



Original Article

Quality of Life and Self-Efficacy in Health Care Providers of Rural Health Centers in Urmia

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ABSTRACT

Background: Considering the complex conditions of work in rural environment, it is important to evaluate the quality of life and its relation with self-efficacy in health care providers**Methods:** This descriptive-analytical study was performed on 301 health care providers working in rural health centers. The short form of quality of life questionnaire (sf36) and Sherer's general self-efficacy scale was used to evaluate the study variables. Data were analyzed using ANOVA, independent t-test, Pearson correlation coefficient and linear regression.**Results:** The average score of quality of life was 65.42 ± 19.1 . Self-efficacy results showed that the mean self-efficacy score was 64.12 ± 10 . According to multivariate linear regression method, there was significant inverse and independent relationship between quality of life with work duration ($B = -0.45$, P -value = 0.001) and income ($B = -6.07$, P -value = 0.001). There was no meaningful relationship between self-efficacy and quality of life in this study ($B = -0.12$, P -value = 0.33).**Conclusion:** This study showed that work duration and income were important predictors of quality of life.**Keywords:** Quality of life, Self-efficacy, Health care providers, Rural centers**Citation:** Zareipour M, Abdolkarimi M, Moradi Z, Mahbubi M. Quality of Life and Self-Efficacy in Health Care Providers of Rural Health Centers in Urmia. Caspian J Health Res. 2020;5(1):3-7.

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Introduction

Providing health cares in rural areas are of great importance (1). In this regard, primary health care is being implemented to meet the needs of this group. In Iran, about 25 percent of the population lives in rural areas, and Local Health Department are considered as the first referral level of health services. The task of providing services in these centers is the responsibility of health care providers. One of the characteristics of these people is the fact that, despite of their heavy duties, they have shorter training courses than other groups (2). Despite huge advances of health system in promoting health indicators, health services are still facing challenges and necessity of promoting health care, especially in rural areas, seems to be in line with equity in health (3). One of the affecting factors on the quality, efficiency and performance of health systems is the

status and quality of life of the human resources that provide health services (4). In recent years, besides the health status, there is a great emphasis on the individuals' quality of life. Quality of life is a multi-dimensional concept that includes the level of physical and psychosocial health, the level of dependency and social interactions, as well as the personal opinions of individuals (5).

In fact, the quality of life is affected by several variables including income level, living conditions, health status, environment, psychological stress, leisure, family happiness and social relationships (6). Quality of life is a mental concept and is influenced by culture and community norms, as well as intra-organizational relationships and work environment (7). One of the influencing factors on the quality of life is self-efficacy. According to Albert Bandura's social cognitive

theory, self-efficacy refers to the sense of competence and the ability to cope with life, and the individual's assurance of the ability to perform his duties in a particular context. In fact, human beliefs can form the basis of the concept of Self-efficacy (8). Lev et al. have found that self-efficacy training can increase the quality of life of women with cancer (9). Enayati showed that there was a positive and significant relation between self-efficacy and teacher's quality of life (10).

While the results of some studies indicated high occupational stress due to enormous workload and the variety of tasks and conditions of the work environment in this group, there are limited research regarding the quality of life of health care providers, who are working in rural areas (11). The study of Hussein Khani and et al on quality of life on health care providers showed that the group had a moderate quality of life (12). On the other hand, the level of self-efficacy in this group and its relationship with the quality of life of health care providers has not been measured in Iran. Regarding the role of determining the quality of life and its associated factors in planning for improving the health and well-being of staff in Local Health Department, we aimed to evaluate the quality of life and self-efficacy of Health care providers and their relationships.

Methods

This descriptive-analytic study was carried out in health centers in Urmia in the second half of 2018. The inclusion criteria in this study were having a permanent health organizational position of health worker, working in the health center and satisfaction for participation in the study. Exclusion criteria were the lack of cooperation and having physical and psychological illness. Out of 370 health care providers, 301 people were eligible to participate in the study. The voluntary nature of the participants in the study, the confidentiality of the information and the namelessness of the forms were the ethical considerations of the research. Research instrument consist of three parts; data collection form about demographic characteristics of the participants including sex, marital status, education level, work experience, and income level according to viewpoint of participants as low, medium and high, quality of life questionnaire, and general self-efficacy scale. The Sheerer General Efficiency Scale was used to evaluate self-efficacy (13). The scale consists of 17 questions and each question was based on the Likert scale ranging from totally disagree to totally agree levels. This scale has been translated and validated in Iran by Barati et al (14). the validity and reliability of this test was obtained by using internal consistency and Cronbach's alpha of 0.83 (15). In this study, Cronbach's alpha was 0.79 on 30 randomly selected health care providers. Self-efficacy questionnaire has a minimum score of 17 and maximum score of 85. Higher score indicates higher perceived self-efficacy. The short form health related quality of life questionnaire was used to assess quality of life (16). The questionnaire evaluates the quality of life in eight areas including physical functioning, limitation in relation to physical problems, physical pain, general health status, vitality, social function, mental health and its restrictions. The total score on all dimensions ranged from 0 to 100 with higher scores indicating higher quality of life. The reliability and validity of the Persian version of this questionnaire was approved and Cranach's alpha was 0.77 to 0.99 (16).

Kolmogorov-Smirnov test was used to determine the normality of the data. To analyze the data, descriptive and Analytical statistics (T-student, ANOVA) were used to compare variables. Pearson correlation coefficient test was used to examine the relationship between quantitative variables. Data were analyzed using SPSS software, version 18.

Results

The majority of participants (61.05%) were women between the age of 25-30 (27%). The mean score of quality of life of individuals was 65.42 ± 19.1 . In the dimensions of quality of life, the highest score pertained to physical function and the lowest score was for happiness (Table 1).

Table 1. Mean Score of the Dimensions of Quality of Life of Health Care Providers in Urmia

Dimensions of quality of life	Mean	SD*
General health	64.48	18.80
Physical functioning	73.65	26.31
Role physical	63.46	37.76
Role emotional	60.69	40.28
Social functioning	69.39	27.63
Bodily pain	70.13	2.70
Vitality	59.26	18.66
Mental health	62.24	20.32

* SD = Standard Deviation.

The mean score of quality of life according to demographic characteristics of study participants are illustrated in table 2. The mean score of women's quality life was lower than men, but there was no statistically significant difference between men and women. (P-value = 0.40). There was significant relationship between quality of life and work experience in a way that people with more than 15 years of experience had reported lower quality of life (P-value = 0.001). Also, there was significant relationship between education level and quality of life of health care providers and people with higher level of education had higher levels of quality of life (P-value = 0.001). The quality of life in people with low income level was significantly lower than those with moderate and high income level (P-value = 0.04) (Table 2).

Table 2. Scores of Quality of Life of Health Care Providers in Health Centers in Urmia According to Demographic Variables

Variables	Frequency (%)	Mean \pm SD	P-value
Gender			
Male	116 (38.5)	66.75 \pm 19.85	0.40
Female	185 (61.5)	64.57 \pm 18.62	
Age group			
Less than 30	103 (34.2)	63.10 \pm 18.1	0.6
30 to 35 years	73 (24.3)	67.13 \pm 17.9	
35 to 40 years	68 (22.6)	62.16 \pm 17.1	
More than 40	57 (18.9)	61.13 \pm 14.1	
Education			
Under diploma	58 (19.2)	52 \pm 16.5	0.001
Diploma	201 (66.8)	69.17 \pm 17.1	
Bachelor	42 (14)	66.14 \pm 18.75	
Income			
Good	30 (10)	71.14 \pm 17.1	0.01
Moderate	201 (66.8)	67.13 \pm 17.9	

Table 3. The Results of the Multiple Linear Regression Analysis for the Effect of *Self-Efficacy* and Demographic Variables on Quality of Life of Health Care Providers

Constructs	Not standardized β	Standardized β	T value	P-value
Self-efficacy	-0.12	-0.006	-0.115	0.632
Work duration	-0.54	-0.138	-3.97	0.001
Income	6.07	0.180	3.31	0.001
Education	2.71	0.093	1.45	0.147

The results of Pearson correlation showed that there was no significant relationship between quality of life score and self-efficacy of health care providers. ($r = 0.31$, P -value = 0.593). The results of multivariate linear regression model showed that by incorporating demographic factors into the model and adjusting for confounding effects, work duration and income were independently associated with quality of life in health care providers (Table 3).

Discussion

In this study the average quality of life of health care providers was 65.42 ± 19.1 , which was similar to the results of Hosseinkhani 's study (12) and lower than the study by Moradian et al. (17). In comparison with the study by Moradian et al., which examined the quality of life of health care workers in urban areas, the lower score of quality of life in this study might be due to work conditions in the village, the lack of social protection, and the variation and workload on the health care providers, which all of them can influence the quality of life in staff working in rural areas.

In this study, there was no significant difference between the quality of life in women and men, which is consistent with Moradian et al. On the other hand, some studies in this field, such as Hosseinkhani 's study and Tountas' study, showed that women who are working in health care had lower quality of life (12, 17).

In this study, the lowest score was related to the level of vitality, and Role emotional. These results are consistent with the study of Moradian, which showed that the lowest score is related to the field of vitality among health workers (17). also our results are in line with the study of Allaf Javadi et al., who have been studying the dimensions of nurse's quality of life, and their study shows lower scores in vitality, agility and emotional roles (19).

Therefore, it seems that in the health care staff, and in particular health care providers, there is a need for programs and interventions to increase the level of vitality and happiness, as well as to improve emotional health.

The present study showed that there was a positive correlation between the economic status and the level of education and the quality of life of health care providers. This is consistent with the results of the study of Teles and colleagues on the affecting factors on the quality of life of health care staff (20).

Also, in this study, people with higher experiences have lower quality of life. The regression results showed that the variables of income level and work experience were able to predict the quality of life in health workers. Thus, health workers with lower economic level and higher work experience reported lower quality of life. This point could be justified due to their higher age, as well as the increasing their needs as well as the reduction of job satisfaction.

Also the study of Enayati which was conducted on

education staff showed that by increasing the work experience, job satisfaction has decreased, especially in terms of salary and benefits. (10).

Therefore, paying attention to increasing motivation in employees with high experience might be associated with improving the quality of life and thereby improving the provided services by them.

In the present study, the average score of self- efficacy for employees was 64.12 ± 10 that was consistent with the results of Hosseini et al.'s study on self-efficacy in nurses (21). In the present study, self-efficacy score based on gender was not significantly different while the results of the Lundberg's study which showed that self-efficacy was lower in women working at health care centers (22). Of course, in some studies, higher self-efficacy has also been reported about men who are working in health systems (20). In justifying this contradiction, it can be said that other factors such as motivation and social support of health workers in different cultures can influence on their self-efficacy.

In this study, it was shown that the level of education was related to self-efficacy, which is consistent with the results of the intervention of Zhang et al. (23). on the relationship between self-efficacy and the level of education, some studies have shown that those with higher education and higher levels of education are more self-efficacious (24, 25). In contrast, in a study on self-efficacy of nurses in Iran, nurses with lower levels of education had higher levels of self-efficacy (26). In justifying this contradiction, it can be said that nurses with higher educational qualifications have multiple job responsibilities, greater responsibility and higher occupational stress, which can have a negative effect on self-efficacy, while higher education increases self-esteem and self-efficacy in carrying out their duties. In contrast with previous studies showing a significant positive relationship between quality of life and self-efficacy among employees and hemodialysis patients (27-29), we found no significant relationship between self-efficacy and quality of life. The difference among study results might be due to various tools that have been used to assess self-efficacy in different studies such as general or work-related self-efficacy questionnaire.

This study had some limitations. First, it is descriptive study and it does not specify causal relationships. Second, we did not examine factors such as social support and occupational stress that may affect the relationship between self-efficacy and quality of life, thus further studies in this field are recommended in order to determine the effective factors on maintaining and improving the quality of life of health care providers. And finally, in this study we used general self-efficacy that might not capture the special characteristics of work related self-efficacy.

Conclusion

The results of this study showed that health care providers

who are working in health centers did not have high quality of life, especially in the dimensions of pleasure and vitality. They also had moderate self-efficacy scores. Therefore, implementation of programs and strategies seems necessary to improve the quality of life and self-efficacy of health care providers and to improve the level of service provision in this group.

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Ethical consideration

The current study was approved by the Research Committee of Islamic Azad University, Urmia Branch, Urmia, Iran.

Conflicts of interests

Authors declared no conflict of interest.

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