

Impacts of New Recruited doctors refrain from Working in Rural Remote Areas at Jordan Southern Badia Region.

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Abstract

Background: *An imbalance exists between offered medical services and needed health care for the people in southern Badia rural areas region of Jordan. Many studies have found non-availability, of health care providers as major contributors to the poor health indicators of the rural areas.*

Methods and Results: *An endeavor to attend the issue has been made through a cross-sectional survey of Medical Officers working in different health facilities of Maan Directorate. The study found that doctors need to have more training courses and access to work at rural setup nor they are given proper facilities and service structure to work there. They perceive to face disadvantages affecting their martial, social, professional and family life, if they join in rural areas.*

Recommendations: *This study recommends strengthening of Community Oriented Medical Education for motivating doctors towards participation in rural health services. Doctors working in rural health facilities might be given financial and professional incentives and a conducting environment to retain them.*

Keywords: Health care providers, Health indicators, Rural Areas, Maan governrate, Badia region.

Introduction

The World Health Report 2006 estimated that the world lacks about 4 million health workers, if a minimum level of health outcomes is to be achieved (**WHO 2006**). However, health worker shortages are currently reported by many other countries, both developed and developing. Such shortages are symptoms of a poorly managed health workforce and health care system. The causes of the crisis are complex, and have to do with insufficient production capacity, but also with an inability to keep the workers that are being produced in the places where they are most needed. Therefore, because of the complex web of factors that influences the mobility of health workers, any efforts to scale up the health workforce in response to the crisis must be combined with effective measures to attract and maintain both existent and newly trained health workers where they are needed most. In many countries, one of the main constraints in achieving population health goals is the lack of health workers.

The 2004 Joint Learning Initiative (JLI) for Human Resources for Health estimated that, sub-Saharan countries must nearly triple their current numbers of workers by adding the equivalent of one million workers through retention, recruitment, and training if they are to come close to approaching the MDGs [Millennium Development Goals] for health (**Joint Learning Initiative, 2006**). Interventions to alleviate health worker shortages in medically underserved areas include selective recruitment of those individuals into health care education who are most likely to work in such areas, training specifically for underserved practice, improvements in working or living conditions in underserved areas, compulsion or incentives. (**Lehmann U & T Martineau, 2008**). The topic of the present article is financial incentives for return of medical service in underserved areas: a health worker enters into a contract to practice for a number of years in an underserved area in exchange for a financial payoff.

In addition, we find that there is poor distribution of national cadres, where the ratio of physicians vary between 55% Jordanian physicians in Amman and 30% of physicians close to Amman, while almost non-existent in rural and remote areas such as Maan physicians with a ratio less than 7%. for both (M&F). This is a serious indicator must be addressed before aggravate and work to promote Jordanian to work in rural areas for the following various reasons:

- 1- Working in rural areas allows workers the quality they practice are rarely available in large cities, in terms of multiplicity and diversity of health problems, and clarity of the causative factors of these problems, as well as bear the major responsibility to solve these problems, all the employees in the need to develop self-reliance and sustainability liability and the acquisition of problem-solving skills and decision
- 2- It also increases the work in rural areas and remote job satisfaction and the desire to work.

3- Performs the work in the countryside to gain leadership skills and interact with the community, through the use of advanced social level health workers in rural areas and giving them practical experience and wealth of experience in the practice of community leadership, not only the health aspect, but as symbols of community leaders in general .

4- The existence of most workers in the health sector for large cities to inequality in the distribution of these cadres stable and therefore poor distribution of health services.

5- The reasons for the urgent necessity for national cadres in rural and remote areas the emergence of the problem of unemployment, where there are now more than 188 doctors out of work for refusing to work outside the big cities, and work in these areas no doubt provide them with opportunities to work rich.

Broadly speaking, Jordan is doing relatively well; it ranks 10th in the region when it comes to Infant mortality; fifth in maternal mortality rate; eleventh for percentage of years of life lost to communicable disease; ninth for percentage of years of life lost to non communicable disease and 18th for percentage of years of life lost to injury. The first for antenatal care 91% percent of pregnant women have at least 4 antenatal care visits and 100 percent birth attended by skilled health personnel alongside United Arab Emirates, Qatar and Kuwait. The MOH (Ministry of health) is considered the implicit insurer of last resort; the ministry's facilities had been constantly under funded and lacked skills, services, advance diagnostic technologies and medications needed for advance and complicated treatment. The MOH offers to poor and uninsured a comprehensive coverage for primary through 11 secondary cares to majority of population in various coverage degrees (according to their income) for Cancer, HIV/AIDS, rare blood diseases like Talasimia and Renal Failure. Additionally, there is a need to study the effect of new pricing policies (full cost recovery for drugs and disaggregating the health service bill) implemented by the MOH since 2003 on the poor and the poor uninsured utilization of MOH health facilities, as well as the effect of this increase on the private sector.

The estimated midyear population of Jordan in 2007 expected to reach 6 million, with an overall population density of 56.5 per square kilometer, great majority of population living in urban areas. The total fertility rate is relatively high, though it has declined steadily in recent years to 3.7 in 2004. The declining mortality rate and the high total fertility rate have contributed to overall population growth that averaged 3.3% per year from 1992–1998. (Jordan Statistical department .1998) As for the remote areas here in Jordan the subject of present study, 90 per cent of the population lives on only 10 per cent of the country's surface area. As a result of the prolonged conflict in the Middle East, Jordan has hosted several waves of refugees, displaced persons and returnees. This has had a significant impact on the population growth rate. Since 1961, the population has increased fivefold, leading to increased pressure on natural resources, income disparities and growing poverty. Since 2000 the rapid growth rate has slowed. Jordan poverty is not concentrated in a particular region or regions in the country. It is found in urban centers, refugee camps and rural areas. The poorest of the poor tend to be in low rainfall zones where agriculture is severely limited and where the environment is significantly degraded, leading to widespread erosion and desertification, this had its impacts due to some certain cause's stands behind poverty in rural areas are mainly:

Landlessness: The landless usually depend on wage labor and informal employment in rural areas as sharecroppers. They may have limited access to government services and may rely on their employer for additional assistance in the form of small loans to pay medical expenses if they are not beneficiaries of social safety net.

Small-scale farms: Unless the family owns livestock or has access to additional off-farm income, small-scale farmers are forced to enter into less profitable farming arrangements, such as renting land and sharecropping. They may be indebted to middlemen who help them market their products

Large families: The average Jordanian family has six children, and many families have nine or more members. The composition of the family varies and may include small children, elderly parents and unemployed young adults. Lack of resources to pay for health care and school fees can reduce the living standards of these families to a level of extreme poverty Access to resources Various development programs provide access to improve health services for rural development. Rural women and isolated, illiterate poor farmers have inadequate access to credit to other services. (www.ruralpovertyportal.org)

MATERIAL AND METHODS:

Jordan Badia is divided into three administrative regions and development: the Northern Badia, Badia Central southern desert.

Southern desert:

Throughout most of territory south of kingdom, with an area of about (38) thousand km², equivalent to 51% of the Jordanian Badia, distributed on the Aqaba Special Economic Zone, three provinces, namely: Karak Governorate, Tafileh and Maan governorate. In (2004) the number of inhabitants estimated (44360) people, equivalent to 0.82% of the Kingdom population equivalent to 16.7% of size of population in territories of the Jordanian Badia. The study is a Cross-sectional survey of the Medical Officers working in the public sector health facilities at Maan governorate situated 255 km from Amman. The main focus of the study was to recognizing assessment of doctor's to extent there performance of roles and characteristics of these roles they are doing. Recognizing assessment of doctor's concepts regarding to some extent benefits like professional and material benefits, sense of security and stability, their relationships with medical staff in the foreground. This task was pursued through census of all medical officers working in public sector health facilities of Maan directorate.

Doctor's both male and female working as Medical Officers at Maan health directorate. The Maan main public hospital headquarter and Queen Rania public hospital (55) km from Maan, during December 2009, the study population were total of 237 doctors who met the study criteria out of these 4 could not be contacted and 5 refused to participate in the study so a total of 228 doctors were interviewed for the study.

The doctors were divided into three categories according to their working experience and a different type of questionnaire was designed using international and national literature for each category.

In all the three categories, structured questions about demographic and other information were used whereas the perceptions were probed through open-ended free-listing type questions. The SPSS and Excel software was used to analyze the data. The study has no external validity beyond doctors working as Medical Officers in Maan Governorate health directorate, which does not dilute the study, as it had same area of focus and extrapolation of its results beyond this scope was never designed.

RESEARCH HYPOTHESIS:

H1. There is no statistically significant relationship between Remuneration and benefits of physical Occupations.

H2. There is no statistically significant relationship between Doctors roles and their relationship to psychological stability and a sense of security.

RESEARCH QUESTIONS:

Determined by the problem of the study to identify the roles and doctor's working in the Ministry of Health, and to achieve the objective referred to above.

This study seeks to answer the following

1. Is there a relationship between studies of medicine and there works?
2. Is there factors drive them to join the physician profession?
3. What is the impact on a range of changes effecting on doctor's profession such as financial remuneration, psychological stability, appreciated by others?

PREVIOUS STUDIES:

(Irene A, 1997) has identified lack of essential equipment, non-availability of resources like electricity, safe water, communication system and isolation from other units as traits of a hardship rural post. She advises not to force and manipulate staff to accept rural postings against their will. Medical staff might accept these postings through mechanisms of differential reward and provision of relief for the hardship involved.

(Humphreys JS, Frances R. A Modified, 1998) concluded at his research the importance of Measures designed to improve levels of practitioner's retention in rural and remote areas should focus on avoiding and controlling frequent transfers and postings of doctors. Some experts like (Khattak FH, 1996) have suggested remedies to the situation including establishment of a rural health academy at divisional level to impart training and refresher courses to doctors working in the rural areas; priority in postgraduate education and training abroad; grant of rural and non-practicing allowance; and regular linkages with administration, management, and academic activities of their concern.

Even (Kristiansen IS, 1992) has also advocate on a proper education facility for the children of the doctors and staff working in rural areas is one of the priority requirements. Duty timings of a doctor should be fixed in a manner that he could easily take rest and perform his other responsibilities; otherwise payment for overtime shall be made to them. according to (Kenneth MC, Azrul A, Gunawon S, Nasye I, 1999) and (Sharpston MJ, 1971). Meanwhile (Rosenberg AM, 1990) emphasizes on the role of governments often have used combinations of compulsory services and incentives to improve the geographical distribution of physicians. Incentives for rural services have been used in the United States, Canada and Norway.

The evaluation according to **(Kristiansen IS, 1992)** made an optimal design, of incentive systems require an understanding of the responsiveness of physicians to these incentives. However, little is systematically known about physicians' preferences. For the developed world there are a handful of studies, most notably **(Bolduc DB, Fortin, 1999)** for Quebec and, **(Hurley 1989, 1990)** for United States whereas for the developing world there is only anecdotal reports.

Results and discussion:

According to **(Rabinwitz HK, 1993)** Refusing of doctors to work at rural areas does not exist only in Jordan, but in most countries, both developed and developing countries alike, for example, there is the United States a continuing shortage of doctors in rural areas, especially family doctors in most states. Canada also **(Chaytors RG, Richard Spooner G. 1998)** suffers from similar problems continuous basis, too, such as the mandate of Alberta. In Denmark as **(Magnus JH, Tollan A, 1993)** identified that there is an acute shortage of doctors in the northern regions of the cold palces, while other developing countries are facing the same problem For example, in Sudan, we find that 60% of doctors working in the capital and home to less than 10% of population as **(Magzoub MMA '1992)** pointed out. To address this dilemma must be encouraged to propose strategies effective at Jordan health sector for choosing of physicians to work in rural areas voluntarily relying on international experience at national levels. This is what this paper aims to study the causes and propose appropriate solutions. There were 228 Medical Officers available and agreeing to participate in the research in at Maan health directorate. These Medical Officers were posted in different health facilities offering varying levels of care as indicated in Table No. 1

Insert table (1) about here

There were 52 individuals from the sample and by 23.8% of males, and 165 Single by 75.3% of females, and 2% by 0.9% is not shown. The study sample included 196 individuals by 89.4% Muslim, 18 Christian 8.4%, while five persons by 2.2% did not specify their religion. The study sample included 114 bachelors by 51.9% and 46.3 per 101 married and four (4) divorced, a rate of 1.8%. The age range for all respondents was 27 to 45 years with the mean age of 33 ± 4 years. There were 13.6% (17) females with mean age of 32 ± 2.5 years whereas the males were 86.4% (108) with mean age of 33.5 ± 3.5 years.

Properties of the sample:

The main element of Doctors Officers working at Ministry of Health, in a civil service system, shows insufficient enjoyment to there certain privileges because of nature of their work. Since they considered as top officials in the line of medical authority in charge for the rest of medical team working hospital, doctors, According to the scope of their responsibilities, in anther meaning the ministry must have ascertain commitment to care for this working class and responsible to ensure that to fulfill their needs at deferent means. It appears from the table No.2 that doctors have expressed dissatisfaction, both in terms of salary they receive, or to the fact of there present profession all the way ahead convinced of their work at remote areas, provide them with their future physical enough, and there average income which is less than average income, possibly due to characteristics of their works characterized with as an important vital factors to humans care profession to sickness.

Insert table (2) about here

It has been noted from above table that doctors are gaining low wages material, and lack of benefits of vocational them bricks material, and securing future of material, this is because health workers doctors both (m , f) serving grades and functional varied greatly within hospital, for example, surgery typically requires concerted efforts on team members gradually differs from anther surgeon's assistants or from one doctor to another based on number of years of experience on medical sector, in addition to degree of doctor Job title or specification wither they are a specialist from first category or a consultant physician. The Long periods and high efforts made by doctors during there periods of studying bound them or requires in search of more benefits and gain in other word substantial material benefits in return, as a result of that public health sector a responsibility to provide financial incentives for those groups of doctors need more incentives to encourage them to work, reflecting basically on their medical achievement and enhancing level of health in areas serving, respondents even feel that there average income is less than average income of other doctors working at other occupations or carrying eligible similar duties at different sector , perhaps due to the characteristics of work as it's noted from previous table doctors were not satisfied with benefits offered for them.

Doctors roles and their relationship to psychological stability and a sense of security:

Social problems challenges facing doctors , cultural, professional and various management, such as obstacles or burdens to there career and domestic work, limited mobility (social), and the absence of job descriptions specific to the doctors can and may effects there stability and psychological sense of security in providing medical knowledge and care to patients . There are several indicators (factors) which may be inferred from it, such as their sense of pride at works , sense of happiness at work, suitability of works according with their wishes, the appreciation of those responsible for them, there since security to continuation of work the availability of opportunities and promotion. These indicators are expressed bellow on Table No.3

Insert table (3) about here

Psychological stability

Its notes from the previous table a sense of doctors regarding to advantages offered by the Doctors profession was moderate, ranging between 3.3 degrees - 3.6 degrees from most benefits available to them, the factor relating elements regarding to there sense of pride and dignity the present or current reality indicates the necessity and importance in providing case of enjoyment and happiness so it can empower them to feel comfort achieving of stability by increasing idea of the place and reflect appreciation of those responsible on them, and a sense of security, and ensure business continuity. But it turned out from the table that doctors facing low degree of chances and promotion, at the beginning of there career as it may resulting at end of career as matter of fact in resettlement of doctors both within the hospital or outside a feature inherent profession thus rejecting the idea of mobility. The degree of doctors qualification which was appointed on the basis of care respondents were asked about some of the factors that hinder the performance of their roles and does it have some relationship with psychological stability and a sense of security, their answers were as shown in table No. (3)

Insert table (4) about here

It's notes from above table (4) that there are an obstacles and clear impede of doctors work, reflects constraints society's resulting on or may have negative opinion for famel doctors profession in particular , this may led to a sense of embarrassment or ashamed, as its referred by the study. Total 25.1% of respondents have a desire to changing there present profession, the analyses indicate 15.1% also have a high desire to change the profession, and 17.8% have a desire or medium scale to change there profession they operate, this is a clear indication of dissatisfaction about their working professionals due to some certain constraints that have been mentioned To address this dilemma must be encouraged to propose strategies effective in the health sector for choosing to work in rural areas voluntarily relying on international experience and national levels.

Hypothesis Testing:

Hypothesis (1):

HO. There is no statistically significant relationship between Remuneration and benefits of physical Occupation.

2. There is no statistically significant relationship between Doctors roles and their relationship to psychological stability and a sense of security.

Ha: There is statistically significant relationship between Remuneration and benefits of physical Occupation.

Insert table (5) about here

One Sample t-test was used to test our hypothesis and we found that (calculated $T = 0.664$) is less than tabulated T . According to our decision rule: Accept H_0 if calculated value is less than tabulated value and reject H_0 if calculated value is greater than tabulated value. So we will accept H_0 and reject H_a . So that there is no statistically significant relationship between Remuneration and benefits of physical Occupation.

Hypothesis (2):

HO. There is no statistically significant relationship between Doctors roles and their relationship to psychological stability and a sense of security.

Ha: There is statistically significant relationship between Doctors roles and their relationship to psychological stability and a sense of security.

Insert table (6) about here

One Sample t-test was used to test our hypothesis and we found that (calculated $T = 2.297$) is greater than tabulated T .

According to our decision rule: Accept H_0 if calculated value is less than tabulated value and reject H_0 if calculated value is greater than tabulated value. So we will reject H_0 and accept H_a . So that There is statistically significant relationship between Doctors roles and their relationship to psychological stability and a sense of security.

Reliability: Cronpanch Alpha was used to test the reliability of the scale and α was (0.8671) which is good because it is greater than accepted percent (0.60).

DISCUSSION AND CONCLUSION

Poor availability of doctors in rural areas is an on going problem in Jordan Badia region. The causes of this reluctance are many folds and all these combine making the problem a complex one. Majority of the studies indicates an urban background has a massive needs to adapt the policy of re rural medical college bee opened at these areas to peruses the internal or external inhabitance to live study and serve these palaces ,studies witnessed that most of medical colleges studies of medicine the curriculum has no community orientation, most doctors thus produced have no orientation or experience of the rural health in other words the doctors are being trained to work only in big hospitals with sophisticated equipment. The service structure of the doctors is such that there are no attractions for working in rural health facilities, rather there are disadvantages affecting their social, professional and family life.In Maan Health Directorate there were 52 sanctioned posts of medical officers in rural health facilities but only 33 were filled. About 38% posts were lying vacant, depicting a very high proportion of medical officers unwilling to work against rural posts.

This is exactly in line with international situation illustrated in literature.Like all individuals, doctors have their own traits and characteristics that distinguish them socially and culturally. Education spanned over 5 to 6 years in medical colleges located in cities and expected living style after graduation, tilts them more to urban living. They develop acquaintances and links with their colleagues and seniors on technical introductions. When sent to rural areas they feel isolated and left out. Irene A identified difficulties in transferring staff to rural areas as many did not want to live in isolated areas. The urban dwellers would willingly go to rural areas of which they have no knowledge, is a killer assumption which might be contributing towards high absenteeism.Although the study showed that 25 % of the doctors had visited the rural health facilities during their student life. But they are lacking training to work in rural health facilities. As mentioned in the “Why medical students will not practice in rural areas” by Zaidi,¹⁷ Students have no community experience and at best gain only superficial knowledge from text books. Although a large number of students had visited primary health care facilities. They very seldom actually interact with rural community.

The infrastructure of our rural Badia health facilities is so poor that a doctor thinks he is being wasted in a rural health facility. He has nothing to offer to his patients, he is clinically deteriorating and a rural posting does not play any role in post graduation. This adds to the reluctance of the doctors which he had developed from family, social and financial reasons.This study showed that a significant number of doctors suggested priority for post graduation as a mean for attracting doctors to rural areas. The same factor was highlighted by Kenneth et al in a study “What Do Doctors Want”. Excessive turn over of doctors in rural areas may be modified by offering them good salaries and locum relief according to the hardship of the area in which they are posted For this purpose an incentive package can be offered to doctors working in rural areas which include higher cash salaries, and special allowances according to the hardship of the post. In this study doctors suggested incentives and salary increase as an important factor for attracting doctors to work in rural areas.

RECOMMENDATIONS

In order to improve the availability of the doctors in public sector health facilities in rural areas following recommendations:

1. There should be special emphasis in MBBS curriculum on primary health care
2. The MBBS curriculum should be made community oriented with more and meaningful visits to rural health facilities
3. The functioning of rural health facilities should be improved by regular and appropriate supply of medicines and diagnostic facilities
4. Rural health Facilities where doctors can not be posted due to absence of basic amenities in recent future might be identified and rather than a doctor a properly trained health technician might be posted there.
5. Rural health academy should be made to train doctors for catering the needs of rural population.
6. There should be regular and meaningful supervision by appointment of properly trained health managers.
7. No doctor should be allowed postgraduate training in any hospital without two years compulsory rural service.

8. Rural posting should be made attractive by providing incentives, such as Special rural allowances based on the hardship of the area to which doctor is posted.
9. Priority should be given for post graduation to the doctors who spend two years in a rural health facility.
10. Special refresher courses should be launched for Medical officers working in rural areas to keep them in touch with the medical advancements.

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Table No. (1)
Distribution of doctors in health facilities in Maan Health Directorate. (n=228)

Facility	%
Maan hospital (Maan)	98
Queen Rania hospital(Wadi Mosa)	64
Rural Health Center (Maan)	38
Basic health center(Wadi Mosa)	28

Remuneration and benefits of physical Occupation:

Table No. (2)

Professional distinctions	Very High		High		Medium		Weak		Very week		Not shown		Total		Degree of job satisfaction	
	Issue	%	Issue	%	Issue	%	Issue	%	Issue	%	Issue	%	Issue	%		
Salary (remuneration)	7	3.2	12	5.5	128	58.4	37	16.9	29	13.2	6	2.7	219	100	2.7	
Secure from material requirements	8	3.7	18	8.2	114	52.1	44	20.1	26	11.9	9	4.1	219	100	2.7	
Income	9	4.1	30	13.7	89	40.6	53	24.2	27	12.3	11	5	219	100	2.7	
Working at health care careers,	7	3.2	29	13.2	102	46.6	37	16.9	37	16.9	7	3.2	219	100	2.7	
Housing	4	1.8	15	6.8	43	19.6	45	20.5	102	46.6	10	4.6	219	100	1.9	

Table No. (3)

Professional distinctions	Very high		High		Medium		Weak		Very week		Not shown		Total		Degree of job satisfaction
	Issue	%	Issue	%	Issue	%	Issue	%	Issue	%	Issue	%	Issue	%	
Gives sense of pride and comfort	55	35.1	66	30.1	55	25.1	24	11	13	5.9	6	2.7	219	100	3.6
Guaranty me of Degree of happiness	42	19.2	57	26	61	27.9	32	14.6	18	8.2	9	4.1	219	100	3.3
Commensurate with my desires	40	18.3	65	29.7	53	24.2	30	13.7	22	10	9	4.1	219	100	3.3
Officials estimation	33	15.1	84	38.4	53	24.2	18	8.2	24	11	7	3.2	219	100	3.4
Stability and a sense of security	28	12.8	74	33.8	72	32.9	21	9.6	15	6.8	9	4.1	219	100	3.4
Ensure continues working	40	18.3	88	40.2	49	22.4	12	5.5	14	6.4	16	7.3	219	100	3.6
Promotion Opportunities	13	5.9	52	23.7	78	35.6	37	16.9	32	14.6	7	3.2	219	100	2.9

A sense of security

Table No. (4)

Constraints play role	Very high		High		Medium		Weak		Very week		Not shown		Total		Average of 5
	Issue	%	Issue	%	Issue	%	Issue	%	Issue	%	Issue	%	Issue	%	
Otherness	42	19.2	47	21.5	75	34.2	22	10	21	9.6	12	5.5	219	100	3.2
Feeling embarrassed	20	9.1	19	8.7	32	14.6	46	21	90	41.1	12	5.5	219	100	3.2
Hard working Occupation	91	41.6	68	31.1	38	17.4	9	4.1	6	2.7	7	3.2	219	100	4
Desire to change profession	55	25.1	33	15.1	39	17.8	38	17.4	48	21.9	6	2.7	219	100	2.8

Table (5)

Test of hypothesis (1)

T calculated	T tabulated	T Sig	Result of Ho
0.664	1.96	0.508	accept

Table (6)

Test of hypothesis (2)

T calculated	T tabulated	T Sig	Result of Ho
2.297	1.96	0.023	reject