances (Murray, 1995; Gilley & Boughton, 1996; Payne, 2006). Mentoring reduces turnover because it increases affective commitment to an organisation and employees involved in the relationship have better career growth, promotions, pay and fringe benefits (Burke, McKeen & McKenna, 1994; Payne, 2006; Okurame, 2008b). Career growth is an important
determinant of job satisfaction and positive attitude (Hackman & Oldman, 1976). Similarly, satisfying pay and promotional opportunities enhance task significance, job satisfaction and organisational commitment (Jans, 1989; Mathieu & Zajac, 1990; Wright, 2004). This conclusion finds support in the variance theory which posits that workers are satisfied to the extent that they get what they want from their work. It is therefore hypothesised in this study that higher levels of informal mentoring will lead to higher levels of job satisfaction and organisational commitment.

The literature also suggests that organisational constraints such as inadequate tools and equipment are important factors in employee attitudes (Peters, O'Connor & Eulberg, 1985; Peters & O'Connor, 1988; Brown & Mitchell, 1993). Organisational constraints are situations or things that interfere with task performance at work (Spector & Jex, 1998). Though many researchers have examined the linkage between organisational constraints and organisational performance, little is known about its link with employee attitude (Eulberg, O'Connor, Peters & Watson, 1984). It is useful to examine the impact of organisational constraints on work attitude given perceived lack of organisational resources in government-owned health organisations and calls for government endowment in this regard. Organisational constraint is a potential source of frustration that can create job dissatisfaction. Often, when individuals join an organisation they have expectations about their work activity and the organisational resources needed to carry it out. Studies have shown that when these expectations are congruent with experience at work, satisfaction is greater (Hawkins, Best & Coney, 1989; Engel, Blackwell & Mniard, 1995). Unfulfilled expectations impact negatively on job satisfaction, organisational commitment and performance (Wanous, Poland, Premark & Davis, 1992). Organisational
constraints must therefore be minimised to create an environment where positive employee attitude and organisational performance can be nurtured (Deming, 1986; Walton, 1986). In line with the position in the literature, this study proposes that lower levels of organisational constraint will lead to higher levels of job satisfaction and organisational commitment.

METHOD

Participants and Procedure

Data were obtained through a survey of 161 health care workers sampled through the purposive method in a large government-owned health institution. The institution provides comprehensive inpatient and outpatient health care in south western Nigeria. The health care workers were approached, assured of confidentiality and invited to complete a self-administered questionnaire. The questionnaires were administered during office hours in outpatient and inpatient clinics of five major departments of the health facility. Administration of the questionnaire was repeated to ensure an appreciable response rate, especially for doctors. This was because some misplaced the initial copy and the skewed doctor-patient ratio gave little room for some to provide responses in the first administration. It took the researcher and two contact persons four weeks to collect data for the study. Of the 250 questionnaires administered, 161 (a response rate of 64.4%) had usable data.

The total sample was made of 88 doctors and 73 nurses. There were 59 male and 29 female doctors; five nurses were males and 68 were females. All together a total of 64 males and 97 females took the survey. Their average age was 38.08 years, ranging from 23 to 61. Their average year of first medical or nursing qualification is 8.01 years, while their mean organisational tenure was 6.65 years. All
participants were in the proximity of their mentor and average length of informal mentoring is 4.91 years.

Measures

The survey instrument was a self-administered questionnaire that contains measures of demographic data, informal mentoring, organisational constraints, and work attitude (job satisfaction and organisational commitment).

Demographics. The demographic information obtained from respondents included age, sex, profession, job status, year of first medical or nursing qualification and organisation tenure. These variables were considered as potential covariates.

Informal mentoring. Informal mentoring was measured with a 15-item scale developed by Okurame (2002). The instrument is rated on a 5-point Likert scale to measure the level of informal mentoring support a respondent feels he or she has received. The author reported an alpha reliability of .93, a .81 split-half reliability using the Spearman-Brown formula, a significant convergent (r = 0.69; p<.01) and divergent (r = -0.63; p<.01) validity. Respondents were also asked questions on the length of relationship, proximity of mentors and sex of mentor. These were considered as potential covariates.

Organisational constraints. An 11-item scale developed by Spector & Jex (1998) was used to measure organisational constraints. The scale tapped information on the 11 areas of constraint identified by Peters and O’Connor (1988). Each item assessed each of the 11 constraint areas, and the sum of all items represents the total score of a respondent. Respondents indicated how often it is difficult or impossible to do their job because of each of the identified constraints. A 5-point scale that
ranged from ‘less than once per month or never’ to ‘several times per day’ was utilized as the response format. High scores represent high levels of constraints.

*Job satisfaction.* A 36-item Job Satisfaction Survey developed by Spector (1985) was used to measure this variable. It assesses employee attitudes about the job and aspects of the job. The nine facet scale has a 6-point response format and each facet is assessed with four items. A total score is computed from all items to make up the total score on the scale. High scores on the scale represent high levels of job satisfaction.

*Organisational commitment.* Organisational commitment was measured by a 9-item scale developed by Porter & Smith (1970). The measure was rated on a five-point likert scale, ranging from strongly agree to strongly disagree.

**RESULTS**

Preliminary statistical analysis using the t-test revealed that male and female participants ($t = 0.817$, df (159), $P > .05$ and $t = 0.875$, df (159), $P > .05$ respectively), and doctors and nurses ($t = 0.817$, df (159), $P > .05$ and $t = 0.875$, df (159), $P > .05$ respectively) do not differ on job satisfaction and organisational commitment. This result provides justification for collapsing data obtained from the sample into one group in analysis. To assess the degree of multicollinearity, an inter-correlation of all variables of study was carried out. The results presented in table 1 reveal that the control variables that are related to the independent variables were not highly correlated. The correlations were below .25. Age was significantly related to organisational constraint ($r = -.24$, $P < .01$); length of relationship was significantly related to organisational
constraint ($r = -.23$, $P < .01$) and informal mentoring ($r = .15$, $P < .05$); and sex of mentor was related to informal mentoring ($r = .19$, $P < .05$). The results in table 1 show that except for the length of informal mentoring relationships, all other potential covariates were not significantly related to the dependent variables. Some of the control variables were, however, highly correlated among each other. Age was highly correlated with year of first medical or nursing qualification ($r = .82$), organisational tenure ($r = .83$) and length of informal mentoring relationship ($r = .83$).

Table 1
Means, standard deviations and inter-correlation of all variables

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- P < .05, ** P < .01, *** P < .001.

Sex of respondent and profession (r = .61); profession and job status (r = .92); year of first medical or nursing qualification and organisational tenure (r = .97) and length of relationship and organisational tenure (r = .91) were highly correlated. When two variables are highly correlated, one of them is eliminated from the analysis (Bordens & Abbott, 1988) to maintain power. Control variables were eventually selected for analysis if they correlated significantly with the independent or dependent variables and were not highly correlated with each other. On the basis of these criteria, sex of respondent, job status,
years of first medical or nursing qualification, length of informal mentoring relationship and sex of mentor were selected as control variables in the analysis. Although a significant moderate relationship exists between job satisfaction and organisational commitment, they were separated for the purpose of analysis since research (e.g. Brooke, Russell & Price, 1988; Mathieu & Farr, 1991) suggests that they measure two distinct concepts.

The results in table I, which examine the relationships among the variables of interest in the study, provide preliminary support for the hypothesis that informal mentoring and organisational constraints predict job satisfaction and organisational commitment. Further analysis to establish the unique contribution of informal mentoring and organisational constraints to job satisfaction and organisational commitment was carried out using hierarchical multiple regression analysis. In the analysis, informal mentoring, organisational constraints and control variables such as sex, job status, length of informal mentoring, year of first medical or nursing qualification and sex of mentor were independent variables, while job satisfaction and organisational commitment were dependent variables. The first step of the hierarchical regression analysis examined the impact of sex, job status, length of informal mentoring, year of first medical or nursing qualification and sex of mentor in order to control for their effects. The results of the analysis are presented in tables 2 and 3.
### Table 2

*Summary of hierarchical regression analysis predicting organisational commitment*

<table>
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<tr>
<th>Predictor/Step</th>
<th>β</th>
<th>At step</th>
<th>Final</th>
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<th>R²</th>
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*aFM/NQ = First medical/nursing qualification.  
bLMR = Length of mentoring relationship  
** P < .01. *** P < .001.*

### Table 3

*Summary of hierarchical regression analysis predicting job satisfaction*

<table>
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<tr>
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<th>Final</th>
<th>ΔR²</th>
<th>R²</th>
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*aFM/NQ = First medical/nursing qualification.  
bLMR = Length of mentoring relationship  
** P < .01. *** P < .001.*
The results in tables 2 and 3 showed that only the length of informal mentoring and the year of first medical or nursing qualification account for a significant proportion of the variance in organisational commitment ($\beta = .96$, $p < .001$ and $\beta = -.84$, $p < .01$ respectively), while the length of informal mentoring, the year of first medical or nursing qualification and sex of the mentor contributed significantly to job satisfaction ($\beta = .74$, $p < .001$, $\beta = -.51$, $p < .01$ and $\beta = .25$, $p < .01$, respectively). Sex of the respondent, sex of the mentor and job status did not significantly contribute to organisational commitment, similarly sex of the respondent and job status were not significant predictors of job satisfaction. The control variables entered in the first step jointly account for a significant variance in organisational commitment ($R^2 = .17$, $p < .01$) and job satisfaction ($R^2 = .15$, $p < .01$). When informal mentoring and organisational constraints were entered in the second step, $R^2$ with respect to organisational commitment increased to .45 ($p = < .001$). An indication of a significant change in $R^2$ ($\Delta R^2 = .28$, $P < .001$). Adjusted $R^2$ for job satisfaction also increased to .49 ($p = < .001$) to indicate a significant change in $R^2$ ($\Delta R^2 = .34$, $P < .001$). Informal mentoring and organisational constraints account for a significant proportion of the variance in organisational commitment ($\beta = .48$, $p < .001$ and $\beta = -.20$, $p < .01$, respectively) and job satisfaction ($\beta = .54$, $p < .001$ and $\beta = -.21$, $p < .01$, respectively). The results also indicate that when informal mentoring and organisational constraints are introduced in the second step, the significant relationship that exist in the first step between control variables (years of first medical or nursing qualification, length of informal mentoring relationship, sex of mentor) and job satisfaction, became insignificant, and the non-significant relationship between sex of mentor and organisational commitment became significant.
DISCUSSION

The present study investigated the impact of informal mentoring and organisational constraints on organisational commitment and job satisfaction among health care workers in Nigeria. Relevant inputs, such as respondents’ sex, job status, year of first medical or nursing qualification, length of informal mentoring and sex of mentor that may result in differences in job satisfaction and organisational commitment were controlled for. The controlled effects of these variables justify the examination of the impact of informal mentoring and organisational constraints in the present population. Results indicate that informal mentoring and organisational constraint are significant predictors of organisational commitment and job satisfaction among health care professionals. The significant effect of these variables typifies findings that employees differ in their levels of job satisfaction and organisational commitment because of differences in mentoring support and perceptions of organisational constraint (See for example, Fagan & Walter, 1982; Brown & Mitchell, 1993; George & Peace, 1997; Mobley et al, 1994; Spector & Jex, 1998; Hill & Bahnink, 2000; Peters & O'Connor, 1988). The implication of a significant positive impact of informal mentoring on work attitude is that when employees have a high level of informal mentoring support they experience more job satisfaction and display a high level of commitment to their organisation. If the mentoring level is minimal the employee’s job satisfaction and commitment to the organisation will be lower. The significant negative impact of organisational constraints implies that when employees perceive that the organisational resources at their disposal are adequate, their job satisfaction and organisational commitment are more favourable, compared to when it is perceived as inadequate.
One practical implication of these patterns of relationship is that the possibility of a positive experience of job satisfaction and organisational commitment in government-owned health organisations can be predicted. Another clear implication is that designs aimed at improving work attitude may not be complete if mentoring support and satisfactory organisational resources for employees to do their jobs are not considered. Interestingly these variables are amenable to organisational intervention, suggesting that findings of this study could be applied to the workplace to enable government-owned health care facilities meet national and international health challenges. Therefore, management would have to be responsive to possible hindrances to the initiation of mentoring relationships and the provision of adequate organisational resources. Obviously, an intervention policy is required to meet this challenge.

It is recommended that health organisations adopt mentoring as a policy. This should be linked to the mission, goals and priority strategies of the organisation for better results (Murray, 1995). The design of this strategy for fostering informal mentoring relationships should be handled by experts in the area of mentoring for it to be effective. This intervention policy would benefit health organisations immensely, especially if the knowledge and skills passed on to junior employees by the managers or senior personnel are evaluated, and positive evaluations are rewarded. Mentoring is particularly encouraged through a reward system that recognises positive outcomes from mentoring (Hunt & Michael, 1983). A policy that makes provision for evaluation will entrench effective mentoring into the system of reward and promotion in the organisation, eliminate perceptions that mentoring is a waste of time and enhance the quality of the relationship. Once a health institution adopts mentoring as a policy, potential mentors have to be trained in how to establish a
successful mentoring relationship. Training of mentors is an essential ingredient of a successful mentoring relationship (Dancer, 2003). Health organisations can also foster informal mentoring by providing opportunities for exchanges between senior and junior employees. They could do this by sponsoring workshops, conferences and discussions relevant to mentoring and design work schedules such that free periods exist for senior executives to interact with junior employees.

A well-cultivated mentoring relationship that is based on mutual admiration also has the potential to positively affect organisational constraints. Indeed, good mentoring helps to prevent situations that interfere with effective task performance. It clarifies roles, provides on-the-job training and enhances a mentee’s perception of positive work environment. Nevertheless, mentoring should not be a replacement for efforts aimed at removing organisational resource constraints. Such efforts should be directed at providing the tools and equipment that are necessary for effective task performance. It may be counterproductive for mentored workers to be unable to do the job for which they have been trained because of inadequate resources. A new policy is also required to make it mandatory for management to point out cogent factors that restrict their ability to address constraints. This would help to reduce unfavourable perceptions of organisational constraints by employees. In addition to ensuring that sufficient resources are available to run a health facility, attention should also be paid to factors such as year of first medical or nursing qualification, length of mentoring relationship and sex of mentor since they were found to have a measure of influence on work attitude in this study. These factors are particularly relevant for organisational commitment because unlike job satisfaction which becomes insignificant when informal mentoring and perceived organisational constraints were introduced, the
factors remained moderately significant for organisational commitment.

The desire of the Nigerian government is to meet public health needs and to promote public and occupational health in the country. However, if health care workers in government-owned health organisations do not exhibit appropriate attitudes to work, the government’s ability to meet the needs of patients will be undermined. The findings of this study are therefore a vital prescription towards the attainment of this objective. An important contribution of the study therefore is the application of the findings to enhance work attitude and the attainment of the objectives of national health and development programmes in Nigerian.

This study has used a number of variables to examine attitudes to work in a government-owned health organisation. The results, however, have to be interpreted with caution because of a number of limitations. First, the independent and dependent variables of the study were tapped with self-report measures. This implies that participants might not have accurately reflected these variables in their responses. This creates room for alternative explanations of results. Second, the variables examined in the study account for only .45 of the variance in organisational commitment and .49 in job satisfaction. This implies that .55 and .51 of the variance in organisational commitment and job satisfaction are not accounted for. A limitation of the study therefore is that it did not completely examine all factors that might affect work attitude. Further study is therefore necessary to bring into play and measure these unexplained variances. Besides, a more controlled and systematic research is needed to find out the specific aspects of mentoring that contribute to the positive work attitude, categories of medical personnel that are helped most by mentoring, and the aspects of organisational constraints that undermine
positive work attitude. Third, because this study is exploratory, additional surveys should be conducted to confirm these findings in the Nigerian work environment. A more extensive study with a larger geographical spread will be useful to find out if current findings can be supported with objective measures from a wider population. The limitation of the study notwithstanding, it presents a practical guideline which can be implemented in government-owned health institutions to improve the health care professional’s job satisfaction and commitment to the organisation.

REFERENCES


