UNIVERSITY OF SOUTHAMPTON

FACULTY OF HEALTH SCIENCES

The association between nationality, job satisfaction and 'intention to leave' among nurses in Saudi Arabian government hospitals

by

Husam Almansour

Thesis for the degree of Doctor of Philosophy

March 2017

UNIVERSITY OF SOUTHAMPTON

ABSTRACT

FACULTY OF HEALTH SCIENCES

Thesis for the degree of Doctor of Philosophy

The association between nationality, job satisfaction and 'intention to leave' among nurses in Saudi Arabian government hospitals

Husam Almansour

Background: Job satisfaction is a vital concept in nurse retention. Two reasons are thought to contribute to the severe scarcity of nurses in Saudi Arabia: (a) the nursing profession is considered a low status profession with associated negative public perceptions; and (b) cultural barriers that restrict female access to education and employment, particularly in jobs that require contact between genders. The substantial shortage of Saudi nurses in the Saudi Arabian health system has led to a heavy reliance on foreign nurses. This historical dependence on massive numbers of non-Saudi nurses from countries around the globe, and a fragmented approach to their recruitment, has led to inequalities in the remuneration and treatment of nurses. The multicultural nature of the workforce and its potential impact on job satisfaction renders an investigation into the role of nationality a research priority.

Aim: To examine whether nationality has an effect on job satisfaction and 'intention to leave' among nurses in Saudi Arabian government hospitals.

Methods/Design: A design of mixed quantitative and qualitative methods was utilised in this study. The quantitative element utilised a survey approach; this approach consisted of McCloskey and Mueller's Satisfaction Scale, which was used to measure nurses' job satisfaction across eight types of satisfaction. Additional questions addressed their intention to leave and demographic variables. The qualitative approach utilised semi-structured interviews to further explain any identified associations. The study was conducted in three major government hospitals in Saudi Arabia. The study sample consisted of 747 participants who completed the questionnaire, of whom 26 also participated in semi-structured interviews. Data were collected over a nine-month period between May 2014 and February 2015.

Results/Conclusion: Nurses in Saudi Arabia who participated in the study rated themselves as 'slightly satisfied', with an overall job satisfaction mean of 3.24 out of 5.00. About one-third (29.5%) of nurses intended to leave their hospitals within one year of data collection. While there is no statistically significant difference in overall job satisfaction based on nationality, significant statistical differences based on nationality were found in five job satisfaction subscales. The mean scores of two job satisfaction subscales (satisfaction with extrinsic rewards as well as the family and work balance) revealed significant differences between Saudi and non-Saudi nurses, with Saudi nurses being more satisfied than expatriate nurses. In contrast, the mean scores of three of the other job satisfaction subscales (satisfaction with professional opportunities, praise and recognition, and relationship with co-workers) revealed significant differences between Saudi and non-Saudi nurses, with Saudi nurses being less satisfied than expatriate nurses. The interview data revealed that there were certain factors that nurses in the Saudi Arabian government hospitals perceived were impacting the levels of their job satisfaction and their intentions to leave, and some of these factors varied according to the nurses' nationalities. The findings of the factors affecting the nurses' job satisfaction suggest areas in their jobs that can be targeted for improvement. Improvement of nurses' satisfaction in different areas of their job can result in greater retention in the face of nursing shortages.

Table of Contents

List of tables

List of figures

DECLARATION OF AUTHORSHIP

I, Husam Almansour, declare that this thesis and the work presented in it are my own and has been generated by me as the result of my own original research.

The association between nationality, job satisfaction and 'intention to leave' among nurses in Saudi Arabian government hospitals

I confirm that:

1. This work was done wholly or mainly while in candidature for a research degree at this University;
2. Where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated;
3. Where I have consulted the published work of others, this is always clearly attributed;
4. Where I have quoted from the work of others, the source is always given. With the exception of such quotations, this thesis is entirely my own work;
5. I have acknowledged all main sources of help;
6. Where the thesis is based on work done by myself jointly with others, I have made clear exactly what was done by others and what I have contributed myself;
7. None of this work has been published before submission.

Signed:

Date: 28/03/2017

Acknowledgements

I wish to acknowledge the many people who contributed to my work during my doctoral journey. This thesis would not have been possible without the support, patience and contribution of these generous individuals.

First, I would like to express my deep gratitude and appreciation for my research supervisors, Professor Mary Gobbi and Dr Jane Prichard, for their insightful feedback, comments, constructive suggestions and patient guidance during my candidature. Besides my supervisors, special thanks go to Dr Sean Ewing and Dr Andrew 'Amos' Channon for their assistance with the statistics employed in this study. In addition, I would like to thank Diana Gillen-Buchert for her assistance in transcribing interviews. My grateful appreciation is also extended to all the participants and all those who helped me in conducting this study.

This thesis is dedicated to my beloved wife for her love, patience and the unlimited support she has given me during this doctoral journey, and to my parents, brothers and sisters for their constant support and encouragement throughout my studies.

Definitions and Abbreviations

Definitions

Nurses' Job satisfaction refers to the nurses' reported degree of positive affect for the overall job and its main components.

Nurses' intention to leave refers to nurses' anticipation of vacating their position in the foreseeable future.

Nationality refers to the status of being a citizen of a particular country, whether through birth or naturalisation.

Abbreviations

ANOVA:	Analysis of variance
BSN:	Bachelor of Science in Nursing
HIV-AIDS:	Human immunodeficiency virus infection and acquired immune deficiency syndrome
ICN:	International Council of Nurses
IWS:	Index of Work satisfaction, Stamps & Piedmonte 1986
JCI:	Joint Commission International
JDI:	Job Descriptive Index, Smith 1969
JIG:	Job in General, Smith 1969
JSS:	Job Satisfaction Survey, Spector 1997
KSA:	Kingdom of Saudi Arabia
MMSS:	McCloskey and Mueller's Satisfaction Scale
MOH:	Ministry of Health, Saudi Arabia
MSQ:	Minnesota Satisfaction Questionnaire, Weiss et al. 1967
NHS:	National Health Service, the United Kingdom

NSS:	Nurse Satisfaction Scale, Ng1993
NWI:	Nursing Work Index, Kramer & Hafner 1989
NWI-R:	Nursing Working Index-Revised, Aiken & Patrician 2000,
PES-NWI:	Practice Environment Scale of Nursing Work Index, Lake 2002.
PHCCs:	Primary Health-care Centres, Saudi Arabia
UAE:	United Arab Emirates
UNDP:	United Nations Development Program
UK:	United Kingdom
US:	United States
WHO:	World Health Organisation

Chapter 1: Introduction

This introductory chapter provides background information about the research project and its significance. It highlights the rationale for the focus of this study, and it presents the research aim and objectives and the research questions. Finally, it introduces the layout of this thesis.

1.1 Background

Job satisfaction is one of the most frequently cited variables in organisational behaviour research, and it is a central element in both the research and the theory of organisational phenomena extending from job design to supervision (Spector 1997). Job satisfaction is an essential issue to any organisation as it is considered an indicator of the physical and psychological states of its employees (Spector 1997).

Price (2001) defined job satisfaction as an affective orientation that an employee has towards his or her work. Job satisfaction was also defined as: 'an affective feeling that depends on the interaction of employees, their personal characteristics, values, and expectations within the work environment, and the organization' (Cumbey & Alexander 1998 p. 39). Similarly, Locke et al. (1981) stated that job satisfaction and dissatisfaction are a result of the perceived association between what one needs from one's job, and what one perceives it offers or entails. Job satisfaction or dissatisfaction therefore relies on a combination of the nature of the job in a particular organisational setting, and on the expectations that individuals have of what their job should offer.

1.2 Rationale for choice of study

Job satisfaction is a topic of wide interest for organisations, managers and researchers, as it relates to performance and productivity within the work setting (Spector 2012). Al-Dossary et al. (2012) stated that it is vital for administrators to understand the basis of job satisfaction because of the serious effects of dissatisfaction in the workplace.

Nurses are the largest group of frontline health care providers both in Saudi Arabia and internationally. In nursing, job satisfaction is a key factor in nurses'

recruitment and retention, as well as patient safety and satisfaction (Murrells et al. 2008; Aiken et al. 2012; Coetzee et al. 2013; You et al. 2013). Ball (2004) found that shortages in the global nurse labour force are attributable in part to dissatisfaction within the nursing profession. This is further supported by other studies, which have suggested that job dissatisfaction is a major factor influencing nurses' turnover (Cavanagh & Coffin 1992; Blegen 1993; Irvine & Evans 1995; Collins et al. 2000; Hayes et al. 2012).

With job satisfaction emphasised as one of the essential reasons for nursing shortages – an issue which has significant effects at a public and strategic level (Newbold 2008; Flinkman et al. 2010) – it is vital to have a thorough understanding of the factors that influence it in both positive and negative ways. The Saudi Arabian health care system suffers from a nursing shortage, as do the systems of many countries in the world. In the most recent Saudi Arabian Ministry of Health statistical book, it was reported that there are only 5.4 nurses per 1000 people in Saudi Arabia (Ministry of Health 2014). The nursing workforce shortage in Saudi Arabia is worse than it is in the United Kingdom where there were 8.8 nurses per 1000 people in 2013 (WHO 2016). In addition, there is a growing demand for nurses in Saudi Arabia because of the major expansion in all health services resulting from rapid population growth.

Research on job satisfaction has been undertaken worldwide, and studies from Western countries have indicated that hospitals with sub-optimal work environments and administrative practices, such as limited nurse participation in decision-making, were more likely to report dissatisfaction and intention to leave the hospital (Aiken et al. 2012). However, given the contingent nature of job satisfaction in the organisational setting, which can vary across many dimensions such as existing health policy frameworks, it is necessary to be cautious about generalising findings from one culture to another. Cultures may vary in terms of how different aspects of a work environment are valued. This is especially the case where that context deviates significantly from Western cultures. In Saudi Arabia, there are some unique cultural issues around the nationality of the nursing workforce and the gender beliefs of the population, which makes it difficult to apply generalisations from existing research. Therefore, in order to understand job satisfaction in a particular setting, it is necessary to undertake primary research within the context of interest.

Evidence is limited on the effect of nationality on nurses' job satisfaction and 'intention to leave'. In Saudi Arabia, there are also unique issues around nursing workforce shortages, which make nationality an important issue in this study because the shortage has led to a heavy reliance on hiring foreign nurses. The shortage of Saudi nurses has been attributed to a lack of interest in professional nurse training among young Saudi Arabians (Al-Omar 2004). This is compounded by cultural barriers that restrict female access to education and employment, particularly in jobs that require contact between males and females (Al-Ahmadi 2002). Another reason for the severe scarcity of Saudi nurses is that the nursing profession has been undervalued and badly misunderstood, as it is considered a low status profession. It has not been appreciated because of an inequality in the perceived values of labour typically performed by men and typically performed by women (Al Osimy 1994). Young Saudis, both males and females, choose professions other than nursing which offer higher financial rewards and greater prestige (Al-Swailem 1990; Al-Omar 2004).

To address the dependency on non-Saudi nurses, in 1987 the government introduced a policy of 'Saudisation', which is a process of replacing non-Saudi employees with Saudi employees (Aboul-Enein 2002). As a result, the percentage of Saudi nurses has risen from 15.5% in 1996 to 33.6% in 2011 (Ministry of Health 1996; Ministry of Health 2011). However, although the policy of 'Saudisation' has led to an increase in the number of Saudi nationals entering the profession, cultural aspects, such as gender inequality in the workplace and a patriarchal power structure, remain as a potentially negative influences on job satisfaction. Therefore, research needs to be undertaken to understand the factors that nurses perceive as important to their job satisfaction and to determine if these factors vary based on the nurses' nationalities.

Despite the Saudisation process, there is still a heavy reliance on foreign nurses. The country's reliance on expatriate nurses places Saudi Arabia's health-care infrastructure in a vulnerable position, specifically considering the worsening worldwide shortage of nurses. In fact, Saudi Arabia is in a unique situation compared to other developed countries that are also experiencing a nursing shortage. Unlike other developed countries, such as the US and the UK, Saudi Arabia's nursing leadership has insufficient nurse labour research to

guide workforce strategies for developing nursing labour in the future. If expatriate nurses are not found for the Saudi health market, Saudi Arabians' public health will be at risk.

Saudi Arabia employs staff from several countries with which it enjoys cooperative and peaceful relationships. Buchan et al. (2005) reported that the UK, Saudi Arabia, New Zealand, and Australia were the most common destinations for migrant nurses. However, the historical reliance on significant numbers of non-Saudi nurses has led to inequalities in the remuneration and treatment of nurses from different countries, which may impact on nurses' job satisfaction and turnover. Ball (2004) stated that Egyptians, Indians, Pakistanis, and Filipinos were working in base-level nursing positions in Saudi Arabian hospitals, whereas North American and British nurses worked in senior or administrative positions. Another crucial element related to foreign nurses' levels of satisfaction is that some nurses are at a disadvantage as care providers because of language barriers, cultural differences, and relatively short-term commitments (Trucker & Zee 1981; Al-Swailem 1990). Furthermore, the Saudi government does not offer Saudi citizenship or permanent residency for foreign workers, which may have an impact on their long-term intentions to stay. Lack of stability for foreign nurses might have an impact on their job satisfaction, commitment, and productivity. Therefore, a complex interplay exists among Saudi Arabia's country-specific factors as they relate to the nationality of nurses, which includes elements such as wages, language, culture and migration status. In addition, issues concerning migrant nurses involve the interaction between the host country (Saudi Arabia) and the nationality of the nurses, specifically regarding cultural similarity, language differences and expectations.

Although many studies have surveyed nurses to measure job satisfaction, no previous study has examined the effects of nationality on job satisfaction and 'intention to leave', using mixed quantitative and qualitative research methods. This study uses a mixed methods design with both quantitative and qualitative data; it seeks to advance our understanding of job satisfaction through considering the under-researched cultural context of nursing in Saudi Arabian government hospitals. Examining the effect of nationality on nurses' satisfaction and their intentions to leave their hospitals can inform the

development of policies designed to create a healthy working environment and to recruit and retain nurses in the face of shortage crises.

1.3 Research aim, objectives and questions

Aim: The overall aim of this thesis is to examine whether nationality has an effect on job satisfaction and 'intention to leave' among nurses in Saudi Arabian government hospitals. Examining these relationships can inform the development of policies designed to create a healthy working environment, and to recruit and retain nurses in the face of shortage.

In order to achieve this aim, the research addresses the following objectives:

1. To examine job satisfaction among nurses in Saudi Arabian government hospitals.

2. To examine the relationship between job satisfaction and the intention to leave among nurses in Saudi Arabian government hospitals.

3. To explore whether nationality has an effect on job satisfaction and intention to leave hospitals among nurses in Saudi Arabian government hospitals.

4. To offer recommendations for policy makers and managers, regarding strategies to retain nurses in Saudi Arabia.

Specifically, this study answers the following research questions:

1. What are the levels of job satisfaction and intention to leave among nurses in Saudi Arabian government hospitals?

2. What is the relationship between job satisfaction and intention to leave for nurses in Saudi Arabian government hospitals?

3. Do job satisfaction and intention to leave vary by nationality for nurses in Saudi Arabian hospitals?

4. What are the factors that nurses perceive as important to their job satisfaction and intention to leave? Do these factors vary across nationalities?

1.4 Layout of the thesis

This thesis is presented in seven chapters. This introductory chapter has highlighted the rationale for the focus of this study, and stated the research aims, objectives, and questions. Chapter 2 describes the cultural context of Saudi Arabia to orient the reader and support the interpretation of the research findings. It briefly sets out information regarding the development of the country, its economy, the role of women in the society, and the Saudi health system. The chapter continues by addressing the nature of nursing in Saudi Arabia. This includes determination of the current issues surrounding nursing in Saudi Arabia, nursing migration globally, and nursing migration to Saudi Arabia. Chapter 3 presents a review of the literature. This presents definitions of the key terms of job satisfaction and intention to leave and the related theories of these concepts. The chapter includes a literature search strategy followed by a systematic process of critiquing and synthesising Saudi and non-Saudi studies related to job satisfaction and intention to leave among nurses. The synthesis reveals a clear gap of knowledge, which provides ample justification for conducting the study. Chapter 4 presents the methodology employed by the research. This includes the research design, the geographic location of the study, data collection tools, reliability and validity of the instruments, data collection and analysis procedures, and ethical considerations.

Chapter 5 presents this study's quantitative results, including descriptive statistics concerning the study's participants. In addition, the quantitative results include bivariate statistics and regression analysis. Chapter 6 reports the qualitative findings of this study, which involve two sources of qualitative data. The primary source of qualitative data came from semi-structured interviews, while the secondary qualitative component consisted of a questionnaire. The discussion chapter follows the quantitative results and qualitative findings chapters. The discussion chapter addresses each of the research questions, and positions these results within the most current literature through comparison with similar studies. The recommendations of the study are presented in the discussion chapter, together with statements concerning the methodological challenges, and limitations of the research methods.

Chapter 2: Context of Study: Saudi Arabia

2.1 Introduction

This research concerns the effects of nationality on job satisfaction and intention to leave among nurses in Saudi Arabian government hospitals. This thesis maintains that in order to understand job satisfaction, it is necessary to consider primary research within the context of interest due to the contingent nature of job satisfaction in the organisational setting, which can differ across many dimensions. Therefore, it is essential to provide an overview of the background context of the study. This chapter presents a brief overview of Saudi Arabia's development, its economy, the role of women in society, its health system, and a description of both the national and expatriate nursing workforce in Saudi Arabia.

Saudi Arabia is an independent Muslim Arab monarchy, established in 1902 by King Abdul-Aziz Al-Saud. The official name of the country, the Kingdom of Saudi Arabia, came into existence in 1932, after an approximately 30-year campaign to unify most of the Arabian Peninsula, when Abdul-Aziz Ibn Al-Saud, who was concurrently King of Hejaz and Sultan of Najd and Dependencies, united the two parts of his state under one kingdom (Al-Sadan 2000). The executive and legislative branches of the Saudi Arabian government are represented by the King, the council of ministers, and the consultative council 'Majlis Al-Shura' (Mufti 2000). The King, known as the Custodian of the Two Holy Mosques, is the head of the country and the prime minister, and is advised by the Council of Ministers, and Majlis Al-Shura (Mufti 2000). The King is supported by the Crown Prince, who occupies the deputy prime minister position, and a second deputy prime minister. The King supervises the cabinet and the government bodies and observes the implementation of rules and regulations. In the Kingdom, the formation of political parties is prohibited.

The Kingdom has a vast area, as it is slightly more than one-fifth the size of Europe. The Kingdom is located in the southwest corner of Asia, occupying a strategic position at the crossroads of Europe, Asia, and Africa. It is surrounded by the Red Sea on the West, by Yemen and Oman on the South, the Arabian Gulf and the United Arab Emirates and Qatar on the East, and Jordan,

Iraq, and Kuwait on the North. Figure 2-1 shows the location of the Arabian Peninsula and how Saudi Arabia occupies the largest part of this area. The topography of the Kingdom is mainly desert with an arid climate evidenced by the extremely high summer temperatures, together with humidity along the coast (Central Department of Statistics & Information 2013).

Figure 2-1: Location of Saudi Arabia (Source: Google Maps)

The Kingdom consists of thirteen different provinces, which include more than 6,000 cities, towns, and villages, as well as the capital city Riyadh, which occupies a central location. The five main cities are: Riyadh, Dammam (the main port in the eastern region), Mecca and Medina (the holy cities of Islam), and Jeddah (the main port in the west) (Central Department of Statistics & Information 2013). Islam is the main aspect that shapes the Saudi culture. Just as the Vatican is the home of Roman Catholicism, the Holy Mosque in Makkah, Saudi Arabia, is the home of Islam. Hundreds of millions of Muslims turn their faces in the direction of the Holy Mosque in Mecca five times a day and pray

toward it. One of the pillars, or central beliefs, of Islam is Hajj—pilgrimage. Saudi Arabia and Mecca host pilgrims for Hajj yearly, which is a one-time journey for those Muslims who can afford it. Millions of Muslims come to Saudi Arabia for that purpose each year. Hajj is performed at a strictly designated time of the year, whereas Umrah can be performed at any time.

Recently, the Central Department of Statistics & Information (2013) estimated that the total population in Saudi Arabia in 2012 amounted to 29,195,895 people. Of these, the Saudi national population in 2012 amounted to 19,838,448, with approximately 10 million non-Saudi residents who comprised 80% of the labour force in the Kingdom. Saudi Arabia has one of the largest oil reserves in the world, thus it is one of the largest oil exporters (Aldossary et al. 2008). After the discovery of oil, the economic status of the Kingdom improved remarkably. In 2011, the Gross Domestic Product (GDP) of Saudi Arabia was estimated to be $576.8 billion, generated primarily from its huge oil resources (World Bank 2013). In 2012, Saudi Arabia was the world's largest producer and exporter of total petroleum liquids, the world's leading holder of crude oil reserves, and the world's second largest crude oil producer behind Russia (US Energy Information Administration 2013). However, although the World Bank placed Saudi Arabia in the 'High income economy' group (World Bank 2013), the percentage of families living in extreme poverty was 1.63% in 2004, and there are still some people living in extreme poverty (United Nation Development Program 2013).

Throughout the nation's history, the Saudi government has attempted to develop and implement services, including health, education and social services, to address the needs of its growing population. Education was seen as essential in building the labour resources in Saudi Arabia. Thus, the Ministry of Education and the introduction of the public education for girls were implemented in the 1950s, despite the consternation from conservatives at the beginning of this initiative. In 1963, the country established its first television station, which like many other new policies also aroused strong objections from the religious and conservative people in the Kingdom. At that time, the government assured the population that Islamic principles of modesty would be strictly observed, and made sure that the broadcasts contained significant levels of religious programming. Currently, in addition to Internet access, people in Saudi Arabia can select between hundreds of government and private

free-to-air satellite broadcasting channels to watch different types of programs such as general family entertainment, movies, music, children's shows, and sports.

2.2 Role of woman in the Saudi society

In Saudi Arabia, there is growing awareness that women have an important role to play in the labour market, but pervasive socio-cultural customs continue to limit the scope and extent of that role (Hamdan 2005). Although many Saudi men appreciate the opportunity for women to contribute economically, others fear change. There are cultural barriers restricting women's access to employment, particularly in jobs that require contact between males and females. Saudi Arabia differs from other Islamic Arab countries in its cultural orientation. For instance, the majority of Saudi women cover their faces in the presence of an unrelated male; wearing a loose-fitting garment called an abaya that covers the body, and a black headscarf that covers the hair. In addition, in order to study or practise nursing, Saudi females need to seek permission from a male member of the family (father or husband). Once in work, patriarchal power patterns continue to influence female nurses on a daily basis, as male relatives must drive these nurses to the hospital or school because women do not drive. These examples illuminate the contrast between the society's religious and cultural norms and those of other Islamic countries. They also help explain why Saudi Arabia's own female labour is reluctant to join in a profession that is fraught with family, cultural, and religious conflicts. Jobs that do not require women to mix with men (e.g. teaching) are regarded as more appropriate by many Saudi families.

The cultural orientation of the Saudi population has led to higher unemployment among Saudi women than among Saudi men, and limited the acceptable work roles for women in the society. The Ministry of Labour (2015) reported that 651,000 Saudis (11.7%) were unemployed by the end of 2014. At the same time, there are 10 million non-Saudi residents, who comprise 80% of the labour force in the Kingdom. The resolution of unemployment among Saudi nationals remains challenging. In general, lower-skilled jobs that pay low wages are occupied by an expatriate work force, whose standard of living is lower than the standard for other socioeconomic classes within the Kingdom. The Saudi government seems reluctant to establish a competitive minimum

wage for these jobs to motivate members of the Saudi workforce to occupy them. Unemployment among Saudi women was 32.8% compared to only 5.9% among men. This suggests more than the failure of Saudi economies to generate enough jobs; it points to entrenched social biases against Saudi women.

Concerns over cultural biases have contributed to the United Nations Development Programme (UNDP) (2009) stating that Arab countries must rebuild their societies based on freedoms associated with human rights and the empowerment of women. Arab women are bound by patriarchal patterns of kinship, social subordination and ingrained male dominance. In Arab countries, women are in a lowly position in relation to decision-making within the family. Marriage laws worsen the problem because the majority of them (including Saudi Arabia's) authorise a husband's custodial rights over a wife. This is further supported by laws on rape, which are either ambiguous or actively biased against women. Family and society join to deny occurrences of rape, preserve the image of virginity, and downplay the crime (UNDP 2009).

Although women's rights in Saudi leave much to be desired, the Saudi government has made significant changes since the beginning of the last decade. For example, the Ministry of Interior started issuing the first ever identity cards for Saudi women, thus making it immensely easier for women to carry out significant financial, legal, and social transactions. Previously, women were registered on their husband's or father's identity cards. Also, in 2005, the foreign scholarship program was established to provide funds for qualified Saudi students to pursue studies in world universities in more than 24 countries. The scholarship program is an opportunity for thousands of Saudi citizens (both men and women) to experience living in other countries with different cultural orientations.

These reforms have had a positive impact on the role of women in Saudi society. For instance, in 2009, Saudi Arabia had its first woman to hold a ministerial rank, as the deputy minister of education, and has had its first 30 women appointed in the consultative council (Majlis Al-Shura). As progress continues, it should have further effects on the role of women in Saudi society, the development of the country, and the health care system.

2.3 Health care system

2.3.1 History and evolution of health care services

Since the Kingdom was established, public health and disease control were among the government's priorities. In 1925, the government established the Public Health Department and the Public Health and Ambulance to meet the needs of the Kingdom's health and environmental sectors (Ministry of Health 2015). In 1946, the total number of hospital beds in the whole Kingdom was around 300.

In 1951, the Ministry of Health was established to create a large-scale, specialised department to oversee the Kingdom's health needs (Ministry of Health 2015). Although the number of beds increased in the following decade, a major part of the population during the 1960s relied on traditional forms of health care (Mufti 2000). These forms included reciting the Holy Quran, herbal medicine, honey, the black grain Nigella sative, and cautery. In 1962, organised health care in Saudi Arabia started although progress was painfully slow due to the limited funds available at this time (Mufti 2000). By 1987, the number of hospitals was 149, with over 26,000 beds, 1,480 dispensaries, more than 4,000 physicians, and more than 30,000 nurses including Saudi and non-Saudi workers (Tumulty 2001).

In approximately six decades, Saudi Arabia has created a health care system that has improved the population's health. According to Al-Yousuf et al. (2002), the nation's oil revenues improve the national economy, which has a positive impact on the country's health care services. More recently, the Ministry of Health (2011) reported that the life expectancy at birth in Saudi Arabia was 72.7 years for males and 75.1 years for females. Due to compulsory vaccinations that took place in the 1980s, the mortality rate of children under 5 years of age has dropped dramatically from 250 per 1000 live births in 1960 to 26 per 1000 in 2005 (Aldossary et al. 2008). The Ministry of Health (2011) reported that there were 420 hospitals in the Kingdom, including 251 hospitals operated by the Ministry of Health (MOH), 39 operated by other government agencies, and 130 hospitals owned and operated by the private sector. In 2011, the total number of physicians including dentists was 69,226,

and the total number of nurses was 134,632 nurses, of whom only 33.6% are Saudi nationals (Ministry of Health 2011).

2.3.2 Components of the health care system

Although providing free health care services for every citizen is outlined in the Basic Law of Saudi Arabia, the health care system is more complicated than it may appear. There are several government and private agencies that provide health care services in Saudi Arabia. The MOH provides the largest part of the total health services in Saudi Arabia (Mufti 2000; Khaliq 2012). The MOH supervises twenty regional directorates of health affairs in various provinces of the Kingdom. These regional directorates supervise health care facilities and hospitals in their areas. The MOH Primary Health-Care Centres (PHCCs) deliver the first point of contact with a public health provider, providing laboratory, radiology, dental, and medical services (Albejaidi 2010). The PHCCs have connections with general hospitals and tertiary care hospitals. A patient referral system from the general hospital to secondary and tertiary care hospitals should insure control over the utilisation of the facilities. The PHCCs and the patient referral system provide accessibility for all Saudi people while reducing costs. All services in the PHCCs and government polyclinics are available free of charge for Saudi citizens.

The other major government health agencies include the Ministry of the National Guard, the Ministry of Defence, and the Ministry of Interior. These other agencies provide primary, secondary, and tertiary care to their staff and dependents and to some eligible patients (Mufti 2000; Khaliq 2012). For instance, the Ministry of the National Guard operates 60 primary or secondary health care centres and four hospitals, with more than 1,400 beds, in different parts of the country. Similarly, the Ministry of Defence operates another 10 hospitals with approximately 3,500 beds. Services at these establishments are available only to employees of those ministries and their families (Khaliq 2012).

In addition, the university hospitals provide primary and specialised health services combined with teaching purposes, while the King Faisal Specialist Hospitals provide services to patients on a referral basis. The Royal Commission of Jubail and Yanbu delivers health care to their employees and

dependents at the two industrial cities, and the presidency of the youth welfare has a specialised sport medicine hospital. Moreover, the Saudi Red Crescent Authority provides emergency services to the population, while yet another agency, the Saudi Food and Drug Authority, authorises the use of new drugs.

Medical care is free at MOH facilities for Saudi people, although an increasing trend is occurring in which Saudis are paying for medical treatment at private hospitals due to lack of access or availability of beds in public facilities. The private sector provides health care to Saudi citizens and private expatriates through health insurance plans with the employer. Over time, policy makers have come to realise that the existing model of health care financing and delivery was neither efficient nor sustainable (Khaliq 2012). One of the challenges in the health care system is the lack of cost awareness on the part of administrators, physicians, and patients. This lack of economic knowledge leads to an unnecessary use of resources without the justification of patient need or resulting health benefits (Mufti 2000). Regardless of whether Saudi oil reserves will be depleted in 50, 100 or 200 years, affecting all government sector financing, there remains a need to establish a third-party payment mechanism and some form of cost-shifting that influences both consumer and provider behaviour (Khaliq 2012). Financing medical care is one of the challenges for the Saudi government. Rising costs in health care in Saudi Arabia have been attributed to several factors such as the growing population, demographic changes, availability of technology, the system of free health care, and the reliance on foreign health-care workers (Mufti 2000). Mufti (2000) stated that the Saudi people are increasingly dissatisfied with the quality and efficiency of health-care services even though the services are delivered free. In 1999, the Saudi government implemented an independent body to control utilisation of health-care services for non-Saudi residents. All private sector companies must now cover their workers with health insurance, and this is linked with the resident certificate renewals (Council of Cooperative Health Insurance 2015).

2.3.3 Type of hospital—operation and accreditation

The MOH in Saudi Arabia carries enormous responsibilities. As well as providing and supervising public health care services, the MOH is responsible for controlling and supervising health care services provided by the private

sector. These numerous public and private health care responsibilities may adversely affect the quality of the services provided to the population directly by the MOH. Almalki et al. (2011) stated that the MOH may not be able to meet the population's health care needs unless serious, well-planned steps were taken to separate these multiple roles. Almalki et al. (2011) further suggested that the regional directorates needed more autonomy. Mufti (2000) opined that the functioning of the regional directorates was adversely affected by their lack of individual budgets and spending authority. Expenditure for the majority of regional directorates' activities must be authorised by the MOH; this oversight affects the autonomy of regional directorates and hampers effective decision-making (Mufti 2000; Almalki et al. 2011).

In terms of hospital autonomy, the MOH has tried a number of strategies for improving the management of public hospitals, including direct operation by the MOH and a system of autonomous hospitals (Almalki et al. 2011). Considering the advantages and disadvantages of these approaches, the MOH has implemented an autonomous hospital system for a number of hospitals in the Kingdom (Almalki et al. 2011), gradually giving more authority and flexibility to hospital administrations in the management and operation of their hospitals (MOH 2014). The hospitals that have more authority are known as Hospital Operation Programme (HOP) hospitals. Therefore, there are two types of hospital operation within the Saudi government-run hospital system: hospitals run directly by the MOH, and hospitals that are run under the HOP. Understanding the type of hospital operation and accreditation in Saudi Arabia is important to orient the reader and to support the interpretation of this study's findings, especially in discussing differences in job satisfaction score across hospitals.

The HOP is expected to raise the efficiency and performance of both medical and managerial functions, achieve financial and administrative flexibility through the adoption of a direct budget strategy, and apply quality assurance programmes (Al Shaikh 2001; Almalki et al. 2011). Currently, there is a lack of solid data differentiating between hospitals that run under the direction of the MOH and hospitals operated under the HOP. However, one confirmed difference between these hospitals is the employment of staff. HOP hospitals often recruit through a self-employment programme that offers autonomy for hospitals to hire the required labour force by establishing their own annual

employment contracts. In hospitals that are directly run by the MOH, the employment of Saudi staff is conducted through the Saudi Arabian civil services, and Saudi health professionals are appointed to their positions by the MOH and the Ministry of Civil Services. In this civil service form, employment is considered a permanent job. In addition, each HOP hospital has its own human resource policies for contracting expatriate health professionals, including nurses; whereas the hospitals that run under direct operation from the MOH do not have an individual recruitment process, so they rely on MOH recruitment and hospital managers do not have the autonomy to select their employees.

Developing quality management programmes is a priority in Saudi Arabia, and resources are being devoted to this effort (Tumulty 2001). Saudi Arabia has recently taken an interest in quality improvement and obtaining international accreditations. Hospital accreditation standards provide the baseline for autonomous hospital administration, including nursing management within the organisation. However, the country's move toward an accreditation system creates a challenge for the health care infrastructure (Almalki et al. 2011). Part of the problem is that there are two types of quality accreditation for hospitals in Saudi Arabia. One type of accreditation is granted by an international organisation, such as the Joint Commission International (JCI). The second type is granted by the Central Board of Accreditation for Health Care Institutions (CBAHI), which is the national accreditation for Saudi Arabia. The JCI accreditation is considered a higher standard than the CBAHI. In pursuit of higher quality standards, the MOH's current accreditation plan includes all MOH and private hospitals in Saudi Arabia, with the explicit goal of implementing the complete CBAHI accreditation system. To date, some MOH hospitals have failed to achieve any form of quality accreditation. Moreover, as the quality management movement continues in Saudi Arabia, health care leaders, including nursing managers and directors, are also seeking 'magnet' status recognition. To date, the King Faisal Specialist Hospitals, with two branches in Riyadh and Jeddah, are the only hospitals that have received the prestigious magnet recognition.

In the past, Saudi health care professionals, including nurses, who worked at accredited hospitals, received higher salaries than their peers at unaccredited hospitals. Therefore, health care professionals who worked in Ministry of Health organisations received lower salaries than at other types of hospitals

(e.g., National Guard Hospitals and King Faisal Specialist Hospitals). In 2008, however, the MOH, with cooperation from other government health agencies, equalised the salaries among Saudi health care professionals working in different types of government hospitals across the country. However, the MOH did not equalise wages across different nationalities.

2.4 Nursing in Saudi Arabia

2.4.1 Nurse education

Early nursing needs in the Kingdom were primarily filled by foreign nurses. For a long period, the nursing profession was condemned and badly misunderstood by Saudi society (Al Osimy 1994; Tumulty 2001). It was not appreciated because of an inequality in the perceived value of labour typically performed by men, and that typically performed by women (Al Osimy 1994). In a study conducted in 2003, Saudi high school students showed little interest in the nursing profession compared with medicine, computer science, and teaching. Nursing was perceived as having long working hours, requiring contact with the opposite sex, and lacking respect in Saudi society (Al-Omar 2004).

The first official training for Saudi nurses was developed at a health institute in Riyadh in 1958 as a cooperative agreement between the MOH and the World Health Organisation (WHO) (Tumulty 2001). Fifteen male students with elementary school preparation were admitted to the 1-year program. Then, two other health institutes were opened in Jeddah and Hofuf. Later, nursing education for women was initiated with the opening of two health institute programs in Riyadh and Jeddah (Tumulty 2001). The educational program for nurses originally included the curriculum of fifth and sixth-grade levels. In 1981, the Gulf countries agreed to accept students after intermediate school (ninth grade), and the curriculum was increased to 3-years (Al Osimy 1994). In 1976, a Bachelor of Science in Nursing program was established in the College of Nursing at King Saud University in Riyadh, followed by the Master of Science in Nursing program in 1987 (Al Osimy 1994).

The Saudi government has attempted to recruit Saudi nurses for their facilities by establishing a number of nursing colleges in different area of the Kingdom.

Recently, the MOH established a new policy to recruit only nurses who acquired a bachelor's degree in nursing for new employment in the Saudi Arabian government hospitals. Thus, the Saudi government transferred the duties of the institutes of health, including responsibility of nursing education, from the MOH and placed them under the umbrella of the country's universities. With nurse diploma qualification certification ceasing in 2011, there are now over fifteen nursing undergraduate and graduates schools in the Kingdom. The bachelor's program takes four years, followed by a twelve-month internship program. In general, nursing education seems to be similar to nursing education in some Western countries in terms of the length of study. In recent years, several countries have started to insist that nurses acquire bachelor's degrees. In the UK, for example, all new nurses must hold bachelor's degrees in nursing to enter the profession beginning in 2013.

In order to get a nursing job in Saudi Arabia, foreign nurses must pass a licensing exam. The Saudi commission for health specialties is responsible for formulating the license exam. It is also responsible for establishing continuing education programs and accrediting organisations that offer training for nurses. Nurses are required to provide proof of continuing education every three years when renewing their registration. In addition, the Saudi commission for health specialties is responsible for the academic side and for the registration process for nurses as well as other health professionals.

2.4.2 Saudisation

In 1987, the Saudi Central Nursing Committee was developed to improve the quality of nursing care, and to lobby for proposals introducing the Saudisation process of replacing non-Saudi employees with Saudi employees (Aboul-Enein 2002). In response, the percentage of Saudi nurses has risen from 15.5% in 1996 to 33.6% (Ministry of Health 1996; Ministry of Health 2011).

In the absence of a sufficient number of national nurses, Saudi Arabia employs staff from several countries. The MOH primarily recruits nurses from India and the Philippines (Tumulty 2001), but there are as many as forty countries represented in the nurse workforce (Kline 2003). In addition to wages, foreign nurses are offered free furnished accommodations, and since women are not allowed to drive in Saudi Arabia, the nurses are also offered free transportation

to and from their hospital workplace. Expatriate nurses in Saudi Arabia have found that contracts and benefit packages differ depending on the standard of living in the nurses' country of origin. Ball (2004) reported that Indians, Filipinos, Pakistanis, and Egyptians work in base-level positions in Saudi Arabian hospitals, whereas North Americans and British work in senior or administrative positions.

2.4.3 Nurse migration

2.4.3.1 Introduction

Since this research aims to examine the effect of nationality on job satisfaction and intention to leave among both Saudi and non-Saudi nurses, it is necessary to provide a quick review of the nursing migration history in order to understand the Saudi pattern of recruitment and retention. Population migration has been a fact of life from time immemorial; however, the current wave of global migration is different in several ways from that which happened in the 19th and early 20th centuries. In the past, migration primarily consisted of poor people who were trying to find jobs (Mejia et al. 1979). In contrast, contemporary migration involves the elite from poorer countries migrating to richer countries, leading to the terms "brain drain" and "brain gain" (Mejia et al. 1979, p. 4). This wave of migration can lead to widening gaps between poor and rich countries.

The WHO recommended an investigation into the reasons behind the health-care migration and a plan to resolve the problem (Mejia et al. 1979). From the investigation, they found that the root reason for the migration was the social and economic problems of every country's health care system, such as poor planning of the health workforce, lack of job satisfaction, economic instability, discrimination and corruption (Mejia et al. 1979). Therefore, the migration of health labour would not be fixed on its own and would take the commitment of governments to resolve the more complex social and economic issues of their health care systems (Kingma 2006; Dywili et al. 2013). The next sections provide a brief review of nurse migration including the push and pull factors, the global nursing migration trends and the effect that migration has on the source and receipt countries and individual migrants.

2.4.3.2 Push and pull factors

The underlying reasons for nurse migration are complicated (Dywili et al. 2013; Li et al. 2014). There are push factors from donor 'source' countries and pull factors from recipient 'destination' countries that influence nurses' migration (Mejia et al. 1979; Kingma 2006). Push factors are forces that inspire health labour from donor countries to migrate, and pull factors are forces that attract nurses to recipient countries (Mejia et al. 1979; Kingma 2006; Alonso-Garbayo & Maben 2009). Push and pull factors are the two essential sets of central and intertwined factors that drive migration (Kingma 2006). Push and pull factors often mirror each other, as without both forms of forces working in unison, little migration would occur. In other words, no matter how strong the pull forces, large-scale migration will not take place from countries where strong push forces do not exist (Mejia et al. 1979; Kingma 2006).

The pull factors include high salaries, job satisfaction, safe work environments, professional development opportunities, political and economic stability, active recruitment strategies, and planned health care systems (Mejia et al. 1979; Kingma 2006; Smith et al. 2009). Other pull factors are the presence of family and friends, and a large expatriate community in the recipient country (Buchan & O'May 1999; Dywili et al. 2013). The push factors include poor planning concerning the health workforce, poor remuneration and salaries, lack of job satisfaction, economic instability, lack of resources to work effectively, high workload, poor management and leadership, discrimination, corruption, professional isolation, lack of education and training, inadequate utilisation of trained personnel, and work-associated risks such as exposure to HIV/AIDS without the proper protection equipment (Mejia et al. 1979; Padarath et al. 2003; Kingma 2006; Smith et al. 2009; Dywili et al. 2013). Saudi Arabia is considered one of the main recipient countries of migrant nurses, as the Kingdom is unable or reluctant to produce enough Saudi nurses. However, there is a lack of literature regarding what pulls migrant nurses to work in Saudi Arabia.

2.4.3.3 Nurses' migration trend

In addition to these push and pull factors, nurse shortages in some countries, including Saudi Arabia, have accelerated international nurse migration. In turn, nursing migration has sparked debate about the consequences for both the

sending and receiving countries in meeting global health care needs (Aiken et al. 2004). Buchan et al. (2005) reported that the UK, Saudi Arabia, New Zealand, and Australia were the most common destinations for migrant nurses.

International organisations have created different initiatives and policies to address the development and retention of the nurse workforce. In 2001, for instance, the International Council of Nurses (ICN) published its statement governing nurse mobility and the ethical recruitment of nurses internationally (ICN 2001). The key principles of the ICN statement include effective human resources management and development leading to national self-sustainability, credible nursing regulation, freedom from discrimination and equal pay for work of equal value (ICN 2001). In 2006, the WHO (2006a) called for strategies to improve nurse education and employment and to promote retention to decrease national nurse shortages. Some countries, however, faced both domestic and international pressures in balancing the demand for nurses. Because the United Kingdom was one of the top destination countries for nurses during the second half of the last century, it was under substantial international pressure to review and revamp its policies regarding the recruitment of foreign nurses (Brush & Sochalski 2007). Subsequently, in 2004, the Department of Health in the United Kingdom issued a list of developing countries that would not be targeted for international recruitment (Buchan et al. 2005; Alonso-Garbayo & Maben 2009).

Since 2006, officials in the United Kingdom have limited nurse recruitment to European Union (EU) countries and only granted work permits to nurses from non-EU countries if National Health Services institutions demonstrated that the jobs could not be filled by United Kingdom or EU applicants (Brush 2008). This change in policy resulted in a change in nursing migration. According to Bach (2010), the number of nurses from non-EU countries who come to the United Kingdom has declined sharply. Brush (2008) stated that the American Nurses Association has been vocal about escalating nurse migration and its opposition to US immigration policies that lift visa caps for importing nurses. Instead, the organisation calls for domestic solutions rather than reliance on migrant nurses to fill nursing staff vacancies (Brush 2008).

The Philippines is the largest source of migrant nurses worldwide (Aiken et al. 2004; Brush & Sochalski 2007; Lorenzo et al. 2007; Li et al. 2014). Filipino

nurses are educated at the baccalaureate level and are proficient in English, which make them attractive for international employment (Aiken et al. 2004; Perrin et al. 2007). In the second half of the last century, India and the Philippines provided approximately half of the foreign nurses in the United Kingdom (Buchan & Sochalski 2004; World Health Organisation 2006b; Smith et al. 2009). In the United States approximately 80% of foreign nurses are from the Philippines, India, Latin America, and the Caribbean (Buchan & Sochalski 2004; World Health Organisation 2006b; Smith et al. 2009).

The exchange of nurses between developed countries has been commonplace for years; likewise, the Philippines, with its government-approved program that produces nurses for export, is not a new subject of debate (Buchan & Sochalski 2004; World Health Organisation 2006b). More recently, Lorenzo et al. (2007) in their study of Filipino migrant nurses, stated that precise figures on Filipino nurse migration are difficult to obtain because many of those who seek work overseas are recruited privately and are not officially documented by Philippines Overseas Employment Agency (POEA). Also, Lorenzo et al. (2007) indicated that data from the Filipino Department of Foreign Affairs are incomplete because many people leave the Philippines as tourists and subsequently become overseas workers. In 2002, however, it was estimated that approximately 85% of employed Filipino nurses were working internationally (Lorenzo 2002). According to Buchan et al. (2005), the United States market was the leading receiver of Filipino nurses in the early 1990s. Between 1992 and 2003, the top destination countries for Filipino emigrant nurses were Saudi Arabia, the United States and the United Kingdom (Buchan et al. 2005; Lorenzo et al. 2007). These countries employed 56.8%, 13.14% and 12.25%, respectively, of the cumulative total of Filipino nurses abroad since 1992 (Lorenzo et al. 2007). Other common destinations for Filipino nurses were the United Arab Emirates, Ireland, Singapore, Kuwait, Qatar and Brunei (Lorenzo et al. 2007).

Filipinos in other professions also deploy to Saudi Arabia. In 2012, there were approximately 1.25 million Filipinos living in Saudi Arabia, with only 0.03% of them describing their migration in Saudi Arabia as permanent (Commission on Filipino Overseas 2012). This is due to the fact that the Saudi government does not provide Saudi citizenship or permanent residency for foreign workers.

However, such policies have not prevented Filipino or other migrant nurses working in Saudi Arabia.

In relation to other national groups, Thomas (2006) noted that the Middle Eastern countries were the main destination for migrating Indian nurses, with nurses returning to India after working abroad for a number of years. Thomas (2006) also described a new migration pattern for Indian nurses, which consisted of migration on a permanent basis with their families to the United States and Western European countries. Other source countries for global nurse migration include the Caribbean, South Africa, Ghana, India, Korea, and China. However, some developed countries, such as the United Kingdom and Australia, are both a source and the recipient of migrating nurses (Li et al. 2014).

2.4.3.4 Effect of migration on donor countries

There is a debate around the effect of nurses' migration in their donor countries. Nurse migration can be beneficial to the donor country. For instance, the experience gained by nurses working abroad in more developed nations may enhance their knowledge, skills, and build self-confidence when they return to practice in their home countries (Dwyer 2007; Lorenzo et al. 2007). Nurses working overseas can help in the development of transnational connections and partnerships.

In addition, one of the most favourable effects of nurse migration on the source countries is the considerable amount of money sent home from nurses abroad each year. For instance, the remittances that transfer from the Filipino and Indian nurses working overseas are reported to create a major economic improvement to their home nations (Stilwell et al. 2003). In the Philippines, migrants were also seen as contributing to the local economy through a reduction in unemployment (Lorenzo et al. 2007).

The Philippines and India as main donor countries have capitalised on shortages in the destination countries by commercialising nurse training, so that nurses are trained for export as a national development strategy (Perrin et al. 2007; Brush 2008). However, most of the money is not reinvested back into the health care system in donor countries (McElmurry et al. 2006). Indeed,

nurses migrating from developing to developed countries are often leaving behind an already disadvantaged system (Kingma 2006).

From this point of view, the nursing shortage is more severe and felt more strongly in the source countries. Nurses' migration drains the source countries of desperately needed skilled nurses. Therefore, several ethical issues are raised for the recipient countries. For some countries, it is a highly contentious matter whether recipient countries should be allowed to recruit nurses from abroad, particularly from countries already experiencing a nursing shortage. For instance, the UK was criticised for recruiting nurses from countries suffering from their own nursing shortages, including a highly-publicised plea from Nelson Mandela for the National Health Services in the UK (NHS) to ban recruitment from South Africa (Kingma 2006). Moreover, Lorenzo et al. (2007) noted that hundreds of hospitals have closed due to shortages of doctors and nurses, and that 800 hospitals have partially closed (e.g. ending services in one or two wards) for the same reasons. Stilwell et al. (2004) and Dywili et al. (2013) suggested that developing countries must be more creative in their retention plans with respect to working conditions and professional development, as they do not have the option of improving remuneration.

2.4.3.5 Effect of migration on the recipient country

Though nurse migration offsets the nursing shortage in recipient countries, several concerns are raised by this process. The primary concerns that recipient countries have with migrant nurses are the safety and quality of care for their patients because migrant nurses may have a different level of education or language ability, both of which could affect the quality of patient care (Habermann & Stagge 2010). Research shows that use of non-UK educated nurses in English NHS hospitals is associated with lower patient satisfaction (Germack et al. 2015).

Nurse migration has led to a multicultural nursing workforce within the global health care system; however, health care standards vary between countries. The performance of the health care labour force may be hindered due to the varying cultural backgrounds and educational levels of the nurses. In addition, extreme multicultural diversity may limit the productivity of nursing labour. Mattson (2009) noted that nurses from diverse cultural backgrounds bring a variety of previous life and learning experiences to the nursing practice

located, by necessity, in a multicultural setting. It also takes time for health care teams to embrace and integrate new cultures (Hunt 2007). Habermann and Stagge (2010) stated that more sophisticated selection procedures for recruitment are needed and an ongoing assessment of health outcomes with respect to diversification of the workforce should be implemented to increase safety and the oversight required due to migrant nurses.

Li et al. (2014) believed that some recipient countries gain an indirect economic benefit from migrant nurses. The authors stated that foreign-educated nurses in Australia are required to complete a 1- to 2-year pre-registration nursing course and language classes prior to employment; individual nurses may pay approximately $20,000 per year for these courses (Li et al. 2014). In addition to these tuition costs, these nurses also pay for their basic living costs. For recipient countries, therefore, Li et al. (2014) considered the training of migrant nurses to be a profitable industry that contributes to the recipient countries' national economies.

2.4.3.6 Effects of migration on nurse immigrants

There are both positive and negative effects of nurse migration for the individual nurses. Typically, the primary benefit for nurses is the improved financial situation for the nurses and their families (Kingma 2006; Li et al. 2014). On the other hand, there is often a period of adjustment to the new work environment that can prove challenging, as many nurses must leave their families behind to work in a new country, and it is difficult to live in an unfamiliar place without the support network of family and friends (Li et al. 2014). Migrant nurses may have trouble adjusting to a new work environment in a foreign country (Omeri 2006). Language and cultural differences are also frequently reported as sources of problems for migrant nurses (Kawi & Xu 2009).

Immigrant nurses also face challenges when forming working relationships with the host nurses in a health care organisation. Some nurses reported feelings of isolation, loneliness, difficulty coping, frustration, confusion, and loss of self-confidence and self-esteem during the adjustment process (Li et al. 2014). Immigrants, particularly those from Asian countries, experienced both high rates of psychological distress and depression (Choudhry 2001). Some migrant nurses also suffered from the emotional loss of their families. Long-

term geographical separation from their families caused the nurses to experience insecurity regarding their marriages and sadness over the lost emotional connection with their children (Li et al. 2014). In addition, discrimination is a critical ethical issue in nurse migration, which is attributed to poorly-implemented equal-opportunity policies and pervasive double standards (Kingma 2006). Immigrant nurses could, potentially, be treated unequally in terms of pay and opportunity because of their nationalities and races, which are blatant violations of human rights (Li et al. 2014).

In Saudi Arabia, factors that affect nurses' job satisfaction and retention have not been studied. It is not known whether these factors vary across nationalities, or whether job satisfaction factors are the same for native-born nurses, particularly considering the language, culture, wages, and migrant statuses that are different to Western countries.

2.5 Chapter summary

This chapter provided an overview of the context of the study, the Kingdom of Saudi Arabia, including a short account of its development as a nation, and a discussion of issues related to the nursing workforce. It included an explanation of how Saudi Arabia came to rely on foreign nurses and an overview of 'Saudisation'. In addition, the chapter explained how the Saudi health care system, and the specific components of its nursing workforce and its cultural context, differ from those of Western countries. It stressed why the nationality of nurses is an important element in this context and briefly reviewed research on nurse migration, the factors that drive it and its consequences.

In short, Saudi Arabia has unique cultural and religious characteristics in comparison to other countries. The application of Islam and the role of women in Saudi Arabia are two of the ways that Saudi Arabia is different from Western countries. The organisation of hospitals, the variety of nationalities of the nursing workforce and how nurses are recruited and treated make it important to investigate the experiences of nurses in this country. The next chapter will include a review of the literature relating to job satisfaction and 'intention to leave' definitions and related theories, as well as a systematic process of critique and synthesis of both the Saudi and global studies on these topics.

Chapter 3: Literature Review

This chapter presents a literature review with the aim of comprehensively exploring the current state of knowledge related to the research topic. This chapter begins by identifying the core concepts of this study, which are job satisfaction and intention to leave, and by providing an overview of the related theories and essential features. This chapter then reviews previous research studies that have investigated job satisfaction and intention to leave, specifically within a nursing context. Gaps in knowledge are identified and justification for conducting the research is presented.

3.1 Introduction

All countries (rich and poor) are affected by nursing shortages and high nurse turnover - although there are varying levels of this sort of crisis (Kingma 2006). Consequently, developed and developing countries have increased their awareness of these issues (Aiken et al. 2001; Lu et al. 2002; Zangaro & Soeken 2007; Aiken et al. 2012), resulting in heightened attention to the recruitment and retention of nursing staff (Buchan et al. 2005; Kingma 2006). Retaining and developing the nursing workforce via 'talent management' is considered a major human resource objective for any health organisation. While a number of factors have been associated with nurses' turnover, job satisfaction is the most cited (Cavanagh & Coffin 1992; Blegen 1993; Irvine & Evans 1995; Hayes et al. 2012). Job satisfaction is a vital factor in nurse recruitment and retention, and a topic of wide interest for organisations, managers, and researchers. Recently, job satisfaction was found to be a crucial factor not only for improving nursing retention, but also for patient safety and patient satisfaction (Aiken et al. 2012; Coetzee et al. 2013; You et al. 2013).

3.2 Job satisfaction definition and related theories

Understanding the factors that motivate workers and how this impacts performance has continuously interested organisations and managers. In an attempt to find answers to this question, different theories have been developed. Fungkam (1998) identified four theories that were developed to understand the nature of job satisfaction: the need/value fulfilment theory, the

person-environment fit theory, the theory of work adjustment and the theory of career. The need/value fulfilment theory proposes that job satisfaction is negatively related to the discrepancy between individual needs and the extent to which a job fulfils these needs. Furthermore, the degree of influence for a particular factor is directly related to the level of importance an individual assigns to it (Vroom 1964; Porter & Steers 1973). The theory of person-environment fit suggests that there are personal characteristics that suit certain working environments and working environment characteristics that suit certain individuals better than others (French & Kahn 1962; Mottaz 1985). Similarly, the theory of work adjustment is concerned with the degree of correspondence between individuals and their work environments (Dawis & Lofquist 1984). For example, Hackman and Lawler (1971) argued that the employees' perception of their job was a better determinant of job satisfaction than the job's objective characteristics. Holland's theory of career suggested that, when possible, individuals choose work environments that are congruent with their personality type; thus, the nature of the work environment is primarily determined by the personality type of the individuals who dominates the environment (Holland 1973; Holland 1997).

The two theories that continue to be influential in the study of nurses' job satisfaction are Maslow's human needs theory (Maslow 1954) and motivation-hygiene theory (Herzberg & Mausner 1959). In 1943, Maslow was the first theorist to connect the satisfaction of human needs to motivation, especially in the context of work environments that foster and encourage the personal and professional growth of employees by satisfying some of their most basic needs. Maslow's human needs theory places five basic sets of needs in a hierarchy, which ranked from bottom to top are: physiological, safety, belongingness, esteem, and self-actualisation needs. Maslow proposed that when the lower needs are realised, the next higher needs emerges. In the workplace, physiological needs are related to basic issues of survival such as salary and stable employment. Safety needs refer to issues such as decent benefits and fair work practices. Belongingness needs are related to good relationships with co-workers. Esteem needs are associated with recognition and respect. Self-actualisation needs refer to achievement issues, such as workplace autonomy and personal advancement. The theory suggests that unsatisfied needs motivate people to find ways to obtain satisfaction in those

areas. Lack of satisfaction with the lower needs will affect attainment of the higher needs. However, Maslow recognised that there can be exceptions to the hierarchy and that some individuals can find higher-level needs to be more important than lower-level needs (Maslow 1954). As an example, there might be some workers who find that achievement or advancement are more important than their relationships with co-workers.

Later, Herzberg and Mausner (1959) formulated the motivation-hygiene theory (two-factor theory) of job satisfaction. The motivation-hygiene theory was developed through interviews, and participants were asked to relate times when they felt satisfied or dissatisfied about their jobs and to provide reasons for that. Herzberg and Mausner (1959) postulated that job satisfaction and dissatisfaction are two separate constructs, and produced by different factors. They argued that 'hygiene factors' can cause dissatisfaction, but would not result in motivated behaviour or a state of positive satisfaction. By contrast, meeting 'motivator needs' would lead to the expenditure of effort and positive satisfaction. According to Herzberg and Mausner (1959), the motivator factors were found to be job 'satisfiers', which refer to factors intrinsic to the nature and experience of doing work and involve achievement, recognition for achievement, a focus on the work itself, responsibility, growth, and advancement. The hygiene factors were found to be job 'dissatisfiers', and related to the work environment, involving such variables as administration practice, supervision, interpersonal relationships, working conditions, salary, and security (Herzberg & Mausner 1959). It seems that the job dissatisfiers relate to Maslow's lower-level needs, whereas the job satisfiers relate to his higher-level needs.

The motivation-hygiene theory emphasises the complexity of measuring job satisfaction, and certainly there are no standardised methods for this. However, a continuing approach to measuring job satisfaction is to use a faceted (multidimensional) approach, of the type supported by both Maslow (1954) and Herzberg and Mausner (1959), which simultaneously take into account the influence of many factors. Therefore, job satisfaction is considered to be a complex concept illustrated by the multiple variables that have been studied in relation to this phenomenon (Lu et al. 2005).

The complexity of job satisfaction is reflected in the definitions that researchers have used. Many authors have defined job satisfaction based on the multi-dimensional approach. For instance, job satisfaction is considered by some researchers as the sum of several discrete dimensions of job facets (Stamps & Piedmonte 1986; Mueller & McCloskey 1990). Similarly, Adams and Bond (2000) defined job satisfaction as the degree of positive affect toward a job and its main components. This was further supported by Spector (1997), who defined job satisfaction as a global feeling about one's job, or a related constellation of attitudes about various aspects of the job.

3.3 Job satisfaction instruments

With job satisfaction defined as a multi-dimensional construct (Stamps & Piedmonte 1986; Mueller & McCloskey 1990; Spector 1997), a number of measurement instruments have been developed using the multi-faceted approach. Job satisfaction instruments relevant to this study can be divided into generic and nursing-specific instruments.

Generic instruments include the Job Diagnostic Survey (JDS) (Hackman & Oldham 1975), the Minnesota Satisfaction Questionnaire (MSQ) (Weiss et al. 1967), the Job Descriptive Index (JDI) (Smith 1969), and the Job Satisfaction Survey (JSS) (Spector 1997). Generally, these instruments adopt similar approaches by using attitudinal scales, although they vary slightly in the range of constructs that constitute the scale. However, generic instruments are recognised by experts as lower-value in this context than nursing-specific instruments, since they were not specifically designed to measure nurses' satisfaction (Mueller & McCloskey 1990; Misener et al. 1996; Coomber & Barriball 2007). Generic instruments might be supportive in comparing job satisfaction across different occupational groups, while nursing-specific instruments can better measure the factors most important to the job satisfaction of nurses.

Therefore, a number of instruments have been developed specifically to measure job satisfaction among nurses. Nursing instruments involve the Index of Work Satisfaction (IWS) (Stamps & Piedmonte 1986), the McCloskey/Mueller Satisfaction Scale (MMSS) (Mueller & McCloskey 1990), the Nurse Satisfaction

Scale (NSS) (Ng 1993), the Nursing Work Index (NWI) (Kramer & Hafner 1989), the Nursing Working Index-Revised (NWI-R) (Aiken & Patrician 2000), and the Practice Environment Scale of Nursing Work Index (PES-NWI) (Lake 2002). There is no universal agreement about which instrument should be used to measure nurse satisfaction and which job facets should be considered (Van Saane et al. 2003). One factor to consider is that almost all job satisfaction instruments have psychometric reliability issues on a number of their subscales; the exception is the PES-NWI, as the Cronbach alphas for its subscales vary from 0.71 to 0.84. However, although the PES-NWI is an important instrument for examining the quality of hospital work environments, it was excluded from this study because it focuses on the characteristics of organisational units and whether these characteristics exist in specific organisations, rather than investigating whether or not nurses are satisfied with their jobs. Therefore, in this context, it is better to use other job satisfaction instruments and forego the use of the PES-NWI.

Among nursing instruments, the McCloskey and Mueller Satisfaction Scale (MMSS) (Mueller & McCloskey 1990) and the Index of Work Satisfaction (IWS) (Stamps & Piedmonte 1986) are noteworthy in that they have been more extensively used in research in this field. The MMSS and the IWS are two of the first reliable instruments designed to measure nurses' job satisfaction using a multi-dimensional approach. The MMSS will be used in this present study to measure nurses' job satisfaction, as it is widely used in nursing research. For instance, the MMSS has been used in studies conducted in many countries, including the United Kingdom (Price 2002), China (Liu et al. 2012a), Slovakia and the Czech Republic (Gurkova et al. 2013), Italy (Caricati et al. 2014) and Lebanon (El-Jardali et al. 2013). The MMSS was also selected for use in this present study because it is cost-effective; the IWS is more expensive to use and to score.

3.4 Turnover and intention to leave definitions and related theory

Intention to leave employment is of interest to many researchers, managers, and organisations. Porter and Steers (1973) maintained that 'intention to leave' is the next logical step after experiencing workplace dissatisfaction. In nursing,

intention to leave was defined as nurses' anticipation of vacating the job in the foreseeable future (Price & Mueller 1981). Turnover intention is thought to be one of the best predictors of actual turnover (Meeusen et al. 2011). The relationship between intention to leave and actual turnover is consistent with the theory of planned behaviour (Ajzen 1991). In the theory of planned behaviour, Ajzen (1991) explained the connection between attitudes, intentions, and behaviour. Ajzen (1991) specified that the intentions to perform different types of behaviours can be predicted with high accuracy from attitudes toward the behaviour, subjective norms and perceived behavioural control. Furthermore, these intentions, together with perceptions of behavioural control, account for the considerable variance in actual behaviour. This was further supported by Takase (2010) who described turnover as a multi-stage process involving psychological, cognitive and behavioural components. Intention to leave begins with psychological responses to the negative aspects of a job, and these psychological responses change into withdrawal cognition and behaviours, resulting in actual turnover (Takase 2010). In support of the strength of this relationship, Irvine's and Evans' (1995) meta-analysis revealed a strong positive relationship between behavioural intentions and actual turnover. With the core concepts of the study defined and their essential features reviewed in the context of existing key theories, this chapter now reviews previous research that has investigated job satisfaction and intention to leave, specifically within a nursing context.

3.5 Determinants of nurses' job satisfaction

An early meta-analysis by Blegen (1993) from 48 studies revealed that nurses' job satisfaction was associated with thirteen variables. These associations varied from strong to weak. The strongest associations were with stress ($r = -0.61$) and organisational commitment ($r = 0.53$). Seven variables had correlations between ($r = 0.20$) and ($r = 0.50$) including communication with supervisor, autonomy, recognition, routinisation, communication with peers, fairness, and locus of control; and four variables had very weak correlations: age ($r = 0.13$), years of experience ($r = 0.09$), education ($r = -0.07$), and professionalism ($r = 0.06$). The weak correlation between job satisfaction and different demographic variables indicates the complexity of the confounding variables related to job satisfaction. The Zangaro and Soeken (2007) meta-

analysis, which built on Blegen (1993), found that job satisfaction was correlated with job stress (ES = -0.43), followed by nurse–physician collaboration (ES = 0.37) and autonomy (ES = 0.30). However, the Blegen (1993) and Zangaro and Soeken (2007) meta-analyses both included findings from different settings, and they were not restricted to hospitals

In a recent systematic review, Lu et al. (2012) identified nineteen key empirical sources of nurses' job satisfaction, as revealed from different instruments as well as from qualitative studies. These sources included working conditions, interactions and relationships (with patients, co-workers and managers), the work itself, workload (staffing, scheduling and shifts), challenging work, routinisation, task requirements, psychological job demands, remuneration (pay and salary), self-growth and promotion, professional training, opportunities for advancement, job promotion, personal achievement, psychological rewards (praise, recognition and encouragement), control and responsibility (autonomy and decision making), job security, leadership style and organisational policies.

Since Lu et al. (2012) systematic review, researchers have continued to investigate the various factors that might influence nurses' job satisfaction. One crucial finding was that the quality of the hospital work environment, which includes managerial support for nursing care, good doctor-nurse relations, nurse participation in decision making and organisational priorities on care quality, is associated with nurses' job satisfaction in twelve European countries as well as the United States, China and South Africa (Aiken et al. 2012; Coetzee et al. 2013; Zhang et al. 2014). These studies formed part of the registered nurses forecasting (RN4CAST) project, which aims to determine whether hospitals with a good organisation of care can affect the quality of patient care and nurses' outcomes, including job satisfaction and intention to leave (Sermeus et al. 2011).

In addition, Stimpfel et al. (2012) and Dall'Ora et al. (2015) showed that an aspect of work environment (length of working shift) was associated with nurses' job satisfaction. Caricati et al. (2014) found that professional commitment and work climate positively predicted nurses' job satisfaction. However, these findings were revealed from cross-sectional study, and consequently could not definitively establish causality, although the results

recorded in relation to the effect of the quality of the hospital work environment were consistent in different countries (Aiken et al. 2012; Coetzee et al. 2013; Zhang et al. 2014).

A growing body of literature has revealed that nurses' job satisfaction levels differ among countries. Lu et al. (2012) suggested that it is preferable to compare job satisfaction levels derived from studies that use the same instrument to provide comparative information, particularly cross-cultural data. Among the 12 European countries, the United States, South Africa and China, job dissatisfaction levels ranged from a low of 11% in the Netherlands to a high of 56% in Greece (Aiken et al. 2012; Coetzee et al. 2013; Zhang et al. 2014). It is important to note that the responses of the participants differed slightly across the studies. In the Aiken et al. (2012) and Zhang et al. (2014) studies, the participants were limited to medical and surgical ward nurses in general acute hospitals. Coetzee et al. (2013) evaluated medical and surgical units in private and public hospitals, so that study was not limited to acute hospitals. The inconsistency in the participant responses included in the various studies limits the ability to compare the findings across studies. It is not known why job satisfaction levels differed in these countries, as it is noticeable that there is no evidence to suggest that the economic status of different countries influenced the nurses' job satisfaction levels. These findings emphasise the complexity of the factors related to job satisfaction. They also underscore the importance of understanding country, system, organisation and individual differences. Therefore, the relevant contribution of different factors requires additional attention, especially when considering the different contexts among countries.

In an attempt to consider national context when investigating nurses' job satisfaction, Atefi et al. (2014) revealed sources of nurses' job satisfaction in Iran which present similarities and dissimilarities with findings from Western countries. An example of findings that slightly differed from those of Western studies is that the spiritual feeling of nurses in Iran when taking care of patients is considered as a main source of their job satisfaction. Nurses stated that helping sick people strengthens their own religious faith, renews their energy, and bring rewards from God, which they consider more important than money (Atefi et al. 2014). Another different finding is that nurses are not positively acknowledged by doctors in Iran. Although the nurse-physician

relationship was considered a source of nurses' job satisfaction in other countries, nurses in Iran revealed unique details regarding this relationship. They maintained that doctors in Iran are accorded an unrealistically superior status by the society in general and by their families in particular (Atefi et al. 2014). These findings underline the importance of considering the cultural context when investigating nurses' job satisfaction, especially when conducting such a study in a country with a very different cultural background from those of the Western cultures that dominate the literature. Therefore, it is important to consider the Saudi context when investigating nurses' job satisfaction in the Kingdom.

3.6 The link between nurses' job satisfaction and turnover

Many authors have suggested that increasing job satisfaction decreases the turnover rate (Price & Mueller 1981; Cavanagh & Coffin 1992; Abu Raddaha et al. 2012; Liu et al. 2012a; Gurkova et al. 2013; Ramoo et al. 2013). Cavanagh and Coffin (1992) found job satisfaction to be a significant variable in the turnover process among several variables that were significantly related to intent to stay ($p < 0.05$): job satisfaction (r = 0.3), pay (r =0.1) and advancement opportunity (r = - 0.1).

The meta-analysis by Irvine and Evans (1995) found a strong positive relationship between behavioural intentions and actual turnover, as well as a strong negative relationship between job satisfaction and behavioural intention. Therefore, the effect of job satisfaction on actual turnover was mediated by behavioural intention. In their meta-analysis, Irvine and Evans (1995) found a small negative relationship between job satisfaction and turnover. The Yin and Yang (2002) meta-analysis of 129 studies in Taiwan regarding nursing turnover found that job satisfaction, autonomy, advancement opportunity, job stress, pay, group cohesion, marital status and educational level were the main individual and organisational factors related to nurse turnover.

The nature of leaving intentions are not all of the same type. Most studies investigated nurses' intention to leave the organisation (Aiken et al. 2012; Liu et al. 2012a; Lu et al. 2012; Stimpfel et al. 2012; Coetzee et al. 2013; Zhang et

al. 2014). In contrast, Heinen et al. (2013) and (Gurkova et al. 2013) examined nurses' intention to leave the profession. However, the global mobility of the nursing workforce means that there is a further type of leaving intention to consider; nurses' intention to leave the country and practice the nursing profession abroad. To date there is a shortage of literature investigating this aspect (Gurkova et al. 2013). Additionally, there is also a debate as to whether to include transfer within an organisation as a leaving definition. For instance, Boyle and Miller (2008) included the process by which nurses transfer within an organisation in their turnover definition, while Beecroft et al. (2008) excluded it from their leaving definition. All the reviewed papers excluded transfer between units from their leaving intention definitions.

3.6.1 Intention to leave the hospital workplace

A number of studies revealed that increasing job satisfaction decreases the intention of leaving hospitals (Liu et al. 2012a; El-Jardali et al. 2013; Gurkova et al. 2013; Ramoo et al. 2013; Alsaraireh et al. 2014). In contrast, a recent study in China revealed that only 5% of nurses reported an intention to leave their current employer, although 45% of the nurses were dissatisfied with their job (Zhang et al. 2014). Although the association between job satisfaction and intention to leave was not examined in the Chinese study, its findings seem to contradict previous results, which have indicated a relationship between job satisfaction and intention to leave the hospital.

In addition, the literature revealed conflicting evidence across countries as to which facets of a job are associated with intention to leave an employer. Liu et al. (2012a) and Gurkova et al. (2013) both used the McCloskey/Mueller Satisfaction Scale, but revealed different facets associated with intention to leave hospitals. In China, Liu et al. (2012a) found satisfaction with extrinsic rewards, satisfaction with interaction, satisfaction with praise and recognition and satisfaction with control and responsibility to be significant factors affecting nurses' intention to leave their hospital workplaces. In contrast, Gurkova et al. (2013) found that satisfaction with control and responsibility, scheduling, co-workers and interaction opportunities were predictors of intention to leave in Slovakian and Czech hospitals. However, caution is needed in interpreting these studies, as there are methodological issues in play. The analysis by Liu et al. (2012a) omits one of the instrument's subscales,

'professional opportunity', although the researchers did not report any modification of the tool in their methods section. The complexity in identifying the factors associated with nurses' job satisfaction was further supported by Aiken et al. (2012), who found countries which have had a considerable economic downturn such as Greece and Spain reported different levels of nurses who intended to leave their hospitals. Therefore, further research is needed to investigate how external market factors influence nurses' satisfaction levels and intention to leave or stay.

Other factors were found to have associations with intention to leave hospital among nurses. Nurses at hospitals with superior work environments, as manifested by managerial support for nursing care, good doctor-nurse relations, nurse participation in decision making, and organisational priorities on care quality, were less likely to express an intention to leave the hospital (Aiken et al. 2012; Coetzee et al. 2013). Stimpfel et al. (2012) revealed that nurses working shifts of ten hours or longer were up to two and a half times more likely than nurses working shorter shifts to express an intention to leave.

There are methodological challenges that continue to limit the ability to compare intention to leave rates between organisations and systems. The inconsistency in measuring intention to leave across different studies appears in two aspects. The first aspect is whether 'involuntary leaving' – forced retirement or separation – is included in the category. In the recent literature, a few studies excluded involuntary leaving when investigating intention to leave by specifically asking nurses whether they had an intention to leave due to job dissatisfaction. On the other hand, a number of studies included both voluntary and involuntary leaving (Liu et al. 2012a; Coetzee et al. 2013; Gurkova et al. 2013; Ramoo et al. 2013; Alsaraireh et al. 2014; Zhang et al. 2014). It is not clear whether Aiken et al. (2012) excluded involuntary leaving in their international study, although Heinen et al. (2013), referring to that study, state that they did. The inconsistency in such measures limits the ability to compare findings from different studies. The inclusion of involuntary leaving in the intention to leave category muddies interpretation of study findings somewhat, but despite that, all the studies do reveal vital data in regard to nurses' expectation regarding their turnover.

The second problematic aspect in comparing the intention to leave data from these studies is the inconsistency in the periods of time being asked about. For instance, most studies asked nurses about their intentions of leaving within one year of data collection (Abu Raddaha et al. 2012; Aiken et al. 2012; Liu et al. 2012b; Stimpfel et al. 2012; Coetzee et al. 2013; Heinen et al. 2013; Zhang et al. 2014). In contrast, a few studies examined nurses' intention of leaving within three years (El-Jardali et al. 2013; Ramoo et al. 2013), while in the Liu et al. (2012a) study, nurses were asked about their intention of leaving without any period of time being specified. Surveying nurses about their intention of leaving without any period of time being specified may not result in valid data, as all nurses will eventually leave, whether voluntarily or involuntarily.

3.6.2 Intention to leave the nursing profession and leaving the country to work abroad

There is a shortage of literature on intention to leave the nursing profession as compared to leaving organisations. Recently, Heinen et al. (2013) found different levels of intention to leave the profession across ten European countries. They also found that burnout, nurses' participation in hospital affairs, positive perceptions of the work environment, nurse-physician relationships, working full-time, older age, and female gender were more associated with intention to leave the nursing profession in ten European countries. However, the relevance of these variables differed for the individual countries.

Another type of leaving intention among nurses is the intention to leave their country and work abroad. Examining this intention to leave the country and work abroad is of special interest in understanding the migration pattern among nurses for both 'donor' and 'recipient' countries of migrant nurses. Gurkova et al. (2013) investigated the effect of different facets of job satisfaction on an intention to leave the country among Czech and Slovak nurses, and found that low levels of satisfaction with control, responsibility, and scheduling were good predictors of intention to leave the country and practice nursing abroad.

3.7 The effect of demographic factors on job satisfaction and intention to leave

One of the arguments often advanced in criticisms of job satisfaction studies is that they take little account of differences between individuals. Spector (2012) claimed that what is needed by one group of individuals in terms of a job is different from what is needed by other groups. Therefore, job satisfaction or dissatisfaction does not just rely on the nature of the job in a particular organisational setting, it also relies on the expectations that individuals have about what their job should offer.

Two of the demographic factors that have been associated with job satisfaction are age and years of experience. The Blegen (1993) meta-analysis found job satisfaction correlated with age (r = 0.13), and years of experience (r = 0.09). Alsaraireh et al. (2014) found female nurses' job satisfaction was significantly higher than that of male nurses in Jordan. In China and Jordan, nurses who are married were found to be more satisfied than nurses who are single, and married nurses are more likely to stay in their jobs (Liu et al. 2012a; Alsaraireh et al. 2014). However, caution is needed in interpreting these findings. The Alsaraireh et al. (2014) study was limited to only one hospital, and there are methodological issues with the Liu et al. (2012a) study that might affect the validity of the findings, including the omission of one of the subscales of the tool in their analysis.

Stimpfel et al. (2012) considered race and ethnicity when examining the relationship between hospitals and nurses' shift length and job satisfaction. However, although Stimpfel et al. (2012) reported that the shift length of these ethnic groups differed, they did not compare their levels of satisfaction. More recently, Xue (2015) found that moderate differences in job satisfaction were observed across racial and ethnic groups in a national sample in the United States.

Most studies used a quantitative cross-sectional design; consequently, they could not definitively establish causality. Investigating job satisfaction using different methods (e.g. longitudinal design, and mixed methods) is needed. Overall, further research is needed to examine which job satisfaction components are more strongly associated with the intention to leave. In

addition, investigating factors related to intention to leave country and practise nursing abroad is needed in order to support retention strategies, as there is a lack of studies regarding this type of leaving. Since this present study aims to examine the effect of nationality on job satisfaction and intention to leave among nurses in Saudi Arabian government hospitals, this chapter now reviews the research that has specifically included nationality when examining nurses' job satisfaction and their intention to leave. In addition, it reviews those studies that examined job satisfaction in Saudi Arabia. First, it presents the literature search strategy that was used to identify relevant research. Then it presents the systematic process of critique to identify the research gaps and justifications for conducting this study.

3.8 Literature search strategy

The purpose of the search strategy is to determine and locate the most appropriate range of resources related to the research questions in order to perform a comprehensive literature review. Different areas of the literature needed to be examined prior to undertaking the study. One area to examine includes all studies that investigated job satisfaction or intention to leave among nurses in Saudi Arabian hospitals. The second area to examine explores all the studies that included nationality as a factor within job satisfaction or intention to leave among nurses.

The main focus of the literature search was using online subject-specific electronic databases. Developing clear inclusion and exclusion criteria contributed to keeping the study focused, since it is usually impossible to review every article on a research topic unless it is a narrow one. Thus, selecting the most significant and relevant articles to the research questions is crucial. In order to assure the quality of the materials, only peer-viewed academic journal articles and reviews were included. Other types such as magazine and trade publication were excluded (Jesson et al. 2011).

According to Jesson et al. (2011) and Aveyard (2014), the first step in implementing a search is identifying the keywords of the research questions. The second step is identifying the synonyms of these keywords. The third step is identifying the truncations and abbreviations. For instance, Boolean operators: AND, OR, and the truncation: * were used. The fourth step is

recording any searches and the results of the searches in an electronic format to be an easily accessible record when it comes to writing up the review (Jesson et al. 2011; Aveyard 2014). A keyword search was performed using the University of Southampton (DelphiS) electronic database. DelphiS is a single interface which permits the obtaining of relevant literature from different resources such as the Cumulative Index for Nursing and Allied Health Literature (CINHAL), Medline, ScienceDirect, PsycINFO, and Web of Knowledge databases. Table 3-1 shows the search terms and the synonyms of the research questions keywords, as well as the truncations that have been used.

Table 3-1: Identifying the search terms of the research questions

Review question 1: What are the levels of job satisfaction and intention to leave among nurses in Saudi Arabian government hospitals?

Research Question 2: What is the relationship between job satisfaction and intention to leave for nurses in Saudi Arabian government hospitals?

Research Question 3: Do job satisfaction and intention to leave vary by nationality for nurses in Saudi Arabian hospitals?

Research Question 4: What are the factors that nurses perceive as important to their job satisfaction and intention to leave? Do these factors vary across nationalities?

Key words	**Synonyms and search terms**
Job satisfaction	Search includes: "job satisfaction" **OR** "job dissatisfaction" **OR** "job commitment"
Intention to leave	Search includes: "turnover" **OR** "intention to leave" **OR** "intention to stay"
Nationality	Search includes: "nationalit*" **OR** "migration*" **OR** "migrant*" **OR** "immigra*"
Nurses	"nurs*"
Hospital	"hospital*"
Saudi Arabia	"Saudi Arabia*"

Inclusion and exclusion criteria were developed in the search strategy. Since the population of the study is limited to nurses, other health care professionals

such as physicians, dentists and pharmacists, and nursing students were excluded (see Table 3-2).

Table 3-2: Inclusion and exclusion criteria

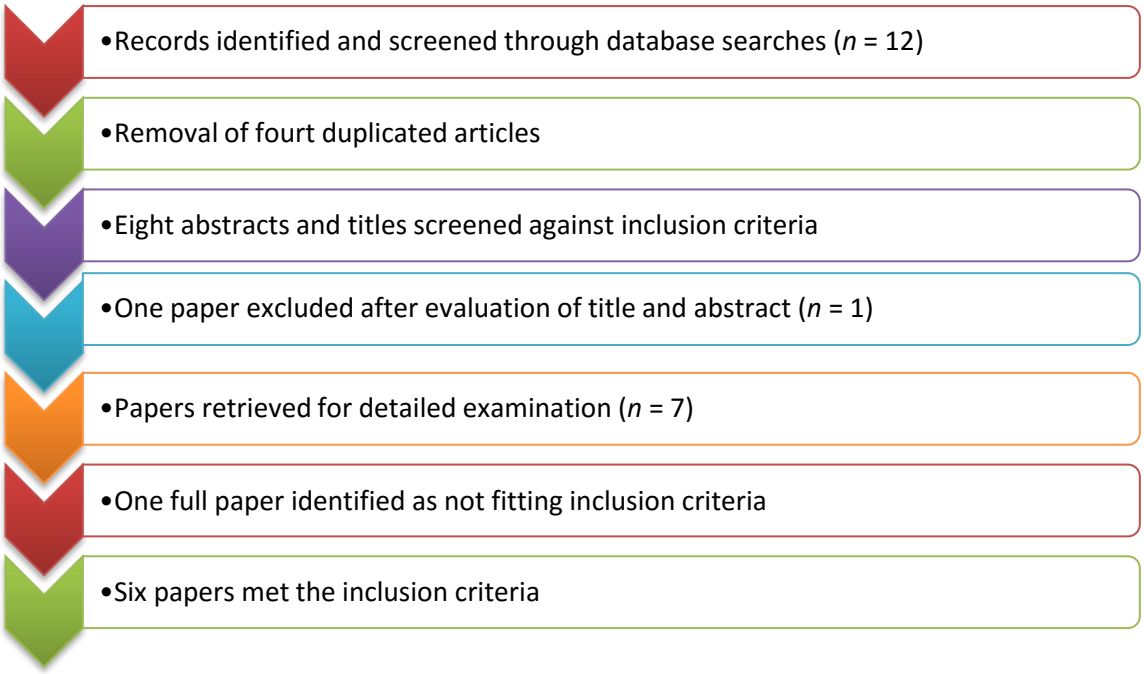
	Inclusion	**Exclusion**
Population	Nurses	Physicians, pharmacist, and dentists
Health setting	Hospitals	Others
Language	English and Arabic	Others
Publication type	Peer-reviewed	Non-peer-reviewed

Electronic searches were undertaken to identify any study related to nurses' job satisfaction or intention to leave in Saudi Arabian hospitals. Table 3-3 illustrates the findings from these electronic searches, which were last updated in November 2016. This resulted in the identification of 12 papers from S6 + S7 (n = 12). Figure 3-1 shows the selection criteria that resulted in six papers related to nurses' job satisfaction and intention to leave in Saudi Arabian hospitals.

Table 3-3: The findings from the electronic searches

#	Keywords	DelphiS
S1	"job satisfaction " **OR** "job dissatisfaction" **OR** "job commitment"	129,566
S2	"nurs"*	1,334,063
S3	"turnover" **OR** "retention" **OR** "intention to leave" **OR** "intention to stay"	368,483
S4	"Hospital"*	3,220,970
S5	"Saudi Arabia*"	130,600
S6	S1 **AND** S2 **AND** S4 **AND** S5	6
S7	S2 **AND** S3 **AND** S4 **AND** S5	6

Figure 3-1: Flow chart of the literature search results of studies related to nurses' job satisfaction or intention to leave in Saudi Arabian hospitals

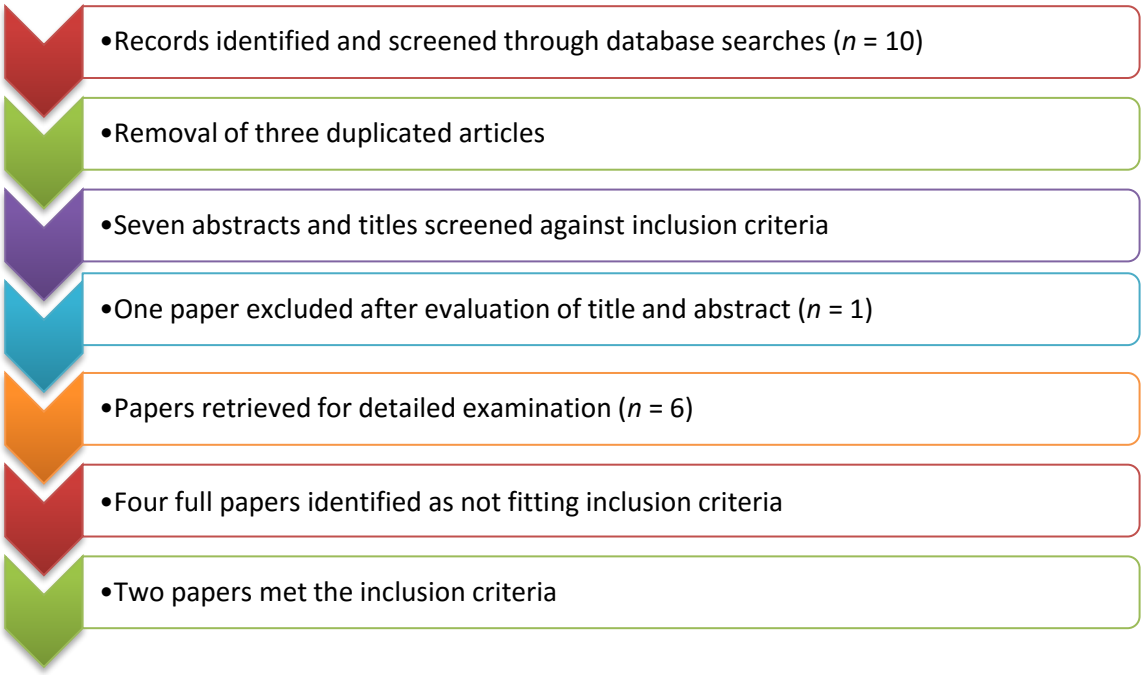


In addition, electronic searches were undertaken to identify any study that included the nationality of nurses when examining job satisfaction or intention to leave. Table 3-4 illustrates the findings of the electronic searches, which were last updated in November 2016. As shown in Table 3-4, this update resulted in the identification of 10 papers from S6 + S7 (n = 10). Figure 3-2 shows that the selection criteria that resulted in two papers that included nationality when examining job satisfaction and intention to leave.

Table 3-4: The findings from the electronic searches

#	Keywords	DelphiS
S1	"job satisfaction " **OR** "job dissatisfaction" **OR** "job commitment"	129,566
S2	"nurs"*	1,334,063
S3	"turnover" **OR** "retention" **OR** "intention to leave" **OR** "intention to stay"	368,483
S4	"nationalit*" **OR** "migration*" **OR** "migrant*" **OR** "immigra*"	301,191
S5	"Hospital"*	3,220,970
S6	S1 **AND** S2 **AND** S4 **AND** S5	5
S7	S2 **AND** S3 **AND** S4 **AND** S5	5

Figure 3-2: Flow chart of the literature search results for studies that included the nationality of nurses when examining job satisfaction or intention to leave



In total, eight papers were selected for full review. They consisted of six studies related to nurses' job satisfaction and intention to leave Saudi Arabian hospitals and two international studies that included nationality when examining job satisfaction and intention to leave.

In order to evaluate the quality of the research literature, each of the studies was read and summarised in a table to capture its key features. The table consists of the relevant essential information including author(s), the year of publication, country in which the study was conducted, aim(s), research design, sample, instruments, and key findings. Table 3-5 provides a summary of the studies relating to nurses' job satisfaction and intention to leave in Saudi Arabia. Table 3-6 provides a summary of the international studies that included nationality when examining job satisfaction or intention to leave.

The Caldwell et al. (2011) framework was employed as a critical appraisal tool to critique the eight relevant studies. This framework was selected because it was specially designed to assist in the critical appraisal of both quantitative and qualitative health-related research. The use of this framework was also suggested by Bettany-Saltikov (2012) who recommended this tool to use in nursing research (see Appendix A for examples of how the studies were critiqued).

This critical appraisal summary provides crucial information about what is already known and what is needed from future studies, and it identifies both the strengths of the findings and the research gaps. The appraisal began with studies that examined job satisfaction and intention to leave in Saudi Arabian hospitals. These studies were followed by international studies that took nationality into account when examining nurses' job satisfaction and their intention to leave their jobs.

3.9 Job satisfaction and intention to leave among nurses in Saudi Arabia

Out of six Saudi studies, four aimed to find out the extent to which nurses are satisfied in Saudi Arabia (Al-Aameri 2000; El-Gilany & Al-Wehady 2001; Al-Ahmadi 2002; Al-Dossary et al. 2012). The difference between these studies is that each has been conducted in different research settings. In addition, Al-Aameri (2000) included the association between nurses' job satisfaction and their organisational commitment. The remaining two Saudi studies included a study by Abualrub and Alghamdi (2012), who examined the impact of leadership styles of nurse-managers on Saudi nurses' job satisfaction and their intent to stay at work, while Alonazi and Omar (2013) examined factors that strongly influenced turnover among nurses who joined and then left the hospital.

All Saudi studies utilised quantitative designs (Al-Aameri 2000; El-Gilany & Al-Wehady 2001; Al-Ahmadi 2002; Abualrub & Alghamdi 2012; Al-Dossary et al. 2012; Alonazi & Omar 2013). There is a lack of studies that examine job satisfaction in Saudi Arabia using qualitative or mixed method research, which Al-Dossary et al. (2012) suggested as needed in future studies. The participants in three Saudi studies were nurses employed in Saudi hospitals, regardless of nationality (Al-Aameri 2000; Al-Ahmadi 2002; Al-Dossary et al. 2012), while El-Gilany and Al-Wehady (2001), and Abualrub and Alghamdi (2012) focused on Saudi nurses specifically. El-Gilany and Al-Wehady (2001) limited their study to female Saudi nurses. In regards to sampling techniques, only one Saudi study utilised a probability sampling technique (Al-Dossary et al. 2012), while the remaining studies utilised non-probability sampling techniques. Using non-probability sampling techniques limits the ability to generalise findings beyond the research population (Kumar 2011).

None of the Saudi studies utilised a nursing-specific instrument to measure job satisfaction, despite the fact that, as already discussed here, nursing-specific instruments can better identify the factors related to the nursing profession. In addition to their use of generic instruments, there are issues regarding the modification of the instruments in some studies, as descriptions of the adjustments and which items were omitted were not provided (Al-Ahmadi 2002). The validity of the modification of the instrument affects the validity of

the findings of such a study. Also, El-Gilany and Al-Wehady (2001) used non-validated questionnaires including only place satisfaction and role satisfaction, without justifying why these items are the most important for their participants. In an attempt to examine factors that influence nurses' turnover, Alonazi and Omar (2013) did not describe the components of the Exit questionnaire, and its reliability and validity.

The Saudi studies illustrate that nurses were slightly satisfied with their jobs, as the means were 3.67 and 3.3 on a scale of 5 in the Al-Aameri (2000) and Al-Ahmadi (2002) studies respectively, and 3.69 on a scale of 6 in the (Abualrub & Alghamdi 2012). Al-Dossary et al. (2012) found that nurses were neither satisfied nor dissatisfied (a mean was not provided). There is conflicting evidence regarding the effects of age and years of experience on job satisfaction in Saudi Arabia (Al-Aameri 2000; Al-Ahmadi 2002), although both studies were conducted in Riyadh city within two years. Al-Aameri (2000) found a significant positive correlation between job satisfaction and age, $r = (0.23, p < 0.05)$, while Al-Ahmadi (2002) found no significant relationship between job satisfaction and age. Similarly, Al-Ahmadi (2002) found a significant positive correlation between job satisfaction and years of experience, $r = (0.13, p < 0.05)$, while Al-Aameri (2000) found no significant relationship between job satisfaction and years of experience.

Two studies found that there is no difference in overall job satisfaction level based on nationality (Al-Aameri 2000; Al-Ahmadi 2002), but neither study conducted an evaluation based on the dimensional approach of job satisfaction. Therefore, it is necessary to investigate whether there is an effect of nationality on specific aspects of job satisfaction. In addition, there is inconsistency in categorising nationality groups, as Al-Aameri (2000) grouped nationalities as Saudi, other Arab, Filipino, Indian, European, and American, which seems more relevant than Al-Ahmadi (2002), who grouped nationality as Saudi, Southeast Asian countries, Arab countries, and Western countries, especially given that the components (countries) of each nationality group were not provided.

The salient studies in Saudi Arabia revealed that nurses are slightly satisfied with their jobs, but this conclusion needs to be viewed in the light of the limitations of these studies. The quality of the findings was limited in the

majority of the Saudi studies by the lack of robust methodologies, the small sample sizes, and the exclusive utilisation of cross-sectional quantitative design (Al-Aameri 2000; El-Gilany & Al-Wehady 2001; Al-Ahmadi 2002; Abualrub & Alghamdi 2012; Al-Dossary et al. 2012; Alonazi & Omar 2013). The cross-sectional design does not establish causality, and the questionnaires that were used did not contain all the elements related to work environments in Saudi Arabia. In terms of methodology, mixed methods research (quantitative and qualitative) was suggested by Al-Dossary et al. (2012) in order to gain a better understanding about job satisfaction in nurses from different nationalities. In addition, none of the Saudi studies have investigated nurses' intention to leave the profession, or to leave the country and practise nursing abroad.

Table 3-5: Summary of Saudi studies relating to nurses' job satisfaction and intention to leave

Author(s) Location	Aim(s) of study	Sample	Instrument	Key findings	Comments
Al-Aameri (2000) Riyadh, Saudi Arabia	To find out the extent to which nurses in public hospitals are satisfied with their jobs and committed to their hospitals.	290 nurses (72.5% response rate)	Brayfield and Rothe's scale of general satisfaction	Nurses slightly satisfied (Mean = 3.67 out of 5). Strong positive correlation between job satisfaction and organisational commitment was found at r = (0.59, $p < 0.01$). No significant differences in job satisfaction according to nationality.	The nationality groups were Saudi, Other Arab, Filipino, Indian, European, and American. The instrument has not been used extensively in similar studies since it was not designed specifically to measure nurses' job satisfaction. The instrument measures overall satisfaction, thus a comparison based on nationality as a contributor to satisfaction was not provided.
El-Gilany and Al-Wehady (2001)	To assess the degree of satisfaction of Saudi female nurses with their work and to study the factors	233 Saudi female nurses (95.9% response rate)	Satisfaction with the place of work and role assigned	Majority of nurses (92.7%) preferred the one-shift duty because of social and family responsibilities, followed by transportation problems.	Sampling technique was not provided. Questionnaire measured only place satisfaction and role satisfaction without justifying

Al-Ahsa, and the north region, Saudi Arabia	that might increase their satisfaction.			Majority of nurses would not accept working with male patients (98.3%).	why these items are more important than others for Saudi female nurses. Issues regarding validity and reliability of the instruments.
Al-Ahmadi (2002) Riyadh, Saudi Arabia	To examine the magnitude and determinants of job satisfaction among nurses working in Ministry of Health hospitals.	366 nurses (73% response rate)	A modified version of the Minnesota Job Satisfaction Questionnaire	Job satisfaction level found to be moderate. No differences in overall job satisfaction according to gender, age, and nationality.	The groups of nationalities were categorised as follows: Saudi, Southeast Asian countries, Arab countries, and Western countries. The components (countries) of each nationality group were not provided. The modification on the instrument was not described, as the Minnesota Job Satisfaction Questionnaire contains 100 items and the short version of the instrument contained 20 items, author used 25 items without explaining what items were modified.

					Comparison based on nationality for satisfaction with subscales was not examined.
Abualrub and Alghamdi (2012) Western Region, Saudi Arabia	To examine the impact of leadership styles of nurse-managers on Saudi nurses' job satisfaction and their intent to stay at work.	308 Saudi nurses (51.3% response rate)	Spector (1997) Job satisfaction Survey	Saudi nurses were moderately satisfied in their jobs (Mean = 3.69 on scale of 6). Nurses were most satisfied with the nature of work, and least satisfied with fringe benefits (Mean = 2.95). Nurses were more satisfied with leaders who demonstrated transformational leadership styles, and those who were more satisfied with their jobs intended to stay at work.	
Al-Dossary et al. (2012) Eastern Province, Saudi Arabia	To measure nurses' job satisfaction in Saudi Arabia in a university hospital and to determine the influencing factors.	189 nurses (87.5%. response rate)	Spector (1997) Job satisfaction Survey	Nurses were satisfied with supervision, co-workers, and the nature of the work. Dissatisfaction was associated with pay, fringe benefits, contingent rewards, and operating conditions.	

Alonazi and Omar (2013) Riyadh, Saudi Arabia	To examine factors that influence (mostly paediatric) female nurses' turnover who joined and left the hospital during the period between January 2006 and October 2010.	126 nurses who resigned in the last 5 years (39.9% response rate) 128 nurses who are still working (88.9% response rate)	EXIT questionnaire for those who resigned Developed questionnaire for those who are still working	75% of nurses remained in their jobs for 2.2 years on average. Nurses left their jobs due to family reasons (39.7%) followed by other reasons (37.3%) including: pregnancy (13.5%), to continue their retirement (1.6%), employment problems (3.2%), and workload (1.6%). Approximately 4.8% of the nurses ticked other reasons, without specifying these reasons. 23% selected personal reasons.	The components of the instrument, and its reliability and validity were not provided

3.10 The effect of nationality on job satisfaction and intention to leave

Two international studies investigated perceptions of specific nationalities of nurses toward job satisfaction and intention to leave. Itzhaki et al. (2013) examined perceptions of job satisfaction among immigrant registered nurses in Israel and the United States, while Goh and Lopez (2016) explored job satisfaction level, work environment, and intentions to leave among migrant nurses in Singapore.

Both Goh and Lopez (2016) and Itzhaki et al. (2013) used a quantitative cross-sectional questionnaire design, which does not establish causality. Although the search criteria were limited to hospital nurses, participants across studies differed slightly. In the Itzhaki et al. (2013) study, participants were immigrant Former Soviet Union nurses in Israel and immigrant Filipino nurses in the United States. In contrast, the participants in the Goh and Lopez (2016) study were migrant nurses working in a tertiary public-funded hospital in Singapore. Goh and Lopez (2016) found Indian nurses reported the highest levels of job satisfaction followed by Malaysian, Filipino, Myanmarese and Chinese nurses. However, Goh and Lopez (2016) used a generic (not nursing-specific) instrument to measure job satisfaction without reporting how the scale was developed, and without reporting the validity of the instrument.

The lack of literature in Western and international studies regarding the effect of nationality on job satisfaction might be attributed to the fact that employment in developed countries (e.g. UK) prohibits discrimination in treating employees based on their nationality or ethnicity. However, there is no evidence in support of the idea that nurses with different nationality have the same level of job satisfaction. It is not known whether nationality groups within a country have different levels of job satisfaction. Therefore, examining the effect of nationality on job satisfaction and intention to leave will fill a gap in the literature and will potentially identify new areas for investigation.

Table 3-6: Summary of the studies that included the nationality of nurses when examining job satisfaction or intention to leave

Author(s) Location	Aim(s) of study	Sample	Instrument	Key findings
Itzhaki et al. (2013) Immigrant nurses in Israel and the United States.	To examine perceptions of job satisfaction among immigrant registered nurses in Israel and the United States.	Seventy-one Former Soviet Union nurses in Israel (82% response rate), and 96 Filipino nurses in the US (70% response rate)	Stamps and Piedmonte (1986) Index of Work Satisfaction	Former Soviet Union (FSU) registered nurses perceived pay and professional status as important, and they were least satisfied with pay. For Filipino nurses, organizational policies and interactions were most important, and they were least satisfied by task requirements.
Goh and Lopez (2016) Singapore	To explore job satisfaction levels, work environment, and intentions to leave among migrant nurses in Singapore.	Four hundred ninety-five migrant nurses (non-response rate of 30%)	Job satisfaction questionnaire (JSQ)	Indian nurses reported the highest levels of job satisfaction, followed by Malaysian, Filipino, Myanmarese and Chinese nurses. Predictors of migrant nurses' intentions to leave included having both supportive nurse managers and a professional nursing practice environment.

3.11 Discussion

The relevant studies, both non-Saudi and Saudi, generally conclude that job satisfaction differs across countries, as well as being based on organisational and individual characteristics. These findings were revealed mainly from cross-sectional quantitative studies, and very little research was conducted using mixed methods. In addition, the quality of relevant studies in Saudi Arabia was limited in terms of research design, data collection instruments, and sampling issues. The effect of nationality on job satisfaction and intention to leave remains a knowledge gap. As a consequence, further investigation is necessary, using mixed methods research to explore whether there is an effect of nationality on job satisfaction and intention to leave.

3.12 Justification for conducting the project

A number of the existing studies revealed important insights regarding nurses' job satisfaction, intention to leave, and associated factors. However, there is little knowledge as to whether there is an effect of nationality or ethnicity on nurses' job satisfaction and intention to leave. Also, the quality of some studies, especially those conducted in Saudi Arabia, seems to be questionable due to deficiencies in research design. Qualitative and mixed methods research have been little used. To date, no study has investigated whether nationality affects different facets of job satisfaction in Saudi Arabia. In addition, no studies have examined the effect of nationality on the intention to leave, nor have any studies investigated the intention to leave among nurses in Saudi Arabia, in terms of leaving the profession or leaving the country and working abroad.

The review of literature highlights the need to explore the effect of nationality on job satisfaction and intention to leave. Such a study should take place where foreign nurses comprise the largest proportion of the workforce. This allows for better understanding as to whether nationality affects job satisfaction and intention to leave. Consequently, this study explores whether nationality affects job satisfaction and the intention to leave among nurses working in Saudi Arabian government hospitals. The results of this study can inform the development of policies that create a healthy working environment

and recruit and retain nurses in the face of shortage crises. The information gained from this project will be used to benefit Saudi society, particularly its health sector.

Chapter 4: Research Methodology

4.1 Overview

The aim of this chapter is to present a coherent research methodology for this study that aligns with the research questions and objectives stated in chapter one. This chapter is divided into several sections to provide explanations of the research design, the appropriateness of the selected design, data collection tools, sampling, data collection and analysis process, and ethical issues related to the study.

A convergent parallel mixed methods design was used in which both forms of data (quantitative and qualitative) were collected at approximately the same time. The quantitative element included a survey approach to answer the first research question, which is measuring nurses' satisfaction with different facets of their jobs. The survey approach provided the mean of job satisfaction of each nationality group. The qualitative element involved conducting face-to-face semi-structured interviews to facilitate the gathering of rich and insightful data regarding the effects of nationality on job satisfaction and intention to leave among nurses. Interviews were utilised to enable nurses to talk about their experiences, opinions, job satisfaction or lack of it, and other issues related to the working environment in Saudi Arabian hospitals.

4.2 Research design

The research design of this study involved mixed quantitative and qualitative methods to enhance the validity of the research results. Creswell (2013b) stated that the mix of qualitative and quantitative approaches offers more understanding of a research problem than either approach alone.

Mixing different methodological techniques within one study began in 1959 with Campbell and Fisk, who mixed multiple research methods to study the validity of psychology trials although their results were expressed as quantitative measures (Campbell & Fiske 1959; Creswell 2013b). By 1973, mixed methods research had developed by mixing traditional quantitative survey methods with qualitative approaches such as observations and interviews. Then in 1979, a convergence between these two methods was

identified (Jick 1979). By the early 1990s, this convergence was transformed into a marriage between different methodologies, where each was recognised as influencing and complementing the other (Tashakkori & Teddlie 1998). Creswell and Clark (2010) stated that mixed methods research is less popular than individual method research. However, mixed methods approaches have come to be preferred in various contexts for the combination of post-positivist and social constructivist research approaches, which facilitates the inclusion of a wide range of research questions (Fielding et al. 1986; Tashakkori & Teddlie 2010; Creswell 2013b; Morgan 2014).

Pragmatism is the philosophical foundation of the worldview presented in the current study. Creswell and Clark (2011) stated that pragmatism is typically associated with mixed methods research. The characteristics of pragmatism include a focus on the consequences of the research, the importance of the research questions rather than the methods, multiple data collection methods that tell the story of the problem, are pluralistic and are real-world practice oriented (Creswell & Clark 2011). Mixed methods research has been defined as "an intellectual and practical synthesis based on qualitative and quantitative research; it is the third methodological or research paradigm (along with qualitative and quantitative research)" (Johnson et al. 2007, p. 129). For a better understanding regarding the nature of mixed methods, Creswell (2013b) suggested that mixed methods research is a design with philosophical assumptions and methods of inquiry. As a methodology, it includes philosophical assumptions that guide the direction of the collection and analysis of data and the combination of qualitative and quantitative approaches in many parts of the research process. The central principle of mixed methods research is that the combination of quantitative and qualitative research methods facilitates a better, more developed understanding of a given research problem (Fielding et al. 1986; Morgan 2014). Thus, mixed methods research includes the collection and analysis of a variety of quantitative and qualitative data in one study (Lawrenz & Huffman 2002; Creswell 2013b). Also, Fielding (2012) believed that certain combinations of research methods allow for better understanding and enable researchers to better address research questions than by using a single-method research design.

The key features common to all qualitative methods can be seen when they are contrasted with quantitative methods. The majority of quantitative data are data condensers. They condense data in order to understand the big picture of a particular topic, whereas qualitative methods are best understood as data enhancers, useful for answering "why" questions (Neuman 2011).

Several factors were considered when selecting the research methods. The mixed methods approach met the goals of the research with a large population sample. The quantitative data collection gathered a large body of information in order to measure job satisfaction levels among each nationality group. However, quantitative data did not capture some of the unique personal experiences of practising nursing in Saudi Arabia. These experiences were captured only via qualitative approaches, such as interviews (Neuman 2011). Also, in consideration of the large variation in characteristics of nurses working in Saudi Arabia, it was difficult to formulate a quantitative questionnaire that captured all the factors related to nurses' job satisfaction. Thus, the mixed methods approach was the most appropriate to answer the research questions and to provide more understanding regarding the effects of nationality on job satisfaction and intention to leave among nurses in Saudi Arabian government hospitals.

Creswell (2013b) clarified different designs of mixed methods research. He reported that a design can be implemented as a methodological protocol from the beginning of the research process, or it can be introduced as an emergent issue arising during the process (Creswell & Clark 2011). There are several basic mixed methods designs, such as convergent, sequential, embedded, and transformative. A convergent mixed methods process includes the use of qualitative and quantitative research methods to collect data concurrently, followed by the merging and integration of the data during the data analysis process to provide a rounded interpretation of the results. Sequential mixed methods allow the researcher to elaborate the findings from one method to another (Creswell & Clark 2011).

Morgan (2014) noted that assigning different methods to different aspects of the overall research question is a common design. However, there is no agreed-upon terminology for all types of mixed methods design. For instance, Morgan (2014) noted that the meaning of the term *triangulation* became

blurred over time because people said they were doing triangulation whenever they were doing any kind of mixed methods research. In this study, a mixed-methods design was used in which both forms of data (quantitative and qualitative) were collected at approximately the same time. Data were then analysed separately before being brought together (Creswell 2013b; Morgan 2014). Morgan (2014) refers to this design as additional coverage, which matches the notation of quantitative and qualitative. This design captures the underlying motivation behind a division of labour that assigns different methods to different aspects of the research question. The label *additional coverage* is presently used to allocate different methods to different purposes, allowing the overall project to pursue a wider range of research goals than would be possible with any single method (Morgan 2014). Additional coverage reinforces the goal of integrating findings from different methods into a more holistic understanding. From a practical point of view, the simplest implementation of additional coverage is a strict division of labour, such that each method plays a separate role within a large project (Morgan 2014). Morgan (2014) argued that additional coverage is most likely to be useful when combining qualitative and quantitative methods in research projects that include diverse or complex goals. Specifically, the need to achieve a variety of goals benefits from a division of labour that matches different methods to those goals, which is the heart of additional coverage.

The advantage of selecting this design was that it enabled the researcher to obtain detailed and in-depth data for the numerical data analysis, with the addition of qualitative data relating to the effects of nationality on job satisfaction and intention to leave among nurses. The quantitative element consisted of a questionnaire which measured the level of job satisfaction among nurses in Saudi Arabian government hospitals using McCloskey and Mueller's Satisfaction Scale (MMSS), intention to leave questions, and a demographic questionnaire. In other words, the purpose for using quantitative data is simply to obtain some data about how satisfied the nurses are, whether these data vary across nationalities and what the basic indicators are surrounding nurses' intentions to leave. However, qualitative data may further explain any association explored and provide reasons for quantitative results. Therefore, both types of data examined the effects of nationality, and additional factors related to work environments, which might influence nurses'

job satisfaction and their intention to leave. An in-depth explanation of the two elements is presented in the subsequent sections of this chapter. Another advantage of this design is the simplicity of the implementation, which was particularly suitable in this study as the researcher was working independently. The third advantage of this design is its time-efficient nature, which allows the researcher to collect two types of data in one phase (Creswell 2013b).

4.3 Geographic Location

The geographic location for this study is Riyadh city, Saudi Arabia. Riyadh city is the capital. It is the largest city in Saudi Arabia and it is located in the centre region of Saudi Arabia. Twelve government hospitals are located in Riyadh city. The list of hospitals and number of nurses at each hospital is presented in appendix B.

4.4 Data collection tools

This section details the data collection tools that were utilised in the study. The quantitative element utilised a survey approach, and the qualitative element involved the collection of data using a researcher-developed, semi-structured interview process.

4.4.1 The survey approach

The survey approach consisted of three parts, which were the McCloskey and Mueller's Satisfaction Scale (MMSS), intention to leave questions, and a demographic questionnaire. The McCloskey and Mueller's Satisfaction Scale (MMSS) was used in this study to measure nurses' satisfaction with their jobs (a copy of the questionnaire is presented in appendix C).

The scale consisted of 31 items including eight types of satisfaction: satisfaction with extrinsic rewards, scheduling, family and work balance, co-workers, interaction opportunities, professional opportunities, praise and recognition, and control and responsibility (Mueller & McCloskey 1990). These types of satisfaction were divided among the items as follows: satisfaction with extrinsic rewards (items 1–3), satisfaction with scheduling (items 4–6, 8–10), satisfaction with family and work balance (items 7, 11, 12), satisfaction with

co-workers (items 14, 15), satisfaction with interaction opportunities (items 16–19), satisfaction with professional opportunities (items 20, 21, 27, 28), satisfaction with praise and recognition (items 13, 24–26), and satisfaction with control and responsibility (items 22, 23, 29–31). Each item was scored from 1 to 5, with 1 corresponding to 'very dissatisfied' and 5 corresponding to 'very satisfied'.

The MMSS supports the original three theoretical dimensions of Maslow and Burns, which are safety, social, and psychological rewards (Maslow 1954; McCloskey 1974). Safety rewards are captured by the three satisfaction factors of extrinsic rewards, scheduling, and family and work balance. Social rewards take the form of satisfaction with co-workers and interaction opportunities. Psychological rewards are represented by satisfaction with professional opportunities, praise and recognition, and control and responsibility (Mueller & McCloskey 1990).

Cronbach's alpha is used to measure scale reliability and internal consistency, that is, how closely related a set of items are as a group (Hatcher & Stepanski 1994). In Mueller and McCloskey's (1990) study, Cronbach's alpha for each of the eight subscales ranged from 0.52 to 0.84, and the alpha for the global scale was 0.89. In this study, Cronbach's alphas for the eight subscales ranged from 0.45 and 0.84, whereas the alpha for the global scale was 0.91. All satisfaction subscales as well as the global scale, except for family and work balance, indicate good reliability, as the widely accepted minimum standard for internal consistency is 0.70 (Nunnally & Bernstein 1994). The researcher sent an official request form to obtain permission to use MMSS, and written permission was obtained (see appendices D and E).

In addition to the items about job satisfaction, the questionnaire was extended to include further items regarding intention to leave, and demographic and professional variables. Nurses were asked about three types of leaving intentions. These types were leaving profession (intention to leave the nursing profession), working abroad intention (intention to leave the country in order to practise the profession abroad), and hospital intention (intention to leave the organisation and practise the profession at another organisation in Saudi Arabia). Nurses who had an intention to leave were asked to state their reasons

for leaving, and where they were planning to work if they had working abroad or hospital leaving intentions.

Demographic variables included gender, age, nationality, length of stay in Saudi Arabia, religion, marital status, and parental status. Professional variables included experience in nursing, length of stay at current hospital, highest level of education, job position, and salary range. Nurses were not asked what hospital they work at. Instead, all forms and questionnaires were identified by a letter (A, B, or C) placed in the top of the forms to identify each hospital (see appendix C).

The questionnaires were provided only in the English language for two reasons. First, although Arabic is the official language of the country, English is consider the field language in the nursing profession in Saudi Arabia. Educational programs in nursing and health sciences are taught in English. Nurses in Saudi Arabian hospitals communicate in English since they come from many countries and speak many primary languages; English is the accepted interlanguage. Second, Al-Dossary et al. (2012) successfully used only English language surveys to measure nurses' satisfaction in Saudi Arabia, confirming the appropriateness of this approach.

4.4.2 Semi-structured face-to-face interviews

The researcher recognised that McCloskey and Mueller's Satisfaction Scale alone might not provide sufficient information regarding the full context, as the questionnaire may not capture all the elements related to work environment. Therefore, the researcher realised that it would be vital to have another data collection procedure that could provide in-depth qualitative data in order to improve and enhance the final findings of the research.

In addition to the questionnaire, interviews were conducted with nurses at each hospital. Holloway and Wheeler (2009) noted that interviews are the most common form of data collection in qualitative research and produce rich data. An interview is defined as ' "a conversation with a purpose" in which the interviewer aims to gain the perspectives, feelings and perceptions from the participant' (Holloway 1997 p. 94). Parahoo (2014) described interviews as a verbal interaction between researcher(s) and respondent(s) for the purpose of collecting data to answer particular research questions. Yin (2013) clarified

that interviews can be guided conversations rather than structured examinations, which means that the researcher will follow the line of inquiry and guide the conversation towards the problem under examination. Consequently, in this method the researcher endeavours to cover a list of questions or issues that are essential to answer the research questions. There is flexibility about how to word the questions, which should include some open-ended questions. The researcher is allowed to digress and probe, according to the interaction that takes place during the interview. The researcher continues to interview until it is realised that no more data can be obtained (Merriam 2009). Achieving the full potential of these interviews can contribute to human understanding, making sense of the world, and presenting these understandings to others (Green & Thorogood 2013).

Merriam (2009) stated that that the semi-structured interview is used if the researcher needs to obtain specific information from the informants, since it is guided by the issues being explored. The semi-structured interview was used in this research project since it offers more flexibility and affords the participants more control over the interview to freely express their own experiences, perceptions, and opinions, which are beneficial to the research (Creswell 2013b).

The interviews included icebreaker questions (e.g. Hi, how are you? Did you have any trouble getting here?). Several follow-up questions were asked, such as ‘what do you mean’ or ‘can you make more clarification, please’. In this study, the interviews were designed to gather information regarding the effects of nationality on nurses’ job satisfaction and retention. Nurses’ personal experiences in the nursing profession were a matter of interest for the researcher. The interview questions were designed to illuminate factors influencing nurses’ job satisfaction levels and their decisions to leave Saudi Arabian government hospitals. The interviews included questions on what attracted nurses to their profession, and what attracted foreign nurses to work in Saudi Arabia. Then the interviews continued with a few questions that were often the sub-questions in the qualitative research plan.

Interviews were conducted in English for all non-Arab nurses. Some of the Arab nurses including Saudis gave the interview in English, while some spoke in Arabic to fluently express their ideas and experiences regarding the topic.

Examples of the questions that were included in the interviews and the translation of the English questions into Arabic are presented in appendix F. In addition to these questions, the researcher asked participants to clarify some of their questionnaire answers. For instance, the researcher asked interviewees about the questionnaire items that they answered 'very satisfied' or 'very dissatisfied'. At the end of each interview, a final thank-you statement was made to acknowledge the time the participant spent during the interview (Creswell 2013b).

4.5 Sampling

4.5.1 Research population

The target population for this study was nurses who were employed in major government hospitals in Riyadh city. Only six hospitals (Hospital A, B, C, D, E, and F) are considered major hospitals in Riyadh city, based on the fact that they each employ 2000 nurses or more (Appendix B). The researcher visited these hospitals while working on the research proposal, in order to make contact with their gatekeepers. The researcher sent letters to remain in touch with those gatekeepers. Each gatekeeper informed the researcher that a formal agreement could not be established until ethical and hospital approvals were obtained.

Based on data about the nationalities of the nursing staff, three hospitals were selected using purposive sampling. At the first selected hospital, non-Saudi nurses formed the more significant percentage of the workforce. At the second hospital, Saudi nurses formed a more significant percentage of the workforce. The third hospital was selected since it employed the largest variation of nationalities. The selected hospitals are designated herewith as Hospitals A, B, and C. However, although the selection of the hospitals was based on their nationality diversity, the hospitals' profiles showed additional differences between them. For instance, Hospital A and Hospital C operated through the Hospital Operation Programme, while Hospital B was run under the direct operation of the MOH. In addition, Hospital A and Hospital C received Joint Commission International (JCI) accreditation, while Hospital B only received the Central Board of Accreditation for Health Care Institutions (CBAHI), which is the national accreditation for Saudi Arabia.

4.5.2 Inclusion criteria

- Hospitals with 2000 nurses or more in Riyadh city.
- All licensed nurses who are working in major hospitals with 2000 nurses or more regardless of their age, experience in nursing, or level of education.
- Voluntary participation by subjects, both hospitals and nurses.

4.5.3 Exclusion criteria

- Hospital with less than 2000 nurses.
- Non-licensed nurses (such as nurse aides and patient-care assistants).
- Nursing students including trainees.

4.5.4 Sampling techniques

4.5.4.1 Sampling technique for questionnaire

In order to provide the necessary sample size to make meaningful comparisons across hospitals, the researcher intended to target approximately 900 participants for the questionnaire part of the study (300 at each hospital). This study utilised purposive sampling as a sampling technique in order to include the most suitable participants who were available to the researcher. Initially, the researcher planned to utilise a random sampling technique, but later discovered that this was not possible due to various challenges. During the researcher's visits to the hospitals while working on the research proposal, the researcher realised that there would be difficulties in utilising random sampling in the study. Also, practical and expense barriers were huge. For instance, there was no solid personnel data in the hospitals under study, as hospitals do not share the human resource department's lists of employees with external researchers. Therefore, the non-probability sampling technique was the most appropriate to use, so as to provide some traction in this very chaotic, difficult situation.

4.5.4.2 Sampling technique for interviews

The sample for the interviews was obtained from the subset of the participants who completed the questionnaire. The questionnaire included a request for nurses to participate in interviews. From those nurses who completed the questionnaire and indicated their interest in taking part in the semi-structured interview, nurses were selected from different groups of nationalities, in order to explore a broader set of experiences of nurses from different cultures. This type of sampling technique is known as purposive sampling. It is considered as acceptable for this study since purposive sampling includes recruiting participants based on knowledge of the sample and the purposes of the study (Kumar 2011).

Sandelowski (1995) argued that the sample size should not be either very small, which makes obtaining sufficient data difficult, or too large, which makes it difficult to undertake the analysis. In the current study, 47 of the nurses who completed the questionnaire expressed interest in taking part in the semi-structured interview, and they left their contact data. The researcher tried to contact those nurses to confirm their participation in the questionnaire and their interest in taking part in a semi-structured interview. Out of the 47 participants, nine could not be reached because they either provided unclear contact data or they did not respond to the emails or phone calls. In addition, five changed their minds and decided to not participate. Four other nurses were not interviewed because it was not possible to find convenient times within the necessary time frame. Additionally, three nurses were not interviewed because further recruitment was no longer needed. The researcher had been taking notes during the interviews and prior to undertaking these three final interviews identified that the data on the factors affecting job satisfaction in respect to the comparison of Saudi vs expatriate nurses appeared to have reached saturation as there were no new themes emerging in the interviews (Baker & Edwards 2012). Therefore, the researcher interviewed 26 participants from those who completed the questionnaire and expressed interest in taking part in the semi-structured interview. At hospital A, the researcher interviewed nine participants (one Saudi, two Filipino, two Indian, two Jordanian, and two South African). At hospital B, the researcher interviewed nine participants (five Saudi, two Filipino, and two Indian). At hospital C, the

researcher interviewed eight participants (two Saudi, two Filipino, two South African, and two Malaysian).

4.6 Data collection and analysis

4.6.1 Access procedure

The first step was sending an official request along with all the relevant documentation such as the peer-reviewed research proposal, participant information sheet, participant consent form, Ethics and Research Governance Online (ERGO) application form, and research risk assessment form, through ERGO to the Faculty Ethics Committee to obtain an ethical approval. An in-depth description of the ethical issues, including the participant information sheet and the informed consent form, is provided in the ethical considerations section. Ethical approval was granted by the Faculty Ethics Committee, University of Southampton (study number 10413). Upon approval from the Faculty Ethics Committee, University of Southampton, the researcher's supervisors sent official requests to each hospital's authorities, along with the peer-reviewed research proposal and all relevant documentation necessary to obtain written permissions and ethical approvals. A copy of the official request is presented in appendix G.

The researcher followed the protocol of each hospital during the data collection process. At Hospital A, hospital authorities transferred the request for ethical approval to the Ministry of Health, since they believed this to be critical research. One of the hospitals required the researcher to obtain the certificate of 'protecting human subject research participants' from the National Institute of Health's Office of Extramural Research in order to for the researcher obtain an ethical approval to conduct the study at their site. The researcher took the quiz and successfully obtained the required certificate. Also, the researcher and researcher's supervisors completed the required applications provided by hospital authorities (copies of these forms are presented in appendix H). The permissions from the first and the second hospitals (Hospital A and Hospital B) were obtained in April 2014.

After agreements and written approvals had been achieved, implementation of the study was achieved through collaboration with each hospital authority. The

researcher negotiated with each hospital authority about how to approach the staff. The researcher followed the protocol of each hospital in the data collection process. Data were collected over a nine-month period between May 2014 and February 2015. At the first two hospitals (Hospital A and Hospital B), data were collected between May and August 2014. The permission from the third hospital (Hospital C) was obtained in October 2014, and data were collected there between December 2014 and February 2015. Copies of the written ethical approvals from the three hospitals are presented in appendix I.

4.6.2 Data collection with the questionnaire

There was inconsistency in the data collection due to the research sites' policies and facilities. At Hospital A, the authority allowed the collection of questionnaire data only via use of the Internet, so all nursing staff were emailed. The authority sent an email, along with participant information sheets and the webpage of the online questionnaire, to all participants eligible to take part in this study.

Follow-up emails were then sent to remind them about the study. The researcher was informed that all eligible staff had access to the Internet. The online questionnaire was housed at the University of Southampton's iSurvey website. iSurvey is a free tool for the use of University of Southampton researchers. Only the researcher had access to the participants' answers to the questionnaire.

Fricker and Schonlau (2002) discussed the advantages and limitations of Internet research surveys. The advantages include a wider global reach, higher speeds and short timelines for the survey process, a high level of convenience for the respondents, ease of data entry and analysis, lower administrative costs, ease of following up with respondents and the option to make the completion of all the answers mandatory. The limitations of this method consisted of low response rates, technological variations and the skewed attributes of the population possessing Internet access, although the gap is closing each year as more people gain access to the Internet. Online surveys are considered a feasible alternative to face-to-face surveys if time, cost, or geographic barriers limit the study (Schonlau et al. 2002; Evans & Mathur 2005).

At Hospital B, the authority issued the researcher a temporary access ID that allowed the latter to approach the staff across all the wards. There was no available electronic database containing nurses' emails. The researcher distributed closed envelopes containing the participant information sheet and the questionnaire to all eligible staff. The researcher also used invitation letters and posters to invite interested participants to take part in the study (a copy of the poster is presented in Appendix J). Several visits were made to ensure a sufficient number of participants. Once nurses completed the questionnaires, they sealed them within the plain envelopes provided and dropped these into a secure box in the Academic Affairs department. The researcher ensured the box was in a secure place with the help of the hospital authority. In addition, the researcher allowed participants to complete their questionnaires online when it was more convenient for them to do so. As with Hospital A, the online questionnaire was housed at the University of Southampton's iSurvey website. Nurses were given details about the online questionnaire option—Including the webpage address and password—on the participant information sheet.

In the third hospital (Hospital C), the researcher emailed and handed out hard copies of the questionnaires. The authority provided the researcher with an email list of the nursing unit managers only. The researcher emailed them a participant information sheet and a copy of the written ethical approval letter, invited them to take part in the study, and asked them to kindly circulate the email to their staff. The researcher did not rely on the email only, but also paid several visits to the research site during the data collection period. The researcher noticed that the nurses did not have access to the Internet in the nursing stations. Only nursing unit managers and clinical resources nurses had Internet access at the hospital. Negotiations took place with each unit manager about how to approach their staff members. In some wards, hard copies of the questionnaire were handed out, while in others, managers asked their staff to complete the online questionnaire at home or at the hospital library during their breaks.

Online questionnaire data were imported into Excel. Data from the questionnaires done in hard copy were entered into two Excel spreadsheets, then checked against one another for discrepancies in order to ensure the accuracy of the data input. Postal collection was not used at all in the hospitals, as the postal service in Saudi Arabia is still not reliable.

4.6.3 Quantitative data analysis

MMSS has 31 items including eight types of satisfaction. These types are satisfaction with extrinsic rewards (items 1–3), satisfaction with scheduling (items 4–6, 8–10), satisfaction with family and work balance (items 7, 11, 12), satisfaction with co-workers (items 14, 15), satisfaction with interaction opportunities (items 16–19), satisfaction with professional opportunities (items 20, 21, 27, 28), satisfaction with praise and recognition (items 13, 24–26), and satisfaction with control and responsibility (items 22, 23, 29–31).

Each item was scored from 1 to 5, with 1 corresponding to 'very dissatisfied' and 5 corresponding to 'very satisfied'. For each subscale, the scores were summed and divided by the number of items to obtain a mean. A total mean for the global scale can be obtained as a general measure of nursing satisfaction. The data analysis was done with the assistance of the SPSS version 22.0 (SPSS Inc., Chicago, IL, USA).

For the first research question, descriptive statistics were used to calculate the mean, standard deviation, median, and interquartile range. Descriptive statistics detailed the study sample and enabled the performance of necessary data diagnostics before proceeding with data analysis techniques (Field 2009). The statistical techniques that were utilised were dependent on the distribution of the data collected.

Since the data followed a normal distribution based on an inspection of the histogram and the P-P plot, parametric tests were utilised to test for differences between groups of interest to the study questions. For example, the independent-samples t-test was used to determine if a difference existed between the means of two independent groups on a continuous dependent variable. More specifically, t-tests were used to determine whether the difference between two groups was statistically significant (Cohen 1988; Field 2009).

In this study, this test was used, for example, to determine whether there is a statistically significant difference between the overall job satisfaction scores of female and male nurses. In addition, one-way analysis of variance (ANOVA) was used to determine whether there were any statistically significant differences between the means of two or more independent groups (Field 2009; Allen et

al. 2014). Specifically in this study, this test was used to determine whether there is a statistically significant difference between the overall job satisfaction scores of the nationality groups.

A multiple linear regression model is used to predict a continuous dependent variable based on multiple independent variables (Field 2009; Pallant 2013). This test was used in the present study to calculate how certain variables—including nurses' nationalities and the type of hospital—can help predict nurses' overall job satisfaction levels. A binomial logistic regression attempts to predict the probability that an observation falls into one of two categories of a dichotomous dependent variable based on one or more independent variables that can be either continuous or categorical (Field 2009). In the present study this was utilised to determine the association between job satisfaction subscales and the likelihood that participants will want to leave their hospitals.

4.6.4 Data collection with semi-structured interviews

The recruitment procedure for participants for the semi-structured interview involved a question at the end of the questionnaire, which asked any nurse who was willing to take part in an interview to indicate their willingness by ticking a box and providing contact details. A copy of the participant information sheet for the interview was sent to each participant interested in taking part. The researcher contacted the interested participants and arranged a time convenient to each participant's work schedule. The interviews took place in a quiet, private room within each hospital for the nurses' convenience.

Nurses were interviewed individually and face to face. Cohen et al. (2011) stated that interviewing is a powerful, flexible tool for researchers to implement for data collection, enabling multi-sensory channels to be used—i.e. the verbal, non-verbal, visual and auditory channels. Similarly, Holloway (1997) stated that interviews are the most common form of data collection in qualitative research—they tend to produce rich data, and they are a well-established research technique in sociology and related disciplines. The advantage of interviewing participants face to face is that it allows the researcher to capture verbal and non-verbal responses, and through facial

expressions and other body language the researcher can detect if the participant experiences any discomfort or stress (Leedy & Ormrod 2005).

Semi-structured interviews were conducted for this study, since they offer more flexibility and afford the participants more control over the interview, allowing them to more freely express their opinions and perspectives (Creswell 2013a). Yin (2013) cautions that interviews can produce biased information because the participants might only provide information that they think the researcher wants to obtain. In order to overcome this problem, Miller et al. (2012) suggested skills that it is important to apply during the course of interviews, which include listening actively, maintaining eye contact, having an appropriate facial expression, being respectful and courteous, and talking in a friendly tone.

Before each interview commenced, the protocol and intention of the interview were explained to each participant. Each participant was asked to read the participant information sheet. All participants were happy to proceed in taking part and signed a consent form indicating their willingness to participate in the interview. An in-depth explanation about the participant information sheet for interviews and the consent form is presented in the ethical considerations section.

All participants were informed that the interview was being voice-recorded and that they would have the right to withdraw at any time. All interviews were recorded using two recording devices for backup, and each interview lasted approximately one hour. During the semi-structured interview, the researcher guided the session. Interview forms included a heading (date, place, interviewer, and interviewee). In this study, the interviews were designed to gather information regarding nurses' job satisfaction. Their personal experiences in the nursing profession were also a matter of interest for the researcher. Participants were assured of confidentiality and anonymity.

4.6.5 Qualitative data analysis

There were two sources of qualitative data, the semi structured interviews and the qualitative component from the questionnaire. The questionnaire included open-ended follow-up questions for those who expressed an intention to leave. Nurses who had an intention to leave, whether this involved leaving the

hospital, the profession, or the country, were asked to state their reasons and where they planned to practise the nursing profession.

Additionally, 26 nurses from three hospitals were interviewed using two audio recording devices. The analysis commenced with the writing of memos during the interviews. Creswell (2013b) stated that analysing interviews includes organising and preparing the data for analysis. For example, each audio file was stored in the researcher's password-protected computer. In addition, the researcher made a backup of each audio-recording file.

All the audio-recorded data obtained from the semi-structured interviews were transcribed verbatim into English or Arabic, using computer word processing to enable computerised storage and organisation of the data. Transcribing was done by the researcher and a professional transcriber, who was recommended by the Faculty of Health Science at the University of Southampton for providing this service. A copy of the agreement between the researcher and the transcriber is presented in appendix K. To preserve the anonymity of the settings and participants, all references to names of places and persons were changed into pseudonyms.

Sandelowski (1994) delivered some suggestions for the transcribing process. Audiotapes shall be transcribed verbatim (i.e., recorded word for word, exactly as said), including any nonverbal or background sounds (e.g., laughter, sighs, coughs, claps, snaps of fingers, car horns) (Sandelowski 1994). The transcript shall not be cleaned up by removing foul language, slang or misused of words or concepts. Filler words such as mm, uh huh, yeah, oh, ah and a-hah shall be transcribed. Word or phrase repetitions shall be transcribed. If a word is cut off or truncated, a hyphen shall be inserted at the end of the last letter or audible sound (Sandelowski 1994).

The transcripts have undergone a rigorous, systematic process of thematic analysis. Aronson (1994) noted that thematic analysis concentrates on identifiable themes and patterns of living and/or behaviour. Thematic analysis is considered a foundational method for qualitative analysis, as it is the first qualitative method of analysis that researchers should learn, since it provides core skills that will be beneficial for conducting different forms of qualitative analysis (Braun & Clarke 2006; Vaismoradi et al. 2013). Boyatzis (1998) described thematic analysis not only as a specific method, but also as a tool to

use across different methods, because it is one of a few shared generic skills across qualitative analysis. However, although thematic analysis is widely used, there is no clear agreement about its definition and how exactly it can be performed (Braun & Clarke 2006). Braun and Clarke (2006) discussed what counts as a theme, stating that a theme captures something important concerning the data regarding the research question and represents some level of patterned response or meaning within the data set.

Braun and Clarke (2006) provided a step-by-step framework for leading thematic analysis, and this thematic analysis framework was followed in the thematic analysis of this study. This guideline involves six steps: familiarising oneself with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes and producing a report (Braun & Clarke 2006). According to Braun and Clarke (2006), familiarisation permits the researcher to listen to interview recordings and re-read transcripts several times to obtain an overview of the information. Generating initial codes consists of coding interesting features of the data in a systematic style across the entire data set, collating data relevant to each code. Searching for themes involved collating codes into potential themes, gathering all data relevant to each potential theme. The phase of reviewing themes includes checking whether the themes work in relation to the coded extracts and the entire data set, generating a thematic 'map' of the analysis. Defining and naming themes was approached by ongoing analysis in order to refine the specifics of each theme and the overall story told by the analysis, generating clear definitions and names for each theme. Producing the report is related to the final opportunity for analysis, which involves the selection of vivid, compelling extract examples, a final analysis of selected extracts and a relation of the analysis back to the research questions and literature at hand, producing a scholarly report of the analysis (Braun & Clarke 2006).

The researcher looked at the interview data and tried to develop a general sense of the data and to take the opportunity to reflect on its overall meaning. This process allowed the researcher to develop a better understanding of the individual pieces of information (Creswell 2013b). Miles and Huberman (1994) contended that the data analysis process in qualitative research involves three broad, interrelated activities: data reduction, data display, and conclusion drawing with verification (Silverman 2013). Tesch (1990) refers to the approach

of analysing qualitative data as decontextualising the data into analysable units through coding and sorting, and then recontextualising them in a way that permits for new insights and interpretations. Next, the main steps in the analysis of the qualitative data in this study were coding, categorizing, and interpretation. Coding has been defined as a process of segmenting data into simpler, analysable units and attaching meaningful labels to codes (Miles & Huberman 1994). It is considered as an essential part of data analysis and is the first step in organising data. Coding is also considered as data reduction or simplification (Coffey & Atkinson 1996; Creswell 2013b). The researcher paid close attention to the transition from one topic to another, and coded the data based on the topic for each data segment. A computer software package, MAXQDA 12, was used to support the coding and storing of texts instead of QSRNvivo 10, because the latter does not support Arabic font.

After coding, categorisation refers to the process of bringing coded data segments together based on their common properties or concepts (Miles & Huberman 1994). It also allows the researcher to think about the data in a new way (Coffey & Atkinson 1996; Richards 2014). The coded data was arranged and grouped together based on similarities and relationships, and each category or cluster of topics was given a name. Finally, interpretation, which can be described as the process of generating meanings by exploring and interrogating the coded data (Coffey & Atkinson 1996; Richards 2014). Coffey and Atkinson (1996) noted that the coded data need to be presented together in one place to allow the researcher to split the categories into subcategories, making links between them. Also, presenting the data in one place enables the interpretation process. These interview excerpts are supported by the nurses' exact quotations, which provide adequately rich and detailed descriptions and allow readers to judge for themselves the quality of the interpretation of the data.

4.6.5.1 Translation

Maneesriwongul and Dixon (2004) discussed six different types of translating instruments, including forward-only translation, forward-only translation with testing, back translation, back translation with monolingual tests, back translation with bilingual tests and back translation with both monolingual and bilingual tests. Brislin's (1970) model suggests starting with forward

translation, recruiting a bilingual person to translate texts from the source language (non-English) into the target language (English). Next, another bilingual person back translates texts from the target language into their source language, and then the two bilingual translators compare both versions to each other in order to check accuracy and equivalence and to catch any discrepancies that may have occurred during the process (Brislin 1970).

Esposito (2001) noted that whereas there are some similarities between the translation techniques used in quantitative and qualitative research, there are also some significant differences between them, based on the underlying methodological processes involved. For instance, unlike the set-in-stone protocol used in quantitative research, data collection and analysis techniques in qualitative research are dynamic processes (Twinn 1998; Esposito 2001). Some authors have warned that translation in qualitative research is a daunting process that is very time-consuming and costly, and might be beyond the capabilities of many researchers (Maneesriwongul & Dixon 2004; Weeks et al. 2007; Regmi et al. 2010). Also, some ideas, concepts and issues cannot be translated literally from one language to another (Jones et al. 2001; Van Nes et al. 2010); concepts in one language may be understood differently in another.

Polkinghorne (2007) stated that qualitative research be considered valid when the distance between the original meanings of the participants' responses to interviews and the meanings interpreted in the report of the study's findings is as close as possible. In addition, Van Nes et al. (2010) recommended staying in the original language of the text for as long and as much as possible when analysing interview transcripts, stating that doing so can help avoid potential losses of meaning and thereby enhance the validity of the qualitative research. In the current study, four postgraduate students who are fluent in both Arabic and English were recruited to work alongside the researcher in the forward-backward translation procedure. First, two of the bilingual students translated the Arabic codes, themes and quotations into English. The other pair of bilingual students reviewed the translation. All four of the students were involved in the translation work, with the researcher as the project manager, working together to settle any differences found within the forward translation and discussing these discrepancies until all four translators could reach an agreement.

4.6.5.2 Trustworthiness

Trustworthiness has been offered as an appropriate means for judging the validity of a qualitative inquiry (Lincoln & Guba 1985; Schwandt 1997). Lincoln and Guba (1985) suggested that the following four criteria be considered in establishing the trustworthiness of qualitative work: credibility, transferability, dependability and conformability. Credibility is defined as 'a twofold task: first, to carry out the inquiry in such a way that the probability that the findings will be found to be credible is enhanced, second, to demonstrate the credibility of the findings by having them approved by the constructors of the multiple realities being studied' (Lincoln & Guba 1985 p.296).

According to Lincoln and Guba (1985), transferability is associated with the issue of generalisation, which relates to the researcher's responsibility to provide readers with sufficient findings to enable them to make a transfer to different settings or contexts. Transferability refers to "providing sufficient description of the particular context studied so that others may adequately judge the applicability or fit of the inquiry findings to their own context" (Guba 1990 p. 236). Dependability is related to the coherence of the inquiry process and the process of taking into account factors linked to changing conditions in the phenomena. Conformability concentrates on research findings as the outcomes of the collected and analysed original data, thus ensuring that they are not figments of the researcher's imagination (Lincoln & Guba 1985).

To further enhance credibility, interview transcripts were given to the participants, allowing them to verify their accuracy. To address transferability, the researcher provided a detailed description of the qualitative data, including the settings and the participants. In the qualitative findings chapter, quotations from participants' transcripts are presented, along with the researcher's interpretations of those quotations, in order to provide a clearer depiction of the findings. To enhance dependability, a recorder was used to tape all the interviews, and the same researcher conducted them. All the transcriptions were checked thoroughly for word-for-word accuracy and were based on an interview guide with semi-structured interview questions.

To maintain conformability, Braun and Clarke's (2006) six-step framework for analysis was used to deliver a logical, accurate interpretation of the data. Also, the validity of this research was enriched by checking the generated themes

with the supervisors of this project (Holloway & Wheeler 2009). One of the lecturers had a nursing background and one had a psychological background, and thus the data analysis was conducted from both nursing and non-nursing viewpoints. The qualitative and quantitative data were treated independently, and each one provided an understanding of the problem under study from a different perspective.

4.6.6 Integrating and interpreting quantitative and qualitative data

The issue of whether to compare the quantitative and qualitative results in the additional coverage design may not be problematic as there is no requirement to keep the two processes independent (Morgan 2014). Morgan (2014) noted that it is possible to treat both types of data as if they were two completely independent studies. Morgan (2014) also stated that it is even acceptable to publish the findings of each method separately without any attempt to integrate them; this approach, however, leaves an exercise for the reader to make sense of the whole project's findings. Leech and Onwuegbuzie (2009), however, implemented the parallel strands where the collection and analysis of the quantitative and qualitative data proceeded along separate tracks. Articles that report on projects with parallel strands often present two separate results sections: one for the quantitative data, and one for the qualitative data, with only minimum integration (Morgan 2014).

Morgan (2014) suggested using sequential contributions, where the goal is to use the results of one method to enhance the performance of another. Morgan (2014) maintained that studies that are motivated by sequential contributions—using the different strengths of different methods for different purposes, with each method contributing to the others in a pre-planned fashion. The researcher reported the quantitative statistical results and then discuss the qualitative findings that either confirm or disconfirm the statistical results. These comparisons are presented in the discussion chapter of this thesis (Creswell 2013b). In a project, a supplementary qualitative method can assist a core quantitative method in demonstrate bases and exploring reasons for the results (Morgan 2014). In addition, qualitative data can comprise a discovery process that sheds new light on the quantitative portion of the project. In many cases, as in this current study, qualitative results may correspond to an understanding of how and why the quantitative results occur

(Morgan 2014). In particular, survey results might rely on this discovery-oriented design when the original goal is to describe an unfamiliar population or complex phenomena; thus, the qualitative portion of the study can expand on what was discovered in the survey results. The findings from the overall project can be strengthened because the results from one method allow another method to reveal more information than it could have by itself.

4.7 Ethical considerations

As Neuman (2011) stated, when conducting research ethically, it is important to identify any concerns, dilemmas, or conflicts that may be present. Research into human subjects in the workplace can reveal sensitive information, which if disclosed can do harm to the participants or to other persons. Harm might be physical, psychological, legal, and/or economic (Neuman 2011). Ethical issues and the safety of the researcher and participants were assessed in four forms. These forms are the participant information sheet, participant consent form, research risk assessment form, and ethics application. Copies of these forms are presented in appendices L, M, N, O, and P. However, the two main ethical issues anticipated in this study were confidentiality and voluntary participation.

4.7.1 Confidentiality

To ensure the confidentiality of the questionnaire, no questions regarding patients or third parties were asked. The questionnaires were filled out on a password-protected computer. Only the researcher (and research supervisors as necessary) have access to the answers. Electronic records were stored in a password-protected external hard drive, and a backup copy on a password-protected flash drive.

Confidentiality in interviews was assured, as any personal details such as names, e-mail addresses, and phone numbers were protected and kept secure and confidential. The interview data were kept in a password-protected computer accessible only by the researcher (and research supervisors as necessary). The researcher reported the information anonymously for both participants and organisations. Pseudonyms and codes were used for participants and hospitals in any data selected for dissemination.

4.7.2 Participant information sheet

Participant information sheets for both questionnaires and interviews included a description of the nature of the study, and reassured participants that there would be no detrimental repercussions as a result of their participation (copies of the participant information sheets for the questionnaire and interviews are presented in appendices L and M). The participant information sheet for the interview included a statement that the participant had the right to withdraw from the interview at any time. The participant information sheet for the questionnaire informed the participants that they could not withdraw once they had completed and returned the questionnaire. Participants' confidentiality was assured, as no questions regarding patients or third parties were asked in the questionnaire. The questionnaires were filled out on a secure password-protected computer. All interview participants were informed that they were being voice-recorded during the interview and that they had the right to withdraw. Contact details were provided in case any questions concerning the study or questionnaire arose. The researcher informed the participants that data would be analysed and kept on a password-protected computer that can only be accessed by the researcher and researcher's supervisors.

4.7.3 Participant consent form

The participant consent form ensured that participants had the opportunity to read and understood the participant information sheet and have had the opportunity to ask questions about the study. Also, it ensured that participants have agreed to take part in this research project and have agreed for their data to be used for the purpose of this study. Additionally, it ensured that participants understood that participation is voluntary. Informed consent for the questionnaire was given by adding a statement at the top of the questionnaire (Appendix C). For the interview, participants were informed that their voices were being recorded throughout the interview (a copy of the consent form for the interview is presented in appendix N).

Chapter 5: Quantitative Results

5.1 Introduction

This chapter presents the quantitative results of this study, involving descriptive statistics of the sample of participants. In addition, quantitative results included bivariate statistics, which explored the relationships between one dependent and one independent variable. For example, bivariate analysis tests whether overall nurses' job satisfaction scores differed based on nationality, or whether overall nurses' job satisfaction differed based on the type of hospital. Quantitative results in this study also extended to multiple regression statistics to predict the value of a variable based on the value of two or more other variables. In this study, the selection of predictors (variables) in the multiple regression models were based on whether there were significant differences in the bivariate analysis. These significant variables were added into the regression models in addition to nationality, which is the variable of interest in this study. An example of multiple regression analysis used in this study is presented in section 5.7, which predicted the value of overall job satisfaction based on the value of particular variables that were significant in the bivariate analysis. These included the type of hospital the nurses worked at, their experience, age and their nationality, which was the variable of interest in this study.

This chapter begins with an introduction containing the response rate for each nationality group and each hospital followed by a descriptive analysis of the demographic data of the participants. The chapter then presents the bivariate analyses of job satisfaction by nationality, type of hospital and other demographic variables. As the nationality was the variable of interest, a detailed description is presented about each nationality group, such as their qualifications, age and salaries. Each participant was grouped by nationality as being either Saudi or expatriate, with the expatriate nurses sharing the features of being foreign to Saudi Arabia and away from their respective countries. Following the bivariate analysis of job satisfaction, the chapter highlights the indicators of the nurses' intention to leave followed by a regression analysis to discover the predictors of the nurses' overall job

satisfaction and their intention to leave their jobs. Finally, this chapter introduces the summary of the quantitative results.

The total number of the returned questionnaires was 807 from three hospitals. Based on a target population of 9,453 and 807 questionnaires received, the response rate was 8.5%. The response rate for Hospital A was 9.6%, while it was 8.3% in Hospital B, and 7.8% from Hospital C. The data illustrate that the response rate for the nationality groups ranged from 7.2% for Indian nurses to 16.2% for British nurses. The response rate was calculated based on the number of respondents within the nursing population at each hospital. Response rate was also calculated based on a conservative estimation, assuming that all nurses at Hospital A and Hospital C received the emails and were able to access the on-line questionnaire, and assuming all nurses at Hospital B recognised the research poster for the study and decided whether or not to participate in the study. Four hundred and ninety-one responded online while 316 responded in hard copy. The on-line questionnaires were imported into Excel. Answers from the hard-copy questionnaires were input into two Excel spreadsheets and checked for differences to ensure the accuracy of the data entered. SPSS version 22.0 was used to perform data analysis.

Sixty-four respondents answered only the demographic questions with no accompanying questionnaires. Therefore, 743 questionnaires were included in the final data analysis. The sample size met the Krejcie and Morgan (1970) and Creswell (2013a) criteria for a sample decision model with a confidence level (CI) of 95% and a margin of error of 5%. The sample size (743) also met the criteria for the study, using rules of thumb for determining the minimum number of subjects required to conduct multiple regression analyses (Green 1991, p. 499; Tabachnick & Fidell 2013, p.159). The following equations demonstrate this decision formula:

$N \geq 50 + 8K$ (N = sample size required; K = number of predictors)

$N \geq 104 + K$ (N = sample size required; K = number of predictors)

There were eight main nationality groups: Saudi, Filipino, Indian, Jordanian, South African, Malaysian and British. The remaining respondents consisted of a range of nationalities, including Canadian, Australian, New Zealander, Irish, German, Slovakian, Czech, Portuguese, Lebanese, Egyptian, Palestinian, Nigerian, Pakistani, Indonesian, Thai, and Chinese. There were very few respondents from each of these nationalities, which were therefore gathered into one group, named 'others'.

Tables 5-1 shows the overall response rates for each nationality group, and Table 5-2 shows the response rate by hospital. These data reveal that the main nationality groups employed in the three hospitals are Saudi, Filipino, and Indian. The data presented in Table 5-2 illustrates that the nursing workforces in the three hospitals differ from each other. In hospital B, for instance, the percentage of Saudi nurses comprised the largest percentage of the nursing workforce, while that is not the case at Hospital A and Hospital C, where foreign nurses made up the highest proportion of the nursing labour. The data shows that there is uneven distribution among the nationalities of nurses in each hospital. For instance, there is a noticeable absence of South African, Malaysian, and British nurses employed in Hospital B. In addition, the data demonstrates that the largest variety of nationalities are employed in Hospital C, where the 'other' category comprised 8.1% of the total nursing staff, while other nationalities were Malaysian 11.9%, and South African 5.8%. These nationalities made up a lower proportion of the nursing workforce in Hospital A and Hospital B. In addition, the data revealed that although Indian nurses comprised a large proportion of the total nursing staff across the three hospitals (20%), there are no Indian nurses in Hospital C, where Filipino nurses are the predominant nationality. This data suggests that there are a mixture of nationalities among the nurses at each hospital. However, although the selection of the hospitals was based on their nationality diversity, the hospitals' profiles showed additional differences between them. For instance, Hospital A and Hospital C operated through the Hospital Operation Programme, while Hospital B was run under the direct operation of the MOH.

Table 5-1: The response rate of each nationality group, and surveys included in analysis

	Total		Participants			
Nationality	Nursing staff n & (%)[a]		Response rate n & (%)[b]		Surveys included n & (%)[c]	
Saudi	1676	(17.7)	151	(9.0)	141	(8.4)
Filipino	4283	(45.3)	329	(7.6)	309	(7.2)
Indian	2020	(21.4)	145	(7.2)	138	(6.8)
Jordanian	230	(2.4)	32	(13.9)	30	(13.0)
South African	294	(3.1)	41	(13.9)	38	(12.9)
Malaysian	454	(4.8)	45	(9.9)	38	(8.4)
British	105	(1.1)	17	(16.2)	15	(14.3)
Other	391	(3.9)	47	(12.0)	34	(9.0)
Total	9453	(100)	807	(8.5)	743	(7.9)

[a] The percentage of each nationality to the total population

[b] The response rate of each nationality group

[c] The percentage of survey included to total population of each nationality

Table 5-2: The response rate of each nationality group by hospital

	Total nursing staff								Participants' response rate							
Nationality	Hospital A N & (%)[a]		Hospital B N & (%)[a]		Hospital C N & (%)[a]		Total N & (%)[b]		Hospital A N & (%)[c]		Hospital B N & (%)[c]		Hospital C N & (%)[c]		Total N % (%)[d]	
Saudi	30	(1.0)	1408	(46.7)	238	(6.6)	1676	(17.7)	10	(33.3)	117	(8.3)	24	(10.1)	151	(9.0)
Filipino	1155	(41.0)	844	(28.0)	2284	(63.0)	4483	(45.3)	118	(10.2)	76	(9.0)	135	(6.0)	329	(7.6)
Indian	1324	(47.0)	696	(23.1)	0	0	2020	(21.4)	93	(7.0)	52	(7.5)	0	0	145	(7.2)
Jordanian	126	(4.5)	30	(1.0)	74	(2.0)	230	(2.4)	19	(15.1)	4	(13.3)	9	(12.1)	32	(13.9)
S.African	84	(3.0)	0	0	210	(5.8)	294	(3.1)	17	(20.2)	0	0	24	(11.4)	41	(13.9)
Malaysian	20	(0.7)	0	0	434	(11.9)	454	(4.8)	4	(20.0)	0	0	41	(9.4)	45	(9.9)
British	5	(0.2)	0	0	100	(2.6)	105	(1.1)	2	(40)	0	0	15	(15.0)	17	(16.2)
Other	74	(2.6)	38	(1.3)	279	(8.1)	391	(4.1)	12	(12.1)	2	(5.3)	33	(11.8)	47	(12.0)
Total	2818	(100)	3016	(100)	3619	(100)	9453	(100)	270	(9.6)	251	(8.3)	281	(7.8)	807	(8.5)

[a] The percentage of each nationality to the total population at each hospital

[b] The percentage of each nationality group to the total population

[c] The response rate of each nationality group at each hospital

[d] The response rate of each nationality group at the two hospitals

5.2 Characteristics of participants

Across the samples from the three hospitals, three main nationality groups together made about 80% of participants. These three groups were Saudi (19.0%), Filipino (41.6%), and Indian (18.6%). In addition to these three main groups, the next four largest groups of participants were Jordanian (4.0%), South African (5.1%), Malaysian (5.1%), and British (2.0%). The "other" category consists of several nationalities including Australian, New Zealander, Canadian, Irish, Czech, Portuguese, Germany, Slovakian, Egyptian, Lebanese, Palestinian, Pakistani, Nigerian, Indonesian, Thai, and Chinese, who together made 4.6% of participants. Participants from Hospital A comprised 33.5% of the total sample, while 32.7% of participants were from Hospital B, and 33.8% were from Hospital C. Table 5-3 shows the surveys included in the analysis by each nationality group and by hospital.

Table 5-3: Surveys included in analysis by nationality and hospital

	Survey included in analysis						
Nationality	Hospital A		Hospital B		Hospital C		Total
	n	%[a]	n	(%)[a]	n	(%)[a]	n
Saudi	7		112		22		141
Filipino	112		74		123		309
Indian	87		51		0		138
Jordanian	18		4		8		30
South African	16		0		22		38
Malaysian	3		0		35		38
British	2		0		13		15
Other	4		2		28		34
Total	249	33.5%	243	32.7%	251	33.8%	743

[a] The percentage of survey included in analysis by hospital

The majority of participants were female (93.1%). The mean participants' age was 35.2 years old (S.D. 9.2). Christianity was the largest religious group at 61.7%, followed by Islam at 34.0%, while Hindu and Buddhism comprised 3.5% and 0.7% respectively. Married participants were the largest group at 58.5%, followed by singles at 35.5%, while divorced and widowed comprised 4.8% and 1.1% correspondingly. Participants with children comprised 52.0%, whereas those who have no children comprised 48.0%.

Participants who had acquired a diploma or associate degree comprised 47.1% of the total participants, followed by participants who had acquired a bachelor's degree, at 45.7% of participants. Participants who had acquired postgraduate degrees including doctorates comprised 7.2% of research participants. Participants employed in senior nurse or higher positions comprised 57.1% of the total participants, while 42.2% of participants were employed in positions lower than senior nurse. It is noteworthy that nursing positions were measured with nurses being asked whether they were employed in lower positions or in senior positions or higher. The questions regarding nursing position in this study were created because there are different levels of nursing positions at each hospital. However, the measurements resulted in an issue, with nurses having the same position such as 'charge nurse' giving different answers to the question. Therefore, in future studies, nurses in Saudi Arabia need to be asked open-ended questions about their nursing positions. The average monthly salary in Saudi Arabian riyal was 8,780.59, which was equivalent to approximately £1,600.

Characteristics of the nurses who participated in this study differed based on nationality. Table 5-4 delineates some of the demographic characteristics of participants including age, gender, and religion. The average age of Saudi nurses (27.7) was the lowest among all nationalities. South African nurses who participated in this study were the oldest with a mean age of 48.8. In addition, the percentage of female nurses for each nationality varied from 30% among Jordanian nurses, to 100% among Indian and Malaysian nurses. The percentage of Muslim nurses varied from 5.3% among South African nurses to 100% among Saudi and Jordanian nurses. Table 5-5 illustrates additional demographic characteristics of the participants, including academic qualifications, years of experience, and monthly salary. Participants who acquired a bachelor's degree ranged from 23.4% among Saudi nurses to 93.3%

among Jordanian nurses. The average years of experience for the nurses varied from 3.5 years among Saudi nurses to 25.9 among South African nurses. The average monthly salary varied from 4,979 to 19,116 Saudi Arabian riyals.

Table 5-4: Demographic characteristics (age, gender, and religion) of participants by nationality

Nationality	N	Age mean (SD)		Gender	Religion
				% female	% Muslim
Saudi	141	27.7	(4.2)	93.6%	100.0%
Filipino	309	36.5	(8.6)	95.5%	12.3%
Indian	138	31.8	(6.4)	100.0%	11.6%
Jordanian	30	35.7	(4.0)	30.0%	100.0%
South African	38	48.8	(7.5)	97.4%	5.3%
Malaysian	38	36.5	(8.5)	100.0%	44.7%
British	15	45.2	(10.0)	86.7%	6.7%
Others	34	43.0	(11.9)	88.2%	20.6%
Total	743	35.2	(9.2)	93.1%	34.0%

Table 5-5: Demographic characteristics [academic qualification, years of experience, and monthly salary in Saudi Arabian riyals (SAR)] of participants according to nationality

Nationality	Bachelor's degree or higher %	Experience mean (SD)		Monthly salary mean (SD) [a]	
Saudi	23.4%	3.5	(3.4)	10,407.7	(4298.5)
Filipino	64.9%	13.1	(8.1)	6,116.2	(1956.2)
Indian	62.0%	8.9	(6.1)	4,979.6	(1188.2)
Jordanian	93.3%	12.8	(3.5)	12,765.5	(1951.6)
South African	31.6%	25.9	(8.0)	19,116.3	(3242.0)
Malaysian	28.9%	13.7	(7.4)	13,425.8	(3268.6)
British	46.7%	19.3	(11.8)	18,907.6	(6166.7)
Others	47.1%	19.2	(10.8)	18,302.0	(7401.5)
Total	52.9%	11.6	(8.9)	8,780.59	(5361.0)

[a] 1.00 Great British Pounds (GBP) = SAR 5.50

5.3 Job satisfaction and nationality

A normal distribution for overall job satisfaction scores and its subscales was satisfied for all group combinations of nationalities and type of hospitals, as assessed by visual inspection of their histograms. The 743 nurses in this sample displayed a mean of 3.24 for overall job satisfaction (SD = 0.52). The percentage of nurses who were dissatisfied with their job in this study was 30%, versus 70% who were either neutral or satisfied. The percentages of dissatisfied nurses were calculated by recoding the 5-level means into a 2-level categorical variable by combining the means lower than the midpoint 3.00 to be 'dissatisfied' responses when compared to the 'neutral and satisfied' categories, which had a mean of 3.00 or higher.

Table 5-6 reveals the percentage of dissatisfied nurses, mean, and standard deviation of overall job satisfaction and each subscale for all the participants. Visual inspection of the data suggests that nurses were more satisfied with co-workers, and interaction opportunities, while they were less satisfied with family and work balance, and professional opportunities. Only satisfaction with family and work balance and satisfaction with professional opportunities were lower than the overall job satisfaction score.

Table 5-6: Mean, and standard deviation of overall job satisfaction and each subscale

	Mean	SD	% Dissatisfied
Job satisfaction (Overall score)	3.24	0.52	30.0%
Extrinsic rewards	3.04	0.81	38.5%
Scheduling	3.44	0.73	20.9%
Family and work balance	2.57	0.73	58.1%
Co-workers	3.59	0.77	13.5%
Interaction opportunities	3.55	0.70	15.5%
Professional opportunities	2.94	0.72	44.5%
Praise and recognition	3.49	0.84	22.7%
Control and responsibility	3.29	0.72	27.5%

Based on the data, there were 141 Saudi nurses and 602 non-Saudi participants. Table 5-7 shows the means of overall job satisfaction and each subscale, by comparing Saudi versus non-Saudi nurses' scores, while table 5-8 displays the results of the test of differences between Saudi and non-Saudi nurses. An independent sample t-test was run to determine if there were differences in overall job satisfaction scores between Saudi (M = 3.25, SD = 0.53) and non-Saudi nurses (M = 3.21, SD = 0.47). There was no statistically significant difference between these groups, (M = 0.04, SE = 0.05, t (741) = 0.75, p = 0.46). Looking at the subscales of the questionnaire, three of the job satisfaction subscales showed no significant differences between Saudi and

non-Saudi nurses (satisfaction with scheduling, with interaction opportunities, and with the control and responsibilities that nurses have).

A score on two of the job satisfaction subscales revealed significant differences between Saudi and non-Saudi nurses, with Saudi nurses being more satisfied than expatriate nurses. These two facets covered satisfaction with extrinsic rewards, and with the balance of family and work. In contrast, three of the job satisfaction subscales scores showed significant differences between Saudi and non-Saudi nurses, with expatriate nurses being more satisfied than Saudi nurses with co-workers, with professional opportunities and with praise and recognition.

Table 5-7: Means of job satisfaction of Saudi and non-Saudi nurses

	Saudi		Non-Saudi		Total	
	Mean	n	Mean	n	Mean	n
Overall job satisfaction	3.21	141	3.25	309	3.24	743
Extrinsic rewards	3.34	141	2.97	309	3.04	743
Scheduling	3.34	141	3.46	309	3.44	743
Family/work balance	3.00	141	2.47	309	2.57	743
Co-workers	3.28	141	3.66	309	3.59	743
Interaction opportunity	3.53	141	3.56	309	3.55	743
Professional opportunity	2.63	141	3.02	309	2.94	743
Praise /recognition	3.28	141	3.53	309	3.49	743
Control/ responsibility	3.29	141	3.29	309	3.29	743

Table 5-8: Test of job satisfaction differences between Saudi and expatriate nurses

	Sig.	Mean Difference	95% Confidence Interval of the Difference	
			Lower	Upper
Overall job satisfaction	0.46	0.04	-0.06	0.13
Extrinsic rewards	0.00	-0.36	-0.51	-0.22
Scheduling	0.06	0.13	-0.01	0.26
Family and work balance	0.00	-0.53	-0.66	-0.40
Co-workers	0.00	0.38	0.24	0.52
Interaction opportunities	0.62	0.03	-0.10	0.16
Professional opportunities	0.00	0.39	0.26	0.52
Praise and recognition	0.00	0.25	0.10	0.41
Control and responsibility	0.95	-0.00	-0.14	0.13

Table 5-9 illustrates the means of overall job satisfaction scores and each subscale with non-Saudi nurses broken down according to each nationality. A one-way ANOVA test was conducted to evaluate the differences in overall job satisfaction across eight nationality groups (Saudi, Filipino, Indian, Jordanian, South African, Malaysian, British and 'others'). This revealed that there were no statistically significant differences in overall job satisfaction levels among the eight groups *(F* (7,735) = 0.935, $p = 0.479$). However, significant differences were found in satisfaction across the nationalities in seven of the eight subscales. Only satisfaction with scheduling shows no statistically significant differences among the nationalities, $p = 0.591$.

Post hoc analysis showed that the satisfaction levels with extrinsic rewards of the Indian and Filipino nurses were lower than the Saudi and Malaysian nurses ($p < 0.05$). The satisfaction level with family and work balance of the Saudi nurses was significantly higher than the Filipino, Indian, Jordanian, South

African, Malaysian nurses and 'others' nurses ($p < 0.05$). The satisfaction level with co-workers of the Saudi nurses was significantly lower than that of the Filipino, Indian, Jordanian and Malaysian nurses ($p < 0.05$). The satisfaction level with interaction of the Saudi nurses was significantly lower than that of the Indian nurses ($p < 0.05$). The satisfaction level with professional opportunities of the Saudi nurses was significantly lower than that of the Filipino, Indian, Jordanian, South African and Malaysian nurses ($p < 0.05$). The satisfaction levels with praise and recognition of the Saudi nurses were significantly lower than that of the Indian and Malaysian nurses ($p < 0.05$). The satisfaction levels with control and responsibility of the South African nurses were significantly lower than that of the Indian nurses ($p < 0.05$).

Table 5-9: Overall job satisfaction and the ranking of eight dimensions according to nationality

Groups of nationalities		Overall	Extrinsic rewards	Scheduling	Family/work balance	Co-workers	Interaction	Professional opportunity	Praise /recognition	Control/ responsibility
Saudi	Mean	3.21	3.34	3.34	3.00	3.28	3.53	2.63	3.28	3.29
	N	141	141	141	141	141	141	141	141	141
Filipino	Mean	3.24	2.94	3.44	2.50	3.69	3.57	2.98	3.52	3.29
	N	309	309	309	309	309	309	309	309	309
Indian	Mean	3.29	2.78	3.49	2.40	3.64	3.70	3.16	3.68	3.46
	N	138	138	138	138	138	138	138	138	138
Jordanian	Mean	3.19	3.11	3.57	2.40	3.80	3.60	2.90	3.50	3.23
	N	30	30	30	30	30	30	30	30	30
S. African	Mean	3.18	3.10	3.50	2.60	3.60	3.35	3.11	3.21	2.98
	N	38	38	38	38	38	38	38	38	38
Malaysian	Mean	3.38	3.20	3.53	2.44	3.82	3.62	3.13	3.74	3.39
	N	38	38	38	38	38	38	38	38	38
British	Mean	3.14	3.19	3.37	2.40	3.30	3.13	3.08	3.50	3.15
	N	15	15	15	15	15	15	15	15	15
Other	Mean	3.16	3.19	3.50	2.45	3.41	3.30	2.90	3.45	3.11
	N	34	34	34	34	34	34	34	34	34
Total	Mean	3.24	3.04	3.44	2.57	3.59	3.55	2.94	3.49	3.28
	N	743	743	743	743	743	743	743	743	743

5.4 Job satisfaction results by hospital

A one-way ANOVA test was conducted to evaluate the differences in overall job satisfaction across the three hospitals (Hospital A, Hospital B and Hospital C). Table 5-10 presents the means for overall job satisfaction and each subscale by hospital. Statistically significant differences in overall job satisfaction levels were found among the three hospitals (F (2,740) = 18.752, $p < 0.05$). Post hoc analysis showed that overall job satisfaction at Hospital A was significantly higher than it was at Hospital B and Hospital C ($p < 0.05$), but the overall job satisfaction difference between Hospital B and Hospital C was not statistically significant.

One-way ANOVA tests were conducted to evaluate the differences in the job satisfaction subscales scores of the nurses at the three hospitals (Hospital A, Hospital B and Hospital C). Of the eight subscales, only the satisfaction level with the balance of family and work was found to have no significant difference between the three hospitals ($p = 0.406$). However, there were significant differences in the satisfaction levels of the other seven subscales among the nurses at the three hospitals.

The satisfaction score for extrinsic rewards showed a significant difference between the nurses at the three hospitals; the nurses at Hospital A had a lower satisfaction level than the nurses at Hospital B and Hospital C ($p < 0.05$). In contrast, six of the job satisfaction subscale scores showed significant differences among the three hospitals; the nurses at Hospital A had significantly higher levels of satisfaction with scheduling, with co-workers, with interaction, with professional opportunities, with praise and recognition and with control and responsibility than the nurses at Hospital B and Hospital C ($p < 0.05$).

Table 5-10: The means for overall job satisfaction and each subscale by hospital

	Hospital A		Hospital B		Hospital C		
	Mean	N	Mean	N	Mean	N	Sig.
Overall job satisfaction	3.39	249	3.12	243	3.20	251	0.001
Extrinsic rewards	2.92	249	3.11	243	3.10	251	0.015
Scheduling	3.64	249	3.31	243	3.37	251	0.001
Family and work balance	2.60	249	2.60	243	2.52	251	0.406
Co-workers	3.87	249	3.31	243	3.59	251	0.001
Interaction	3.70	249	3.48	243	3.49	251	0.001
Professional opportunities	3.23	249	2.62	243	2.97	251	0.001
Praise and recognition	3.68	249	3.31	243	3.46	251	0.001
Control and responsibility	3.50	249	3.24	243	3.12	251	0.001

5.5 Job satisfaction and other demographic variables

An independent samples t-test was administered to determine if there were differences in overall job satisfaction between female nurses (M = 3.25, SD = 0.51) and male nurses (M =3.12, SD = 0.65). There was no statistically significant difference between these groups, M = 0.13, SE = 0.08, t (741) = 1.71, p = 0.09.

A one-way ANOVA test was conducted to evaluate the differences in the overall job satisfaction score based on marital status. The findings revealed that there were no statistically significant differences in overall job satisfaction based on marital status (F (3,739) = 2.022, p = 0.11). An independent samples t-test was conducted to determine if there were variations in overall job satisfaction between nurses who have children (M = 3.27, SD = 0.54) and nurses who do not have children (M =3.21, SD = 0.49). This findings revealed that there was no statistically significant difference between these groups, M = 0.06, SE = 0.04, t (741) = 1.55, p = 0.12. A one-way ANOVA test was conducted to

evaluate the differences in the overall job satisfaction score based on educational qualifications. The findings revealed that there were no statistically significant differences in overall job satisfaction based on educational qualifications (F (2,740) = 1.203, p = 0.30).

Though there was a small positive correlation between age and overall job satisfaction, r (741) = 0.102, $p < 0.005$, as well as between years of nursing experience and overall job satisfaction, r (741) = 0.112, $p < 0.002$, there was no correlation between monthly salary and overall job satisfaction, p = 0.369. As a consequence of the bivariate analyses, only the type of hospital the nurses worked at and the nurses' age and experience were added with nationality as a variable of interest in the multiple linear regression model of job satisfaction presented in section 5.7.

5.6 Intention to leave

Of 743 participants, 732 answered the intention to leave questions, while 11 participants did not complete this section. These eleven participants were from Hospital A and Hospital C. Out of the 732 participants only 4.1 % of participants expressed an intention to leave the nursing profession ('professional intention') within 12 months of the data collection period; 16.3 % had an intention to leave the country to practise the profession abroad ('working abroad intention'); and 9.2 % had an intention to leave the organisation and practise the profession at another organisation in Saudi Arabia ('hospital intention'). On the other hand, 70.5 % of participants had no intention to leave their current job within 12 months of the data collection period ('staying intention'). Tables 5-11 and 5-12 illustrate the number of participants who had staying, professional, working abroad, and hospital intentions by nationality and by hospital.

Based on the data, 70.5% of participants had no intention to leave their current hospital, while 29.5 % had an intention to leave their current hospital, across all leaving intention categories. Table 5-13 shows the frequency and percentage of participants from each nationality who had an intention to leave their hospitals, within the next 12 months. The level of intention to leave hospitals varied among nationalities, differing from 10.0% among Jordanian nurses to 46.7% among British nurses. The average length of employment of

those who had an intention to leave their hospitals was 5.63 years. This figure ranged from 2.45 years among British nurses to 9.00 years among Jordanian nurses.

Table 5-11: Intention to leave frequency by nationality

Nationality	Staying intention	Professional intention	Working abroad intention	Hospital intention	Total
Saudi	112	3	3	22	140
Filipino	201	17	60	26	304
Indian	106	2	20	9	137
Jordanian	27	2	0	1	30
South African	22	1	14	0	37
Malaysian	22	2	5	7	36
British	8	1	5	1	15
Others	18	2	12	1	33
Total	516	30	119	67	732

Table 5-12: Intention to leave frequency by hospital

Hospital	Staying intention	Professional intention	Working abroad intention	Hospital intention	Total
Hospital A	177	13	35	18	243
Hospital B	194	2	23	24	243
Hospital C	145	15	61	25	246
Total	516	30	119	67	732

Table 5-13: Intention to leave hospital by nationality

		Intention to leave hospital		
		leaving	staying	Total
Saudi	Count	28	112	140
	Percentage	20.0%	80.0%	100.0%
Filipino	Count	103	201	304
	Percentage	33.9%	66.1%	100.0%
Indian	Count	31	106	137
	Percentage	22.6%	77.4%	100.0%
Jordanian	Count	3	27	30
	Percentage	10.0%	90.0%	100.0%
South African	Count	15	22	37
	Percentage	40.5%	59.5%	100.0%
Malaysian	Count	14	22	36
	Percentage	38.9%	61.1%	100.0%
British	Count	7	8	15
	Percentage	46.7%	53.3%	100.0%
Others	Count	15	18	33
	Percentage	45.5%	54.5%	100.0%
Total	Count	216	516	732
	Percentage	29.5%	70.5%	100.0%

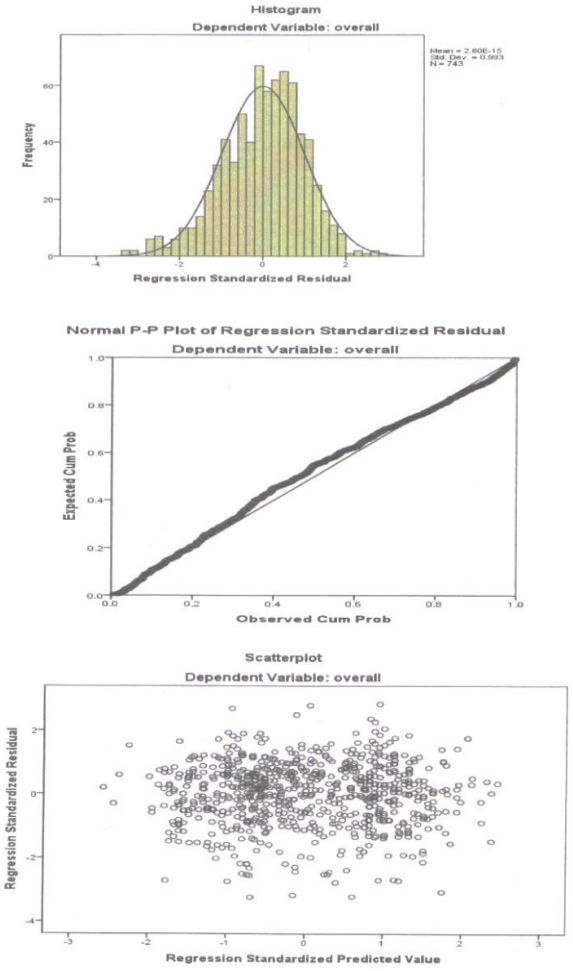
5.7 Regression analysis

5.7.1 Job satisfaction

A multiple linear regression analysis was used to calculate how nationality, years of experience and type of hospital are able to predict nurses' job satisfaction. Similarly, in another model, a multiple linear regression analysis was used to calculate how nationality, age and type of hospital are able to predict nurses' job satisfaction. The reason for not including age or years of experience in the same model of analysis is that these two independent variables are highly correlated. Including both variables in the same model can

lead to problems with understanding which independent variable contributes to the variance explained in the dependent variable—as well as technical issues in calculating a multiple regression model. In order to conduct the multiple linear regression test, dummy coding for the categorical (independent) variables was applied. Preliminary analysis was conducted to ensure no violation of the assumptions of multicollinearity, normality, homoscedasticity, and linearity of the residuals. The initial analysis showed that there was no violation of these assumptions. A Durbin-Watson statistic result of 1.679 indicated that there was independence of residuals. Visual inspection of a plot of standardised residuals versus standardised predicted values indicated that there was homoscedasticity. Visual inspection of a normal probability plot showed that residuals were normally distributed (see Figure 5-1).

Figure 5-1: Regression analysis histogram P-P plot of standardised residuals for overall job satisfaction



In the first model, a significant regression equation was found F (10, 731) = 6.625, $p < .001$, $R^2 = .081$. Filipino, Indian, Jordanian, South African, British and 'other' nationality nurses were predicted to have lower job satisfaction compared to Saudi nurses when controlling for other predictors. Nurses from Hospital A were predicted to be more satisfied with their jobs than nurses at Hospital B and Hospital C when controlling for other variables. Increased nurses' experiences was associated with increased likelihood of nurses' job satisfaction when controlling for other variables (see Table 5-14).

Table 5-14: Regression of job satisfaction, nationality, type of hospital, and experience

			95.0% Confidence Interval for B	
	B	Sig.	Lower Bound	Upper Bound
(Constant)	3.452	0.001	3.330	3.575
Filipino vs Saudi	-0.198	0.001	-0.318	-0.077
Indian vs Saudi	-0.143	0.031	-0.274	-0.013
Jordanian vs Saudi	-0.307	0.004	-0.518	-0.096
South African vs Saudi	-0.428	0.001	-0.650	-0.206
Malaysian vs Saudi	-0.034	0.746	-0.237	0.170
British vs Saudi	-0.336	0.022	-0.624	-0.048
Other vs Saudi	-0.313	0.004	-0.528	-0.098
Hospital B vs Hospital A	-0.311	0.001	-0.412	-0.211
Hospital C vs Hospital A	-0.206	0.001	-0.306	-0.106
Years of experiences	0.011	0.001	0.006	0.016

In the second model, a significant regression equation was found F (10, 732) = 6.435, $p < .001$, $R^2 = .083$. Filipino, Indian, Jordanian, South African, British and 'other' nationality nurses were predicted to have lower job satisfaction compared to Saudi nurses when controlling for other variables. Nurses from

Hospital A were predicted to be more satisfied with their jobs than nurses at Hospital B and Hospital C when controlling for other variables. Older age was associated with an increased likelihood of nurses' job satisfaction when controlling for other variables (as shown in Table 5-14).

Table 5-15: Regression of job satisfaction, nationality, type of hospital, and age

			95.0% Confidence Interval for B	
	B	Sig.	Lower Bound	Upper Bound
(Constant)	3.239	0.001	3.057	3.421
Filipino vs Saudi	-0.177	0.003	-0.296	-0.059
Indian vs Saudi	-0.125	0.044	-0.255	-0.005
Jordanian vs Saudi	-0.286	0.008	-0.496	-0.076
South African vs Saudi	-0.389	0.001	-0.606	-0.172
Malaysian vs Saudi	-0.010	0.924	-0.212	0.192
British vs Saudi	-0.333	0.024	-0.623	-0.043
Other vs Saudi	-0.291	0.008	-0.505	-0.077
Hospital B vs Hospital A	-0.317	0.001	-0.418	-0.217
Hospital C vs Hospital A	-0.206	0.001	-0.307	-0.106
Age	0.009	0.001	0.004	0.014

The same test was conducted using the same variables, but with nationality computed as a comparison between Saudi and expatriate nurses. A significant regression equation was found $F(4, 737) = 12.527$, $p < .001$, $R^2 = .064$. Expatriate nurses were predicted to have lower job satisfaction compared to Saudi nurses when controlling for other predictors. Nurses from Hospital A were predicted to be more satisfied with their jobs than nurses at Hospital B and Hospital C when controlling for other variables (see Table 5-16).

Table 5-16: Regression of job satisfaction, type of hospital, experience, and nationality (expatriate nurses vs. Saudi nurses)

			95.0% Confidence Interval for B	
	B	Sig.	Lower Bound	Upper Bound
(Constant)	3.458	0.001	3.336	3.580
Hospital B vs Hospital A	-0.302	0.001	-0.402	-0.201
Hospital C vs Hospital A	-0.212	0.001	-0.302	-0.123
Years of experience	0.007	0.003	0.003	0.012
Expatriate nurses	-0.163	0.005	-0.275	-0.050

5.7.2 Intention to leave

Univariate analyses were performed using simple logistic regression tests to assess the association between nurses' intention to leave their jobs and different variables, such as age, experience, qualifications, salary, gender, marital status and parental status. The logistic regression models ware not statistically significant ($p > 0.05$). A simple logistic regression was performed to discover whether there is an association between a nurse's nationality (Saudi vs. expatriate) and a nurse's intention to leave their jobs. The logistic regression model was statistically significant, X^2 (2) = 7.981, $p < 0.001$. Analysis showed that expatriate nurses were more likely to leave their jobs than Saudi nurses (odds ratio (OR) 1.861; 95% CI: 1.188–2.916) (see Table 5-17). The same test was performed to determine the association between nurses' nationalities and intention to leave their jobs. The logistic regression model was statistically significant, X^2 (7) = 28.437, $p < 0.001$. Filipino, South African, Malaysian, British, and 'other' nurses were more likely to report an intention to leave their jobs than were Saudi nurses (as shown in Table 5-18).

Table 5-17: Logistic regression of intention to leave by nationality (expatriate vs. Saudi nurses)

			95% (CI for EXP(B)	
Predictor	Sig.	Exp(B)	Lower	Upper
Expatriate nurses	0.007	1.861	1.188	2.916

Table 5-18: Logistics regression of intention to leave and nationality

			95% (CI for EXP(B)	
Predictor	Sig.	Exp(B)	Lower	Upper
Filipino vs Saudi	0.003	2.050	1.272	3.304
Indian vs Saudi	0.593	1.170	0.658	2.081
Jordanian vs Saudi	0.208	0.744	0.446	1.771
South African vs Saudi	0.011	2.727	1.255	5.926
Malaysian vs Saudi	0.020	2.545	1.158	5.596
British vs Saudi	0.025	3.500	1.170	10.469
Other vs Saudi	0.003	3.333	1.497	7.423

A logistic regression was performed to determine the association between overall job satisfaction and the likelihood that participants intend to leave their hospitals. The logistic regression model was statistically significant, X^2 (1) = 124.553, $p < 0.001$. The model explained 22.3% (Nagelkerke R^2) of the variance in intention to stay and correctly classified 74.3% of cases. Increasing job satisfaction (overall score) was associated with an increased likelihood of intention to leave their hospital (odds ratio (OR) 0.142; 95% CI: 0.096–0.209) (see Table 5-19).

The logistic regression model was statistically significant, X^2 (8) = 169.342, $p <$ 0.001, between the elements of job satisfaction and whether nurses wanted to leave their current jobs. The model explained 29.4% (Nagelkerke R^2) of the

variance in intention to leave and correctly classified 77.7% of cases. Of the eight job satisfaction subscales, two types of satisfaction were statistically significant: satisfaction with extrinsic rewards (OR 0.482; 95% CI: 0.372-0.624), and satisfaction with control and responsibility (OR 0.357; 95% CI: 0.245-0.520). Tables 5-20 illustrate the regression of intention to leave and job satisfaction.

Table 5-19: Regression of intention to leave and job satisfaction

			95% (CI for EXP(B)	
Predictor	Sig.	Exp(B)	Lower	Upper
Overall satisfaction	0.000	0.142	0.096	0.209

Table 5-20: Regression of intention to leave and job satisfaction

			95% (CI for EXP(B)	
Predictor	Sig.	Exp(B)	Lower	Upper
Extrinsic rewards	0.001	0.482	0.372	0.624
Scheduling	0.669	0.935	0.689	1.270
Family and work balance	0.130	0.810	0.617	1.064
Co-workers	0.445	0.889	0.656	1.203
Interaction opportunities	0.441	0.875	0.623	1.228
Professional opportunities	0.149	1.290	0.912	1.824
Praise and recognition	0.807	0.961	0.695	1.327
Control and responsibility	0.001	0.357	0.245	0.520

A logistic regression was performed to determine the association of job satisfaction and nationality (Saudi vs. expatriate nurses) on nurses' intentions to leave their jobs. The logistic regression model was statistically significant, X^2 (2) = 134.582, $p < 0.001$. The model explained 23.9% (Nagelkerke R^2) of the variance in intention to leave and correctly classified 73.9% of cases. Both predictive variables were statistically significant; nurses with higher overall job satisfaction were associated with lower odds of intention to leave their hospitals (OR 0.139; 95% CI: 0.094–0.205). In addition, non-Saudi nurses were twice as likely to report an intention to leave their hospitals compared with Saudi nurses (OR 2.125; 95% CI: 1.306–3.455) (see Table 5-21).

A logistic regression was performed to ascertain the effects of overall job satisfaction and nationality on the likelihood that participants had an intention to leave their jobs. The logistic regression model was statistically significant, X^2 (8) = 158.597, $p < 0.001$. The model explained 27.7% (Nagelkerke R^2) of the variance in intention to leave and correctly classified 75.5% of cases. Nurses with higher overall job satisfaction were associated with lower odds of intention to leave their hospitals (OR 0.125; 95% CI: 0.083–0.188). Filipino, South African, Malaysian, British, and 'other' nurses were significantly more likely to leave their hospitals compared to Saudi nurses when controlled for overall job satisfaction (as shown in Table 5-22).

Table 5-21: Association between nationality (Expatriate vs. Saudi nurses), job satisfaction, and intention to leave

			95% (CI for EXP(B)	
Predictor	Sig.	Exp(B)	Lower	Upper
Overall	0.000	0.139	0.094	0.205
Non-Saudi nurses	0.002	2.125	1.306	3.455

Table 5-22: Association between nationality, job satisfaction, and intention to leave

Predictor	Sig.	Exp(B)	95% (CI for EXP(B) Lower	Upper
Overall satisfaction	0.001	0.125	0.083	0.188
Filipino vs Saudi	0.001	2.409	1.427	4.065
Indian vs Saudi	0.350	1.347	0.721	2.516
Jordanian vs Saudi	0.101	0.544	0.242	1.604
South African vs Saudi	0.017	2.888	1.204	6.928
Malaysian vs Saudi	0.000	4.501	1.930	10.500
British vs Saudi	0.042	3.900	1.049	14.495
Other vs Saudi	0.008	3.349	1.377	8.147

Moderation analyses were conducted using Hayes' PROCESS (2012) to explore whether job satisfaction moderates the relationship between nationality and turnover intention. The results indicate that indicate job satisfaction moderates the relationship between nurses' nationality and intentions to leave (as shown in Table 5-23).

Table 5-23: Regression analysis of overall job satisfaction's moderation of the relationship between nationality and turnover intention

	coefficient.	p	LLCI	ULCI
Constant	9.9399	0.0001	5.4303	14.4494
Overall job satisfaction	-3.7082	0.0001	-5.2138	-2.2025
Expatriate nurses vs. Saudi nurses	-5.0564	0.0345	-9.7431	-0.3698
Interaction	1.9296	0.0153	0.3708	3.4884

5.8 Summary

In summary, the survey found that the nurses in Saudi Arabia, who participated in the study, rated themselves between 'slightly satisfied' and 'somewhat satisfied' in their job, with a mean of 3.24 on a scale of 1 to 5. A bivariate analysis was performed between overall job satisfaction and different predictors, one of which was nationality. The bivariate analysis revealed that there was no significant difference in overall job satisfaction based on nationality. Only type of hospital, years of experience and age were correlated with overall job satisfaction in the bivariate analysis. These predictors were added to multiple regression models, in addition to nationality, which is the variable of interest in this study. The regression analysis predicted that expatriate nurses, except for Malaysian nurses, had lower overall job satisfaction in comparison to Saudi nurses, when controlling for the other predictors.

Increasing nurses' job satisfaction was associated with a decreased likelihood of intention to leave their jobs. Based on the data, 70.5% of participants had no intention to leave their current jobs, while 29.5 % had an intention to leave their jobs. The survey's results confirmed that non-Saudi nurses are twice as likely to report an intention to leave their hospitals compared with Saudi nurses when controlling for overall job satisfaction. The percentage of nurses intending to leave their hospitals ranged from 10% among Jordanian nurses to 46.7% among British nurses. The regression analysis predicted that expatriate nurses, except for Indian and Jordanian nurses, are more likely to leave their jobs, in comparison to Saudi nurses, when controlling for job satisfaction. A moderation analysis suggested that job satisfaction moderates the relationship between nurses' nationality and intentions to leave.

Chapter 6: Qualitative Findings

6.1 Introduction

This chapter reports the qualitative components of this study. There were two sources of qualitative data: semi-structured interviews and the qualitative component of the questionnaire. The primary source of qualitative data for this study consisted of twenty-six interviews, which were conducted with nurses from three hospitals, from the primary nationalities. The data set came from participants' responses to interview questions, which included factors that attracted nurses to select their profession, and what drew expatriate nurses to work in Saudi Arabia. In addition, participants were asked about factors that affected their job satisfaction in Saudi Arabia.

In addition to the semi-structured interviews, the second form of qualitative data came from responses to open-ended follow-up questions used in the questionnaire. Nurses who had any intentions of leaving either their jobs or Saudi Arabia were asked to state their reasons, and where they planned to practise the nursing profession in the future (see appendix C). Out of 216 participants who had an intention to leave, 149 participants filled out the open-ended follow-up questions. This chapter comprises seven main sections. Sections 6-2 to 6-6 are related to the data from the semi-structured interviews. Section 6.7 presents findings from responses to the open-ended follow-up questions in questionnaire responses.

6.2 Demographic data

There were 24 females out of the total 26 participants in the semi-structured interviews. Participants were from a large range of nationalities, including five participants from Saudi Arabia, six from the Philippines, four from India, two from Jordan, four from South Africa, and two from Malaysia. Participants were almost equally distributed across hospitals; nine were from Hospital A, nine from Hospital B, and eight from Hospital C. Table 6-1 illustrates the distribution of demographic characteristics of the semi-structured interview participants.

Table -6-1: Distribution of demographic characteristics of the semi-structured interview participants (n = 26)

Demographic data		Frequency
Gender	Female	24
	Male	2
Nationality	Saudi	8
	Filipino	6
	Indian	4
	Jordanian	2
	South African	4
	Malaysian	2
Type of Hospital	Hospital A	9
	Hospital B	9
	Hospital C	8
Age	<30	8
	30- 45	14
	>45	4
Educational qualifications	Diploma or associate degree	14
	Bachelor's degree	10
	Postgraduate degree	2
Years of experience	< 5	5
	5-10	9
	>10	12

6.3 Factors influencing selection of nursing profession

Participants provided several factors that influenced them to select nursing as their professions. Half of participants provided their own explanations, in addition to several themes that were common among the participants.

Three themes emerged from the findings of the twenty-six interviews that influenced choice of the nursing profession: the nature of the job itself, family influence, and the opportunity to migrate. Two out of three themes were common among all the nationalities, except for the opportunity to migrate, which was discussed only by Filipino participants as an essential factor in selecting nursing. However, these themes are now discussed in turn.

6.3.1 Nature of the job

The nature of the job was discussed by nearly all participants from every nationality to be an important factor when selecting nursing as their profession. First, some participants believed that the variety of the work was one of the reasons for selecting nursing. For example, nursing involves working in different shifts, working in different venues, with different tasks, including working at the bedside, teaching, and management.

> *'There are a lot of avenues that you can follow once you are in the nursing profession. You don't have to focus just on the bedside. If you want to be a teacher, you can go into education. You can go into clinics. There are many various options—forensic nursing, lots of different things that you can look at and go into.' (South African nurse, Hospital A)*

Another feature related to the qualities of the nursing profession allowed them to help sick people, which was an important factor for many nurses in selecting nursing as their profession. Almost all participants discussed feeling cheerful and satisfied when patients return home safe and well. One participant summarised:

> *'Ever since I was a child, I wanted to be involved in a career where you could be of service to people.' (Filipino nurse, Hospital A)*

Some participants admitted that other health care professions can help sick people too: therefore, some nurses considered nursing as an alternative career option, indicating the difficulty of attending medical school due to its high cost compared to nursing. However, some participants emphasised that nurses do most of the care for patients and stay closest to patients during care delivery.

A significant aspect that influenced nurses to select their profession was that nursing would allow them to get a job easily. Some participants noted that the career opportunities in nursing are greater than many other professions, due to the shortage in nurses. Some participants went to nursing school after completion of a degree in biology because it was difficult to find employment in other professions. A career in nursing was therefore a strategic choice. Two nurses gave the following explanations:

> *'I studied biology, and because of the lack of job opportunities, I went to work as a cashier in a private clinic with a poor salary for three years in the hopes of getting a job in biology. Then, I decided to study nursing to get a job that I wanted.' (Saudi nurse, Hospital B)*

> *'With nursing I was able to get a job quickly within sixteen days of the graduation, while I have friends who studied other majors and have been looking for a job for about three years'. (Jordanian nurse, Hospital A).*

Specific to Saudi national nurses, participants indicated that one of the reasons for selecting nursing was that it would lead to a permanent government job in their home cities with no requirement to work in rural areas. One nurse summarised:

> *'One reason for selecting nursing [was that] it would allow me to get a permanent government job in Riyadh or any city that I wanted to work in because of the huge shortage in nurses.' (Saudi nurse, Hospital B).*

In addition, nursing was described as a profession that offers job security. Nurses from all nationalities described that a good salary was also an essential factor in selecting nursing as a profession. Some participants stated that nurses' salaries are greater than in many other professions.

'…Average salary for nurses is greater than many other professions, for instance, nurses receive about 2 times more than teachers'. (Jordanian nurse, Hospital A)

6.3.2 Influence of family

Some participants indicated that their family influenced them to select nursing as their profession. Family influence operated in different ways. For example, some participants were not sure what to do after high school, so they followed their parents' suggestions.

'I didn't know where I wanted to go. Actually, my mum was the world I knew. She introduced me to the nursing profession, you know, as my auntie was a nurse. Mainly because of that, my mum encouraged me to join nursing. At that time, I was very young, and I did not know what to do. I just wanted to do what my mum said.' (Malaysian nurse, Hospital C)

Having a relative who worked in nursing which had exposed the participants to the profession was a further source influencing the decision to become a nurse. One of the nurses gave the following explanation:

'One big influence was my aunt. She worked in the operating room. I was between 5 and 6 years old, and I used to go with her inside the operating room, so I was exposed [to the profession], and when I grew up, I told myself that I wanted to work in the OR [operating room]. She [my aunt] was a big influence. After graduation, I always wanted to be an operating room nurse.' (Filipino nurse, Hospital A)

6.3.3 Opportunity to migrate

The increased opportunity to migrate was discussed by five out of six Filipino participants as an essential reason to select nursing as their profession. However, opportunity to migrate was not mentioned by any other nationality to be a factor in selecting the nursing profession. Filipino nurses stated that the economic status of the Philippines influenced them to select nursing, as other countries are interested in hiring Filipino nurses. One of the Filipino participants summarised:

'The Philippines is a third-world country. We are not, um, we are not very rich, so when you become a nurse, you go abroad, you earn more, and then you have more opportunities, and that is why I took up nursing. Even doctors are taking up nursing just to get into the UK or US. If you are a doctor, you do not have as many opportunities to migrate as if you were a nurse.' (Filipino nurse, Hospital A)

6.4 Hospital recruitment practices

Recruiting practices in Saudi Arabia vary based on the hospital and the nationality of the nurse. Hospital B is run under the direct operation of the MOH, and employment of Saudi staff occurs through the Saudi Arabian civil services, in which Saudi health professionals are appointed to their positions in collaboration with the MOH and the Ministry of Civil Services. In its civil service form, hospitals do not have the autonomy to select their employees, and employment is considered to be permanent. Hospital A and Hospital C recruit through a self-employment programme that offers autonomy for hospitals to recruit the needed labour force by establishing their own annual employment contracts. Hospital A and Hospital C received Joint Commission International (JCI) accreditation, while Hospital B only received the Central Board of Accreditation for Health Care Institutions (CBAHI), which is the national accreditation for Saudi Arabia.

Expatriate nurses noted that they had to apply through agencies in their home countries, and they reported variations among the three hospitals in their recruitment practices. Hospital A and Hospital C had their own agencies, which informed candidates where they would be assigned. In contrast, Hospital B was part of the Ministry of Health's recruiting office. Therefore, nurses did not know to which organisation or city they would be assigned.

'When I met with the recruitment agency in India, they did not tell me in which hospital or city I was going to work. You knew that you would work in one of the Ministry of Health organisations, but we did not know where exactly. Working in this hospital is not primarily our choice, but it is OK.' (Indian nurse, Hospital B)

'It's not a choice as when you applied in the Philippines for the MOH—for the Ministry of Health—you did not know where you would be assigned. I used to work at the other type of hospital, one of the Ministry of Defence hospitals. They told me where I would be assigned, but the Ministry of Health, they did not tell.' (Filipino nurse, Hospital B)

Some participants believed that recruitment agency practices are biased, as they tend not to consider older nurses. One of the participants remarked:

'When I was interviewed to work in Saudi Arabia, they asked how old I was. I was in my 30s. I think that nowadays, if you're 40 or older, they will not consider you to work, um, to be hired. Unless you apply for a higher post, a managerial post or something, then they will consider you. The job vacancy advertisements in the Philippines—you know, if a hospital is hiring, they will say 30 between, uh, up to 40 years old only. It's quite difficult.' (Filipino nurse, Hospital A)

6.5 Pull factors of working in Saudi Arabia

Pull factors to work in Saudi Arabia can be represented by six themes that developed from the findings of the sixteen interviews with expatriate nurses. These themes involved a competitive benefits package, fewer job requirements, religion, experience, changing work environment, influence of family and friends, and high-quality facilities and technologies. These themes are discussed as follows:

6.5.1 Competitive benefits package

The competitive benefits package in Saudi Arabia was the primary pull factor for non-Saudi nurses working in Saudi Arabia. Almost all expatriate participants indicated that salaries were lower in their home countries. Some participants said that they received a competitive salary in Saudi Arabia, which could be up to three times more than back home. In addition, this salary is tax-free in Saudi Arabia. Nurses reported spending their money on buying houses in their home countries, supporting their children and sending their children to school or college. These next three participants illustrate these points by demonstrating the importance of the salary to their family finances back home.

'…Because of the financial aspect. I would earn more here. In here (Saudi Arabia), it is better pay for me. Aside from that, I do not have to pay tax. My kids are growing, and I want them to have good education, and better life. I have four kids. Now, it is all a matter of, uh, finances. So, I decided to come to Saudi Arabia to able to get good salary.' (Filipino nurse, Hospital A).

'I wanted to leave South Africa for number one for money, for better money, better opportunities going overseas… In South Africa, you work very hard for your money, and it is worse now. You have to do five nursing jobs, because a lot of nurses have gone, and me as a single parent, I had to take care of my children's studies. So now they were growing up, they are going to go to university, and there was no way I was going to be able to pay for them with the salary that I was getting in South Africa. So in my mind, the first thing, to be honest with you, is to get better money than what I get.' (South African nurse, Hospital C)

'In Malaysia, if I do overtime, my salary will be 3,000 to 4,000 Saudi Arabian Riyal, with overtime. In here, I get about 12,000 Riyal from the beginning. I am now about 16,000 Riyal if there is no overtime' (Malaysian nurse, Hospital C)

In addition to the amount of tax-free salary, some participants indicated that free housing, paid annual vacations, and free annual flights to visit their home countries were provided as part of the competitive package. One of the participants gave the following explanation about her beliefs on the relative benefits in Saudi Arabia compared to other countries:

'I saw my classmates during our high school reunion. They are working in America [and] Canada. One of them is working in Ireland. They do not have annual paid leave. They don't have annual leave. They do not get flight tickets to the Philippines, which are very expensive. They are the ones paying, so it's not paid—it's not paid vacation. They have to pay for the flight tickets, too. That's why they have to save before coming home [to the Philippines].' (Filipino nurse, Hospital B)

The competitive benefits package in Saudi Arabia encouraged expatriate nurses to save money. Some participants stated that spending their salary was not easy compared to even neighbouring countries, such as Qatar and United Arab Emirates (UAE), especially if they do not like shopping. This is partly because salaries are large and tax-free; partly because nurses receive free housing, and partly because social life is restricted. There is no cinema or alcohol consumption permitted in the Kingdom. Participants also stated that the cost of living is cheaper in Saudi Arabia compared to some countries. One participant gave the following explanation:

> *'Spending is not as easy here [Saudi Arabia] as it is in Oman or in Dubai. Here, in Saudi Arabia, I thought that I would be able to save more if I came here. There are not movies to go to, all those kinds of thing—you know, the different freedoms in social life. You don't spend as much on that kind of thing as you would if you were in Oman or in the Emirates. What we spend money on is going out for meals. We eat a lot. That's why we all gain weight when we are here!' (South African nurse, Hospital C).*

6.5.2 Job entry requirements

Some participants reported that one of the pull factors of working in Saudi Arabia was their beliefs about the simplicity of getting a nursing role when compared to some Western countries, such as the UK, the United States and Canada. Those participants listed some of the difficult requirements needed to land a job in Western countries, such as taking board exams, having experience, providing certain documentation. Some participants stated that Saudi Arabia was a better option as they did not require any experience, or any exams when they applied for their jobs. Two participants stated:

> *'Actually, in Saudi Arabia, the requirements are not that tough. For example, as I told you, the board exam, it's not important to them. That was really a major important factor so I could really … see myself [going] to Saudi Arabia. Here [in Saudi Arabia], they give you chances. They don't require years of experience, but they do accept people.' (Filipino nurse, Hospital B)*

'It's hard to get a job in Canada, of course, much harder than in Saudi Arabia.' (Indian nurse, Hospital A)

Some participants addressed the difficulty of language requirements when applying to work in Western countries, such as the UK. One participant explained her situation with the International English Language Test System (IELTS) in the UK.

'The IELTS is mandatory to work in the UK. In my country, the language of my syllabus is Malila. That's why we have difficulty with English. The accent which the UK people speak is different and very difficult for me, and the writing tasks in the IELTS, they ask about literature topics [which are] very hard to understand. I took the test many times and tried. ... That is why I am living here! [Laughs]' (Indian nurse, Hospital B)

Some participants noted that the process of landing a job and getting a visa to work in Western countries took a long time. Consequently, some nurses decided to work in Saudi while working on their immigrant visa and job. One participant described her situation:

'I applied to immigrate to the United States, and it has already taken me, I think, at least 10 years of waiting time. It is difficult. The processing was too long, so I ended up working in the Philippines and here in Saudi Arabia while waiting for my immigrant visa to the US.' (Filipino nurse, Hospital A)

Some Filipino nurses also discussed with sadness the difficulty of getting a job in their home country. They noted some factors pushing them away from their own country, such as needing a high grade point average (GPA) with their degrees, and limited opportunities to work in some settings, such as government hospitals. Two of the Filipino participants summarised:

'The moment that I applied to the best hospital, I said, 'Well, I'm a nurse, so now I want to be at this hospital'. The requirements say you must have a GPA of this; you must have this. I can't even start

applying as I don't have those as I did not excel in school.' (Filipino nurse, Hospital C)

'The problem in the Philippines is that government slots are limited. That is a sad thing as in the Philippines, [you] especially [want] to [work in] government hospitals. You have to have a good backer, meaning you have to know someone in a higher position to recommend you to work in government hospitals… Even if you are well qualified, you won't work in a government hospital if you don't have anyone.' (Filipino nurse, Hospital B)

6.5.3 Religion

Three out of four expatriate Muslim participants said that religion was one of the pull factors for working in Saudi Arabia. Those participants believed that Saudi Arabia is the home of Islam. As Muslims, the opportunity to work in Saudi Arabia allowed them to earn money for their families as well as live in an environment that shares their religious beliefs. Participants stated it can be difficult and costly to travel to Saudi Arabia to attend important pilgrimages (Hajj and Umrah) when living overseas. While they are residents of Saudi Arabia, expatriate Muslim nurses have the opportunity to practice their religion, obtain visas for their families to visit, and perform religious ceremonies.

'In Malaysia, you have to wait for a turn to come on the Hajj, OK? I would need to enrol on the list. If I put my name [on it] now, I don't know when my turn would come. This is one place—I went to Saudi Arabia, as this is the holy place where I want to be. For me, [it is] like doing two things at one time: I work, and I can go for my Umrah. I have not counted how many times I have performed Umrah [laughs]—nearly three or four times per year. Sometimes, I perform more than one Umrah in one visit to Mecca.' (Malaysian nurse, Hospital C).

On the other hand, some non-Muslims noted that religious practice in the Kingdom precludes religious practice for non-Muslims. Nurses must respect and obey all Islamic laws while in Saudi Arabia. They are not allowed to eat or

drink publicly while Muslims are fasting during Ramadan. One participant related the following anecdote:

> *'At the time of Ramadan, we have to fast. Although I am a Christian, I cannot drink or eat in front of people during Ramadan even if I am thirsty or hungry' (Indian nurse, Hospital B).*

6.5.4 Experience and exposure to a different work environment

The pull factors for working in Saudi Arabia included gaining experience, increasing knowledge, and getting exposure to a different work environment, which nurses believe they need to move on in their careers, as well as exposure to allow them to grow. Participants mentioned that working in different work environments, in multi-speciality hospitals and with different nationalities, allowed them to gain new experiences and knowledge, as well as save money for migration.

> *'I decided to work in the Philippines and here in Saudi Arabia while waiting for my immigrant visa to the US… Saudi Arabia hires young nurses with less experience. Then we come over here, [and] we work in big hospitals. We get experience, you know. We get all the necessary skills. Since we don't have the security of tenure here, that's why we're leaving. Most of the nurses from here get one experience, then leave, going to Australia, New Zealand, looking for better opportunities.' (Filipino nurse, Hospital A)*

> *'I want to get experience, and I want to—I want to introduce myself to multiple nationalities. I can gain experiences [with many different people to help] my personal growth.' (Malaysian nurse, Hospital C)*

Some nurses said that they wanted to work in Saudi Arabia to experience a change in working environment and gain exposure to a different culture. Some participants stated that they came to Saudi Arabia as they had worked at their previous hospitals for many years and wanted to change their work environment and be exposed to other cultures. Two participants summarised these views:

'I wanted to change my environment. I had spent 14 years in one place, at the same institute in Jordan, so I felt the need for change. I had worked 14 years in a military hospital, so I wanted to change, not to stay in Jordan but to go outside [the country].' (Jordanian nurse, Hospital A)

'The other reason was that it was an opportunity to work in a different environment. You know, when you work for many, many years in the same place… and I was at the same hospital for 21 years. I was… I was really in a rut. I knew that I wanted to see how the other side works and how the other side lives, so that was probably part of the reason. It was probably 50% money and 50% an opportunity to—to have—work in a different environment.' (South African nurse, Hospital A)

6.5.5 Influence of friends and family

Some participants discussed the influence of family and friends as a pull factor to work in Saudi Arabia. They emphasised the influence of their friends or family members who had worked in Saudi Arabia and recommended working there. One participant explained her situation:

'I was influenced by my best friend. She has been working here [Saudi Arabia] since 1994. She is the one; she is the great influence. I trust her. She's been my best friend since our high school days.' (Filipino nurse, Hospital B)

6.5.6 Facility and technology

One of the pull factors for working in Saudi Arabia for some expatriate nurses who come from the Philippines and India, as they are less well-developed economies, is the developed facilities and technology compared to the nurses' home countries. Some participants stated that these aspects are poor in their home countries and patients' safety is negatively affected. One of the participants stated:

'One thing was the facilities as in the Philippines, I … worked in a government hospital, [and it was] very sad. Patients might come for a work-up, but there were no facilities, and the patients had no money,

[and] sometimes, they would die because of that. In the Philippines, we are still using the aneroid BP apparatus, mercury, doing things like that. We are still using those. This ABG machine, we have to send [the tests] to private laboratories … so the patient will pay again. … Not like here [where] there are developed facilities.' (Filipino nurse, Hospital B)

6.6 Factors affecting nurses' job satisfaction in Saudi Arabia

Participants addressed a range of factors that influenced their job satisfaction in Saudi Arabia. Factors affecting nurses' job satisfaction can be represented by nine themes that emerged from the results of the twenty-six interviews: social and cultural factors, language and communication, rewards, security for nurses, recognition, 12-hour shifts, development opportunities, task requirements, and professionalism. These themes are now discussed in turn.

6.6.1 Social and cultural factors

Participants identified a range of social and cultural factors that influence their job satisfaction in Saudi Arabia. Participants consistently discussed seven subthemes they viewed as relevant: separation from family, social activity in the Kingdom, gender segregation, dress code, gender differentiation, using traditional forms of health care, and the slow pace of cultural change.

6.6.1.1 Separation from family

Almost all expatriate nurses stated that being away from family and friends was the strongest personal and social factors influencing their happiness while working in the Kingdom. They discussed with sadness how hard it was to live away from spouses, children and parents. One of the nurses remarked:

'I want to be with my husband, it is hard to stay away from my family.' [Chuckle].' (Filipino Nurse, Hospital A)

Expatriate nurses in Saudi Arabia live in hospital compounds or with a family in the community. Many expatriate nurses indicated the challenges of having

their spouses with them while working in Saudi Arabia, because it is usually difficult to find local employment for their husbands.

Often, the difficulties in bringing their families were attributed to their single contract status. Some expatriate nurses said that, consequently, they decided to leave Saudi Arabia for countries where their families could join them. Some expatriate participants discussed the emotional importance of having their families nearby to release stress and provide support; many felt that being with family while working in Saudi Arabia would be a significant positive influence on encouraging nurses to stay in the Kingdom for longer periods of time. Two nurses made these typical statements about being away from family:

> *'If you are alone and you feel pressure at work, you do not have anyone to express it to, but if you have family here, at least you can talk with them. Family support is very important. Well, I have a husband here. When I was alone here before I was married, I always felt that I wanted to leave. I wanted to go as I missed my family in Malaysia. Why I have been able to stay for as long as 10 years, truly speaking, is as my husband has been with me. If I didn't have a husband here, I definitely would have already left as I could not stay alone here.' (Malaysian nurse, Hospital C)*

> *'I would like a family status contract so that I could bring my family. Then, I would not leave my job. If my family were here, almost 90% of my problems would be solved [laughs]' (Indian nurse, Hospital A)*

Expatriate nurses are employed under either married or single contracts. Married contacts provide certain additional privileges and options such as treatment in the hospital for family members, family accommodations and air tickets for family members. Some expatriate nurses stated that there was no clear recruitment policy regarding who received single as opposed to married contracts. They said that it depended on what you have signed for, and sometimes it was not related to the nursing position in question.

> *'I have some colleagues who are on married contracts as they came to Saudi Arabia and signed for [a staff nurse 1] position. However, there are also some nurses who are in higher positions, and they are on*

single contracts. I do not know how that happened. It depended on your luck when you signed a contract. I think that the hospital previously provided married contracts for everyone, but then it changed its plan.' (Jordanian nurse, Hospital A)

6.6.1.2 Gender segregation

Some expatriate nurses found the gender segregation in Saudi Arabia very difficult for them, noting that where they grew up they were able to mix and develop friendships with members of the opposite sex. However, they notes that there is no unsupervised mixing of the sexes in the Kingdom. People are not allowed to go out for meals or other leisure activities with members of the opposite sex who are not relatives, unless one has a relative from the opposite gender present. One of the participants gave the following explanation:

'I would like to choose with whom I am allowed to be friends. If it happens to be a man and I'm not sleeping with him [laughs raucously], there's nothing wrong with friendship. I like men! I like—I like their sense of humour. I like the way they are, and I have many really good friends that are male who have never ever been boyfriends, love interests or anything… I miss that, and it's hard here when you are not born into it, and it's something that you have to do, you know. I think it's the norm, you're used to it, and you get support from your brothers, your sisters, your mother and your aunties. So it's—it's a different mind-set than the way we are, and I'm not used to it. Socially, those are the things that I find hard.' (South African nurse, Hospital A)

Some participants noted that although Saudi Arabia does have some accommodation compounds that do not segregate the sexes, it is not always easy to gain entry into the buildings. A visitor must know someone who lives in a compound and who will allow an outsider to visit or stay. Some nurses reported going to these compounds to meet with male friends. One of the participants explained the differences between her situation as a single woman and as a married woman:

'I have been single here before. Every time when I wanted to meet my male friends outside [work], we could only go to the compound. In order to go to that compound, we must have somebody so we can stay

in the compound. In my country, we can mix, [and] we can talk to males in public. We can even go out to eat, you know, to drink and that [sort of thing]. But here, no, so it is very difficult for single people. If they have male friends, they cannot mix together, so there are limitations there. … If you are married here, [there is] no problem. We can mix as wives; if our husbands are here, we can still mix, yeah. For me, single life is a bit challenging here.' (Malaysian nurse, Hospital C)

6.6.1.3 Dress code

Some expatriate female nurses provided stimulating findings regarding the public dress code in Saudi Arabia. Females in public places in the Kingdom must wear an abaya, a loose-fitting garment that covers the body, and a black headscarf called a tarha that covers the hair; the dress code is compulsory even for non-Muslim women. Some female nurses reported having some issues with members of the religious police, who as an individual person is called in Arabic [Mutawwi, مطوع]. One of the nurses remarked:

'In public places, like when we go to malls, [Mutawwi] will say, 'Cover your hair. Cover your body'. What do I need to cover? I already have on an abaya. What else do we need to cover?' (Filipino nurse, Hospital A)

Expatriate female nurses also discussed how the dress code diverged slightly between the three hospitals in the study. For example, nurses in Hospital C, which recruits a number of Western nurses and has the largest group of nationalities, are not required to cover their hair while they are at the hospital. Female nurses in Hospital B and Hospital A must cover their hair. Nurses from Hospital A and Hospital B are not even allowed to let their hair loose freely where they live. Some female nurses from Hospital A and Hospital B describe the dress code at their sites as follows:

'Speaking about a very, very critical issue … we can't let our hair fall down even at home. I mean just loose. It needs to be, you know … we also need a ponytail. It must be neat. If they can remove it [this regulation], I think it would release some of, you know, the pressure. I will lose a lot of hair. Also, at work, come on! We are all health workers

here. We are colleagues, so what's the point of hiding everything [and our] hair? [Tuts]' (Filipino nurse, Hospital A)

'They should permit an accommodation for nurses, especially for women so that they can use a cap. Some of the non-Muslims really prefer to wear the non-cap [or] the cap instead of the tarha. They really want it to be a cap or somewhat like the bonnet which [Hospital A] is offering. They are in scrub suits, and then they have this nurse's cap, so there is no … no need for them to wear the [tarha].' (Filipino nurse, Hospital B)

The dress code, which is immensely important socially, can affect patient care in the Kingdom. One of the nurses at Hospital C explained a situation when she was working at another hospital and the dress code was even crucially important to some Saudis when nurses were trying to provide patient care and save a human life:

'Previously, when I worked in another hospital, they [employees and local people] were really conservative, and you had to cover your hair. Even if you were in the hospital and even when you were in an emergency or you were trying to resuscitate patients, and your hair was not covered, they were trying to cover your hair or something like that. Somebody tells you—yells at you, 'Cover your hair' while you are trying to save somebody's life. When I am here [in this hospital], though, the way of life is different. People are more open-minded. They look at you as a nurse, and they respect you as a nurse, so nowadays, the dress code here [in this hospital] does not affect my satisfaction at all.' (Filipino nurse, Hospital C)

6.6.1.4 Gender differentiation

Participants' talk often raised issues related to gender differentiation in Saudi Arabia and considered it as was one of the factors influencing their job satisfaction. Some participants discussed with sadness that there was less respect for women in the Kingdom. For example, female nurses experienced some incidents with adult Saudi male patients or visitors; some Saudi males

scream and yell at female nurses because they cannot receive any empowerment of women. One of the nurses explained her situation when talking to fathers about their children, who were the nurse's patients:

> *'People feel that females [should] have no part in life. They cannot talk or stand up for themselves; they cannot talk to a man. I faced this many times when I talked with patients' fathers. When I came to talk to them about something, they felt that I was offending them. They said, 'How come this lady is telling us you can do this? You cannot do that one'? They do not accept it easily, but if you are a guy and you talk to them, they take it easily; they accept it.' (Jordanian nurse, Hospital A)*

The situation for some Saudi female nurses appears worse than for other nationalities because of the behaviour of some of their male family members. Saudi females are bound by deeply patriarchal patterns of kinship and an ingrained male dominance of all aspects of life. Some Saudi female participants stated that they had appropriate support from their families to work as nurses, but others faced family challenges by continuing to work in nursing. Some noted that simply becoming a nurse has become one of the reasons for the fact that many Saudi nurses remain single, as they work in a mixed-gender environment. Although there has been some improvement, female Saudi nurses are still looked down upon by some members of Saudi society.

> *'Although there have been improvements in society's appreciation for Saudi nurses compared to 10 years ago, nurses are still looked upon as inferior in some parts of society.' (Saudi nurse, Hospital C)*

Another participant was very blunt, giving this explanation:

> *'Joining nursing increases the chances of being a spinster. There is still misunderstanding of the nursing profession in society.' (Saudi nurse, Hospital B)*

6.6.1.5 Social activities in Saudi Arabia

Some expatriate nurses indicated that limited social activities affected their job satisfaction in Saudi Arabia. Nurses indicate that the country's laws are very

strict, which some nurses found very different from their home countries. This was even noted by Muslim nurses, as Saudi laws differed from their Islamic home countries by limiting outside activities so much that there is no cinema or proper leisure activities for people. One of the participants summarised her feelings in this way:

> *'There is no social life here [in Saudi Arabia]. There is only shopping—shopping, visiting and eating out in restaurants, so there is not really much choice. Yeah, we have a lot of activities in other countries, like going to the cinema to watch movies but not in this country.'*
> *(Malaysian nurse, Hospital C)*

6.6.1.6 Using traditional forms of health care

One challenge related to Saudi culture was the use of traditional forms of health care. Some participants stated that the belief in traditional treatments among some Saudis was neither realistic nor helpful. Some people used traditional forms of health care even if they were harmful to patients. Two participants summarised the situation as follows:

> *'Some parents of patients newly diagnosed with cancer refuse to let their children be administered surgery or chemotherapy. They decide to take them to Mutawwi [مطوع] to receive recitation of the Holy Quran or cauterisation* or *branding. Instead of treating patients when they are newly diagnosed, they come back in the late stages [of cancer].'*
> *(Saudi nurse, Hospital C)*

> *'Some people have different norms. For example, some parents cauterise [brand] their three-month-old infants to fix congenital heart disease! It is painful. Also, some people believe that visitors who wear cologne or perfume might infect their relatives' open wounds. I do not know where they got that idea!' (Jordanian nurse, Hospital A)*

6.6.1.7 The slow pace of cultural change

The majority of participants indicated that there was a positive but slow change in the local culture. Changes include more respect for women and the nursing workforce. Some participants emphasised the effect of the Internet on

personal freedom. Another participant provided a different example of the slow change in the culture, which involved taking photographs in malls.

'Previously, if my family wanted to send a letter, it took about a month to get here from the Philippines. When you opened your letter, if there were pictures, they would shade it in black if somebody from your family was wearing a short sleeveless shirt, and they showed their arms. They covered it with black. They opened your letters. I can't believe that they opened letters. I think the change happened because of the Internet; it's open to everybody, male and female. (Filipino nurse, Hospital A)

'I see that it's changed a lot since I came here. Riyadh is beautiful. You see beautiful malls; you want to take a picture and send it home. Previously, we were not allowed [to do that], but now we are allowed to take pictures. I've seen great changes since I started working in Saudi Arabia. Before, it was very strict. It was a family here, single person there, only men outside; [women were] covered. Now I see it's mixed up. Now, I see a lot of changes, even among patients. They understand. They know. I feel that the culture has changed since I came to Saudi Arabia.' (South African nurse, Hospital C)

'It's changing. Women are becoming educated. I think it's fantastic, I really do, as there are a lot of fantastic women out there.' (South African nurse, Hospital A)

6.6.2 Language and communication

Language barriers were cited by some nurses as a fundamental factor influencing their job satisfaction. Language barriers affect different groups of nurses in two different ways. First, non-Arab nurses face difficulties in communicating with patients and understanding their needs, especially because most patients speak only Arabic and do not understand English. Some nurses stated that language was a very large problem early in their careers in Saudi Arabia, because they came to the country with absolutely no Arabic and found it a very difficult language to learn. In this situation, nurses must rely on their other nurses or clerks who speak Arabic to understand and communicate

with patients. Some nurses suggested that having more interpreters would help nurses meet patients' needs. Participants said that that their hospitals provided small booklets in Arabic and English, which concentrated on patient care and health care arrangements. The nurses reported that CDs and dictionaries were given to non-Arabic nurses to understand the language, but they emphasised the need for Arabic classes for non-Arabic speakers to understand the language and thus their patients more easily. Some non-Arab nurses also mentioned that they might have left Saudi Arabia because of language issues. Two nurses explained their experiences with language:

> *'My first patient was an adult man, and he was crying from pain. I couldn't speak to him. He was crying after an operation. He was a recovery patient. He was crying, and I couldn't save him from pain as I couldn't say anything to him, you know. That can make you feel, 'I'm useless here. Why am I working here'? That can make you go home. The language barrier can make you go back home.' (South African nurse, Hospital A)*

> *'When I arrived in Saudi Arabia, I had problems with the Arabic language. A language barrier was there. It was difficult to communicate with my patients and [other] people. Later, my Arabic skills improved, and then, I felt that I liked to work here in this country.' (Indian nurse, Hospital B)*

The second aspect of the language barrier affected newly graduated Saudi nurses, almost all of whom at Hospital B identified the language barrier as a critical issue influencing their job satisfaction. English is the language used by staff in all cases, and those Saudi nurses noted that they were dissatisfied with their English. This issue was also verified by non-Saudi nurses at Hospital B, who said that that newly graduated Saudi nurses typically have poor English. The new Saudi nurses stated that, although the nursing education curriculum was in English, it was difficult to communicate with expatriate nurses in a real-world setting, especially because their English listening and speaking skills were rudimentary. Those nurses all have degrees, most graduated from private nursing schools before being hired by Hospital B and they make up the largest

proportion of nursing workforce (see Chapter 5). Three nurses gave the following comments:

'Although we studied nursing in English, we have difficulties understanding and speaking with non-Saudi co-workers. I think that offering advanced English classes would improve our communication skills.' (Saudi nurse, Hospital B)

'Before Saudi nurses are sent to hospitals, they should be equipped with English skills. Although this is an Arabic-speaking country, our mode of writing and communication is English. They must be equipped. Their writing skills might be acceptable, but their speaking and listening skills are poor. How can they communicate with us? Their language skills should be improved. I know that some of them are working well. They are working with their hearts. They touch patients' hearts, but, only, their English is really … I will ask you to help them so that they will improve.' (Indian nurse, Hospital B)

'I'll tell you one thing. We know our work. We have our job descriptions, but teaching English is not part of our job description. We have become teachers, and it creates more work for us.' (Filipino nurse, Hospital B)

6.6.3 Rewards

Participants consistently discussed that rewards were a main factor that affected their job satisfaction in Saudi Arabia. Rewards were discussed via two main subthemes, which were pay and additional benefits packages. The nurses' outlooks on pay consisted of two aspects: the amount of payment and the fairness of payment. Benefits packages included vacation time, accommodation, transportation, and flight tickets.

6.6.3.1 Amount and fairness of payment

Pay was indicated by almost all the participants as an essential factor affecting their job satisfaction. Nurse's views on pay covered two aspects; the amount of payment and the fairness of payment. A contract signed in a nurses' home country is not always the same contract when expatriate nurses arrive to work in Saudi Arabia. Some participants stated that their actual salary was lower

than what they had been promised in their home countries. They mentioned that agencies misled them in contract issues. This included salaries and other benefits, such as airfare tickets, single and married contracts, cost of working visas, and recruitment placement fees. One of the nurses mentioned that her pay was poor and, as a result, she intends to leave Saudi Arabia. She addressed with frustration that her salary was not competitive compared to her salary when she was working in her home country. She expected her salary in Saudi to be higher, and was frustrated when she received her salary package. She made the following comment regarding her situation:

> *'I thought it would be a better salary as when I was in India, I received about 25,000 of Indian money, 25,000, which is around 2000 riyal. When they interviewed me, they told me [that] my salary would be about 6,000 riyal. But when I came here, my salary package, was much less than that. It was a little salary.' (Indian nurse, Hospital A)*

The fairness of payment is a different concept from the amount of payment. The fairness of payment was discussed by the majority of participants from Hospital A and Hospital C. In these hospitals, some participants stated that there is a lack of fairness in the payment that nurses receive for their work. A lack of fairness in salaries at these two hospitals was discussed in two main scenarios. First, it was stated that some nurses received different wages based on their nationalities, although they were doing the same jobs with the same responsibilities. The participants noted that they were satisfied when they were told their salaries at these hospitals during the recruitment process, as the amount of their salaries was distinct and attractive. However, they felt dissatisfied and disappointed when they realised that their nursing co-workers received higher salaries although they worked in the same positions with the same responsibilities and had the same experience. Some participants mentioned that some nurses in higher positions received lower salaries than their staff nurses, a difference attributed to their nationalities. Most participants dissatisfied with the wage disparity based on nationality described this situation as discriminatory. Three nurses gave the following explanations regarding salary disparities based on nationality:

> *'When you get here [in Saudi Arabia] and you get to know your friends and everything, then you find out (very much later) that there are*

different categories of salaries depending on from where you come. If you come from Canada and the US, your salary is top-top. So it's about the equity, OK? It's not the amount; it's the equity. Why should a nurse manager who comes from the States or Canada get more money than I do because of a passport, not because of her knowledge, not because of her qualifications, not experience but purely because of nationality? That makes me very dissatisfied; I think that is not fair.' (South African nurse, Hospital C)

'The Western nurses receive about four times the salaries of Filipino nurses. Come on, is this fair? No, it is not fair. It is not fair for Saudis that I take the same assignment, and my salary is half of her [another nurse's] salary just because she is Western. I think everybody in the same position should get the same salary. I think this is one huge [instance of] discrimination in this organisation and other organisations in Saudi Arabia. I think people who have the same capabilities, the same qualifications, no matter what their religion is and no matter what their nationality is, should be treated equally.' (Saudi nurse, Hospital C)

'When I was a staff nurse, I worked all the same cases as, let's say, this person. At the end of the month, you heard that she was getting more than you, uh, but it was already a given. You didn't know that before you left your country—that these people earn more—but when you came to know about it, sometimes it, uh, it hurts you a little bit.' (Filipino nurse, Hospital A)

Some participants said that unequal pay based on nationality created problems in the workplace. It was noted that some nurses with lower salaries would not help their co-workers, as they thought that the nurses of other nationalities who received higher salaries should have more responsibilities and accountability. Two nurses explained this situation:

'Some staff [members] think that she [another nurse] is getting a better salary, and we are doing the same job and the same position, [so] let her work more than me! [Chuckles]. They think like that. Let her

work more than I! [Chuckles]. They think like that. Let her work more than I am working. Let her take more accountability and responsibility. This is happening, but it's not [a] good [situation].' (Indian nurse, Hospital A)

'Sometimes you heard people [say], 'Ha, I'm not going to help her because she has a big salary', but with me, no. Other people, when they were so tired and stressed and people would ask for help, they would say, 'I'm not helping her. I'm not helping her. She has, she has a bigger salary than me'.' (Filipino nurse, Hospital C)

Participants emphasised the importance of treating expatriate nurses equally and felt that there was no logical explanation for differentiating salary on the basis of nationality. Some participants discussed that hospitals offered salary packages based on their home countries' economic status. They explained that salary differences were due to the exchange rates, so the money that nurses could save would allow them to afford to buy the same amount of stuff in their home countries. Some participants said that the cost of living in Saudi Arabia is the same for all nationalities, so there is no point in differentiating their salaries. One participant related the following anecdote:

'We buy the same food, and we buy the same rice and the same commodities at the same prices, so what is the difference? For instance, [one nurse gets] a salary of SR 15,000, and [another gets] a salary of SR 3,000, but both spend the same, for example, SR 1,000 a month, so you have 2,000 left; the other will have 14,000 left. The store is the same, [but] when you buy outside, [the vendors say,] 'Oh, you're a Filipino? Uh, this, the price is 1 riyal'. 'Oh, you're an American. The price is 5 riyal'. Is it not like that, right?' (Filipino nurse, Hospital C)

The second aspect of unfair salaries was related to the new salary scale for Saudi nurses. This issue was discussed by all the Saudi nurses at Hospital A and Hospital C, who suffered from salary increase freezes as a result of the new salary scale. These participants stressed that the new scale demotivated them to work in specialised areas and increased their intention to leave. They

said that they were working harder than the nurses at the hospitals that run under the direct operation of the MOH and primary health centres, but they received the same salaries.

In Hospital B, however, Saudi nurses benefited from the new scale as their salaries were raised. The Saudi nurses at Hospital A and Hospital C argued that it was admirable to motivate MOH employees, including nurses, with the new salary scale, but it should not affect other government hospitals. They believed that they were doing harder, more complex work at their hospitals for the same salary. They saw it as unfair to equalise their salaries with those of nurses who did not work in patient-safety-centred facilities, JCI-accredited hospitals or high-reliability organisations. They believed that they worked longer hours under a strict standard of care and argued that the new salary scale was unfair as it paid them the same as those working in different settings, such as clinics or hospitals providing secondary and primary care. They said that the new salary scale demotivated them to seek promotion to higher positions as there was no increase for those working as head nurses or staff nurses. They stated that the new scale demotivated them to do their job as they would not be financially rewarded whether their evaluation was the best or only fair. Two nurses shared their experience:

> *'My job in this hospital is fine, except for the scaling issue. It is depressing. They have frozen our salary increases for the next eight years. Freezing the increase of our salaries is a bad decision. It makes us disappointed in the hospital, and it is actually affecting us. [Based on] my performance evaluation—whether is it good or bad, whether it is 80 or 90 or even 100—I will not get anything. Even when someone thinks about getting a promotion, they will think, 'What will I get from that promotion as the salary will be the same. I am getting the same salary. In this position or a higher position, the salary is the same. Why should I bother and give myself a headache?' (Saudi nurse, Hospital C)*

> *'The new salary scale is not fair as the expectations for you when you work in a hospital that is not patient-safety centred, not a JCI-accredited hospital, not a high-reliability organisation are totally different from [when you are] working in an organisation with high expectations, with longer working hours, with strict standards of care.*

Then, you will be paid like someone who just works morning shift at primary health centres. The new salary scale is driving people crazy.' (Saudi nurse, Hospital C)

6.6.3.2 Other benefits packages

Additional benefits packages were discussed as a fundamental factor affecting nurses' job satisfaction. Benefit packages included vacations, accommodation, transportation, and flight tickets. Annual vacation was roughly the same across the three hospitals. Nurses enjoyed approximately 60 days' vacation, including the Eid public holidays and emergency leave. Maternity leave was offered only to Saudi nurses, but the length and regulations of maternity leave varied among the three hospitals. For example, Saudi nurses at Hospital A and Hospital C said that they may not combine their maternity leave with their annual leave to have more than the set number of days.

In addition, hospital accommodations affected the daily life and satisfaction of expatriate nurses. Accommodation quality varies among the three hospitals. The accommodation at Hospital B is of poorer quality compared to those at Hospital A and Hospital C, and nurses were aware of these differences. Expatriate nurses at Hospital B described serious issues with their accommodation, while nurses at Hospital A and Hospital C were more comfortable with their accommodation. Issues related to the accommodations at Hospital B included having too many nurses in one apartment, placing more than one nurse in a bedroom, lacking recreational facilities and dealing with broken equipment, such as laundry machines. Two participants from Hospital B gave the following explanations:

'First, it's really the accommodations. Work is only eight hours. Uncomfortable or comfortable, it is eight hours. We spend most of our time in our accommodations, but our accommodations are not what accommodations should be. This sometimes causes dissatisfaction. We have problems. The washing machine did not work for months, and we washed our clothes manually. Finally, I bought my own [washing machine] as if you waited for the machine to be repaired, it would take months. [Chuckles]' (Filipino nurse, Hospital B)

'The problem is the accommodations. The room should be for only two [occupants], but we [have] three. Also, there are no accommodation facilities. We don't have recreation activities. It is not like at other hospitals. For example, I see my colleagues who are at [Hospital A]. They have their own single rooms. They have a lawn tennis court, they have a volleyball court, and they have an outdoor pool, which I can truly say would help encourage people to stay. We watch TV; we have the Internet, which we provide for ourselves. However, we have to go out, and sometimes, we have to stress out.' (Filipino nurse, Hospital B)

Nurses at Hospital A and Hospital C have more comfortable accommodation and recreational facilities. They have a lawn tennis court, volleyball court, swimming pools and gym. The nurses at these hospitals had their own single rooms, but except for some nurses in higher positions who had their own apartments, they shared apartment facilities, such as the kitchen and sitting rooms. However, there were a few differences in the accommodations at Hospital A and Hospital C. The participants at Hospital C noted that they had more social freedom and recreational activities in their accommodations. The nurses at Hospital C could invite men to their accommodations, whereas those at Hospital A could not. Also, the nurses stated that Hospital C had a recreation centre that organised weekend excursions and trips to other cities in Saudi Arabia. In contrast, the nurses at Hospital A noted that it was important to improve the recreational activities at their hospital. They longed to engage in outdoor activities and organise holiday visits to other cities and places. The nurses from Hospital A and C gave the following descriptions of the recreational activities at their hospitals:

'We need more recreation for the nurses, to bring them outside for picnics, to show what is, you know, what Saudi Arabia is like [chuckles], to learn history and to go outside and ventilate us … more recreational centres, those things, to make them feel happy. We work, and we go home and sleep; there is no recreation for the nurses. We are staying alone here, so you sometimes feel so depressed, even with your job. You don't have ventilation—ways to ventilate your mind. We, we should have good recreation for the staff to bring them outside.' (Indian nurse, Hospital A)

'We went to Abha for a weekend. We went to Hofuf for a weekend. We went to Madain Saleh for a weekend, so it was very nice to have the opportunity to see a little bit of the Kingdom. It was nice that the recreation department organised these little trips and things. Thirty of us went together to Abha, we stayed at a hotel, and there was a bus that drove us around. It was lovely.' (South African nurse, Hospital C).

'It's very nice. I mean, if you really think about it, it's like a holiday resort as I don't have to share as I'm a manager. … I've got my own little apartment. It's small, but it's more than big enough for myself ... Everything I have in the flat that they supply (furniture, crockery and everything) is great. … The fact that you can pick up the phone and say, 'The light on my stove is not working. Please come, and change it' is wonderful as I would not have that if I were at home. I would have to pay big time to get people to come in and do maintenance. The amenities that they have there for us (the swimming pool, the sauna, the steam room, the Jacuzzi, tennis courts), everything that they have, the gym—everything is really, really, really nice. When you leave here after a very stressful day, it's lovely to walk into your own place and do what you want to do.' (South African nurse, Hospital C)

One participant said that she worked at Hospital C before joining Hospital A. She described the social freedom in the accommodations provided by these respective hospitals, and she explained how it affected her job satisfaction.

'[Hospital C was] much freer. … In [Hospital C], socially, it was a very friendly environment, and socially, we had a lot of—we were able to have get-togethers and a lot of parties. You could invite married couples to your home, so if it was a male/female [event], it wasn't a problem. There were a lot of people that were married living in the compound and living outside he compound, but you could invite them into your apartment for dinner as a married couple, and it was nice. Here, you can't do that. Men, whether we are married to them or not, are not allowed into our accommodations at all.' (South African nurse, Hospital A)

Expatriate nurses at all the three hospitals noted that the transportation services provided by the hospitals were not convenient and mentioned such issues as far-away bus stops, inconvenient timetables and late coaches. Two nurses gave the following explanations:

> *'The biggest problem for us is transportation. They [the coaches] are always late. They do not come on time. Imagine, our work is at 7 o'clock. Actually, our accommodations are not that far. We could wake up at maybe 6 o'clock and still come on duty by 7. But no, we have to wake up at 5 or earlier and then come down to the waiting area. You can wait up to 30, sometimes 40 minutes before the coach comes, so how many minutes have they wasted for us? We could sleep in that time.' (Filipino nurse, Hospital B)*

> *'I'm too lazy to walk so far to the bus stop. It's very far, so if I have to catch the bus at 4:15 pm, I have to leave here just before 4 to be able to get to the bus stop in time, and then I've got to rush. The next one is at 5:15 pm, so it's much easier to use a taxi. Yes, it costs me, but it's easier.' (South African nurse, Hospital C)*

Moreover, there were differences between the three hospitals regarding the number of tickets provided annually for expatriate nurses. Nurses at Hospital A and Hospital B received one outward and one forward air flight ticket to their home country annually, while Hospital C offered two tickets. Nurses at Hospital A were disappointed about having only one flight ticket. The Indian and Filipino nurses at Hospital A and Hospital B seemed to encounter difficulties travelling to their home countries twice a year on their poor salaries. They had difficulty affording travelling; as discussed in chapter 5, these nationalities received the lowest salaries compared to other nationalities. The expatriate nurses at Hospital C acknowledged that two yearly flight tickets were valuable to them, made them feel happy and were one factor that influenced them to stay at the hospital. Two participants gave the following explanations of the situations at their hospitals:

> *'[Hospital C] offers two tickets a year. We only get one here, so I think that is an issue for some people. You know, take our Indian and Filipino*

staff, they get one ticket a year and only go home once a year. I think where they [hospital management] could make life better for them would be, for example, to throw in that extra ticket. It would mean they could split their leave, and they could go home twice a year—with three weeks and three weeks—and at least see their children more often. That would be a huge perk for a lot of them. A lot of them just don't do it because they don't want to pay the extra money for that air ticket on their own. I go three times a year. I pay for my tickets because I can afford it.' (South African nurse, Hospital A)

'Some people are also happy as they can go home for a twice-yearly holiday. Sometimes, they even go home without money, without an allowance, just to go home to their family as they want to utilise the ticket. It is one of things that keep us at this hospital.' (Filipino nurse, Hospital C)

6.6.4 Long-term security for nurses

One issue that was discussed by the majority of expatriate nurses was the lack of long-term security for them while working in Saudi Arabia. The main aspect related to the lack of long-term security for nurses was the inability to retire in Saudi Arabia. Some mentioned with sadness that they cannot retire in Saudi Arabia and must retire somewhere else, as there is no permanent immigration to the Kingdom. A lack of long-term security for expatriate nurses was mentioned as one of the reasons for leaving Saudi Arabia. Two participants gave the following representative statements about the lack of security for expatriate nurses in the Kingdom.

'Saudi Arabia is not a forever place, and one has got to accept that. That is why I think it would be a good thing to have a couple of years at home to get some benefits at home before I retire. That's one of the reasons.' (South African nurse, Hospital A)
'There are a lot of Filipino nurses who stay here until they reach the age of retirement and go home. You cannot retire in Saudi Arabia. You have to go or retire somewhere else but not in Saudi Arabia. It is not allowed [chuckle]. Expats cannot stay here for good. Sooner or later, they have to leave.' (Filipino nurse, Hospital A)

6.6.5 Recognition

Recognition from managers was mentioned as important to nurses' job satisfaction. Some nurses believed that their nurse managers were unsupportive and uncooperative and neither acknowledged their staff members' work problems nor listened to their issues (e.g. poor scheduling, staffing rate). Unsupportive management caused high levels of job dissatisfaction among nurses.

Some participants declared that they felt disappointed with their nurse managers' unfair and discriminatory actions. The participants believed that the managers tended to favour certain staff members regardless of ability and performance and did not fairly distribute shifts, staffing rates and weekend days off among nurses. The participants related their examples of unfair and discriminatory practices, as shown in the following excerpts, to staffing rates decided by nurses' nationalities.

> *'My nurse manager is unfair. I handle eight patients. Some staff members handle one patient, maybe as they are Saudi, or they are her friends. It is not only the staffing ratio. My head nurse prefers her friends in assigning weekends off. She is unsupportive and discriminatory.' (Filipino nurse, Hospital B)*

> *'My nurse manger embarrasses us, and if someone makes even a little mistake, everyone will be disciplined, which is unfair. She will ask us to do further assignments, do research and read things. She sometimes stands in the middle of the nursing station and says, 'The nurses are only working for the salary'! She should not say this to all the staff members in front of all the workers and doctors. I left that area because of her.' (Saudi nurse, Hospital C)*

In addition, one issue cited by many participants as a factor affecting nurses' job satisfaction was their relationships with physicians. Some participants stated that doctors did not recognise nurses' caring skills. They noted with sadness that physicians were granted an unrealistic superiority to nurses, and some said that physicians did not respect nurses' decisions. Two nurses gave the following explanations:

'When I want to discuss something related to patient care with the doctors, they refuse to discuss it with me. Doctors just give orders. They do not respect nurses' point of view. One of the physicians complained when I discussed patients with him. He told my head nurse [Chuckles]. They told me I have to respect doctors. I respect them, but nurses are the part of the health care profession which provides patient care, and there should be respect for our viewpoints.' (Saudi nurse, Hospital B)

'Some doctors, especially Saudi doctors, are very arrogant. They say, 'I am a consultant or a doctor, and I have studied at that university, and you are coming now to talk with me! You are just a nurse'.' (Jordanian nurse, Hospital A)

The doctors' attitudes of superiority caused the nurses to fall behind in their work; as some of the participants noted, doctors attempted to have the nurses do the doctors' work. Two participants provided detailed explanations of this issue.

'In addition to my work, I have to look at the doctors' paperwork. Are they finished? Have they completed everything? Have they written down everything? Did they seal it? Did they stamp it? I have to look for everything, and I have to go behind the doctors and say, 'Doctor, could you please sign for me'? 'Could you please stamp it'? 'Would you please complete it'? Daily three or four times, I'm going behind them! At the end of the day, he starts to shout at me. [chuckles] I feel so bad. When I get shouted at by doctors, I feel so bad. … In our country [India], we do not follow any doctor; we do not tell any doctor, 'Do this'. They finish their work completely, but here in Saudi, they do not complete their work. In India, we follow their orders, but we do not follow and check whether they sign, whether they write the date and the time. In India, when doctors do something, they complete it. They do not leave anything behind [undone]. I have not seen anything like that in Saudi Arabia. No doctors do this.' (Indian nurse, Hospital A)

'Doctors add pressure to us as they [keep] saying, 'Why is this patient waiting? Why is this …'? We have residents [who say]: 'Sister, can you give me the vital signs'? Sometimes, [they ask,] 'Can you count the RR [respiratory rate] for me'? Excuse me! They are learners, aren't they? They are supposed to be here to learn. Back home [the Philippines], the residents, the physicians, the interns, they do our jobs. [They ask,] 'Sister, can I do the IV computation, please'? 'Can I do the NG tube [*nasogastric tube]'? 'Can I do this'? They have to master the skills as at the end of the day, nurses will rely on them, and they are going to be consultants, you know… I manage to reach out to these physicians, like [saying], 'Doc, I think you have to start debriefing your residents to stop chasing nurses as the nurses already are overwhelmed. … If they can help the nurses, they should help nurses rather than chasing them'. …This problem is caused by all physicians, I guess, but, of course, it's dominated by Saudi physicians.' (Filipino nurse, Hospital C)*

Two participants talked about incidents in which doctors faulted nurses for medical errors. In one incident, the patient passed away. These incidents added pressure on nurses and affected their job satisfaction. One of the participants detailed an incident in which some nurses were held responsible for a doctor's fault.

'The physician ordered a medication to which the patient was allergic; he [the doctor] put in the wrong medication. The pharmacy verified the order and accepted it, and then the nurses didn't check to see if the patient was allergic before they gave it to him. The patient died. The case is still on-going. They took the two nurses that did the transcribing as well. Even though they followed policy, they've taken the two that did the transcribing and the two that did the administration to find the root cause. They also appeared in publicly in court. The pharmacist appeared at court, and my nurses were at court. The nurses, though, told me that they didn't see the doctor at court, no. He was a Saudi consultant. [It was] very sad. The doctor was gone. I was told he went to another hospital!' (South African nurse, Hospital C)

Additionally, some nurses noted that the lack of recognition by higher management at their hospitals was associated with their hospitals' characteristics: bureaucratic, with slow processes, and a strict chain of command. Two participants gave representative statements:

> *'The processes are quite slow in comparison to at home. There's just a lot of red tape. You know, you've got to get 20 signatures for something that in fact probably two people could sign. That is still a little bit of an issue with me as I just don't understand why it needs so many steps in order to achieve something. The processes are very slow.' (South African nurse, Hospital A)*

> *'If we have an issue, we are not allowed to go talk to the directors. We have to start with our manager, and our manager will go to them. … There is a chain of command. They're getting worse and worse; there are no changes. You start talking to your manager, and the manager will be the one to raise the issue with the director. … You cannot just go directly to the director without the manager knowing [pause]. Although before, if you wanted to travel, for example, within three days, you got permission within three days. Now, no, you have to book it 45 days [early].' (Filipino nurse, Hospital C)*

6.6.6 12-hour shifts

Most of the participants stated that working 12-hour shifts caused job dissatisfaction. All three hospitals assigned 12-hour shifts to some nurses. Some nurses said that, after completing these long shifts, they felt tired and had limited time to do their daily activities. The following are typical explanations of how the 12-hour shifts negatively affected the nurses.

> *'I have no problem right now as I work 8-hour shifts. I still have time to shop. I still have time to watch movies and do my things. [However,] when I was working 12-hour work shifts when I was still a staff nurse, I did not like it, as it is so difficult. You wake up early in the morning, you sleep a very short time, and then you work a very long time, so there is nothing that you can do after work. All you have to do is eat*

and sleep, you know. Until now, it [work] was just existing.' (Filipino nurse, Hospital C)

'Working hours are problematic. I feel very tired after a 12-hour shift. You just go to bed. You do not have time for your family. The hospital should minimise working hours.' (Jordanian nurse, Hospital A)

'Previously, when I was working 12-hour shifts, they were very long, so I came [home] immediately to pray and sleep. I did not have time to see my family, enjoy my friends [or] participate in occasions that my family has.' (Saudi nurse, Hospital C)

6.6.7 Development opportunities

The majority of nurses argued that development opportunities were an important factor in their job satisfaction. Nurses discussed development opportunities from different angles. Development opportunities were discussed in terms of occupying higher positions and furthering nursing education.

First, variations in how participants discussed the concepts of positions and promotions were based on the hospital and the nationality of employees. Saudi nurses at Hospital A and Hospital C stated that they have become similar to Saudi nurses at Hospital B, which offered no financial compensation for higher-level nursing positons. Without financial compensation, some nurses were not motivated to seek higher-level positions. One Saudi nurse summarised this situation:

'When someone is thinking about getting a promotion, they will think, 'What I will get from that promotion as the salary will be the same? I am getting the same salary for this position or a higher position. The salary is the same. Why should I bother and give myself a headache'?' (Saudi nurse, Hospital C)

Some participants argued that there was no fair system for promotions and occupying higher positions. Some believed that Wasta [واسطة], which loosely translates to nepotism, affected promotion decisions. Most participants at

Hospital B claimed that higher positions at their hospital were reserved for Saudi nurses. The Saudi participants at the same hospital mentioned that Saudi candidates' priority for positions was affected by their age and years of service. They claimed that this system led to frustration as hospitals did not take into account candidates' evaluations or knowledge. The participants said that some nurses in higher positions (e.g. head nurses) at their hospital were not qualified.

> *'Nominations for higher positons in this hospital do not rely on the candidates' monthly evaluations or the nurses' actual experience. Priority goes first to Saudi nationals and then depends on age and years of experience in nursing. One of the Saudi head nurses did not have sufficient knowledge for her position, and my evaluation was better than hers. I do not know; it just depends on age and years of experience. On top of that, there is Wasta [واسطة].' (Saudi nurse, Hospital B)*

Educational opportunities were brought up by participants within two patterns: continuing education, and lack of sufficient nursing preparation. There were difficulties continuing education for nursing degrees in Saudi Arabia. Some participants stated that pursing higher education in nursing would enable them to secure better salaries and more job opportunities. However, it was not possible to purse higher education because nurses were not able to take the time away from their jobs to do so; there was no proper scheduling to compensate for the ongoing nursing shortages in hospitals. Participants demonstrated that they had heavy responsibility and high accountability with no extra time to pursue higher education.

In addition to the lack of time, some non-Saudi nurses stated that they could not enrol in Saudi public universities. Some participants questioned how they could obtain the necessary continuing education when they could not attend some symposiums and training workshops as there were no substitute employees to cover at their positions at their hospitals. Educational opportunities affected nurses' job satisfaction and were mentioned as one reason for turnover. Three participants provided explanations about the situation:

'There are no educational opportunities for expatriate nurses. As expatriate nurses, we need opportunities to study here. For example, there is a university here, which could give us master's degrees, so we could work and also study. This would also give us an opportunity to be on a good career pathway. It would be a big advantage for us.' (Filipino nurse, Hospital B)

'We [non-Saudi nurses] are not given scholarships or any opportunities to study. They are only for Saudi nurses. Give us a chance, or allow us to study, and we will pay.' (Filipino nurse, Hospital A)

In addition to continuing education, there were some issues discussed related to the newly employed Saudi nurses at Hospital B. In particular, it was argued that some Saudi nurses were not prepared. Participants explained that the majority of these nurses did not have the necessary skills to be nurses. According to the participants, the lack of skills associated with newly graduated nurses was more practical than theoretical. Some nurses at Hospital B stated that there was no clear strategy for practical training in nursing at their site. Some nurses described the situation at Hospital B.

'They [Saudi nurses] need more education. They come without any knowledge. They do not know how to give injections! We [expatriate nurses] deal with patients. This is not a place to educate them [the new nurses]. Our function is to work. This is not a place to educate [the new nurses]. This is not a school; this is a hospital. We cannot ignore this problem anymore. They are here to save lives. This [the patient] is a human life! Training them is difficult, and it is painful. We have to teach them two, three, and sometimes 10 times. This is not a place to study. Not a place to study! No! It's a human life.' (Indian Nurse, Hospital B)

'I had to teach myself. I had to be brave to learn. This is how I learnt.' (Saudi nurse, Hospital B)

'Most Saudi nurses come to the hospital unprepared. They are newly graduated nurses, so I do not expect them to know everything, but

somehow … there is something. Even taking these vital signs, they do not know what they are seeing in the... That makes our job even more difficult.' (Filipino nurse, Hospital B)

6.6.8 Task requirements

The nurses at Hospital A and Hospital C described paperwork and documentation as challenging factors in their work. Some participants said that that they spent too much of their time on paperwork and did not have enough time to give patient care, especially because they had to enter data into the electronic system and write hard copies. One participant gave a representative statement:

'We have paperwork and system work. We have to finish our paperwork, and we have to take care of our patients, and after that, we have to enter all the data into the system, so [it's] double work really. It is really time consuming, and it is stressful to finish all the work. Then, I cannot give much care to my patients. My manager [and] the higher authorities, they are forcing us to do this.' (Indian nurse, Hospital A)

6.6.9 Professionalism

A lack of professionalism among some Saudi nurses was discussed as a critical factor causing nurses' job dissatisfaction. Many participants detailed frustrating problems with work habits and work ethic among many Saudi nurses. Participants discussed various issues, including coming to work late, leaving work early, exhibiting laziness, being tardy and not showing passion for the work. The issue of the work ethic of the Saudi workforce was described as not limited to Saudi nurses but extending to other disciplines in the Saudi labour force. Three participants explained the situation:

'The Saudis, they are not serious about their jobs. Out of 10, maybe only two or three nurses are serious. The rest, they only come to drink tea. They bring coffee and eat dates and enjoy their [social] life during their duty. They don't like to work. They come and chat with each other. That [is] the situation we are [experiencing] here, and we

[expatriate nurses] are now doing other people's work.' (Filipino nurse, Hospital B)

'I can say that Saudi nurses, male and female, they come to work and want to sleep because they partied the whole night, or they sleep late. I mean, with us, we know 9 o'clock, 10 o'clock at the latest; you must go to bed so that tomorrow you will be fresh. [However,] with your culture (I don't know whether it's your culture), they don't mind going to sleep at 4 am or at 3 am, and tomorrow morning, the first thing they do at work—they are dragging their feet. They go for coffee, [but] they don't come back, yeah, just like that. If they want to be nurses, they should show that they've got a passion for nursing. If a person will come to work and sleep in the tea room, does that person like their job? I see them; they come to work, and they want to go to sleep. I think it's the culture; initially, you [Saudi people] do not work. Even in other areas not in nursing, you'll find that they are supposed to be at work at 8 o'clock. You're lucky if they are in the office by 8:30 am or 9 am. Then, if you look for them at 3 o'clock, they are no longer there. They have already gone home.' (South African nurse, Hospital A)

'I'm sorry to say that Saudi nurses do not help us!' (Indian nurses, Hospital B)

One of the main aspects related to the lack of professionalism among Saudi nurses was the type of shift. Although some participants stated that working night shifts and on weekends affected their social life and job satisfaction, Saudi nurses dominated the dialogue on this issue. Saudi participants believed that these duties limited their ability to look after their spouses and children. Indeed, some Saudi nurses said that night duty was one of the main factors that influenced them to leave their organisations and work in other settings where they do only morning duties. Three participants made the following comments:

'When I started nursing, [I found that] it affects your social life big time, big time. You give up a lot. You give up birthday parties. You know, [it's] your best friend's birthday, and you are on night duty, [so]

you can't go. You give up social activities with your family—birthdays, festivals, Christmas, Easter—no matter what religion you are, it doesn't matter. If you work on Eid, and you are Muslim, you [still have to be] working [while] your family is celebrating. Right away, you give up a lot. You've got to do night duty, work on the weekends. When your friends are having fun on the weekends and are sitting swimming at or lying on the beach, you are at work. And what I found was that you … through the years, people start to forget about you. You find yourself getting invited less often because [others think,] 'Ah, don't worry about her. She's going to be working, so she won't be able to come'.' (South African nurse, Hospital A)

'Most Saudi nurses want to work morning duties. They do not want to work at night. This is a problem. Head nurses cannot assign all Saudi nurses morning duties all the time.' (Saudi nurse, Hospital B)

'I know many Saudi nurses who have already left this hospital for primary health centres as they do not want to work night shifts.' (Saudi nurse, Hospital B)

In addition, many participants reported that Saudi nurses avoiding working night shifts and on weekends was also a result of their family members' desires. It was discussed that many Saudi nurses favoured working in morning shifts, and they emphasised that it was important for Saudi nurses to be aware that the nursing profession is a 24-hour commitment. This following is a representative description of the situation of many Saudi nurses.

'Half of the Saudi nurses are not allowed to work weekends; they are not allowed to work nights. How can you staff a hospital with nurses who can't work night duty and who can't work weekends? I'm telling you, I'm pretty sure that three-quarters of the nurses training in this hospital will work regular hours, so what type of nursing are they going to do? They are not going to genuinely nurse patients. They are going to go into office jobs in hospitals. You know, you can't just close the door at 4 o'clock in the afternoon and say, 'The hospital is closed now'.' (South African nurse, Hospital A)

A final area discussed in interviews about professionalism and job satisfaction was related to the work practices of Saudi nurses. Many participants stated that absenteeism was a common practice among some Saudi Arabian nurses and caused job dissatisfaction among the rest of the nurses. This particular issue was discussed most frequently by the participants that worked at Hospital B. Some participants discussed that some of those frequently absent did not care whether their salaries would be reduced. The situation was worse at Hospital B, where some participants described the conditions as a lack of discipline, and they stated that rule-breakers were not terminated for excessive absenteeism. The majority of participants from Hospital B discussed that absenteeism among Saudi nurses led to serious problems in the workplace. Some nurses questioned whether Hospital B disciplined excessive absenteeism among Saudi nurses. They stated that absenteeism led to staffing problems (patient–nurse ratio). In addition, Saudi nurses tended to take advantage of the system: they were too demanding, as they selected which patients and how many patients they would care for:

> *'Saudi nurses are always absent, and they cause trouble with our schedule.' (Filipino nurse, Hospital* B)

> *'Saudi nurses have fewer patients than expatriate nurses. They have only one or two patients. That makes our job difficult. When Saudi nurses come to work, they say, 'I will not take this patient. I will not take this patient. I will not take that one'. They have preferences; they choose.' (Filipino nurse, Hospital A)*

> *'I think that about half of the Saudi nurses in this hospital do not come to the hospital to work. I know one Saudi nurse. I do not know how much she receives of her salary—1 riyal, 10 riyals! [Chuckles]. I do not know as she comes to work three days a month and is always absent. I do not think that the hospital takes deductions from her salary. I am just wondering why she has not gotten sacked from the hospital.' (Saudi nurse, Hospital B)*
>
> *'I cannot express how hectic it is in our ward. In my ward, we are handling [a] 1:8 [nurse–patient ratio]. Sometimes, it is 1:6. If somebody*

is absent, it is 1:10 or 1:12. We have this situation frequently as Saudi nurses are always absent.' (Indian nurse, Hospital B)

6.7 Reasons for intentions of leaving a hospital: follow-up questions from the questionnaire

This section is limited to the findings from responses to the open-ended follow-up questions from the questionnaire. Nurses who had intentions of leaving their positions were asked to state their reasons, and where they planned to practise the nursing profession next. Out of 216 participants who had the intention to leave their jobs, 149 participants filled out the open-ended follow-up question. Table 6-2 illustrates the distribution of demographic characteristics of these participants.

Reasons for leaving a hospital among nurses in Saudi Arabian government hospitals appeared as nine broad themes that developed from the findings of the 149 responses to the open-ended questions. These themes were pay, influence of family, lack of autonomy, burnout, age of retirement, bad management, the culture of Saudi Arabia, working night shifts, and lack of security. These reasons were related to a nurse's intention to leave a hospital, and they are presented in a sequence, depending on whether the reason for leaving was related to working abroad or leaving the profession entirely.

Table 6-2: Distribution of demographic characteristics of responses to the open-ended follow-up questions in the questionnaire (n = 149)

Nationality	Hospital A	Hospital B	Hospital C	Total
Saudi	2	9	8	19
Filipino	24	13	31	68
Indian	14	8	0	22
Jordanian	0	0	3	3
South African	4	0	9	13
Malaysian	2	0	6	8
British	0	0	4	4
Australian	1	0	0	1
New Zealander	0	0	2	2
Irish	1	0	2	3
Canadian	0	0	2	2
Slovakian	0	0	1	1
Czech	0	0	1	1
Portuguese	0	0	1	1
Lebanese	0	0	1	1
Total	48	30	71	149

6.7.1 Pay

Salary was the main reason for leaving intention among many nurses. Many participants, especially expatriate nurses, cited salary as why they intended to leave their hospital and work either at another facility in Saudi Arabia or go abroad. Participants noted that their issues with salaries had two aspects. First

was the amount of pay, as some participants reported that they could receive higher salaries if they left their current hospitals:

'Higher salaries and good financial benefits are offered elsewhere.' (Indian nurse, Hospital A)

'Another reason is my salary is very low.' (Filipino nurse, Hospital B)

'I'm not getting paid enough.' (Filipino nurse, Hospital C)

Fairness with regard to pay was cited as a reason for leaving Hospitals A and C to work elsewhere, either within Saudi Arabia—as frequently cited by Saudi nurses, or to work abroad—especially mentioned by expatriate nurses. Three participants gave representative statements:

'I will go to the United States. The salary there would not be based on your nationality, age or gender, but would be based on your qualifications.' (Filipino nurse, Hospital A)

'The salary is not fair compensation between we Filipinos and other nationalities. I am going to Europe or Canada.' (Filipino nurse, Hospital C)

'I am going to Aramco Hospital, away from any change in salary that could be imposed on government hospitals by the MOH'. (Saudi nurse, Hospital C)

6.7.2 Lack of security

One of the reasons for leaving Saudi Arabia and practising nursing abroad by many expatriate nurses was a lack of security. Some participants reported that they could not retire in Saudi Arabia, and so they had to leave whether they could get a better pension. Two nurses offered representative testimony:

'Because of the lack of pension entitlement, we cannot retire in Saudi Arabia.' (Filipino nurse, Hospital A)

'I'm leaving for a better opportunity and a better pension.' (Filipino nurse, Hospital A)

6.7.3 Night shifts

Night shifts were noted by many Saudi nurses as a main reason for leaving their hospitals to work in primary health centres. Some Saudi participants stated that night shifts were very challenging for them and their family members:

'I am going to work at a primary health centre; the night shift is hard for me and my family.' (Saudi nurse, Hospital B)

'I am leaving for a primary health centre; it is the same salary, fewer working hours and has no night shift.' (Saudi nurse, Hospital C)

6.7.4 Influence of family

The influence of family was cited as an important factor in the intention to leave. Many expatriate nurses indicated that they wanted to work in their home countries or in a country where they could be joined by their families:

'I would like to join my family since there is no family status provided.' (Filipino nurse, Hospital A)

'I'm planning to find a country where my husband and I can work together, maybe the United States or Europe.' (Indian nurse, Hospital B)

'I'm going back to my home country; it's difficult to stay without family.' (Indian nurse, Hospital A)

The influence of family was also cited as a key reason for leaving the nursing profession by both Saudi and expatriate nurses. Two participants gave representative statements:

''I have to take care of my children and my husband' (Saudi nurse, Hospital B)

'It is very hard to balance family and work; my children are my priority. I am quitting the nursing profession, I have had enough.' (Indian nurse, Hospital A)

6.7.5 Lack of autonomy

A lack of autonomy was cited by many expatiate nurses as a key reason for intending to leave their current hospitals and work elsewhere, as one put it:

'I am going to work in Abu Dhabi. I am dissatisfied with a number of factors at my hospital. There is a complete lack of autonomy for nurses. We are not recognised as a profession in our own right; we are considered handmaids for doctors. We are not given the respect we deserve. We have no control over our working environment; all the managers micromanage. There is resistance to change it at all levels. There is no concept of practice at the front-line level.' (British nurse, Hospital C)

6.7.6 Burnout

High levels of burnout were cited by many participants as a reason for leaving a particular job, including leaving the profession, working abroad, and leaving the particular hospital. These are typical quotations regarding the effect of burnout on a nurse's intention to leave:

'I am burned out. I am tired of nursing; nursing is a very stressful profession.' (Filipino nurse, Hospital A)

'There's too much stress, and I'm not happy anymore.' (Malaysian nurse, Hospital C)

'I am leaving the hospital because of stress. I am exhausted and burned out. I will go to another hospital in Saudi or I may go to Canada.' (Indian nurse, Hospital B)

6.7.7 Managers

Managers were cited by some participants as a reason for leaving their current hospitals and working for another organisation, either in Saudi Arabia or abroad:

> *'My boss controls us, he does not manage us. I am being manipulated and psychologically abused by my boss. Every meeting is a chance for him to treat us badly, depending on his mood. The direction of our department changes with his mood. He tells me very confidential information about my colleagues and how he knowingly manipulates them to get what he wants. I can only assume he is doing the same with the information he has about me. I am simply tired, burned out emotionally and stressed out by his management style. I hate coming to work.' (Canadian nurse, Hospital C)*

> *'My nurse manger is not fair; I do not like her managerial style. I will find a better place.' (Filipino nurse, Hospital B)*

6.7.8 The culture of Saudi Arabia

Some expatriate participants mentioned that the culture of Saudi Arabia was a reason to leave. They said that that they were going to other Gulf countries or to Western countries where they could enjoy better lifestyles. Following are typical concerns about Saudi culture:

> *'There is no recreation after work to relax and de-stress; the culture of this country really cannot be explained.' (South African nurse, Hospital A)*

> *'I want to experience working in an open city with fewer restrictions and have a change in lifestyle. Riyadh is a strict city in terms of religion, culture, norms and the whole way of life.' (Filipino nurse, Hospital C)*

> *'I am planning to go to a more open country such as the United Kingdom, Canada or even to another Middle Eastern country like Qatar or the UAE. In my 14 months here in Saudi, I have realised the*

importance of having a better quality of life, and I believe that the strict norms and regulations here are hindering me from achieving that goal.' (Filipino nurse, Hospital C)

'I am planning to go to the United Arab Emirates or the United States; a change of lifestyle is more important to me than financial gain.' (Malaysian nurse, Hospital C)

'Hopefully I can go to Bahrain, where life as a single female is "normal", and be able to drive and socialise freely.' (British nurse, Hospital C)

6.7.9 Age of retirement

The retirement age was the leading reason for leaving the nursing profession altogether. Below is a typical statement for those intended to leave nursing in order to retired:

'I am leaving the nursing profession because I am almost at the age for retirement.' (Filipino nurse, Hospital B)

Chapter 7: Discussion

7.1 Introduction

The aim of this study was to examine whether nationality had an effect on job satisfaction and 'intention to leave' among nurses in Saudi Arabian government hospitals. In view of the nursing shortage, it was proposed that an examination of these relationships could inform the development of policies to improve the working environment for nurses and support recruitment and retention.

The previous two chapters described in detail both the quantitative and qualitative results of the present study. The purpose of this chapter is to discuss the key findings presented in the light of earlier literature. It will further use the study findings to present recommendations for workforce development and organisation and provide suggestions for future research.

As discussed in chapters 2 and 3, the Saudi Arabian health care system suffers currently from a nursing shortage, as do the systems of many countries in the world. Based on the literature, it is known that job satisfaction is an important concept in nurses' recruitment and retention. A low level of job satisfaction among nurses is considered to be one of the contributing factors that lead to nursing turnover and, therefore, shortages (Cavanagh & Coffin 1992; Blegen 1993; Irvine & Evans 1995; Ball 2004; Hayes et al. 2012). Consequently, it is important to have an understanding of the factors that influence the level of job satisfaction.

In addition, as discussed earlier, there is limited evidence to support the effect of nationality on job satisfaction and 'intention to leave' among nurses in Saudi Arabia, or indeed elsewhere. Certainly, there are distinctive issues related to the nationality of the nursing labour force in Saudi Arabia, which makes nationality a key issue in this context. In particular, the substantial shortage of Saudi nurses in the Saudi Arabian health system has led to a heavy reliance on foreign nurses. This historical dependence on massive numbers of non-Saudi nurses from countries around the globe, and a fragmented approach to their recruitment, has led to inequalities in the remuneration and treatment of nurses. One of the unique aspects of the migration of foreign nurses to Saudi

Arabia is that Saudi Arabia does not offer Saudi nationality or permanent residency to foreign workers. This is completely different from other developed countries, such as the United Kingdom and the United States, and it is likely to have implications for the nurses' perceptions about job security, working conditions and even personal relationships. Therefore, the multicultural nature of the workforce and the impact that this might have on job satisfaction renders an investigation into the role of nationality an important priority for research.

The current study was based on the following objectives:

1. To examine job satisfaction among nurses in Saudi Arabian government hospitals.

2. To examine the relationship between job satisfaction and the intention to leave among nurses in Saudi Arabian government hospitals.

3. To explore whether nationality has an effect on job satisfaction and intention to leave hospitals among nurses in Saudi Arabian government hospitals.

4. To offer recommendations for policy makers and managers, regarding strategies to retain nurses in Saudi Arabia.

Specifically, the study addressed the following research questions

1. What are the levels of job satisfaction and intention to leave among nurses in Saudi Arabian government hospitals?

2. What is the relationship between job satisfaction and intention to leave for nurses in Saudi Arabian government hospitals?

3. Do job satisfaction and intention to leave vary by nationality for nurses in Saudi Arabian hospitals?

4. What are the factors that nurses perceive as important to their job satisfaction and intention to leave? Do these factors vary across nationalities?

7.2 Key findings of the study

7.2.1 Level of job satisfaction and intention to leave

The first research question of this study sought to examine overall job satisfaction and intention to leave among nurses in Saudi Arabian government hospitals. The survey found that the nurses in Saudi Arabia who participated in the study rated themselves as between 'slightly satisfied' and 'somewhat satisfied' in their job. The overall satisfaction mean was 3.24 on a scale of 5, as compared to the overall satisfaction mean results of 3.67 and 3.3 reported by Al-Aameri (2000) and Al-Ahmadi (2002), respectively. These results suggest that overall job satisfaction among the nurses at Saudi Arabian government hospitals remained roughly the same over a period of approximately 10–15 years, given that those two studies and the current study measured job satisfaction using a different scale.

The percentage of nurses at Saudi Arabian government hospitals who were dissatisfied with their jobs (30%) was higher than the dissatisfaction rates found in studies that investigated this in other countries, such as the United States, Switzerland, Sweden, Poland, Norway, the Netherlands, Finland and Belgium (Aiken et al. 2012). However, in this current study, the percentage of nurses that were dissatisfied with their jobs was lower than the percentages found in England, Germany, Greece, Spain, Ireland, South Africa and China (Aiken et al. 2012; Coetzee et al. 2013; You et al. 2013). It is important to note that there are methodological challenges that continue to limit the ability to compare job dissatisfaction rates between countries and systems. In particular, the inconsistency in measures limits the ability to compare findings from different studies. In the studies conducted by Aiken et al. (2012), Coetzee et al. (2013) and You et al. (2013), overall job satisfaction was measured using a single question, which is different from the measurements used in this current study.

In relation to the second research question of this current study, the results further revealed that increasing nurses' overall job satisfaction was associated with a decreased likelihood of intention to leave their jobs. This finding was consistent with other studies that have found job satisfaction to be associated

with nurses' intention to stay at their jobs (Cavanagh & Coffin 1992; Irvine & Evans 1995; Yin & Yang 2002; Hayes et al. 2006; Gurkova et al. 2013).

The percentage of nurses in Saudi Arabian government hospitals intending to leave their hospitals (29.5%) was lower than the percentages found in studies that have investigated this in other countries, such as South Africa, Malaysia, Jordan, Belgium, England, Finland, Germany, Greece, Ireland, Poland, Sweden, and South Africa. However it was higher than the percentages found in the United States, China, the Netherlands, Spain, Switzerland and Norway (Abu Raddaha et al. 2012; Aiken et al. 2012; Coetzee et al. 2013; Ramoo et al. 2013; Zhang et al. 2014). Also, this study's findings suggest that the percentage of nurses who intend to leave the nursing profession is lower than in ten European countries (Belgium, Finland, Germany, Ireland, the Netherlands, Norway, Poland, Spain, Switzerland and the United Kingdom) (Heinen et al. 2013).

The survey data suggest that Saudi Arabian government hospitals are able to retain nurses to a greater degree than some European countries. However, this study does not provide statistical data about the quality of the work environment, working conditions, or staffing levels as in other studies (Aiken et al. 2012; Coetzee et al. 2013; You et al. 2013). Therefore, it is not known whether the quality of the work environment in Saudi Arabian government hospitals is perceived to be better or worse than in other countries that reported higher dissatisfaction. The interview data provides some insight by revealing that there are serious issues related to the quality of the work environment at some Saudi Arabian government hospitals, including staffing levels, absenteeism and a reported lack of discipline. These issues were presented in detail in Section 6.9.9, and this suggests that the lack of professionalism, including a weak work ethic among Saudi nurses, and the lack of discipline for nursing rule-breakers at some Saudi hospitals affected the quality of the work environment and the nurses' job satisfaction. These findings were consistent with other studies that showed that job satisfaction was dynamic and varied according to not only the quality of hospital work environment and staffing levels but also job expectations, style of management, changes to policy, individual characteristics and lifestyle choices (Blegen 1993; Zangaro & Soeken 2007; Aiken et al. 2012; Lu et al. 2012).

7.2.2 Job satisfaction and intention to leave differences by nationality

In relation to the third research question, the findings suggest that there is no statistically significant difference in overall job satisfaction based on nationality. Although no significant difference was found, there are trends in the data showing that the Malaysian and Indian nurses in Saudi Arabian government hospitals had a higher level of overall job satisfaction than the nurses with other nationalities, including Saudi nurses. In a study conducted in Singapore, Goh and Lopez (2016) found that Indian and Malaysian nurses had a higher level of job satisfaction than other migrant nurses. In her study of the nursing workforce in India, Thomas (2006) suggested that the majority of Indian migrant nurses were unhappy due to economic factors and the lack of high societal regard for nursing in India, which prompted them to consider migration. Therefore, Indian nurses may have felt more valued and may have been paid better after migrating to the Kingdom, which resulted in higher job satisfaction.

The percentage of Jordanian, Malaysian and South African nurses who were dissatisfied with their jobs and intending to leave their hospitals was lower than nurses of those same nationalities within their home countries (Abu Raddaha et al. 2012; Coetzee et al. 2013; Ramoo et al. 2013). These results might suggest that the availability of competitive jobs or comparatively better pay and conditions within Saudi Arabian government hospitals fulfilled migrant nurses' initial intentions to migrate (Kingma 2006).

The survey's results confirmed that non-Saudi nurses are twice as likely to report an intention to leave their hospitals compared with Saudi nurses when controlling for overall job satisfaction. This might be because many expatriate nurses are away from their families, or it might be because expatriate nurses have short-term contracts with no possibility of obtaining citizenship, while many Saudi nurses have fixed-term contracts. A moderation analysis suggested that job satisfaction moderates the relationship between nurses' nationality and intentions to leave. The percentage of nurses in the present study intending to leave their hospitals ranged from 10% among Jordanian nurses to 46.7% among British nurses. The regression analysis predicted that expatriate nurses, with the exception of Indian and Jordanian nurses are more likely to leave their jobs in comparison to Saudi nurses when controlling for job

satisfaction. Low intention to leave among Jordanian nurses, when compared to other nationalities, might be due to Jordan's similarities with Saudi Arabia: both are Arabic monarchies that share the same language and culture, and Jordan shares geographic proximity to Saudi Arabia. In a study of the nursing workforce in India, Thomas (2006) argued that the majority of Indian migrant nurses were unhappy due to economic factors and the lack of high societal regard for nursing in India, which prompted them to consider migration. Therefore, Indian nurses may have felt more valued after migrating to Saudi Arabia, which may have resulted in a low leaving intention.

Job satisfaction is considered to be a complex concept illustrated by the multiple variables that have been studied in relation to this phenomenon (Lu et al. 2005). There is no single, simple answer regarding the effects of nationality on job satisfaction and intention to leave among nurses in Saudi Arabian government hospitals. However, the effect of nationality on the nurses' job satisfaction varies across the dimensions of satisfaction. When comparing Saudi Arabian nurses and non-Saudi nurses, the scores on two of the job satisfaction dimensions revealed significant differences between Saudi and non-Saudi nurses, with Saudi nurses being more satisfied than expatriate nurses. These two facets covered satisfaction with extrinsic rewards, and with the balance of family and work lives. In contrast, the mean scores of three of the other job satisfaction subscales revealed significant differences between Saudi and non-Saudi nurses, with Saudi nurses being less satisfied than non-Saudi nurses. The job aspects with which the Saudi nurses were less satisfied included relationships with co-workers, professional opportunities and praise and recognition. The next section expands on these issues by discussing the factors that nurses in Saudi Arabian government hospitals perceived as important to their job satisfaction and intention to leave, and some of these factors vary based on the nurses' nationalities.

7.2.3 Factors affecting job satisfaction and intention to leave among nurses in Saudi Arabian government hospitals

The factors that nurses in Saudi Arabian government hospitals perceived as important to their job satisfaction and intention to leave are discussed in consideration of how some of these factors varied based on the nurses' nationalities.

7.2.3.1 Rewards

Reward is recognised as a key source of nurses' job satisfaction (Blegen 1993; Zangaro & Soeken 2007; Lu et al. 2012; Atefi et al. 2014). In the current study, scores for satisfaction with extrinsic rewards varied based on nationality. The items related to extrinsic rewards included items referring to nurses' salaries, vacations and other benefits (Mueller & McCloskey 1990). The survey results suggest that the levels of satisfaction of Saudi nurses with extrinsic rewards were higher than those of other nationality groups. Indian and Filipino nurses' satisfaction with extrinsic rewards was significantly lower than that of Saudi and Malaysian nurses. There are several factors that might explain why Saudi nurses reported higher satisfaction with extrinsic rewards when compared to non-Saudi nurses. One explanation might be related to Saudi culture: males are responsible for paying the family's necessary living expenses, such as housing accommodation, food, and transportation, which might allow female nurses to save their salaries or use them to purchase extra material goods or accessories, because they may not have the same financial responsibilities when compared to men. Another reason for lower job satisfaction concerning rewards for non-Saudi nurses when compared to Saudi nurses was the lack of security for expatriate nurses because they do not receive a competitive pension in Saudi Arabia, which causes them to leave the Kingdom and retire in another country. In addition, lower satisfaction with extrinsic rewards among Indian and Filipino nurses might be because they receive the lowest monthly salaries on average. The interview data revealed that Indian and Filipino nurses are aware of the pay and work benefits that other national groups receive; thus, they feel relatively worse off, which impacts their level of satisfaction. This study's results were consistent with the relative deprivation theory that emphasises intra-group inequality to understand the motivations and implications of social behaviours (Easterlin 1995).

Promoting rewards' packages for nurses forms an essential step in enhancing nurses' job satisfaction and retention (Abu Raddaha et al. 2012; Al-Dossary et al. 2012; Zhang et al. 2014). Both surveys and interview data of the current study suggest that lower satisfaction with rewards is one of the reasons for nurses to leave their hospitals. In a recent study in China, salaries were a source of dissatisfaction for 76% of the nurses (You et al. 2013). In line with Alonso-Garbayo and Maben (2009), the present study found that the amount of

their salaries in Saudi Arabian government hospitals was competitive compared to their home countries, and the salary was the leading pull factor to work in Saudi Arabian government hospitals. Also, these findings are consistent with Li et al. (2014), who suggested that the higher salary available in another country can improve the financial situation for migrant nurses and their families. However, expatriate nurses at Saudi Arabian government hospitals felt dissatisfied when they realised the disparity of wages based on nationality, despite having the same jobs with the same responsibilities.

In addition, Saudi nurses at some government hospitals thought that their new salary scale was unfair. Freezing of salary increases for Saudi nurses at some government hospitals is one of the temporary consequences of the new salary scale in Saudi Arabian government hospitals. Participants noted that the new scale does not distinguish the salary for new nurses based on the work settings or whether they are working in high quality, accredited hospitals. The new scale was found to demotivate some of the Saudi nurses from seeking promotion to higher positions, as there was no salary increase for those working as head nurses or staff nurses. Therefore, financial considerations seem crucial to the nurses' thinking.

The outcome of this study are consistent with the motivation-hygiene theory, which proposed that salary was one of the primary job dissatisfiers (Herzberg & Mausner 1959). Moreover, the quality of facilities among Saudi Arabian government hospitals is not equal. Some hospitals, such as Hospitals A and C, provide more comfortable accommodation and recreational facilities. The accommodations at Hospital B did not meet the requirements that the participants in this study regarded as important, such as their own single room to sleep in and proper maintenance and recreational activities. The inequality among hospital accommodation affects privacy, quality of home life, social freedom and outdoor activities.

As a further aspect of the differences across nationalities and the relationship between rewards and job satisfaction, the recruitment procedures used to bring non-Saudi nurses to the Kingdom lacks transparency among different recruitment agencies. Reliable data about the recruitment process of expatriate nurses in Saudi Arabian government hospitals is not available to those seeking to migrate. This led to the participants reporting that some agencies mislead

expatriate nurses about their salary and benefits package, with some expatriate nurses receiving lower salaries than they claimed to have been promised in their home countries

7.2.3.2 Scheduling

Scheduling is recognised as a key factor influencing nurses' job satisfaction (Mueller & McCloskey 1990; Aiken & Patrician 2000; Atefi et al. 2014). The survey found that the nurses in Saudi Arabian government hospitals who participated in the study rated their satisfaction with scheduling between 'slightly satisfied' and 'moderately satisfied' with a mean of 3.44 on a scale of 1 to 5. There was no statistically significant difference found in scheduling satisfaction scores according to nationalities. The interview data related to scheduling is that working 12-hour shifts is a common practice in Saudi Arabian government hospitals. All three hospitals assigned 12-hour shifts to nurses, which caused job dissatisfaction. This finding is consistent with previous research that found that nurses working shifts over 10 hours were up to two and a half times are more likely than nurses working shorter shifts to experience burnout and job dissatisfaction and to have the intention to leave the job (Stimpfel et al. 2012). Also, the findings of the current study are in line with Dall'Ora et al. (2015), who found that nurses working shifts of 12 hours or more were more likely than nurses working fewer than 8 hours to experience burnout, job dissatisfaction, and pose safety risks to patients and themselves.

The interview data revealed that the type of shift worked is an important aspect of the nurses' satisfaction with scheduling. Saudi nurses dominated the dialogue on the issue of night and weekend shifts. Some Saudi nurses reported that night duties limited their ability to look after their spouses and children. Such results are congruent with the observations of El-Gilany and Al-Wehady (2001), who noted that female Saudi nurses who were allocated to only day shifts had increased levels of job satisfaction. In addition, the findings of the current study were consistent with Tumulty (2001), who noted that Saudi female nurses and their families often demanded that they be scheduled to work only mornings and early afternoons. Moreover, the current study revealed that night duty was one of the main factors that influenced Saudi nurses to leave their hospitals and work in primary health centres where the only shifts available were morning shifts. This finding suggests that, over a period of

approximately 15 years, hospitals failed to resolve the pejorative response among Saudi nurses of working unfavourable shifts, such as night or weekend duties.

7.2.3.3 Family and work balance

The balance of family and work life was an important factor for nurses' job satisfaction and turnover (Hayes et al. 2012; Lu et al. 2012; Alonazi & Omar 2013). This study's survey results indicate that the nurses in Saudi Arabian government hospitals who participated in the study were least satisfied with family and work balance in comparison to the other job dimensions. The survey results indicate that nurses in Saudi Arabian government hospitals who participated in the study rated their balance of family and work between 'slightly dissatisfied' and 'moderately dissatisfied' with a mean of 2.57 on a scale of 1 to 5. The survey results suggests that the levels of satisfaction of Saudi nurses with family and work balance was higher than those of non-Saudi nurses. This may be because Saudi nurses live in their home country, while other nationalities do not. Being away from family and friends was a critical factor in expatriate nurses' job satisfaction, which corresponded with Li et al. (2014), who noted that it is difficult to live in an unfamiliar place without the support of family. As a result, migrant nurses suffer from isolation, loneliness, lack of support and frustration (Choudhry 2001; Li et al. 2014)

In this study, being away from family is influenced by several factors. There are difficulties in finding employment for their spouses in Saudi Arabia. In addition, the difficulty in moving nurses' spouses and children to Saudi Arabia is often attributed to their 'single' contract status. In this status, a nurse's family is not given any benefits, such as health care, airline tickets and accommodation. Therefore, some expatriate nurses leave Saudi Arabia in favour of countries where their families can join them. These findings are in line with Ball (2004) and Alonso-Garbayo and Maben (2009), who considered Saudi Arabia to be a stepping stone country for expatriate nurses who eventually migrate to developed countries.

7.2.3.4 Co-workers and interaction

The survey results suggest that the levels of satisfaction of Saudi nurses with co-workers and interaction were lower than those of non-Saudi nurses. A range

of causes might contribute to such findings. First, poor English among many Saudi nurses might affect their ability to establish better relationships with their non-Saudi co-workers, although English is the field language in the clinical setting in Saudi Arabia. Aboul-Enein (2002) suggested that different language and cultural background perhaps negatively affect communication and interaction with others. Second, nurses' higher satisfaction with interaction among non-Saudi nurses might be because they live together on the same compound, and sometimes live in the same apartments, which allows them to interact more with their co-workers.

The interview data also revealed that there is a poor relationship between nurses and some physicians in Saudi Arabian government hospitals. The doctors' attitudes of superiority delayed the nurses' work because some of the participants noted that doctors attempted to use nurses to do their work. The nurse-physician relationship has been similarly identified as an important factor that influences nurses' job satisfaction and intention to leave (Zangaro & Soeken 2007; Aiken et al. 2012; Heinen et al. 2013; Atefi et al. 2014). In the current study, the nurses noted with sadness that physicians were granted an unrealistic superiority over them. This is similar to what nurses experience in Iran, a country that might share the same cultural background as Saudi Arabia (Atefi et al. 2014). The Saudi Arabian health care system seems to be a physician-centred system that does not respect nurses. This finding is consistent with Mufti (2000), who noted that most key positions at the Ministry of Health are occupied by Saudi physicians.

7.2.3.5 Development opportunity

Career development opportunities are considered an important factor that affects nurses' job satisfaction (Aiken et al. 2001; Ramoo et al. 2013; Atefi et al. 2014). The survey results suggest that the nurses in Saudi Arabian government hospitals who participated in this study were somewhat dissatisfied with professional opportunities; they ranked it as being second in terms of least satisfaction in comparison to the other job dimensions. There was a statistically significant difference in satisfaction with professional opportunities scores between Saudi and non-Saudi nurses. The survey results show that Saudi nurses' levels of satisfaction with professional opportunities were lower than those of non-Saudi nurses. These findings are consistent with

the interview data, which revealed that some newly employed Saudi nurses with a diploma degree are missing some key nursing skills, which might be due to a lack of preparation. Some of those nurses are aware of this problem, and they felt frustrated because it holds them back professionally. International studies have suggested that newly qualified nurses are not fully prepared for their jobs at the time of qualification and that even when shown to be competent, they do not have the self-confidence to be autonomous professionals (Kelly & Ahern 2008; Whitehead et al. 2013). Studies have also found a high turnover of newly qualified nurses and a questionable level of pre-registration preparation (Giallonardo et al. 2010; Hickey 2010).

In addition, the outcomes of the interview data show that there are difficulties in continuing education for nursing degrees in Saudi Arabian government hospitals. Many nurses cannot attend symposiums and training workshops, as there are no substitute employees to cover their positions at their hospitals. Increasing the level of nurse education has been advocated for improving nurses' job satisfaction and patient outcomes (Lu et al. 2012; Aiken et al. 2013; You et al. 2013).

7.2.3.6 Praise and recognition

Praise and recognition have been linked to job satisfaction (Mueller & McCloskey 1990; Lu et al. 2012; Aiken et al. 2013). The survey results suggest that the levels of satisfaction with praise and recognition among Saudi nurses were lower than those of non-Saudi nurses. These results indicate that Saudi nurses were dissatisfied because their managers might discipline them for their weak work ethic. In addition, the interview data suggest that some managers in the Saudi Arabian government hospitals were perceived to be unfair in their decisions. According to participants, nepotism existed among some managers in the Saudi Arabian government hospitals. Nepotism is shown toward certain staff members regardless of their ability and performance, and nurses' shift type, staffing rate and off days on the weekends are not fairly distributed. Consistent with the findings of the present study, Atefi et al. (2014) found that favouritism toward staff members by head nurses, regardless of nurses' abilities and performance, was a source of job dissatisfaction in Iran, which might share the same cultural background (Atefi et al. 2014). The clear implication is that nurses' managers should treat their

staff equally and support them fairly. Aiken et al. (2012) found that lack of managerial support was associated with lower quality of nursing care and lower patient satisfaction.

7.2.3.7 Control, responsibility and professionalism

Autonomy and professionalism were identified as factors associated with nurses' job satisfaction (Blegen 1993; Aiken et al. 2001; Zangaro & Soeken 2007; Lu et al. 2012; Aiken et al. 2013). The survey results indicated that nurses in Saudi Arabian government hospitals who participated in the study rated their satisfaction with control and responsibilities as 'slightly satisfied'. The items related to control and responsibilities included factors such as decision making, priorities in the work setting, the amount of responsibility that nurses had, autonomy over working conditions, and participation in decision making (Mueller & McCloskey 1990). Increasing satisfaction with issues over control and the amount of responsibility that nurses had was associated with a decreased likelihood of intention to leave their hospitals, which was similar to results in other studies (Liu et al. 2012a; Gurkova et al. 2013). The interview data revealed that that paperwork and electronic documentation at hospitals with higher accreditation standards was time-consuming and added more responsibilities for nurses. These findings were consistent with previous studies that indicated that nurses felt that too much time was spent on paperwork, leaving nurses without enough time to provide patient care (Atefi et al. 2014).

Additionally, language barriers affected nurses' autonomy in two different ways. First, non-Arab nurses faced difficulties in communicating with patients who could only speak Arabic. Those nurses faced challenges in understanding patients' needs. Such findings were congruent with the results of Kawi and Xu (2009) and Li et al. (2014), both of whom identified language differences as a sources of difficulty for migrant nurses. In addition, some newly employed Saudi nurses noted that they were dissatisfied with their ability to communicate with expatriate nurses in a real-world setting, particularly because their English listening and speaking skills were rudimentary.

Moreover, the interview data highlighted that there was a lack of professionalism and weak work ethic among the Saudi nursing workforce. Weak work ethic was revealed through activities, such as absenteeism among

some Saudi nurses, which affected staffing levels (patient–nurse ratios) and impacted the rest of the nurses. Poor staffing levels have previously been associated with lower nurses' job satisfaction and lower patient safety in other countries (Aiken et al. 2012; Coetzee et al. 2013; You et al. 2013). The interview data suggest that weak work ethic and a lack of professionalism appeared to be more common in hospitals run under the direction of the MOH, such as Hospital B. This factor was most likely due to the lack of autonomy for hospitals' administrators and nursing directors, which prevented them from disciplining nursing rule-breakers. Therefore, the interview data suggest that the quality of the work environment in Saudi Arabian government hospitals was not the same across all hospitals.

7.2.3.8 Type of hospital, demographic and cultural factors

The confusing picture and complexity about the factors affecting nurses' job satisfaction and their intention to leave that was reported in the literature is confirmed in this current study. One of the critical elements that emerged from this study was that the nurses at one of the Saudi Arabian government hospitals were more satisfied than nurses at the other hospitals. The survey results suggest that overall job satisfaction scores at Hospital A were significantly higher than those at Hospital B and Hospital C. Differences across types of hospital have been found in other studies. In South Africa, for example, nurses in public hospitals reported higher job dissatisfaction compared to private hospitals (Coetzee et al. 2013). Coetzee et al. (2013) also found that differences of job satisfaction between private and public hospitals were associated with the quality of the practice work environment at these hospitals. This notion, of the positive effects of the work environment, was further supported by Aiken et al. (2012) and You et al. (2013), both of whom discovered that nurses in hospitals with better quality work environments, including the nurse to patient ratio, had a lower probability of experiencing job dissatisfaction and intention to leave.

The current study did not offer statistical data about the quality of the practice work environment at the three hospitals, though the hospitals' profiles showed variation in environmental factors. For instance, Hospital A and Hospital C operated through the Hospital Operation Programme, while Hospital B was run under the direct operation of the Ministry of Health. As discussed earlier, lack

of autonomy for nursing directors and hospital managers at the hospitals run directly under the supervision of the Ministry of Health might have led to a lack of discipline for nursing rule-breakers (Almalki et al. 2011). In six of the job dimensions, nurses at Hospital A had a higher significant level of satisfaction than the nurses at Hospital C, although both hospitals have the same type of operation and both are JCI accredited. It is unknown whether there were differences in the staffing levels or working conditions between these two hospitals.

In the current study, age and years of experience correlated with overall job satisfaction among the nurses, which is in line with the findings reported in other studies (Blegen 1993; Al-Aameri 2000; Al-Ahmadi 2002). The Saudi nurses that participated in this current study were younger and had fewer years of experience in comparison to the nurses' with other nationalities. Regression analysis predicted that expatriate nurses, with the exception of Malaysian nurses, had lower overall job satisfaction in comparison to Saudi nurses when controlling for type of hospitals, age and years of experience. In a study conducted in Singapore, Goh and Lopez (2016) found that Indian and Malaysian nurses had a higher level of job satisfaction than other migrant nurses.

The interview data showed that cultural characteristics affect the nurses' job satisfaction in Saudi Arabia. As discussed in Section 6.6.1, these factors include gender segregation, dress code, and gender differentiation. The current study has revealed that the Saudi Arabian culture was a reason why some expatriate nurses wanted to leave the Kingdom and went to work abroad. Nurses intended to move to other Gulf countries, such as the United Arab Emirates and Qatar or to Western countries, where they could enjoy a better lifestyle. These finding are in line with the results reported by Alonso-Garbayo and Maben (2009), who found cultural perspective to be the main push factor for foreign nurses from Saudi Arabia who work in the United Kingdom.

7.3 Theoretical and methodological implications

This study examined job satisfaction among nurses of different nationalities who work in Saudi Arabian government hospitals. As discussed above, the findings of this project provide strong support for the idea that job satisfaction is a complex concept, with many factors shaping nurses' overall satisfaction and dissatisfaction with their job. This was revealed in both the quantitative and qualitative aspects of the study with regard to factors such as rewards, scheduling, and work/family balance. The results showed that the mean calculations of overall job satisfaction across a hospital's nursing workforce hide the nuances of how the influences on satisfaction vary when analysed at different levels—for example, when explored by nationality. Significantly, this study revealed the necessity of researching the roles of nationality, organisation, and individual differences when examining job satisfaction and intention to leave. It is, therefore, important to incorporate the theoretical and methodological implications of this study into future research on this topic.

The concept of job satisfaction and its nature as a multidimensional construct are complicated by the impact of nationality on nurses' job satisfaction. This study found statistically significant differences across nationalities in a number of job satisfaction subscales, but these effects were variable. For some subscales, native Saudi nurses were more dissatisfied than migrant nurses, while for other subscales, the opposite was true. The findings show that nationality should be included in job satisfaction studies in countries where there is a migrant workforce. Nationality-based differences may have been present but masked in earlier international studies that examined job satisfaction without taking nationality into account. As seen in this study, nationality may not affect the overall satisfaction level even when it affects nurses' satisfaction level with certain dimensions of their job. It is necessary to understand the differences in satisfaction between indigenous and migrant nurses in order to identify targeted strategies for reducing the intention to leave. Therefore, future research in countries employing a migrant workforce should consider nationality-based differences.

Nationality-based differences in job satisfaction levels could be attributed to nurses' working conditions in the context of cultural and religious differences. Understanding the existence of disparities in nurses' job satisfaction across

nationalities is an important step in developing effective strategies to improve job satisfaction and retain nurses. Even in a country without a migrant workforce, differences in satisfaction may arise due to the ethnicity or culture of heterogeneous, multicultural workers. More research is needed to understand the factors underlying the job satisfaction differences based on nationality and ethnicity; such research can help nursing and hospital managers to develop effective strategies for improving job satisfaction and enhancing the institutional climate to ensure that racial diversity is sustained in the nursing workforce. As the nursing workforce in some countries becomes more diverse due to the global mobility of nurses, the retention of ethnic minorities in the nursing workforce is of vital importance.

Before turning to the limitations and recommendations of this study, it is also pertinent to reflect on the job satisfaction measurement scale used in this study and to assess its value for future research. The McCloskey/Mueller satisfaction scale was selected for this study because it identifies eight subscales for assessing specific areas of satisfaction among nurses. The difference in responses across nationalities with regard to these different subscales shows the importance of using a multidimensional scale. Single-item questions about job satisfaction levels are unlikely to capture nationality- or ethnicity-based differences in these levels. Future research on the role of nationality in job satisfaction in a country with a migrant workforce should, therefore, employ a multidimensional scale such as the McCloskey/Mueller satisfaction scale.

The qualitative part of the study provided rich data on nurses' perceptions and explanations of their satisfaction and dissatisfaction, but the data did not raise any new constructs. This study supports the use of the McCloskey/Mueller satisfaction scale to examine nurses' job satisfaction in Saudi Arabian government hospitals while acknowledging that the scale is even more effective when combined with qualitative data to understand the effect of nationality on nurses' job satisfaction. Consequently, the present study shows that a mixed methods approach would be effective in future studies on similar topics.

7.4 Potential limitations of the study

There are four potential limitations that may impact the study findings. These relate to pragmatic decisions taken in the research process to deal with the real-world environment, and the implications of these limits warrant discussion. The first limitation relates to the approach to sampling the nurses, which utilised non-probability sampling techniques. Using non-probability sampling techniques limits the ability to generalise findings to populations beyond 'nurses in major Saudi Arabian government hospitals'. As discussed in Chapter 4, utilising probability sampling technique in this study was found not to be possible due to hospital policies. Hospital authorities did not offer lists of all nurses, as they do not share human resources lists of employees with external researchers.

The second limitation of the study is related to the McCloskey/Mueller Satisfaction Scale (MMSS) and its reliability. Cronbach's alphas for each of the eight subscales in this study ranged between 0.49 and 0.81, whereas the Cronbach's alpha for the global scale was 0.92. All the satisfaction subscales as well as the global scale, except for family and work balance, indicate good reliability, as the widely accepted minimum standard for internal consistency is 0.70 (Nunnally & Bernstein 1994). Another limitation related to the job satisfaction instrument is that it might not contain all elements related to nurses' satisfaction in the work environment of Saudi Arabian hospitals. As this was a recognised limitation from the start of the study, semi-structured interviews were conducted to obtain the nurses' personal experiences. Analysis of the interview data explored factors which nurses perceive as important for their job satisfaction and which influenced their intention to leave. For instance, qualitative data revealed that cultural characteristics, such as gender differentiation, affected some of the nurses' job satisfaction and their leaving intention.

The third potential limitation of the study is related to inconsistency in the data collection methods, which was due to the research sites' differing policies and facilities. At Hospital A, the authority allowed the researcher to collect the questionnaire data only via use of the Internet, so all nursing staff were emailed. At Hospital B, the questionnaire was handed out across all wards. The use of an online survey is linked to the lack of sampling frames, which might

lead to sample selection bias that is out of the researcher's control and to non-probability samples. However, there is no evidence to suggest that study participants provide different answers when they used an alternative approach.

Finally, this study cannot establish causality about the impact of nationality on nurses' job satisfaction and intention to leave because this is a cross-sectional study. As Neuman (2011) argued, analytical cross-sectional studies can only be used to investigate associations between variables. Therefore, causation might be determined by longitudinal studies.

7.5 Recommendations and conclusions

The nursing shortage is a serious issue affecting the health care system in Saudi Arabia and many other countries; and this shortage has an effect on the quality of health care. Based on the findings of the current study, there is an urgent need to improve the nurses' job satisfaction level in Saudi Arabia, which can reduce the turnover level and, therefore, decrease nursing shortages. The findings of the factors affecting the nurses' job satisfaction suggest areas that could be targeted for improvement. Based on the study's findings, the following sections provide recommendations for nursing education, health policy and practice and future research to ensure enhancement of retention and job satisfaction among nurses in Saudi Arabian government hospitals.

7.5.1 Recommendations for education

This study has revealed that some newly employed Saudi nurses with a diploma degree are missing some key nursing skills, which might be due to a lack of preparation. A programme is needed to improve the skills and knowledge of Saudi nurses. The faculties at the nursing schools in Saudi Arabia need to review their courses and curricula in order to ensure that they contain sufficient practical training to advance Saudi nurses' skills. Recently, the Saudi government instigated a new policy to recruit only nurses who had a bachelor's degree in nursing for new employment in Saudi Arabian government hospitals. However, this study emphasises the importance of collaboration between nursing colleges, hospital administrators, and the Ministry of Health, to ascertain the strengths and weaknesses of Saudi nurses. This collaboration may improve nursing students' skills, which eventually will allow these future

nurses to meet hospitals' needs. Supporting nurses during their transition from being a student to being a nursing professional may reap long-term benefits of reduced job dissatisfaction, and better patient care. To achieve these goals, Whitehead et al. (2013) recommended more support from preceptors for newly qualified nurses, use of a programme of preceptorship, objective assessments of nurses' ability to perform, and peer support to show new nurses that their peers are having similar experiences while adjusting to their new profession.

In addition, as the nursing curriculum is provided in English, extensive English language courses should be established to improve nurses' skills and abilities to communicate with non-Arabic co-workers. Language courses to improve communication could be provided for staff from other countries in order to improve communication between Saudi and non-Saudi nurses. This would assist non-Saudi nurses who cannot understand Arabic and enhance their communication skills with patients. Arabic training should also be offered in the home countries of the expatriate nurses or once they arrive in the Kingdom. The completion of such a course could be a pre-employment requirement for the sake of patient care. Hiring interpreters appears to be an expensive choice to help nurses who come to the Kingdom with no Arabic. Another recommendation for nursing institutions in Saudi Arabia is to provide access to part-time studies, and on-line education and training courses.

7.5.2 Recommendations for policy and practice:

The findings of this study have significant implications for nursing policy and practices. The recommendations regarding policy and practice are related to different aspects: recruitment, hospital operations, work environment, and a reward system. Recruitment could be a healthier experience for expatriate nurses wanting to work in the Kingdom. The Ministry of Health, and other government agencies that provide health care in Saudi Arabia, should ensure that recruitment agencies hiring expatriate nurses are legitimate and transparent businesses. Effective induction programmes seem to be needed at Saudi Arabian hospitals to allow newly employed nurses to clearly understand their job, role and responsibilities. Effective induction might support the nurses' efforts to achieve the expected performance levels.

In addition, the work environment in Saudi Arabian government hospitals could be improved by applying specific recommendations. The findings of the current study provide a basis for managers to balance the nurses' preference for 12-hour shifts with considerations of possible burnout and a dissatisfied workforce. Policymakers and nurse managers should make decisions concerning working hours in order to maintain the nurses' job satisfaction and the quality of the care they provide. Nurses need more support in their relationships with other health care professionals, and clear job descriptions explaining nurses' responsibilities are crucial to reducing conflicts with other health care professionals, especially doctors. The Ministry of Health needs to support nurses in Saudi Arabia to occupy a place next to physicians and as equal partners in promoting quality care for patients. This might be achieved by paying nurses greater respect in order to create a culture of partnership.

Managers need to create a professional work environment where nurses can work as professionals within their scope of practice, which might be achieved by motivating staff nurses to create a recognition programme for the daily work of nurses. Any lack of fairness exhibited by nurse managers towards certain staff members must be investigated by the Ministry of Health. Nursing directors at each hospital need to listen to the difficulties reported by the nursing staff. The Ministry of Health should offer a fair appeal process for nurses when they experience unresolved unfair practice, to ensure a more responsive system of governance.

Furthermore, it appears that some members of Saudi society undervalue female nurses and the nurse's role within the health care system. Zero tolerance policies and procedures can protect nurses from physical and verbal abuse by co-workers, patients, and families. Health leaders must empower female nurses to report any physical or verbal abuse. Managers need to support female nurses by investigating all incidents and instituting measures to reduce the risk of reoccurrence. In addition, the image of the nursing profession and the role of female nurses might be improved by explaining their role to the public. This might be achieved through a positive media campaign to improve the respect that society affords female nurses.

The salaries of non-Saudi nurses in Saudi Arabian government hospitals appear to be competitive when compared to those in their home countries. However,

policymakers and managers should be conscious that some expatriate nurses found that the rewards in Saudi Arabia were not fair. Further investigation by the Ministry of Health is recommended in order to provide good evidence for any required modifications to the reward system to ensure fairness.

Moreover, allowing family members of expatriate nurses to live in Saudi Arabia would increase their job satisfaction and retention. The difficulty in moving expatriate nurses' spouses and children to Saudi Arabia is often attributed to their 'single' contract status. Due to this status, a nurse's family is not provided with any benefits, such as health care, airline tickets, or accommodation. Therefore, some expatriate nurses leave Saudi Arabia to work in other countries where their families can join them. Offering 'married' or 'family' contracts to non-Saudi nurses while working in the Kingdom would encourage these nurses to stay longer. In the context of managing the cost of health services in Saudi Arabia, it is important that policymakers and managers have good evidence on which to base decisions when offering 'married' contracts to expatriate nurses in order to ensure job satisfaction and greater retention. Childcare may encourage female Saudi nurses to work night shifts, while part-time employment could be implemented in Saudi Arabian government hospitals, which would help nurses who have social responsibilities.

Weak work ethic and a lack of professionalism appeared more commonly in hospitals run under the direction of the MOH, such as Hospital B. Hospital Operation Programme (HOP) hospitals seem to have a more prominent culture of praising and disciplining their employees. Therefore, the Ministry of Health should probably accelerate the process of changing the operating systems of its hospitals to the HOP in order to alleviate the adverse effects currently found in the workplace, such as rule-breakers being allowed to keep their jobs.

7.5.3 Recommendations for future research

This study has identified several areas that could be investigated in future research. This is the first study that has examined the effect of nationality on job satisfaction and intention to leave among nurses using mixed methods research, and further studies are required to enhance knowledge regarding the impact of nationality in different work settings and/or in different countries.

As discussed earlier, Saudi Arabian government hospitals are not all the same, as they vary in different aspects such as nationality mixture, operation types and accreditation standards. Therefore, one important area of research would be to measure the quality of the work environment in a wider range of Saudi Arabian government hospitals. Further investigation is needed on behalf of the Ministry of Health to examine the lack of professionalism and the weak work ethic among Saudi nurses.

Moreover, prior studies in several countries have suggested that nurses' dissatisfaction with their jobs and staffing adequacy signal problems related to the quality of patient safety and satisfaction (Aiken et al. 2012; Coetzee et al. 2013; You et al. 2013). However, additional empirical research is needed to determine whether nurses' job satisfaction and their intention to leave jobs are associated with patient safety and satisfaction in Saudi Arabian hospitals.

7.6 Conclusion

This study measured the levels of job satisfaction and intention to leave among nurses in three major government hospitals in Saudi Arabia. It examined how job satisfaction and intention to leave varied across nurses' nationalities. The findings of this study provide strong support for the idea that job satisfaction is a complex concept, with many factors shaping nurses' overall satisfaction and dissatisfaction with their job. This study found statistically significant differences across nationalities in a number of job satisfaction subscales. For some subscales, Saudi nurses were more dissatisfied than migrant nurses, while for other subscales, the opposite was true. As seen in this project, nationality may not affect the overall satisfaction level even when it affects nurses' satisfaction level with certain dimensions of their job. By systematically examining these crucial factors, this study has contributed valuable knowledge that can inform policy and practice to enhance nurses' job satisfaction and the retention of nurses of different nationalities.

This study acknowledged the complex nature of job satisfaction, while clearly recognising the complex interplay within Saudi Arabia's country-specific factors and emphasising the importance of improving nurses' satisfaction within a range of job aspects. For instance, this study recognised the disparity of rewards that existed, based on the individual hospitals and the nationalities

of the nurses. In response, this study suggested that policy makers should provide good evidence for required modifications to the reward system to ensure fairness. When nurses experience favouritism, this study recommended better managerial response and a fair appeals process to ensure a more responsive system of governance for nurses.

It is important that policymakers and managers have good evidence on which to base decisions when offering 'married' contracts to expatriate nurses to ensure job satisfaction and greater retention. Policymakers and nurse managers also should have sufficient evidence when making decisions concerning shift lengths to ensure that nurses' maintain job satisfaction. In particular, management must empower and respect female nurses by implementing zero tolerance policies and procedures to lessen gender discrimination.

This study also recommended further attention to nursing education of Saudi nurses. Specifically, the findings suggested further collaboration between hospitals and universities to enhance nursing students' skills, which eventually may allow future nurses to meet hospitals' increased needs for high-quality nursing staff. In addition, this study recommended further attention and consideration by the Saudi government and the Ministry of Health to address specific faults found among Saudi nurses, including poor work ethic and lack of professionalism.

Moreover, this study has identified several areas that could be investigated in future research. One important area of research would be to measure the quality of the work environment in a wider range of Saudi Arabian government hospitals. This is recommended because the Saudi Arabian government hospitals are not all the same, as they vary in different aspects such as operation types, accreditation standards, and the diversity of nurses' nationalities at each hospital. In addition, further studies are needed to enhance knowledge regarding the impact of nationality in different work settings and/or in different countries. The results show that nationality should be included in job satisfaction studies in countries where there is a migrant workforce. It is important to understand the differences in satisfaction between indigenous and migrant nurses in order to identify targeted strategies for reducing the intention to leave.

This is the first study that has examined the effect of nationality on job satisfaction and intention to leave among nurses using mixed methods research. The findings of this study provided important insights for policy makers and nurses' managers on how to improve nurses' job satisfaction and retention. Improvement of nurses' satisfaction with different features of their job can result in greater retention in Saudi Arabian government hospitals.

Appendix A : Examples of critiquing the literature

Example 1 (Quantitative study): Al-Dossary et al. (2012) Job satisfaction of nurses in a Saudi Arabian university teaching hospital: a cross-sectional study. International Nursing Review 59(3): 424-430

1. Is the rationale for undertaking the research clearly outlined?	Yes, the authors presented a clear rationale for the research, setting it in the context of current issues and knowledge of the topic to date.
2. Is the aim of the research clearly stated?	Yes, the authors clearly stated the aim of the research as measuring nurses' job satisfaction in Saudi Arabia at a university teaching hospital.
3. Are all ethical issues identified and addressed?	The authors identified and addressed all ethical issues. Ethical approval was obtained from the Human Studies Review Board of the University Teaching Hospital, where the research was conducted.
4. Is the design clearly identified and a rationale provided?	Yes, the use of a cross-sectional survey appears appropriate, as suited to the expressed aim (see above).
5. Is there an experimental hypothesis clearly stated and are the key variable identified? In survey research, the researcher may choose to provide a hypothesis, but it is not essential, and alternatively a research	The research had a clear aim.

question or aim may be provided.	
6. Is the population identified?	The population consists of nurses at a university teaching hospital in Saudi Arabia.
7. Is the sample adequately described and reflective of the population?	The authors used a systematic sampling technique, which is appropriate, as it is a probability sampling technique.
8. Is the method of data collection valid and reliable?	Yes, the authors reported the methods of data collection, and they appear valid and reliable. However, the instrument has not been used extensively in similar studies (since it was not designed specifically to measure nurses' job satisfaction).
9. Is the method of data analysis valid and reliable?	Yes; however, the authors did not report the mean for overall job satisfaction. The use of inferential statistics seems appropriate. For example, the authors used a one-way ANOVA (analysis of variance) test to examine any differences in satisfaction levels according to different demographic variables.
10. Are the results presented in a way that is appropriate and clear?	Yes, the results were clear, consistent and easy to interpret.
11. Is the discussion comprehensive?	The discussion was comprehensive and balanced. The authors compared and contrasted the findings with similar studies. They identified the limitations of the study. For instance, they acknowledged that the narrow context of the study, which comprises a single university

	hospital and a modest sample size, limited the generalisation of the results.
12. Is the conclusion comprehensive?	The findings support specific conclusions. Namely, the conclusion of the study presented a need to increase nurses' salaries and bonuses for extra duties. However, this did not account for potential financial considerations.

Example 2 (Qualitative study): Atefi et al. (2014): Factors influencing registered nurses perception of their overall job satisfaction: a qualitative study. International Nursing Review 61(3): 352-360

1. Is the rationale for undertaking the research clearly outlined?	Yes, the authors present a clear rationale for the research, setting it in the context of current issues and knowledge of the topic to date.
2. Is the aim of the research clearly stated?	Yes, the aim of the research is clearly stated as exploring factors related to critical care and medical-surgical nurses' job satisfaction as well as dissatisfaction in Iran.
3. Are all ethical issues identified and addressed?	Yes, ethical approval was obtained from Mashhad University of Medical Science. There were no known risks to the participants. All participants were informed about the aim of the study, and written consent was obtained. Participation was voluntary and participants were informed that they could withdrawal from the study at any time. Participants were informed that their confidentiality and anonymity would be respected in any report and subsequent publication. Confidentiality would continue to be maintained by keeping all records in a secure location.
4. Are the philosophical background and study design identified and the rationale for choice evident?	The study design was based on focus group discussions, which seem appropriate. Conducting individual interviews might contribute to additional findings as the topic is well-known and quite sensitive, and some participants might not disclose data regarding job dissatisfaction in the presence of their colleagues.

5. Are the major concepts identified?	No, this qualitative research was pursued to explore factors that influence the participants' job satisfaction.
6. Is the context of the study outlined?	Yes, the authors provided a description of the context of the study, how the study sites were determined, and how the participants were selected. Participants were selected conveniently.
7. Is the selection of participants described and sampling method identified?	Yes, sample size was determined through saturation. Convenience sampling technique was used. It seems that informants were selected for their relevant knowledge or experience. However, head nurses were excluded, who might have had more knowledge about the issues investigated.
8. Is the method of data collection auditable?	Yes, the authors carefully documented their research process. The use of the recorder to tape all the focus-group interviews, and having the same researcher and note-taker in all the focus groups, helped to ensure auditability.
9. Is the method of data analysis credible and confirmable?	Yes, The data analysis strategy was identified. Transcriptions were given to the participants to ensure the accuracy of the transcriptions and preserve credibility. Braun & Clarke's (2006) six-step framework for analysis provides logical and accurate interpretation of the data. The validity was enriched by checking generated themes with two university lecturers and some of the participants. Two of the researchers were nurses and the third was a social scientist,

	and thus the data analysis was conducted from both nursing and non-nursing perspectives. The authors constantly reflected and debated on the potential biases that they might carry with them due to their backgrounds, in order to improve the credibility of the analysis.
10. Are the results presented in a way that is appropriate and clear?	Yes, the presentation of data was clear, easily interpreted, and consistent.
11. Is the discussion comprehensive?	Yes, the authors compared the findings with that of previous research on the topic, and the discussion was balanced.
12. Is the conclusion comprehensive?	Yes, the authors identified limitations of the study, as well as recommendations for further research. The implications of their findings for practice were discussed.

Example 3 (Systematic review): Lu et al. (2012): Job satisfaction among hospital nurses revisited: a systematic review. International Journal of Nursing Studies 49(8): 1017-1038

1. Was an 'a priori' design provided? Yes, the objectives were to analyse the literature relating to job satisfaction among hospital nurses and its associated factors.	□ Yes □ No □ Can't answer □ Not applicable
2. Was there duplicate study selection and data extraction? Yes.	□ Yes □ No □ Can't answer □ Not applicable
3. Was a comprehensive literature search performed? Yes, a comprehensive literature search was carried out in more than two electronic sources. The report included years and databases used. It includes traditional data bases such as CINAHL, Medline, PsycINFO, and British Nursing Index, and the Applied Social Science Index. Chinese databases were also used to identify further studies.	□ Yes □ No □ Can't answer □ Not applicable
4. Was the status of publication (i.e. grey literature) used as an inclusion criterion? Can't answer. The authors provided only the number of included and excluded papers without listing them.	□ Yes □ No □ Can't answer □ Not applicable
5. Was a list of studies (included and excluded) provided? Cannot answer, authors provided only the number of included and excluded papers without listing them.	□ Yes □ No □ Can't answer □ Not applicable

6. Were the characteristics of the included studies provided? Yes, the characteristics of the included studies were provided.	□ Yes □ No □ Can't answer □ Not applicable
7. Was the scientific quality of the included studies assessed and documented? Yes, the authors used the Strobe guidelines (Altman et al, 2007) to evaluate the studies.	□ Yes □ No □ Can't answer □ Not applicable
8. Was the scientific quality of the included studies used appropriately in formulating conclusions? Yes, assessments of methodological rigor and scientific quality were considered in the analysis and the conclusions of the review.	□ Yes □ No □ Can't answer □ Not applicable
9. Were the methods used to combine the findings of studies appropriate? Yes.	□ Yes □ No □ Can't answer □ Not applicable
10. Was the likelihood of publication bias assessed? No.	□ Yes □ No □ Can't answer □ Not applicable
11. Was the conflict of interest stated? Yes, there was no conflict of interest.	□ Yes □ No □ Can't answer □ Not applicable

What is your overall assessment of the methodological quality of this review?

Acceptable

Appendix B : Hospitals list in Riyadh city

This section was viewed by only the examiners, as this information is confidential and excluded from the final publicly accessible version.

Appendix C : Research Questionnaire

By completing this questionnaire, I am giving my consent to participate in this study.

- I understand my participation is voluntary but, I cannot withdraw from the study once I complete and return the questionnaire
- I understand that information collected about me during my participation in this study will be stored on a password protected computer. All files containing any personal data will be made anonymous.

Version (A OR B OR C)

Please √ one for the following questions:

Part 1: Demographic part:

1. What is your gender?

□ Female

□ Male

2. What is your age? ……..

3. What is your nationality? ……

4. How long have you been in Saudi Arabia? ……

5. What is your religion? ……

6. What is your marital status?

□ Single

□ Married

□ Divorced

□ Widowed

7. What is your parental status?

□ Have no children

□ Have a child or more

Part 2: Professional part:

1. How long have you been working in this hospital? ……

2. How long have you been working as a qualified nurse? ……..

3. What is your highest nursing education?

□ Diploma or associate degree

□ Bachelors

□ Masters or post graduate certificate

□ Doctorate

4. What is your current job position?

□ Lower than senior nurse

□ Senior nurse or higher

5. What is your monthly salary range?

…… Saudi Arabian Riyals

Part 3: McCloskey/Mueller Satisfaction Scale (MMSS) **Copyright 1989**

This section was viewed by only the examiners, as this information is confidential and excluded from the final publicly accessible version.

Part 4: Intention to leave part:

1. Do you have an intention to leave nursing profession during the next 12 months?

□ Yes (If you choose yes, Please state why in the following box)

□ No

2. Do you have an intention to leave your employment in Saudi Arabia in the next 12 months?

□ Yes (If you choose yes, Please state where are you going? and why? in the following box)

□ No

3. Do you have an intention to leave your current nursing job at this hospital in the next 12 months and start a new nursing post in another hospital in Saudi Arabia?

□ Yes (If you choose yes, Please state which hospital are you going and why? in the following box)

□ No

- If you are interested in taking part in an interview to tell the researcher more about your experience, views and opinions regarding job satisfaction among nurses, please tick the box and provide a contact telephone number or e-mail address. The interview is expected to last approximately one hour. Please be aware that these details will be kept confidential.

□ Yes, I would like to take part in an interview

My telephone number is……

My e-mail address is ……

Appendix D : Request form for the MMSS

Name: Husam Almansour
Email address: hba1g12@soton.ac.uk
Address: 6 Vectis Court, Talbot Close, Southampton, UK

Organization: University of Southampton

Address: University of Southampton
SO17 1BJ, United Kingdom

Phone No: +447596138144

Country: United Kingdom

Please briefly describe the proposed purpose of the request:
I'm a PhD student at the University of Southampton, UK. My research topic is: Job satisfaction and intention to leave among nurses in Saudi Arabian government hospitals. I am currently reviewing the instruments regarding job satisfaction among nurses. I might use this instrument in my research

Please send me an electronic copy of the McCloskey/Mueller Satisfaction Scale (MMSS) and permission to use the scale.

Check which type of permission you are requesting:

Type:	**Handling Fee**
-- Student For use in a thesis/dissertation. (Request must be accompanied by a statement from the advisor verifying use.)	$10.00

I will use the MMSS tool only for the purpose indicated above and will not distribute the instrument further without the author's permission.

Signed: HUSAM BRHEEM ALMANSOUR Date: 15/09/2013

Send this completed form to:

Center for Nursing Classification & Clinical Effectiveness
Attn: Sharon Sweeney
College of Nursing 407 CNB
University of Iowa
Iowa City, Iowa 52242
sharon-sweeney@uiowa.edu
319-335-7051

Make checks or money order payable to the College of Nursing, University of Iowa.

Appendix E : Permission to use the MMSS

THE UNIVERSITY OF IOWA
COLLEGE OF NURSING

Permission to use form:

This gives permission to use the McCloskey/Mueller Satisfaction Scale (MMSS) to Husam Brheem Almansour for the purpose as stated in the request dated September 15, 2013.

The instrument may be reproduced in a quantity appropriate for this project.

Signed:

Sue Moorhead

Sue Moorhead, Associate Professor, College of Nursing

Date: September 16, 2013

The University of Iowa
The Center for Nursing Classification & Clinical Effectiveness
College of Nursing 407 CNB

Appendix F : Translation of the interview questions

1) What attracted you to the nursing profession?

ما الذي جذبك إلى مهنة التمريض؟

2) What attracted you to work in this hospital/ Saudi Arabia?

ما الذي جذبك للعمل في هذا المستشفى / المملكة العربية السعودية؟

3) Do you like your job in this hospital?

هل تحب وظيفتك في هذا المستشفى؟

4) What are the factors that affect your job satisfaction?

ما هي العوامل التي تزيد من الرضا الوظيفي الخاص بك؟

5) Have you felt satisfied in your current job? When?

هل شعرت بالارتياح في وظيفتك الحالية؟ متى؟

6) Have you felt dissatisfied in your current job? When?

هل شعرت بعدم الارتياح في وظيفتك الحالية؟ متى؟

7) Does working as a nurse influence your social life?

هل عملك في التمريض له تأثير على حياتك الاجتماعية؟

8) Have you experienced any social or cultural factors that influence your job satisfaction? If yes, what are they?

هل واجهت بعض العوامل الاجتماعية او التقاليد الثقافية اثرت على رضاك الوظيفي الخاص بك؟ إذا كان الجواب نعم، ما هي؟

9) From your point of view, what are the factors that influence turnover in nursing positions in Saudi Arabia?

في اعتقادك: ما هي العوامل التي تؤثر على ترك الوظيفة بين كادر التمريض في المملكة العربية السعودية؟

10) What suggestions do you have for hospital directors and policy makers who wish to retain nurses in Saudi Arabia?

ما هي الاقتراحات لديك للمحافظة على كادر التمريض في المملكة العربية السعودية؟

Appendix G : A copy of the official request for Saudi hospitals

This section was viewed by only the examiners, as this information is confidential and excluded from the final publicly accessible version.

Appendix H : Hospitals Forms

This section was viewed by only the examiners, as this information is confidential and excluded from the final publicly accessible version .

Appendix I : Hospitals Approvals

This section was viewed by only the examiners, as this information is confidential and excluded from the final publicly accessible version.

Appendix J : Research poster

Are you a qualified nurse?

Would you like to participate in our research about job satisfaction among nurses?

Take part in our research study!

This study will involve only completing a questionnaire that should take between 15 and 20 minutes.

Please be assured that all information obtained will be held confidentially and securely, and reported anonymously.

For more information and to participate, contact Husam Almansour

Mobile: +966541222352
Email: hba1g12@soton.ac.uk

Appendix K : Transcription form

UNIVERSITY OF Southampton
School of Health Sciences

Research and Enterprise Services Office
C1/Oct 2015/ v3.0

Researcher: HUSAM ALMANSOUR

Project: PHD

To whom it may concern

Re. Transcription Services for Health Sciences

In connection with your engagement to provide transcription services in relation to [recordings/documents of patient/respondent interviews] which you will make during the course of the Project please hereby undertake and agree to the following:

1. All information of whatsoever nature and in whatsoever medium disclosed by me to you in connection with the Project ("the Information") shall be treated as strictly confidential and shall not, without my prior written consent, be disclosed to any person other than me, save as required by law.

2. The phrase "Information" shall not include any of the following:-

   (a) information lawfully in your possession prior to its disclosure by me to you;
   (b) information in the public domain prior to its disclosure by me to you;
   (c) information which comes into the public domain after its disclosure by me to you (other than by reason of action by you);
   (d) Information which is also disclosed to you by a third party who is not legally precluded from disclosing the same to you.

3. None of the Information shall be used by you for any purpose other than in connection with the provision of transcription services for the Project.

   You shall not take or make copies of any of the Information or authorise any other person to do so.

4. You shall keep the Information safe, secure and free from harm and shall deliver up the Information to me on demand and/or on completion by you of the transcription services.

5. The ownership of and copyright in all reports, documents and/or data in whatsoever medium prepared by you using the Information shall belong to me and may not be reproduced or disclosed in any way without prior written consent.

6. If the transcriber is working from home, all recordings/documents must be locked away at the transcriber's house. Transcribers should have adequate levels of electronic security and must securely shred/dispose of any electronic information at the end of the transcription project.

HPB

UNIVERSITY OF Southampton
School of Health Sciences

7. If these terms are acceptable to you I would be obliged if you could sign and date a copy of this letter and return it to me at the address below:

Margaret Bush
Research and Enterprise Support Office
Health Sciences
Building 67
University of Southampton
Highfield
Southampton
SO17 1BJ

I, **Diana Gillen-Buchert** agree to accept the above the terms and conditions.

SIGNATURE [signature] DATE 1 October 2015

Address: 5 Gilbury Close
Southampton
SO18 2RF

Contact details: 0790 563 5716

Appendix L : Participant information sheet for questionnaire

Study Title: Job satisfaction and "intention to leave" among nurses in Saudi Arabian government hospitals.

Reference No.: 10413

My name is Husam Almansour, I am a Saudi PhD student at the Faculty of Health Sciences, University of Southampton. I am carrying out this research as part of my PhD.

Please read this information carefully before deciding to take part in this research. If you are willing to participate, please complete the accompanying questionnaire.

What is the research about?

Job satisfaction is an essential issue to any healthcare organisation as it is considered an indicator of the physical and psychological states of its employees. This research will examine the effects of nationality on job satisfaction and intention to leave among nurses in Saudi Arabian government hospitals. Examining these relationships will inform the development of policies designed to create a healthy working environment so contributing to developing measures to recruit and preserve nurses in the crisis of nurse shortages. In order to provide real sense of job satisfaction and intention to leave, I would like you to answer the questions within a questionnaire as honestly as possible.

Why have I been chosen?

You have been chosen because you are a qualified nurse employed in a major government hospital in Saudi Arabia.

What will happen to me if I take part?

Your participation is voluntary. If you do decide to take part, it will take you 15-20 minutes to complete a questionnaire. The questionnaire involved in this study is McCloskey/Mueller Satisfaction Scale (MMSS), and intention to leave.

Demographic and professional variables are included in this questionnaire. If you would like to participate in this study, please complete the questionnaire and leave it in the secure box. If you would like to complete the questionnaire on-line, you can visit the following website:
https://www.isurvey.soton.ac.uk/10987

Password is: zbdu4m

Are there any benefits in my taking part?

There are no direct benefits for you taking part in this study. However, the findings of this research will inform the development of policies designed to create a healthy working environment. The research findings intend to improve the work environment in the Saudi hospitals and manage any associated factors to job dissatisfaction and turnover intentions among nurses.

Are there any risks involved?

The questionnaire that will be used in this study is simple and short. No risks are involved in taking part. However, you cannot withdraw from the study once you complete and return the questionnaire.

Will my participation be confidential?

You will not be required to put your name or any other personal identifying details on the questionnaire. All the data collected will be kept strictly confidential according to the Data Protection Act/University policy. Your personal details will be kept strictly confidential on a password-protected computer that can only be accessed by the researcher.

What happens if I change my mind?

Your participation is voluntary, however, you cannot withdraw from the study once you complete the questionnaire.

What happens if something goes wrong?

If you have a concern or a complaint about this study you can contact Dr Martina Prude, Head of Research & Enterprise Services, at the Faculty of Health Sciences at the University of Southampton in UK.

(Address: University of Southampton, Building 67, Highfield, Southampton, SO17 1BJ; Tel: +44 (0)2380 595058, Email: mad@soton.ac.uk

Where can I get more information?

If you have any concerns about this study, please do not hesitate to contact the researcher and his supervisors.

1. Husam Almansour, PhD student, School of Health Sciences, University of Southampton. Mobile: +966541222352; +447596138144, Email: hba1g12@soton.ac.uk

2. Dr. Mary Gobbi, Senior Lecturer in Nursing and Erasmus Co-ordinator Faculty of Health Sciences, University of Southampton, Email: M.O.Gobbi@soton.ac.uk

3. Dr. Jane Prichard, Senior Lecturer, Faculty of Health Sciences, University of Southampton, Email: J.S.Prichard@soton.ac.uk

Appendix M: Participant information sheet for interview

Study Title: Job satisfaction and "intention to leave" among nurses in Saudi Arabian government hospitals.

Reference No.: 10413

My name is Husam Almansour, I am a Saudi PhD student at the Faculty of Health Sciences, University of Southampton. I am carrying out this research as part of my PhD.

Please read this information carefully before deciding to take part in this research.

What is the research about?

Job satisfaction is an essential issue to any healthcare organisation as it is considered an indicator of the physical and psychological states of its employees. This research will examine the impact of nationality on job satisfaction and intention to leave among nurses in Saudi Arabian government hospitals. Examining this relationship will inform the development of policies designed to create a healthy working environment so contributing to developing measures to recruit and preserve nurses in the crisis of nurse shortages. I would like you to take part in an interview that will ask you questions about your experience, opinions and views of job satisfaction and turnover intention among nurses. Please answer the questions in the interview as honestly as possible in order to provide real sense of the issue of job dissatisfaction among nurses and their turnover intention.

Why have I been chosen?

You have been chosen because you are a qualified nurse employed in a major government hospital in Saudi Arabia, and because you have completed the questionnaire and wish to take part in the interview.

What will happen to me if I take part?

Your participation is voluntary. If you do decide to take part, you will be involved in approximately one hour phone or face to face interview. Face to face interview will take place in a private room with the researcher located within hospital. The interview will include a few brief questions and will be recorded using a recording device.

Are there any benefits in my taking part?

There are no direct benefits for you taking part in this study. However, the findings of this research will inform the development of policies designed to create a healthy working environment. The research findings intend to improve the work environment in the Saudi hospitals and manage any associated factors to job dissatisfaction and turnover intentions among nurses.

Are there any risks involved?

The interview will take place at a time that is convenient for you and the interview is anticipated to last approximately one hour. No risks are involved in taking part and you can withdraw at any time.

Will my participation be confidential?

All the data collected will be kept strictly confidential according to the Data Protection Act/University policy. All voice recordings will be kept strictly confidential, as transcripts will be assigned an identity code, which will be used throughout the study. Data will be analysed and kept in a password-protected computer that can only be accessed by the researcher. The researcher will report information anonymously for both participants and organisations.

What happens if I change my mind?

You have the right to withdraw from this study at any time.

What happens if something goes wrong?

If you have a concern or a complaint about this study you can contact Dr Martina Prude, Head of Research & Enterprise Services, at the Faculty of Health Sciences at the University of Southampton in UK.

(Address: University of Southampton, Building 67, Highfield, Southampton, SO17 1BJ; Tel: +44 (0)2380 595058, Email: mad@soton.ac.uk

Where can I get more information?

If you have any concerns about this study, please do not hesitate to contact the researcher and his supervisors.

1. Husam Almansour, PhD student, Faculty of Health Sciences, University of Southampton. Mobile: +966541222352; +447596138144, Email: hba1g12@soton.ac.uk

2. Dr. Mary Gobbi, Senior Lecturer in Nursing and Erasmus Co-ordinator, Faculty of Health Sciences, University of Southampton, Email: M.O.Gobbi@soton.ac.uk

3. Dr. Jane Prichard, Senior Lecturer, Faculty of Health Sciences, University of Southampton, Email: J.S.Prichard@soton.ac.uk

Appendix N : Participant consent form for interview

Participant Consent Form for Interview

Study title: Job satisfaction and "intention to leave" among nurses in Saudi Arabian government hospitals.

Researcher name: Husam Almansour
Study reference:
Ethics reference:

Please initial the box(es) if you agree with the statement(s):

I have read and understood the participant information sheet and have had the opportunity to ask questions about the study.	☐
I agree to take part in this research project and agree for my data to be used for the purpose of this study	☐
I understand my participation is voluntary and I may withdraw at any time without my legal rights being affected	☐
I have been informed and understand that my voice is being recorded throughout the interview	☐
I understand that the details that I disclose in the interview may be anonymously quoted both in this publication and potentially in reference to this publication in later work.	☐

Data Protection
I understand that information collected about me during my participation in this study will be stored on a password protected computer and that this information will only be used for the purpose of this study. All files containing any personal data will be made anonymous.

Name of participant (print name).....

Signature of participant.....

Date.....

Appendix O : Research risk assessment form

Health Sciences

UNIVERSITY OF Southampton

Research Risk Assessment Form

IMPORTANT
If you have any queries please contact the Faculty Health and Safety officer, Peter Fisk at P.Fisk@soton.ac.uk

Please read the following before completing this form

i. If this is a student project this risk assessment needs to be completed by the student (applicant) and supervisor (reviewer).
ii. If this is a staff project this risk assessment needs to be completed by the Principal Investigator (applicant) and reviewed by the head of the actual research programme/area/unit relevant to the proposal.
iii. If this is a staff project and the risk assessment is completed by a Research Assistant/Fellow, then it needs to be checked by the Principal Investigator and reviewed by the head of the actual research programme/area/unit relevant to the proposal. If the Principal Investigator is head of the actual research programme/area/unit relevant to the proposal, then the Director of Research needs to be the reviewer.
iv. If the Principal Investigator completes the risk assessment and the applicant is the head of the actual research programme/area/unit relevant to the proposal then it needs to be reviewed by the Director of Research (reviewer).
v. If you are an international student undertaking your research fieldwork entirely within your own country this risk assessment needs to be completed by you (applicant) and supervisor (reviewer)

Once complete, the risk assessment form should be uploaded via the University Ethics system ERGO at www.ergo.soton.ac.uk

Applicant Name:	Husam Almansour				
Project Title:	Job satisfaction and "intention to leave" among nurses in Saudi Arabian government hospitals				
Type of project: (Please tick or insert X)	**Staff**		**Student**	X	
Supervisor's Name: *(if relevant – see point i above)*	Dr. Mary Gobbi, Dr. Jane Prichard,				
Principal Investigator's Name: *(if relevant- see point iii above)*					
Who will this risk assessment/research involve: *(please provide a brief description of your proposed sample and/or research site)*	Nurses in different Saudi Arabian government hospitals				
Where appropriate list the individuals doing the work	Husam Almansour				
Does the work/research involve lone working: *(for example working outside of office hours in your office or a lab-based environment) or conducting interviews with subject in their own homes in which case please*	**Yes**		**No**	X	

complete Forms RA2, RA3 and RA4 as necessary with this assessment.					

Health & Safety Risk Assessment

Work task / activity	Data collection through questionnaires and semi-structure interviews at Saudi Arabian government hospitals				
Assessor	Husam Almansour	**Responsible Manager**	Supervisors as above	**Date**	03/01/2014
Faculty	Faculty of Health Sciences	**Academic Unit/Team**	Supervisors as above	**Location**	Saudi Arabian government hospitals
Brief description of task / activity	The data collection procedure will take place in the Saudi Arabian government hospitals				

Reasonably Foreseeable Hazards	Inherent risk	X	Controls	Residual risk	X
The questionnaire will take 15- 20 minutes to complete and the researcher will be available to answer any of the participants questions	Low	X	Training received in conducting questionnaires and interviews	Low	X
	Med			Med	
	High			High	
None of the questionnaire questions are likely to produce distress, but the researcher will be available to clarify any points should the process or content be found confusing	Low	X	As above	Low	X
	Med			Med	
	High			High	
None of the interview questions are likely to produce distress, but the researcher will clarify any points should the process or content be found confusing	Low	X	Participants will be invited to an accessible well ventilated room with easy chairs to avoid physical discomfort Participants can withdraw or take a break at any point	Low	X
	Med			Med	
	High			High	

Reasonably Foreseeable Hazards	Inherent risk	X	Controls	Residual risk	X
Isolation/displacement of student when data collecting overseas	Low	X	I will be staying with my family in Saudi Arabia	Low	X
	Med			Med	
	High			High	
Prolonged use of computers to review questionnaire data collection/research.	Low	x	Computer workstation to meet the UK Display Screen regulations as a minimum. Student to ensure that they take short frequent breaks away from computer work.	Low	x
	Med			Med	
	High			High	
	Low			Low	
	Med			Med	
	High			High	
	Low			Low	
	Med			Med	
	High			High	
	Low			Low	
	Med			Med	
	High			High	
Declaration by responsible manager: I confirm that this is a suitable & sufficient risk assessment for the above work task / activity.					
Signed			**Print name**	Jane Prichard	**Date** 10/03/2014

Part 2: To be completed by the Reviewer					
Can the risks be further reduced?				Further precautions/additional controls required	Date to be completed
YES		NO			
Reviewer name			Reviewer Signature		Date

Part 3: To be completed by the Applicant (if required)		
3a. Please outline how vou have addressed the reviewers comments: *Please resubmit your study protocol along with this form to the original reviewer*		
Applicant name	**Applicant signature**	**Date**
Husam Almansour		03/01/2014

Part 4: To be completed by the Reviewer (if required)					
4a. Are the precautions now satisfactory?	Yes		No		
Reviewer name	**Reviewer Signature**			**Date**	
Jane Prichard				10/03/2014	
Date reassessment required					

Health & safety risk assessment: A basic guide

(1) **Identify all hazards and reasonably foreseeable worst case consequences.** A 'hazard' is anything with the potential to cause an adverse consequence, such as an injury or illness.

Reasonably foreseeable worst case consequence: 'Worst case' means it is not necessarily the most likely consequence that should be considered, but, 'reasonably foreseeable worst case' means that far-fetched, improbable hazards and consequences need not be considered.

(2) **Estimate inherent risk for each hazard.** 'Inherent' risk is that without any controls applied.

Risk: Is likelihood of hazard event and reasonably foreseeable worst case consequence combined.

In estimating risk, consider factors that could exacerbate risk, such as reasonably foreseeable emergencies, lone work, inexperience, new & expectant mothers, waste disposal, potential effects on others such as contractors or visitors, etc. A separate 'row' for a particular hazard / consequence may be needed to account for these.

Estimate risk using the matrix on the next page, and place an X in the appropriate box.

'High' risks must be reduced before activity / task can commence or continue.
'Medium' risks must be reduced as much and as soon as is reasonably practicable.

(3) **Devise controls for each hazard.** A 'control' is a measure taken to reduce risk.

Controls: As a general principle, the 'hierarchy' of control that is to be applied (from most to least preferable) is: avoid the risk; substitute something less hazardous that gives same or similar outcomes; 'engineering' controls
(i.e., equipment and articles that mitigate or contain a hazard); safe system of work (ie, a prescribed work method); and personal protective equipment ('PPE', eg, gloves, helmet, boots, etc). So, PPE is a last resort.

Other controls that should be considered: training and supervision, planning for possible emergencies, health surveillance, validation and maintenance of any engineering controls, and correct specification of any PPE.

'Low' risks, by definition, do not require controls.

(4) **Estimate residual risk for each hazard.** 'Residual' risk is that with controls applied.

Residual risk is estimated as above, and the objective is for all risks to be low so far as is reasonably practicable.

(5) **The responsible manager, principal investigator, project leader, etc. must sign the Declaration at the end of the risk assessment section and at parts 2 and part 4 as required.**

- Health & safety risk assessments must be 'suitable and sufficient',
  ie, cover all relevant issues and include enough detail.
- It is activities / tasks should be risk assessed, and not, as such, substances (but rather use of substances), or equipment (but rather use of equipment), or locations (but rather activities therein), or people (but rather what they do).
- This template is for 'general' health & safety risk assessment, suitable for most hazards, but certain hazards require additional regulatory and technical detail (e.g., ionising radiations, biological agents, genetic modification, noise, hazardous chemicals, etc.).
- Health & safety risk assessments can be generic, provided they remain 'suitable and sufficient'.
- Health & safety risk assessments need to be reviewed periodically (at least every two years or sooner if inherent risk is high), and also after incidents, after significant changes to the activity / task, if staff raise any concerns, if there is a relevant change to the law or to other relevant standards, or if there is anything to suggest the assessment is not suitable or sufficient.
- You may remove pages 5 and 6 from the final assessment.

Risk estimation matrix

High risk – requires controls to reduce risk before activity / task can commence (or continue).

Medium risk – requires controls to reduce risk as much and as soon as is reasonably practicable.

Low risk – all risk should be reduced to this tolerable level, so far as is reasonably practicable.

Reasonably foreseeable worst case consequence / Likelihood [3] of hazard event	Minor superficial injury; or slight and temporary health effect	Moderate significant injury or illness [1]; or temporary minor disability	Major serious injury or illness [2]; or significant or permanent disability	Critical fatal injury or illness; or substantial and permanent disability	Catastrophic fatal injury or illness for multiple persons
Likely high probability, 1 in 10 chance or higher, once in two weeks or longer for activities on a daily basis	medium risk	high risk	high risk	high risk	high risk
Possible significant probability, 1 in 100 chance or higher, once in six months or longer for activities on a daily basis	low risk	medium risk	high risk	high risk	high risk
Unlikely low probability, 1 in 1,000 chance or higher, once in four years or longer for activities on a daily basis	low risk	low risk	medium risk	high risk	high risk
Rare very low probability, 1 in 10,000 chance or higher, once in a decade or longer for activities on a daily basis	low risk	low risk	low risk	medium risk	high risk
Almost never extremely low probability, less than 1 in 100,000 chance, once in a century or longer for activities on a daily basis	low risk	low risk	low risk	low risk	medium risk

[1] 'Significant injury' could include, for example, laceration, burn, concussion, serious sprain, minor fracture, etc.
'Significant illness' could include, for example, dermatitis, minor work-related musculoskeletal conditions, partial hearing loss, etc.

[2] 'Serious injury' could include fracture or dislocation (other than digits), amputation, loss of sight, penetration or burn to eye, electric shock, asphyxia, or any injury leading to unconsciousness or requiring resuscitation or admittance to hospital for more than twenty-four hours. 'Serious illness' could include, for example, requiring medical treatment after chemical, biological or radiological exposure, severe debilitating musculoskeletal conditions, severe dermatitis, asthma, etc.

[3] For likelihoods in between the listed values, use the higher likelihood to estimate risk. These probability definitions are only a guide.

Appendix P : ERGO application form – Ethics form

UNIVERSITY OF Southampton

ERGO application form – Ethics form

All mandatory fields are marked (M*). Applications without mandatory fields completed are likely to be rejected by reviewers. Other fields are marked "if applicable". Help text is provided, where appropriate, in italics after each question.

1. APPLICANT DETAILS

1.1 (M*) Applicant name:	Husam Almansour
1.2 Supervisor (if applicable):	Dr. Mary Gobbi and Dr. Jane Prichard
1.3 Other researchers/collaborators (if applicable): *Name, address, email, telephone*	n/a

2. STUDY DETAILS

2.1 (M*) Title of study:	Job satisfaction and "intention to leave" among nurses in Saudi Arabian government hospitals
2.2 (M*) Type of study (*e.g. Undergraduate, Doctorate, Masters, Staff*):	Doctorate
2.3 i) (M*) Proposed start date:	01/05/2014
2.3 ii) (M*) Proposed end date:	28/02/2015

2.4 (M*) What are the aims and objectives of this study?

- Aim: The research will examine the effect of nationality on job satisfaction and intention to leave employment among nurses in Saudi Arabian government hospitals. Examining these relationships will inform the development of policies designed to create a healthy working environment, so contributing to developing measures to recruit and retain nurses in the crisis of nurse shortages.
- Objectives:

1. To measure the level of job satisfaction among nurses in Saudi Arabian government hospitals.
2. To examine the relationship between job satisfaction and the intention to leave employment among nurses in Saudi Arabian government hospitals.
3. To explore the effect of nationality on job satisfaction and intention to leave among nurses in Saudi Arabian government hospitals.
4. To offer suggestions to policy makers and managers regarding strategies to retain nurses in Saudi Arabia.

2.5 (M*) Background to study (*a brief rationale for conducting the study*):

Globally, job satisfaction is emphasised as one of the essential reasons for nursing shortages (Newbold 2008). In Saudi Arabia, the relationship between job satisfaction and intention to leave was not investigated in any study. However, there are some cultural issues around the nationality of the nurse workforce and gender beliefs of the population. For instance, the historical reliance on significant

numbers of non-Saudi nurses and how this introduces inequalities in remuneration and treatment. Non-Saudi nurses who work in Saudi Arabia come from several countries that enjoy cooperative and peaceful relationships with Saudi Arabia. Mitchell's (2009) analysis of foreign nurses employed in Saudi Arabia found that contracts and benefit packages differ depending on the standard of living in the nurses' country of origin. Findings revealed that two Western nurses (one American and one South African) would have different salaries in Saudi Arabia. Similarly, Ball (2004) stated that Egyptians, Indians, Pakistanis, and Filipinos work in base level nursing positions in the Saudi Arabian hospitals, whereas North Americans and the British nurses work in senior or administrative positions.

On the other hand, the severe scarcity of Saudi nurses was attributable to a lack of interest among young Saudi Arabians in professional nurse training, combined with cultural and religious barriers that restrict female access to education and employment, particularly in jobs that require contact between males and females (Al-Ahmadi 2002).
Therefore, it is necessary to understand the impact of nationality on job satisfaction and intention to leave among both Saudi and non- Saudi nurses in order to retain and preserve nurses in the crisis of nurse shortages.

2.6 (M*) Key research question (*Specify hypothesis if applicable*):

1.What is the level of job satisfaction among nurses in Saudi Arabian government hospitals?
2.What is the effect of nationality on job satisfaction and intention to leave among nurses in Saudi Arabian government hospitals?
3.What are the cultural factors that influence job satisfaction among nurses in Saudi Arabian government hospital?

2.7 (M*) Study design (*Give a brief outline of basic study design*)
Outline what approach is being used, why certain methods have been chosen.

The research will involve mixed quantitative and qualitative approaches to enhance the validity of the research results. Creswell (2013) stated that the mix of qualitative and quantitative approaches offers more understanding of a research problem than either approach alone.
The research design for this study is convergent parallel mixed methods. In convergent parallel mixed methods design, the researcher collect both forms of data (quantitative and qualitative) at approximately at the same time, and then the quantitative and qualitative data will be analysed separately and then brought together (Creswell 2013). Convergent parallel mixed methods design will be selected because it is an efficient- time design and allows the researcher to collect two types of data in one phase.

1- Questionnaire:
McCloskey/Mueller Satisfaction Scale (MMSS) will be used to measure job satisfaction among nurses. It is a questionnaire that consists of 31 items including eight types of satisfaction: satisfaction with extrinsic rewards, scheduling, family/work balance, co-workers, interaction, professional opportunities, praise/recognition, and control/responsibility. The researcher sent an official request form to have a permission to use MMSS (Appendix 6). Sue Moorhead, College of Nursing, University of Iowa, United States waived the handling fees and provided a written permission to use the MMSS (Appendix 7). MMSS is one of the popular instruments that have been developed specifically to measure job satisfaction amongst nurses (an in-depth description about MMSS, reliability and validity is presented in the method section of the research proposal. In addition to

the items about job satisfaction, the questionnaire will contain other items regarding intention to leave, demographic and professional variables. Nurses will be asked about three types of leaving intention. These types are leaving profession, leaving country and working abroad, and leaving the hospital and working within the country. However, a copy of the questionnaire is presented in appendix 5. In total, questionnaire should take approximately 15– 20 minutes to complete.

The questionnaires will be provided only in English language for two reasons. Firstly, although Arabic is the official language of the country, the educational system in nursing and health sciences, are taught in English. Secondly, AL - Dossary et al. (2012) successfully used only English language surveys to measure nurses' satisfaction in Saudi Arabia confirming its appropriateness with this group. Thus, nurses have reasonable understanding of English to answer surveys questions.

2. Semi–structure interview

Conducting face–to–face and phone interviews will facilitate the gathering of rich and insightful qualitative data regarding job satisfaction and intention to leave among nurses, and would be more conducive to Saudi cultural sensitivities. Specifically, nurses can talk about cultural factors that influence their satisfaction in Saudi hospitals environment, which is difficult to articulate in questionnaires.

The interview will take place in a quiet, private room within each hospital depended on the hospital protocol and the agreement between the researcher and the hospital authority. A semi–structured interview will be used since it offers more flexibility and affords the participants more control over the interview to freely express their own experiences, opinions and views, which are beneficial to the research.

3. SAMPLE AND SETTING

3.1 (M*) How are participants to be *approached*? *Give details of what you will do if recruitment is insufficient. If participants will be accessed through a third party (e.g. children accessed via a school) state if you have permission to contact them and upload any letters of agreement to your submission in ERGO.*

Participants will be approached through several stages. The first stage is to send official requests to both the University of Southampton, and hospital authority to obtain written permissions and ethical approval. The researcher will negotiate with each hospital authority about how to approach the staff. The researcher will follow the protocol of each hospital. Preliminary enquiries in Saudi hospitals indicate that formal agreement cannot be established until ethics and hospital approval is obtained.

Once the agreement and written approval is achieved, collaboration for implementation of the study will be through hospital authority. A convenience sampling technique will be utilised in order to include the most suitable participants that are available to the researcher.

Distribution of a closed envelope containing the participant's information sheet, and questionnaire will be by the hospital authority to all eligible staff. Additionally, the researcher will use an invitation letter and posters to invite interested participants to take part in the study (a copy of the research poster is presented in appendix 4). Once nurses complete the questionnaires, they will all be asked to drop the sealed plain envelope containing the questionnaires into the secure, locked box in the nursing administration or academic affairs department depended on the agreement between the researcher and hospital authority. The

researcher will ensure the box is in a secure place with cooperation and collaboration with hospital authority. Only the researcher and co-investigator/s at each hospital will have an access to the secure box for the questionnaires. Similarly, the researcher will further allow participants to complete their questionnaires by Internet where it is more convenient for them to do so. The on-line questionnaire will be housed in the University of Southampton iSurvey website. iSurvey is a free tool to use for the University of Southampton members. Nurses will have the details of the on-line questionnaire option in participant information sheet. The on-line questionnaire will be available in the following webpage:

https://www.isurvey.soton.ac.uk/10987

Webpage and Password to the questionnaires will be given to participants with participant information sheet. Protecting the on-line questionnaire with password is necessary because the researcher accepted the condition of using MMSS "I will use the MMSS tool only for the purpose indicated above and will not distribute the instrument further without the author's permission".

On the other hand, participants will be approached for a semi-structure interview by including a question at the end of questionnaire, which asks any nurse that are willing to take part in an interview to indicate their willingness by ticking a box and providing contact details. The researcher does not anticipate any difficulties in recruiting a sufficient number of participants for the interview. It is most likely that participants will conduct interviews in their own time. However, the researcher will negotiate with each hospital authority whether participants can conduct interviews in their paid time.

If there are not sufficient numbers of respondents for both questionnaires and interviews, the researcher will send another invitation letter to interested participants three weeks after the initial invitation. Additional visits to the hospital will be made to ensure the sample size is sufficient, which will be convenient to the participants' work schedule.

3.2 (M*) Who are the proposed sample and where are they from (e.g. fellow students, club members)? *List inclusion/exclusion criteria if applicable. NB The University does not condone the use of 'blanket emails' for contacting potential participants (i.e. fellow staff and/or students).*

It is usually advised to ensure groups of students/staff have given prior permission to be contacted in this way, or to use of a third party to pass on these requests. This is because there is a potential to take advantage of the access to 'group emails' and the relationship with colleagues and subordinates; we therefore generally do not support this method of approach.

If this is the only way to access a chosen cohort, a reasonable compromise is to obtain explicit approval from the Faculty Ethics Committee (FEC) and also from a senior member of the Faculty in case of complaint.

The target population for this study is nurses who are employed in major government hospitals in Riyadh city. Only six hospitals are considered major hospitals in Riyadh city based on employing 2000 nurses or higher. The criteria of sampling will be based on the number of Saudi nurses. Hospitals that employ the highest and lowest number of Saudi nurses will be selected in this study.

Inclusion criteria:

- Hospitals with 2000 nurses or more in Riyadh city, Saudi Arabia.
- All licenced nurses who are working in major hospitals with 2000 nurses or more regardless of their age, experience in nursing, and level of education.
- Voluntary participation by subject, both hospitals and nurses.

Exclusion criteria:
- Hospital with less than 2000 nurses.
- Non-licensed nurses (such as nurse aides and patient-care assistants) will be excluded in this study.
- Nursing students including trainees.

- Participants for Questionnaire
It is anticipated that approximately 900 participants will be recruited into the study (300 at each hospital) in order to provide the necessary power to make meaningful comparisons across hospitals. However, in practice this may vary dependent on the nationality mix at each hospital in order to achieve the necessary statistical power to make comparisons across nurse nationality. Provisional figures of nationality mix have been received from the target hospitals however; as participation in the survey will be voluntary, the researcher will need to purposively sample some national groups in order to perform analysis. The researcher does not anticipate high difficulties in recruiting 900 participants (300 at each hospital) since 300 participants represent less than 15% of the total number of nurses at each hospital.

- Participants for semi-structure interview
The researcher will further select 20-24 nurses from those have completed the questionnaire and invite them to a semi-structured interview (an in-depth description regarding the recruitment process is presented in data collection section). In order to provide a data from different groups of nationalities, precise numbers that represent specific group of nationality will be selected to take part in the interview, 10- 12 Saudi nurses, and 10-12 non- Saudi nurses. The researcher intends to recruit different groups of nationalities to represent different cultures (e.g. Pilipino, Indians, Arab, and Western). This will allow the researcher to gain opinions from a variety of disciplines. It is anticipated that a sample size of 20-24 will provide adequate amount of qualitative data to provide useful information.

If there are not sufficient numbers of respondents for both questionnaire and interviews, the researcher will send another invitation letter to interested participants three weeks after the initial invitation. Additional visits to the hospital will be made to ensure the sample size is sufficient, which will be convenient to the participants' work schedule. Moreover, focus group may be carried out if there are some issues need more investigations.

3.3 (M*) Describe the relationship between researcher and sample (*Describe any relationship e.g. teacher, friend, boss, clinician, etc.*)

No relationship between the researcher and participants. So, it is unlikely that participants know the researcher.

3.4 (M*) Describe how you will ensure that fully informed consent is being given: (*include how long participants have to decide whether to take part*)

Participant information sheets for both questionnaire and interviews will include the nature of the study, and will be no detrimental repercussions as a result of their participation (a copy of the participants' information sheet for questionnaire and interview is presented in appendix 10 and 11). Participant information sheet for interview includes that participant have the right to withdraw from the study at any time. However, participant cannot withdraw from the questionnaire part once they complete and return the questionnaire. Contact details will be provided in case questions concerning the study or questionnaires occur. Participants can take participant consent formaway with them to read and complete them at their convenience.

Informed consent will ensure that participants have read and understood the participant information sheet and have had the opportunity to ask questions about the study. Also, it will ensure that participants will take part in this research and have agreed for their data to be used for the purpose of this study. Additionally, it will ensure that participants understand that participation is voluntary and they may withdraw at any time without my legal rights being affected. Participants will be informed that their voices are being recorded throughout the interview (a copy of the consent form for interview are presented in appendix 12.Researcher will ensure that participants have completed their consent form before the interview commence.

However, researcher will ensure that fully informed consent is being given for questionnaire by adding a statement at the beginning of the questionnaire to inform participants that when they complete and return the questionnaire, they are giving their consent to participate in the study. Thus, there is no need for participants to sign a consent form for the questionnaire. However, consent form for questionnaire will be provided if hospital policy require participants to sign consent form.

4. RESEARCH PROCEDURES, INTERVENTIONS AND MEASUREMENTS

4.1 (M*) Give a brief account of the procedure as experienced by the participant
(Make clear who does what, how many times and in what order. Make clear the role of all assistants and collaborators. Make clear total demands made on participants, including time and travel). Upload any copies of questionnaires and interview schedules to your submission in ERGO.

Official requests to both the University of Southampton, and hospital authority to obtain written permissions and ethical approval. The researcher will meet and negotiate with each hospital authority about how to approach the staff. The researcher will follow the protocol of each hospital.
Once the agreement and written approval is achieved, collaboration for implementation of the study will be through each hospital authority. Distribution of a closed envelope containing the participant's information sheet, and questionnaire will be by the hospital authority.

Additionally, the researcher will use an invitation letter and posters to invite interested participants to take part in the study (a copy of the research poster is presented in appendix 4). Also, nurses will collect their questionnaires by secure e-mail when they contact the researcher.
Once nurses complete the questionnaires, they will all be asked to drop the sealed plain envelope with the questionnaires into the secure, locked box in the nursing administration or academic affairs department depended on the agreement between the researcher and hospital authorities.
The researcher will ensure the box is in a secure place with cooperation and collaboration with hospital authority. Only the researcher and co-investigator/s will have an access to the secure box. Similarly, the researcher will further allow participants to complete their questionnaires by Internet where it is more convenient for them to do so. The on-line questionnaire will be housed in the University of Southampton iSurvey website. iSurvey is a free tool to use for the University of Southampton members. Participants will have the details of the on-line questionnire in the participant information sheet.

Completed questionnaires will be filled into a password protected computer. Only the researcher and research supervisors as necessary would have access to the answers. Electronic records will be stored in a password protected external hard drive with and a backup copy on a password protected flash drive.

In addition, the researcher will include a question at the end of the questionnaire, which ask any nurse that are willing to take part in an interview to indicate their willingness by ticking a box and providing contact details. The researcher does not anticipate any difficulties in recruiting a sufficient number of participants for the interviews.

If there are not sufficient numbers of respondents for both questionnaires and interviews, the researcher will send another invitation letter to interested participants three weeks after the initial invitation. Additional visits to the hospital will be made to ensure the sample size is sufficient, which will be convenient to the participants' work schedule.
The researcher will conduct face-to-face and phone interviews to facilitate the gathering of rich and insightful qualitative data regarding job satisfaction and intention to leave among nurses. The interview will take place in a quiet, private room within each hospital depended on the hospital protocol and the agreement between the researcher and the hospital authority.

5. STUDY MANAGEMENT

5.1 (M*) State any potential for psychological or physical discomfort and/or distress?

This study has a low risk of either physical or psychological distress. The researcher will negotiate and agree in advance with hospital authorities about what access to support people during the interviews. The researcher will inform hospital authority immediately when he discover any physical and psychological serious risk to both patients and employees. The researcher will guide participants to appropriate support when it is needed. In addition, voluntary and confidentiality of participants will be mandatory for the research.

5.2 (M*) Explain how you intend to alleviate any psychological or physical discomfort and/or distress that may arise? (if applicable)

This study has a low risk of either physical or psychological distress. The researcher will negotiate and agree in advance with hospital authorities about what access to support people during the interviews. The researcher will inform hospital authority immediately when he discover any physical and psychological serious risk to both patients and employees. The researcher will guide participants to appropriate support when it is needed.

However, the anticipating ethical issues in this study would be confidentiality and voluntary of the participants. To ensure confidentiality in questionnaire, no questions regarding patients or third parties would be asked. Participants will drop their closed envelopes containing the questionnaire in a locked box, which will be in a secure place by the collaboration between the researcher and hospitals authority. Only the researcher and co-investigator/s will have an access to the secure box.

The questionnaires would be filled into a password protected computer. Only the researcher and research supervisors as necessary would have access to the answers. The researcher will further allow participants to complete their questionnaires by Internet where it is more convenient for them to do so. The on-line questionnaire will be housed in the University of Southampton iSurvey website. iSurvey is a free tool to use for the University of Southampton members. Participants will have the details of the on-line questionnire in the participant information sheet. Electronic records will be stored in a password protected external hard drive with and a backup copy on a password protected flash drive.

Also, confidentiality in interview will be assured, as any personal details (such as names/ e-mails addresses/ phone numbers) will be protected and will be kept secure and confidential. The interview data will be kept in a password protected computer, which will be accessed only by the researcher and research supervisors as necessary. The researcher will report the both quantitative and qualitative information anonymously for both participants and organisations.
However, ethical approval from University of Southampton through a structured peer review process will be obligatory. The proposed research and all relevant documentation will be submitted through ERGO to the Faculty Ethics Committee for approval. Upon approval, the research proposal and associated documentation will then be submitted to the Saudi Arabian hospitals for approval by their system.

To ensure voluntary, participant's information sheets for both questionnaire and interviews include the nature of the study, and will be no detrimental repercussions as a result of their participation (a copy of the participants' information sheet for questionnaire and interview is presented in appendix 10 and 11). Participant's information sheet includes that participant have the right to withdraw from the interview at any time. However, participant cannot withdraw from the questionnaire part once you complete and return the questionnaire.

Informed consent will ensure that participants have read and understood the participant's information sheet and have had the opportunity to ask questions about the study. Also, it will ensure that participants will take part in this research project and have agreed for their data to be used for the purpose of this study. . Participants will be informed that their voices are being recorded throughout the interview (a copy of the consent form for the interview is presented in appendix 12).

5.3 Explain how you will care for any participants in 'special groups' *(i.e. those in a dependent relationship, vulnerable or lacking in mental capacity)* **(if applicable)?**

No vulnerbale groups will be recruited.

5.4 Please give details of any payments or incentives being used to recruit participants (if applicable)?

No payments will be involved in this study.

5.5 i) How will participant anonymity and/or data anonymity be maintained (if applicable)?
Two definitions of anonymity exist:
i) Unlinked anonymity - *Complete anonymity can only be promised if questionnaires or other requests for information are not targeted to, or received*

from, individuals using their name or address or any other identifiable characteristics. For example if questionnaires are sent out with no possible identifiers when returned, or if they are picked up by respondents in a public place, then anonymity can be claimed. Research methods using interviews cannot usually claim anonymity – unless using telephone interviews when participants dial in. *ii)* Linked anonymity - *Using this method, complete anonymity cannot be promised because participants can be identified; their data may be coded so that participants are not identified by researchers, but the information provided to participants should indicate that they could be linked to their data.*
1. Unlinked anonymity can be promised in the questionnaire if they choose not to do interview, but linked if they give contact details for interview but then a reassurance about keeping data confidential. 2. Linked anonymity might occur interviews. However, the researcher will report the information anonymously for both participants and hospitals. Additionally, since the study will be conducted in more than one hospital, participants will be unlikely to be identified. Pseudonyms/codes will be used for participants, or identifying hospitals in any data exerts used in dissemination. My supervisors do not need to know full participant name. It is unlikely demographic information in the questionnaire might reveal someone's identity.

5.5 ii) How will participant confidentiality be maintained (if applicable)? *Confidentiality is defined as the non-disclosure of research information except to another authorised person. Confidential information can be shared with those who are already party to it, and may also be disclosed where the person providing the information provides explicit consent.*
Participants' confidentiality will be assured, as any personal details (such as names/ e-mails adresses/ phone numbers) will be held in password protected computer and be made available only to the reseacher and supervisors. .

5.6 (M*) How will personal data and study results be stored securely during and after the study? *Researchers should be aware of, and compliant with, the Data Protection policy of the University. You must be able to demonstrate this in respect of handling, storage and retention of data.*
To ensure confidentiality in questionnaire, no questions regarding patients or third parties will be asked. Participant will drop their closed envelopes containing the questionnaire in a locked box, which will be in a secure place via the collaboration between the researcher and hospitals authority. The questionnaires would be filled into a secure computer. Only the researcher and research supervisors as necessary would have access to the answers. Electronic records will be stored in an external hard drive with and a backup copy on a flash drive. Also, confidentiality in interview will be assured, as any personal details (such as names/ e-mails addresses/ phone numbers) will be protected and will be kept secure and confidential. The interviews data will be kept in a secureThe researcher will report the both quantitative and qualitative information anonymously for both participants and organisations. Pseudonyms/codes will be used for participants, and identifying hospitals in any data exerts used in dissemination.

5.7 (M*) Who will have access to these data?
Only the researcher will have access to personal data of participants.

N.B. – Before you upload this document to your ERGO submission remember to:

1. Complete ALL mandatory sections in this form

2. Upload any letters of agreement referred to in question 3.1 to your ERGO submission

3. Upload any interview schedules and copies of questionnaires referred to in question 4.1

Bibliography

Aboul-Enein FH (2002) Personal contemporary observations of nursing care in Saudi Arabia. *International Journal of Nursing Practice* 8(4): 228-230

Abu Raddaha AH, Alasad J, Albikawi ZF, Batarseh KS, Realat EA, Saleh AA and Froelicher ES (2012) Jordanian nurses' job satisfaction and intention to quit. *Leadership in Health Services (1751-1879)* 25(3): 216

Abualrub RF and Alghamdi MG (2012) The impact of leadership styles on nurses' satisfaction and intention to stay among Saudi nurses. *Journal of Nursing Management* 20(5): 668-678

Adams A and Bond S (2000) Hospital nurses' job satisfaction, individual and organizational characteristics. *Journal of Advanced Nursing* 32(3): 536-543

Aiken LH, Buchan J, Sochalski J, Nichols B and Powell M (2004) Trends in international nurse migration. *Health Affairs* 23(3): 69-77

Aiken LH, Clarke SP, Sloane DM, Sochalski JA, Busse R, Clarke H, Giovannetti P, Hunt J, Rafferty AM and Shamian J (2001) Nurses' reports on hospital care in five countries. *Health Affairs* 20(3): 43-53

Aiken LH and Patrician PA (2000) Measuring organizational traits of hospitals: the Revised Nursing Work Index. *Nursing Research* 49(3): 146-153

Aiken LH, Sermeus W, Van Den Heede K, Sloane DM, Busse R, Mckee M, Bruyneel L, Rafferty AM, Griffiths P and Moreno-Casbas MT (2012) Patient safety, satisfaction, and quality of hospital care: cross sectional surveys of nurses and patients in 12 countries in Europe and the United States. *British Medical Journal* 344: e1717

Aiken LH, Sloane DM, Bruyneel L, Van Den Heede K and Sermeus W (2013) Nurses' reports of working conditions and hospital quality of care in 12 countries in Europe. *International Journal of Nursing Studies* 50(2): 143-153

Ajzen I (1991) The theory of planned behavior. *Organizational Behavior and Human Decision Processes* 50(2): 179-211

Al-Aameri AS (2000) Job satisfaction and organizational commitment for nurses. *Saudi Medical Journal* 21(6): 531-535

Al-Ahmadi HA (2002) Job satisfaction of nurses in Ministry of Health hospitals in Riyadh, Saudi Arabia. *Saudi Medical Journal* 23(6): 645-650

Al-Dossary R, Vail J and Macfarlane F (2012) Job satisfaction of nurses in a Saudi Arabian university teaching hospital: a cross-sectional study. *International Nursing Review* 59(3): 424-430

Al-Omar BA (2004) Knowledge, attitudes and intention of high school students towards the nursing profession in Riyadh city, Saudi Arabia. *Saudi Medical Journal* 25(2): 150-155

Al-Sadan I (2000) Educational assessment in Saudi Arabian schools. *Assessment in Education: Principles, Policy & Practice* 7(1): 143-155

Al-Swailem A (1990) Assessing health care delivery in Saudi Arabia. *Annals of Saudi Medicine* 10(1): 63-69

Al-Yousuf M, Akerele T and Al-Mazrou Y (2002) Organization of the Saudi health system. *Eastern Mediterranean Health Journal* 8(4-5): 645-653

Al Osimy MH (1994) *Nursing in Saudi Arabia.* Jeddah, Saudi Arabia King Fahd Hospital

Al Shaikh A (2001) *An assessment of operating performance in contract managed hospitals versus traditionally managed hospitals: a case study of Ministry of Health hospitals in Saudi Arabia.* Lancaster University

Albejaidi FM (2010) Healthcare system in Saudi Arabia: An analysis of structure, total quality management and future challenges. *Journal of Alternative Perspectives in the Social Sciences* 2(2): 794-818
Aldossary A, While A and Barriball L (2008) Health care and nursing in Saudi Arabia. *International Nursing Review* 55(1): 125-128
Allen P, Bennett K and Heritage B (2014) *SPSS Statistics Version 22: A practical guide.* Melbourne: Cengage Learning
Almalki M, Fitzgerald G and Clark M (2011) Health care system in Saudi Arabia: an overview. *Eastern Mediterranean Health Journal* 17(10): 784-793
Alonazi NA and Omar MA (2013) Factors affecting the retention of nurses. a survival analysis. *Saudi Medical Journal* 34(3): 288-294
Alonso-Garbayo A and Maben J (2009) Internationally recruited nurses from India and the Philippines in the United Kingdom: the decision to emigrate. *Human Resources for Health* 7(37): 1-11
Alsaraireh F, Quinn Griffin MT, Ziehm SR and Fitzpatrick JJ (2014) Job satisfaction and turnover intention among Jordanian nurses in psychiatric units. *International Journal of Mental Health Nursing* 23(5): 460
Aronson J (1994) A pragmatic view of thematic analysis. *The Qualitative Report* 2(1): 1-3
Atefi N, Abdullah K, Wong L and Mazlom R (2014) Factors influencing registered nurses perception of their overall job satisfaction: a qualitative study. *International Nursing Review* 61(3): 352-360
Aveyard H (2014) *Doing a Literature Review in Health and Social Care: a practical guide.* (3rd Edition) Maidenhead, Berkshire, England McGraw-Hill International
Bach S (2010) Managed migration? Nurse recruitment and the consequences of state policy. *Industrial Relations Journal* 41(3): 249-266
Baker SE and Edwards R (2012) *How many qualitative interviews is enough* National Centre for Research Methods Review Paper

Available from http://eprints.ncrm.ac.uk/2273/ [Accessed 06/03/2014]
Ball RE (2004) Divergent development, racialised rights: globalised labour markets and the trade of nurses—The case of the Philippines. *Women's Studies International Forum* 27(2): 119-133
Beecroft PC, Dorey F and Wenten M (2008) Turnover intention in new graduate nurses: a multivariate analysis. *Journal of Advanced Nursing* 62(1): 41-52
Bettany-Saltikov J (2012) *How to do a Systematic Literature Review in Nursing : a step-by-step guide.* Maidenhead: Open University Press
Blegen MA (1993) Nurses' job satisfaction: a meta-analysis of related variables. *Nursing Research* 42(1): 36-41
Boyatzis RE (1998) *Transforming Qualitative Information: thematic analysis and code development.* London: Sage
Boyle DK and Miller PA (2008) Focus on nursing turnover: a system-centered performance measure. *Nursing Management* 39(6): 16-18
Braun V and Clarke V (2006) Using thematic analysis in psychology. *Qualitative Research in Psychology* 3(2): 77-101
Brislin RW (1970) Back-translation for cross-cultural research. *Journal of Cross-cultural Psychology* 1(3): 185-216
Brush BL (2008) Global nurse migration today. *Journal of Nursing Scholarship* 40(1): 20-25
Brush BL and Sochalski J (2007) International nurse migration lessons from the Philippines. *Policy, Politics, and Nursing Practice* 8(1): 37-46

Buchan J, Kingma M and Lorenzo FME (2005) International migration of nurses: trends and policy implications. Geneva: International Council of Nurses

Buchan J and O'may F (1999) Globalisation and healthcare labour markets: a case study from the United Kingdom. *Human Resources for Health Development Journal* 3(3): 199-209

Buchan J and Sochalski J (2004) The migration of nurses: trends and policies. *Bulletin of the World Health Organization* 82(8): 587-594

Caldwell K, Henshaw L and Taylor G (2011) Developing a framework for critiquing health research: an early evaluation. *Nurse Education Today* 31(8): e1-e7

Campbell DT and Fiske DW (1959) Convergent and discriminant validation by the multitrait-multimethod matrix. *Psychological Bulletin* 56(2): 81-105

Caricati L, Sala RL, Marletta G, Pelosi G, Ampollini M, Fabbri A, Ricchi A, Scardino M, Artioli G and Mancini T (2014) Work climate, work values and professional commitment as predictors of job satisfaction in nurses. *Journal of Nursing Management* 22(8): 984-994

Cavanagh S and Coffin D (1992) Staff turnover among hospital nurses. *Journal of Advanced Nursing* 17(11): 1369-1376

Central Department of Statistics & Information (2013) *Facts About Kingdom* Riyadh, Saudi Arabia Central Department of Statistics & Information, Saudi Arabia

Available from http://www.cdsi.gov.sa/english/index.php?option=com_content&view=article&id=56&Itemid=147 [Accessed 21/04/2013]

Choudhry U (2001) Uprooting and resettlement experiences of South Asian immigrant women. *Western Journal of Nursing Research* 23(4): 376-393

Coetzee SK, Klopper HC, Ellis SM and Aiken LH (2013) A tale of two systems-Nurses practice environment, well being, perceived quality of care and patient safety in private and public hospitals in South Africa: a questionnaire survey. *International Journal of Nursing Studies* 50(2): 162-173

Coffey A and Atkinson P (1996) *Making Sense of Qualitative Data: complementary research strategies.* London: Sage

Cohen J (1988) *Statistical Power Aanalysis for the Behavioral Sciences.* (2nd Edition) London: Hillsdale

Cohen L, Manion L and Morrison K (2011) *Research Methods in Education.* (7th Edition) Abingdon, Oxon: Routledge

Collins K, Jones ML, Mcdonnell A, Read S, Jones R and Cameron A (2000) Do new roles contribute to job satisfaction and retention of staff in nursing and professions allied to medicine? *Journal of Nursing Management* 8(1): 3-12

Commission on Filipino Overseas (2012) *Stock estimate of overseas Filipinos* Manilla, Philippines Department of Foreign Affairs, Philippine Overseas Employment Administration, Commission on Filipinos Overseas. Available from http://cfo.gov.ph/images/stories/pdf/2012_Stock_Estimate_of_Filipinos_Overseas.pdf [Accessed 31/01/2015]

Coomber B and Barriball KL (2007) Impact of job satisfaction components on intent to leave and turnover for hospital-based nurses: A review of the research literature. *International Journal of Nursing Studies* 44(2): 297-314

Council of Cooperative Health Insurance (2015) *Council of Cooperative Health Insurance: Rules* Riyadh, Saudi Arabia Council of Cooperative Health Insurance, Saudi Arabia. Available from http://www.cchi.gov.sa/en/Rules/Pages/default.aspx [Accessed 09/01/2015]
Creswell JW (2013a) *Educational Research: planning, conducting, and evaluating quantitative and qualitative research.* (4th Edition) London: Pearson
Creswell JW (2013b) *Research Design: qualitative, quantitative, and mixed methods approaches.* (4th Edition) London: Sage
Creswell JW and Clark VLP (2011) *Designing and Conducting Mixed Methods Research.* (2nd Edition) London: Sage
Cumbey DA and Alexander JW (1998) The relationship of job satisfaction with organizational variables in public health nursing. *Journal of Nursing Administration* 28(5): 39-46
Dall'ora C, Griffiths P, Ball J, Simon M and Aiken LH (2015) Association of 12 h shifts and nurses' job satisfaction, burnout and intention to leave: findings from a cross-sectional study of 12 European countries. *British Medical Journal* 5(9): e008331
Dawis RV and Lofquist LH (1984) *A Psychological Theory of Work Adjustment: an individual-differences model and its applications.* Minneapolis, Minnesota University of Minnesota Press
Dwyer J (2007) What's wrong with the global migration of health care professionals? *Hast Center Rep* 37(5): 36-43
Dywili S, Bonner A and O'brien L (2013) Why do nurses migrate? – a review of recent literature. *Journal of Nursing Management* 21(3): 511-520
Easterlin RA (1995) Will raising the incomes of all increase the happiness of all? *Journal of Economic Behavior & Organization* 27(1): 35-47
El-Gilany A and Al-Wehady A (2001) Job satisfaction of female Saudi nurses. *Eastern Mediterranean Health Journal* 7(1/2): 31-37
El-Jardali F, Alameddine M, Jamal D, Dimassi H, Dumit NY, Mcewen MK, Jaafar M and Murray SF (2013) A national study on nurses' retention in healthcare facilities in underserved areas in Lebanon. *Human Resources for Health* 11(1): 1-13
Esposito N (2001) From meaning to meaning: the influence of translation techniques on non-English focus group research. *Qualitative Health Research* 11(4): 568-579
Evans JR and Mathur A (2005) The value of online surveys. *Internet Research* 15(2): 195-219
Field A (2009) *Discovering statistics using SPSS.* (3rd Edition) London: Sage
Fielding NG (2012) Triangulation and mixed methods designs data integration with new research technologies. *Journal of Mixed Methods Research* 6(2): 124-136
Fielding NGF, Fielding JLNG and Fielding JL (1986) *Linking Data.* Thousand Oaks, CA: Sage
Flinkman M, Leino-Kilpi H and Salantera S (2010) Nurses' intention to leave the profession: integrative review. *Journal of Advanced Nursing* 66(7): 1422-1434
French JR and Kahn RL (1962) A programmatic approach to studying the industrial environment and mental health. *Journal of Social Issues* 18(3): 1-47
Fricker RD and Schonlau M (2002) Advantages and disadvantages of Internet research surveys: Evidence from the literature. *Field Methods* 14(4): 347-367

Fungkam L (1998) Job satisfaction and autonomy of Hong Kong registered nurses. *Journal of Advanced Nursing* 27(2): 355-363
Germack HD, Griffiths P, Sloane DM, Rafferty AM, Ball JE and Aiken LH (2015) Patient satisfaction and non-UK educated nurses: a cross-sectional observational study of English National Health Service Hospitals. *British Medical Journal* 5(12): e009483
Giallonardo LM, Wong CA and Iwasiw CL (2010) Authentic leadership of preceptors: predictor of new graduate nurses' work engagement and job satisfaction. *Journal of Nursing Management* 18(8): 993-1003
Goh YS and Lopez V (2016) Job satisfaction, work environment and intention to leave among migrant nurses working in a publicly funded tertiary hospital. *Journal of Nursing Management* 24(7): 893-901
Green J and Thorogood N (2013) *Qualitative Methods for Health Research.* (3rd Edition) London: Sage
Green SB (1991) How many subjects does it take to do a regression analysis. *Multivariate Behavioral Research* 26(3): 499-510
Guba EG (1990) *The Paradigm Dialog.* Newbury Park, CA: Sage
Gurkova E, Soosova MS, Harokova S, Ziakova K, Serfelova R and Zamboriova M (2013) Job satisfaction and leaving intentions of Slovak and Czech nurses. *International Nursing Review* 60(1): 112-121
Habermann M and Stagge M (2010) Nurse migration: a challenge for the profession and health-care systems. *Journal of Public Health* 18(1): 43-51
Hackman JR and Lawler EE (1971) Employee reactions to job characteristics. *Journal of Applied Psychology* 55(3): 259-286
Hackman JR and Oldham GR (1975) Development of the job diagnostic survey. *Journal of Applied Psychology* 60(2): 159-170
Hamdan A (2005) Women and education in Saudi Arabia: challenges and achievements. *International Education Journal* 6(1): 42-64
Hatcher L and Stepanski EJ (1994) *Step-by-Step Approach to Using the SAS® System for Univariate and Multivariate Statistics.* Cary, NC: SAS Institute
Hayes AF (2012) *PROCESS: A versatile computational tool for observed variable mediation, moderation, and conditional process modeling*. Available from http://afhayes.com/public/process2012.pdf [Accessed 18/09/2017]
Hayes LJ, O'brien-Pallas L, Duffield C, Shamian J, Buchan J, Hughes F, Laschinger HKS and North N (2012) Nurse turnover: a literature review - an update. *International Journal of Nursing Studies* 49(7): 887-905
Hayes LJ, O'brien-Pallas L, Duffield C, Shamian J, Buchan J, Hughes F, Laschinger HKS, North N and Stone PW (2006) Nurse turnover: A literature review. *International Journal of Nursing Studies* 43(2): 237-263
Heinen MM, Van Achterberg T, Schwendimann R, Zander B, Matthews A, Kózka M, Ensio A, Sjetne IS, Casbas TM, Ball J and Schoonhoven L (2013) Nurses' intention to leave their profession: A cross sectional observational study in 10 European countries. *International Journal of Nursing Studies* 50(2): 174-184
Herzberg F and Mausner B (1959) *The Motivation to Work.* (2nd Edition) London: John Wiley & Sons
Hickey MT (2010) Baccalaureate nursing graduates' perceptions of their clinical instructional experiences and preparation for practice. *Journal of Professional Nursing* 26(1): 35-41

Holland JL (1973) *Making Vocational Choices: a theory of careers.* New York: Prentice-Hall
Holland JL (1997) *Making Vocational Choices: a theory of vocational personalities and work environments.* (3rd Edition) Odessa, Florida: Psychological Assessment Resources
Holloway I (1997) *Basic Concepts for Qualitative Research.* London: Wiley-Blackwell
Holloway I and Wheeler S (2009) *Qualitative Research in Nursing and Healthcare.* (3rd Edition) London: John Wiley & Sons
Hunt B (2007) Managing equality and cultural diversity in the health workforce. *Journal of Clinical Nursing* 16(12): 2252-2259
International Council of Nurses (2001) *Position statement on ethical nurse recruitment*. Available from http://www.icn.ch/images/stories/documents/publications/position_statements/C03_Ethical_Nurse_Recruitment.pdf [Accessed 18/12/2016]
Irvine DM and Evans MG (1995) Job satisfaction and turnover among nurses: integrating research findings across studies. *Nursing Research* 44(4): 246-253
Itzhaki M, Ea E, Ehrenfeld M and Fitzpatrick JJ (2013) Job satisfaction among immigrant nurses in Israel and the United States of America. *International Nursing Review* 60(1): 122-128
Jesson J, Matheson L and Lacey FM (2011) *Doing Your Literature Review: traditional and systematic techniques.* London: Sage
Jick TD (1979) Mixing qualitative and quantitative methods: triangulation in action. *Administrative Science Quarterly* 24(4): 602-611
Johnson RB, Onwuegbuzie AJ and Turner LA (2007) Toward a definition of mixed methods research. *Journal of Mixed Methods Research* 1(2): 112-133
Jones PS, Lee JW, Phillips LR, Zhang XE and Jaceldo KB (2001) An adaptation of Brislin's translation model for cross-cultural research. *Nursing Research* 50(5): 300-304
Kawi J and Xu Y (2009) Facilitators and barriers to adjustment of international nurses: an integrative review. *International Nursing Review* 56(2): 174-183
Kelly J and Ahern K (2008) Preparing nurses for practice: a phenomenological study of the new graduate in Australia. *Journal of Clinical Nursing* 18(6): 910-918
Khaliq AA (2012) The Saudi health care system: a view from the minaret. *World Health & Population* 13(3): 52-64
Kingma M (2006) *Nurses on the Move: migration and the global health care economy.* London: Cornell University Press
Kline DS (2003) Push and pull factors in international nurse migration. *Journal of Nursing Scholarship* 35(2): 107-111
Kramer M and Hafner LP (1989) Shared values: Impact on staff nurse job satisfaction and perceived productivity. *Nursing Research* 38(3): 172-177
Krejcie RV and Morgan DW (1970) Determining sample size for research activities. *Educational and Psycholal Measurement* 30: 607-610
Kumar R (2011) *Research Methodology : a step by step guide for beginners.* (3rd Edition) London: Sage
Lake ET (2002) Development of the practice environment scale of the nursing work index. *Research in Nursing & Health* 25(3): 176-188
Lawrenz F and Huffman D (2002) The archipelago approach to mixed method evaluation. *American Journal of Evaluation* 23(3): 331-338

Leech NL and Onwuegbuzie AJ (2009) A typology of mixed methods research designs. *Quality & Quantity* 43(2): 265-275
Leedy PD and Ormrod JE (2005) *Practical Research: planning and design.* (8th Edition) London Pearson
Li H, Nie W and Li J (2014) The benefits and caveats of international nurse migration. *International Journal of Nursing Sciences* 1(3): 314-317
Lincoln YS and Guba EG (1985) *Naturalistic Inquiry.* London: Sage
Liu C, Zhang L, Ye W, Zhu J, Cao J, Lu X and Li F (2012a) Job satisfaction and intention to leave: a questionnaire survey of hospital nurses in Shanghai of China. *Journal of Clinical Nursing* 21(1/2): 255-263
Liu K, You L-M, Chen S-X, Hao Y-T, Zhu X-W, Zhang L-F and Aiken LH (2012b) The relationship between hospital work environment and nurse outcomes in Guangdong, China: a nurse questionnaire survey. *Journal of Clinical Nursing* 21(9/10): 1476
Locke EA, Shaw KN, Saari LM and Latham GP (1981) Goal setting and task performance: 1969–1980. *Psychological Bulletin* 90(1): 125-152
Lorenzo F (2002) Nurse supply and demand in the Philippines. Manila, Philippines: University of the Philippines, Institute of Health Policy and Development Studies
Lorenzo FME, Galvez-Tan J, Icamina K and Javier L (2007) Nurse migration from a source country perspective: Philippine country case study. *Health Services Research* 42(3 Part 2): 1406-1418
Lu H, Barriball KL, Zhang X and While AE (2012) Job satisfaction among hospital nurses revisited: a systematic review. *International Journal of Nursing Studies* 49(8): 1017-1038
Lu H, While AE and Barriball KL (2005) Job satisfaction among nurses: a literature review. *International Journal of Nursing Studies* 42(2): 211-227
Lu K-Y, Lin P-L, Wu C-M, Hsieh Y-L and Chang Y-Y (2002) The relationships among turnover intentions, professional commitment, and job satisfaction of hospital nurses. *Journal of Professional Nursing* 18(4): 214-219
Maneesriwongul W and Dixon JK (2004) Instrument translation process: a methods review. *Journal of Advanced Nursing* 48(2): 175-186
Maslow AH (1954) Motivation and personality. *Psychological Review* 50(4): 370-396
Mattson S (2009) A culturally diverse staff population: challenges and opportunities for nurses. *Journal of Perinatal and Neonatal Nursing* 23(3): 258-262
Mccloskey J (1974) Influence of rewards and incentives on staff nurse turnover rate. *Nursing Research* 23(3): 239-247
Mcelmurry BJ, Solheim K, Kishi R, Coffia MA, Woith W and Janepanish P (2006) Ethical concerns in nurse migration. *Journal of Professional Nursing* 22(4): 226-235
Meeusen VC, Van Dam K, Brown-Mahoney C, Van Zundert AA and Knape HT (2011) Understanding nurse anesthetists' intention to leave their job: how burnout and job satisfaction mediate the impact of personality and workplace characteristics. *Health Care Management Review* 36(2): 155-163
Mejia A, Pizurki H and Royston E (1979) Physician migration and nurse migration: analysis and policy implications. Geneva, Switzerland: World Health Organisation

Merriam SB (2009) *Qualitative Research: a guide to design and implementation.* London: John Wiley & Sons
Miles MB and Huberman AM (1994) *Qualitative Data Analysis: an expanded sourcebook.* (2nd Edition) London: Sage
Miller T, Birch M, Mauthner M and Jessop J (2012) *Ethics in Qualitative Research.* (2nd Edition) London: Sage
Ministry of Health (1996) *Health statistical year book* Riyadh, Saudi Arabia Department of Statistics, Ministry of Health, Kingdom of Saudi Arabia. Available from http://www.moh.gov.sa/Ministry/Statistics/Book/Pages/default.aspx [Accessed 10/01/2014]
Ministry of Health (2011) *Health statistical year book* Riyadh, Saudi Arabia Department of Statistics, Ministry of Health, Kingdom of Saudi Arabia. Available from http://www.moh.gov.sa/Ministry/Statistics/Book/Pages/default.aspx [Accessed 22/04/2013]
Ministry of Health (2014) *Health statistical year book* Riyadh, Saudi Arabia Department of Statistics, Ministry of Health, Kingdom of Saudi Arabia. Available from http://www.moh.gov.sa/en/Ministry/Statistics/book/Documents/Statistical-Book-for-the-Year-1435.pdf [Accessed 20/07/2016]
Ministry of Health (2015) *About the Ministry* Riyadh, Saudi Arabia Ministry of Health, Kingdom of Saudi Arabia. Available from http://www.moh.gov.sa/en/Ministry/About/Pages/default.aspx [Accessed 07/01/2015]
Ministry of Labour (2015) *Unemmployment* Riyadh, Saudi Arabia Ministry of Labour, Saudi Arabia Available from http://portal.mol.gov.sa/ar/News/Pages/%D8%A8%D9%8A%D8%A7%D9%86_%D8%A5%D8%B9%D9%84%D8%A7%D9%85%D9%8A_%D9%85%D8%B4%D8%AA%D8%B1%D9%83.aspx [Accessed 17/02/2015]
Misener TR, Haddock KS, Gleaton JU and Ajamieh ARA (1996) Toward an international measure of job satisfaction. *Nursing Research* 45(2): 87-91
Morgan DL (2014) *Integrating Qualitative and Quantitative Methods: A pragmatic approach.* London: Sage
Mottaz CJ (1985) The relative importance of intrinsic and extrinsic rewards as determinants of work satisfaction. *The Sociological Quarterly* 26(3): 365-385
Mueller CW and Mccloskey JC (1990) Nurses' job satisfaction: a proposed measure. *Nursing Research* 39(2): 113-116
Mufti MH.(2000) *Healthcare Development Strategies in The Kingdom of Saudi Arabia.* New York: Kluwer Academic/Plenum Available from: http://site.ebrary.com/lib/soton/Doc?id=10047019
Murrells T, Robinson S and Griffiths P (2008) Job satisfaction trends during nurses' early career. *BioMed Central Nursing* 7(1): 7
Neuman WL (2011) *Social Research Methods : qualitative and quantitative approaches.* (7th Edition) London Pearson
Newbold D (2008) The production economics of nursing: a discussion paper. *International Journal of Nursing Studies* 45(1): 120-128
Ng SH (1993) A job satisfaction scale for nurses. *New Zealand Journal of Psychology* 22(1): 46-53
Nunnally JC and Bernstein IH (1994) *Psychometric Theory.* (3rd Edition) New York: McGraw-Hill

Omeri A (2006) Workplace practices with mental health implications impacts on recruitment and retention of overseas nurses in the context of nursing shortages. *Contemporary Nurse* 21(1): 50-61
Padarath A, Chamberlain C, Mccoy D, Ntuli A, Rowson M and Loewenson R (2003) Health personnel in Southern Africa: confronting maldistribution and brain drain. *Durban: Health Systems Trust*
Pallant J (2013) *SPSS Survival Manual.* (5th Edition) London: McGraw-Hill Education (UK)
Parahoo K (2014) *Nursing Research: principles, process and issues.* (3rd Edition) Basingstoke: Palgrave Macmillan
Perrin ME, Hagopian A, Sales A and Huang B (2007) Nurse migration and its implications for Philippine hospitals. *International Nursing Review* 54(3): 219-226
Polkinghorne DE (2007) Validity issues in narrative research. *Qualitative Inquiry* 13(4): 471-486
Porter LW and Steers RM (1973) Organizational, work, and personal factors in employee turnover and absenteeism. *Psychological Bulletin* 80(2): 151-176
Price JL (2001) Reflections on the determinants of voluntary turnover. *International Journal of Manpower* 22(7): 600-624
Price JL and Mueller CW (1981) A causal model of turnover for nurses. *Academy of Management Journal* 24(3): 543-565
Price M (2002) Job satisfaction of registered nurses working in an acute hospital. *British Journal of Nursing* 11(4): 275-280
Ramoo V, Abdullah KL and Piaw CY (2013) The relationship between job satisfaction and intention to leave current employment among registered nurses in a teaching hospital. *Journal of Clinical Nursing* 22(21-22): 3141-3152
Regmi K, Naidoo J and Pilkington P (2010) Understanding the processes of translation and transliteration in qualitative research. *International Journal of Qualitative Methods* 9(1): 16-26
Richards L (2014) *Handling Qualitative Data: a practical guide.* (3rd Edition) London: Sage
Sandelowski M (1994) Focus on qualitative methods. Notes on transcription. *Research in Nursing & Health* 17(4): 311-314
Sandelowski M (1995) Sample size in qualitative research. *Research in Nursing & Health* 18(2): 179-183
Schonlau M, Ronald Jr D and Elliott MN (2002) *Conducting Research Surveys via E-mail and the Web.* Santa Monica, California: Rand Corporation
Schwandt TA (1997) *Qualitative Inquiry: a dictionary of terms.* London: Sage
Sermeus W, Aiken LH, Van Den Heede K, Rafferty AM, Griffiths P, Moreno-Casbas MT, Busse R, Lindqvist R, Scott AP, Bruyneel L, Brzostek T, Kinnunen J, Schubert M, Schoonhoven L and Zikos D (2011) Nurse forecasting in Europe (RN4CAST): Rationale, design and methodology. *BMC Nursing* 10(1): 6-14
Silverman D (2013) *Doing Qualitative Research: a practical handbook.* (4th Edition) London: Sage
Smith PC (1969) *The Measurement of Satisfaction in Work and Retirement: a strategy for the study of attitudes.* Chicago: Rand McNally
Smith RD, Chanda R and Tangcharoensathien V (2009) Trade in health-related services. *The Lancet* 373(9663): 593-601

Spector PE (1997) *Job Satisfaction: application, ssessment, causes, and consequences.* London: Sage
Spector PE (2012) *Industrial and Organizational Psychology: research and practice.* (6th Edition) New York: John Wiley & Sons
Stamps PL and Piedmonte EB (1986) *Nurses and Work Satisfaction: an index for measurement.* Chicago, Illinois: Health Administration Press Perspectives
Stilwell B, Diallo K, Zurn P, Dal Poz MR, Adams O and Buchan J (2003) Developing evidence-based ethical policies on the migration of health workers: conceptual and practical challenges. *Human Resources for Health* 1(1): 8-20
Stilwell B, Diallo K, Zurn P, Vujicic M, Adams O and Dal Poz M (2004) Migration of health-care workers from developing countries: strategic approaches to its management. *Bulletin of the World health Organization* 82(8): 595-600
Stimpfel AW, Sloane DM and Aiken LH (2012) The longer the shifts for hospital nurses, the higher the levels of burnout and patient dissatisfaction. *Health Affairs* 31(11): 2501-2509
Tabachnick BG and Fidell LS (2013) *Using Multivariate Statistics.* (6th Edition) London: Pearson
Takase M (2010) A concept analysis of turnover intention: implications for nursing management. *Collegian: Journal of the Royal College of Nursing Australia* 17(1): 3-12
Tashakkori A and Teddlie C (1998) *Mixed Methodology: combining qualitative and quantitative approaches.* Thousand Oaks, California: Sage
Tashakkori A and Teddlie C (2010) *Handbook of Mixed Methods in Social & Behavioral Research.* (2nd Edition) London: Sage
Tesch R (1990) *Qualitative Research: analysis types and software tools.* New York: The Falmer Press
Thomas P (2006) The international migration of Indian nurses. *International Nursing Review* 53(4): 277-283
Trucker G and Zee E (1981) International nursing: the need for a comprehensive orientation program. *The King Faisal Specialist Hospital Medical Journal* 1(1): 69-72
Tumulty G (2001) Professional development of nursing in Saudi Arabia. *Journal of Nursing Scholarship:* 33(3): 285-290
Twinn DS (1998) An analysis of the effectiveness of focus groups as a method of qualitative data collection with Chinese populations in nursing research. *Journal of Advanced Nursing* 28(3): 654-661
United Nation Development Program (2013) *UNDP report Saudi Arabia* Available from http://www.undp.org.sa/sa/ [Accessed 22/04/2013]
United Nations Development Programme (2009) *Arab human development report: challenges to human security in Arab countries* New York United Nations Development Programme,. Available from www.arab-hdr.org/publications/other/ahdr/ahdr2009e.pd [Accessed 07/01/2015]
Us Energy Information Administration (2013) *Independent Statistics and Analysis, Country analysis briefs: Saudi Arabia.* Available from http://www.eia.gov/countries/cab.cfm?fips=SA [Accessed 01/04/2013]
Vaismoradi M, Turunen H and Bondas T (2013) Content analysis and thematic analysis: implications for conducting a qualitative descriptive study. *Nursing & Health Sciences* 15(3): 398-405
Van Nes F, Abma T, Jonsson H and Deeg D (2010) Language differences in qualitative research: is meaning lost in translation? *European Journal of Ageing* 7(4): 313-316

Van Saane N, Sluiter JK, Verbeek J and Frings-Dresen MHW (2003) Reliability and validity of instruments measuring job satisfaction - a systematic review. *Occupational Medicine* 53(3): 191-200

Vroom V, H (1964) *Work and Motivation.* New York: John Wiley & Sons

Weeks A, Swerissen H and Belfrage J (2007) Issues, challenges, and solutions in translating study instruments. *Evaluation Review* 31(2): 153-165

Weiss D, Dawis R, England G and Holquist L (1967) Manual for the Minnesota Satisfaction Questionnaire. Minneapolis, MN: University of Minnesota

Whitehead B, Owen P, Holmes D, Beddingham E, Simmons M, Henshaw L, Barton M and Walker C (2013) Supporting newly qualified nurses in the UK: a systematic literature review. *Nurse Education Today* 33(4): 370-377

World Bank (2013) *Country and Lending Groups*. Available from http://data.worldbank.org/about/country-classifications/country-and-lending-groups [Accessed 22/04/2013]

World Health Organisation (2006a) Working together for health. Geneva: World Health Organisation

World Health Organisation (2006b) World health report. Geneva: World Health Organisation

World Health Organisation (2016) *Health workforce: Density of nursing and midwifery personnel (total number per 1000 population)* Geneva World Health Organisation. Available from http://gamapserver.who.int/gho/interactive_charts/health_workforce/NursingMidwiferyDensity/atlas.html [Accessed 04/12/2016]

Xue Y (2015) Racial and ethnic minority nurses' job satisfaction in the US. *International Journal of Nursing Studies* 52(1): 280-287

Yin J-CT and Yang K-PA (2002) Nursing turnover in Taiwan: a meta-analysis of related factors. *International Journal of Nursing Studies* 39(6): 573-581

Yin RK (2013) *Case Study Research: design and methods.* (5th Edition) London: Sage

You L-M, Aiken LH, Sloane DM, Liu K, He G-P, Hu Y, Jiang X-L, Li X-H, Li X-M and Liu H-P (2013) Hospital nursing, care quality, and patient satisfaction: cross-sectional surveys of nurses and patients in hospitals in China and Europe. *International Journal of Nursing Studies* 50(2): 154-161

Zangaro GA and Soeken KL (2007) A meta-analysis of studies of nurses' job satisfaction. *Research in Nursing & Health* 30(4): 445-458

Zhang L-F, You L-M, Liu K, Zheng J, Fang J-B, Lu M-M, Lv A-L, Ma W-G, Wang J and Wang S-H (2014) The association of Chinese hospital work environment with nurse burnout, job satisfaction, and intention to leave. *Nursing Outlook* 62(2): 128-137