Exploring Job Satisfaction of Nursing in Fiji

A thesis presented in fulfilment of the requirements for the degree of Doctor of Philosophy in Nursing

Auckland University of Technology, Auckland, New Zealand

Kesaia Tawa Nawaqaliva

2022

Abstract

Globally, nurses are the largest group of health professionals. Their job satisfaction impacts on the delivery of quality health care, patient safety, and a reduction in the burden of disease. Conversely, their job dissatisfaction is associated with attrition, burnout, low morale, staff shortage, adverse patient outcomes, and commonly workforce migration

This study, set in Fiji aimed to explore the factors influencing job satisfaction amongst nurses in order to pose recommendations for improving their work-related conditions. The key research questions were to understand personalised and professionalised meanings of job satisfaction; explore the personal, organisational, managerial, and professional challenges that nurses in Fiji experience; and to recommend strategies that support improvement in work conditions for nurses in Fiji, leading to enhanced job satisfaction. The Fijian Vanua framework provided the theoretical approach that encompassed the Fijian worldview in terms of the way of living, interacting, and sharing knowledge that framed both the epistemology and methodological approach of this study.

The three cohorts of participants were recruited included primarily registered nurses working in urban, peri-urban, rural, and remote rural nursing facilities; as well as nursing managers and government officials from the two main divisional areas.

Data were collected through individual Talanoa interviews with Fijian nurses(n=20), and two Talanoa focus group discussions with nurse leaders and government administration officials (n=9). Purpose sampling included 5 male and 15 female registered nurses with ages ranging between 27 and 48 years. The two Talanoa focus groups included one for nursing leaders (n = 4) and another for government administration officials (n = 5). They were all females in leadership roles and had between 5- and 10-years' experience in their respective roles. Both sets of Talanoa focus group participants had background experience in leading or policy making in urban and rural nursing.

Thematic analysis was used to identify the embedded themes related to philosophies of the Vanua framework. The four main themes identified were: organisation, management, work, and nurse characteristics; from which eight sub-themes emerged: authoritative decision making, devaluing of nurses, unclear promotion pathways, lack of leadership, workforce environment, stress, burnout and stigma, unsafe working condition, nurses' roles, and responsibilities. The study recommended that improving the nurses' working conditions could be facilitated through empowering nursing leaders with management training,

improving nursing remuneration, comprehensive review of the nursing scope of practice, nursing inclusion in health policy planning, review of nursing curriculum, and leadership management on mental health.

The research found that generalised challenges encountered by the Fiji nurses within the context of their developing country requires comprehensive review of their understanding of job satisfaction shaped strongly by the Vanua and socio-political and cultural contexts.

Table of Contents

List of Figures

List of Tables

Attestation of Authorship

"I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning."

Students Name: Kesaia Tawa Nawaqaliva

Students Signature:

Date:

26/04/2020

Dedication

To my dear mother, Mereseini Tokalau Nawaqaliva, and my late husband, Iokimi Senitiri, who both supported me throughout my years of study and being away from my children. Both were called to eternal in 2016 the year before I pursued my PhD studies.

This thesis is dedicated to their memory.

Acknowledgement

"Trust in the Lord with all thy heart and lean not unto thy own understanding; in all things acknowledge him and he shall direct thy paths" (Proverbs 3: 5-6)

I would first like to acknowledge the Almighty God Jehovah for his never-ending blessings and guidance over my life; who is author of my life's journey and made everything work according to His will. This thesis is a testament to His Glory. There are many people, families, institutions, and organisations that have contributed to the completion of this thesis, and I would like to take this time to acknowledge each one of them.

My supervisors—Dr Sandra Thaggard and Professor Eleanor Holroyd of Auckland University of Technology (Northshore campus)—who have worked tirelessly in ensuring I reach the end of the line amidst all the uncertainty surrounding the COVID-19 pandemic. I am thankful for their never-ending support and grateful that I was counselled with kindness and professionalism during our four-year journey together.

Organisations and institutions

I wish to acknowledge the contribution and support of the following organisations and institutions. The New Zealand Ministry of Foreign Affairs and Trade for sponsoring me as a New Zealand Manaaki scholar with a 4-year fully funded scholarship. This provided me with the financial and academic support needed to fulfil a lifelong dream of pursuing this programme.

The Auckland University of Technology Scholarship team—Sacha Pointon, George Kimani, Sandelyn Agnes Lua, Petrina Hibben, and Prerna Taneja. I sincerely thank the team for ensuring my experience of studying in New Zealand was a memorable one with guidance relating to both academic and social support.

The Fiji Ministry of Health research committee for supporting and facilitating my research in allowing me to conduct my study. I am indebted to the Fiji nurses, leaders, and government administration officials who volunteered to participate in my research, and acknowledge their assistance and support.

Fijian community New Zealand

I would like to acknowledge the members of the Fiji New Zealand Registered Nurses Association (FNZNA) for their support, encouraging words, and comradeship during my stay

in New Zealand. It has been such an honour to be among nurses who have strived to make a mark in a foreign country despite their humble nursing career from Fiji.

The support of the Fountain of Praise Assemblies of God church Mount Roskill, Matasiga Number 2 and the Auckland New Life Methodist Church Henderson, Auckland; their fellowship and spiritual guidance during the challenging moments in the 4-year journey is greatly appreciated.

I would like to acknowledge Lome Lawe and her children, with Mosese Saurara, who have always welcomed me to their home; it has truly been an honour and privilege to be part of your family receiving encouraging words of support.

I thank Filipe and the Batiwale family, Laite and the Baleisomosomo family, Munesh Naicker and family, Elemeci and family, Akariva Raveti, Vaciseva Barinisavu, Tevita Suraki, Inise Matea, Eta Vukona, Luke Qila, Rusiate Vatuniqere, and Naita Simione Tagicakibau for all your small contributions that assisted me in my study. To the rest of my friends that I may have forgotten to mention, please note that all your kind assistance is acknowledged and gratefully appreciated.

Family

This thesis would not have been possible without the sacrifice and support provided by my New Zealand brother Vunirewa Uluilakeba who has been my mentor, companion, colleague, and friend; ensuring that I was well supported with accommodation and with any assistance needed. I will be forever grateful to Vunirewa and my Legacy family, Ratu Meli and Leweni Mocevakaca, for all the love and support that I had received during my four years stay in New Zealand.

I wish to acknowledge my siblings—Iloi Nawaqaliva, Ratu Josiua Nawaqaliva, Necani Talekinona—and especially Unice Mary for taking up the responsibility of looking after my children during my absence to complete my study. My gratitude to my Fiji family and relatives who have supported me through prayers and my Nema sisters for their unconditional emotional support.

Lastly, I would like to acknowledge my two little boys—Misiwata Senitiri and Iokimi Senitiri Jnr—for patiently enduring the absence of their mum during my four years away from home, even just after a year of losing dad. You both have had to endure a challenging journey during your childhood with tears and frustration, but know that I love you both and that this thesis is for you.

Glossary Of Fijian Words

B

Bati	traditional warriors who protect the village, chief, and people; they also fight for the protection of the vanua interests
Bati Lekaleka	short or close warrior
Bati Balavu	ong or distant warrior
Bula	greeting, literally means 'life' or 'health'
Bula Taucoko	better wellbeing, quality of life
Bure	traditional Fijian thatched house serving a special function in villages such as meeting place, men's house, or women's house

D

Duavata	to be united
Dravudravua	the state of being poor, or in poverty
Doko levu	experienced sailors, skilful in taking the chief and passengers out into the deep sea
Doko lailai	sail the chief or others around the lagoon areas and usually areas close to the beach

G

Gonedau	village fishermen who hold the role of experts in their field
Gonedau ni wasawasa	fishermen of deep sea
Gonedau ni vatu	fishermen of the rock

I

iKanakana	to feed from; name given to the piece of land used to grow food gardens
iSevu	traditional presentation of the first fruit of the land to the church and the chiefs

Isevusevu	(entry protocol) presentation of yaqona root in a ceremony of introduction or greeting by a visitor. It is an acceptable behaviour to present the isevusevu and seek entry to a Fijian village or home
iTaukei	indigenous Fijian people: natives of Fiji Islands
iTatau	(departure protocol) presentation of yaqona root by a group in a ceremony to inform of their departure
iTeitei	food gardens or farms
iTokatoka	extended family within a clan, (mataqali). The itokatoka is literally a family and all members are intimately related by birth and marriage
iYau	traditional artefacts used in ceremonies like mats, tapa cloths, and tabua

K

Kalou	God/Supernatural deity
Kalou Vu	ancestral spirit
Koro	village

L

Lagi	sky and heaven
Lewenivanua	ordinary people or population of a village
Lotu	religion

M

Magiti	food (Syn. Kakana)
Marama	woman, lady
Mataisau	known as the carpenter
Matanitu	state, government, or a nation
Matanivanua	traditional role as an orator who speaks on behalf of the vanua or a chief
Mataqali	clan, more inclusive than the extended family

S

Sautu	peace and prosperity in the land
Solesolevaki	a social, cultural capital where people work together for a common good without being paid
Solevu	a traditional ceremony (Syn. Soqo)

T

Tabu	forbidden, prohibited
Tabua	whales' tooth. Valuable artefact used in most Fijian ceremonies such as birth, marriages, death, and seeking forgiveness between families, clan, and tribes
Talanoa	to yarn, chat or discuss. Usually done around kava bowl to discuss issues of importance to the family and village; veitalanoa when more than 2 people are involved
Tokatoka	sub-clan
Tui/Turaga	chief
Turaga	reference to a male or a chief
Turaga ni Koro	village Headman

V

Valavala vakavanua	traditional or cultural protocols
Vale	dwelling house
Vakaturaga	chiefly demeanour or chief like manners
Vanua	the universal whole and the interconnectedness of people to their land, environment, cultures and epistemology, history, chiefs, relationships, spirituality, beliefs, knowledge systems, values and God(s)
Veinanumi	considerate of others
Veirairaici	looking after one another
Veirokorokovi	humility/mutual respectful towards others

Veidokai	respect
Veilomani	the act of love and caring for each other
Veiwekani	kinship, relative
Veivakarogotaki	to inform or to hold discussion and consultation
Veivakaturagataki	Chiefly system by custom
Vola ni kawa bula	a record of genealogy for indigenous Fijians who belong to a particular sub clan, clan, and tribe
Viti	Fijian for Fiji
Vuravura	the earth
Vutuniyau	to be rich
Vuvale	family

Y

Yalomatua	to have wisdom or maturity
Yaqona	(Piper methysticum) plant that is the basis of the traditional Fijian drink also known as kava
Yasana	province with a geographical entity. There are 14 provinces in Fiji. Rotuma an independent island across the Northern part of Fiji is categorised as the 15th province for operational and administrative purposes only
Yavusa	the largest kinship group within the Fijian social system. A combination of several clans form the yavusa
Yavu	tribe, largest patrilineal grouping of families related by blood; may also be referred to as the vanua or government

CHAPTER 1: SETTING THE SCENE

1.1 Introduction

Globally, nurses are the largest group of health professionals. Their job satisfaction impacts on the delivery of quality health care, patient safety, and a reduction in the burden of disease. Conversely, their job dissatisfaction is associated with attrition, burnout, low morale, staff shortage, adverse patient outcomes, and, commonly, immigration. Nurses in Fiji, as elsewhere, seek better working conditions, improved professional development, improved conditions for their families, and better pay incentives, which have informed Fijian based nursing resignations and outward migration of the skilled nursing workforce.

My research questions were to understand the meaning and influencing factors of job satisfaction among a cohort of registered nurses in Fiji. These data were triangulated from nurse leaders and government officials, and my methodological approach drew on the adaption of the Fijian Vanua Framework used as both the epistemology and methodology of the study.

This chapter outlines my positionality and sets the scene with the geography, socio-cultural landscape, the setting and context of the study; Fijian social structure, historical and contemporary governance system; health services and development of the nursing profession. The impact of immigration of Fiji registered nurses and the effect it has on the health care system is also discussed to set the scene for the subsequent chapters.

Researcher Positionality

As the primary researcher, my background has played an important role in the selection of my research topic. I was born on the smaller island of Fiji (Vanua Levu) and was fortunate to grow up between the cities of Suva and Lautoka; this was due to my father's work as a civil servant being posted around, before eventually settling in the Western side of the country (Lautoka). Thus, the majority of my education was in the West, and I attended my nursing education in the capital city of Suva which, at the time, was the only nursing school in the country (Fiji School of Nursing). I graduated from the school with a *Diploma in General and Obstetric Nursing* and was absorbed by the Ministry of Health working in Western division. Overtime, between the years 2004 and 2016, I attained my bachelor's in public health nursing, post graduate certificate in public health, certificate in sexual reproductive health management, and a master's degree in nursing. In 2018, I received a scholarship to pursue

my PhD in New Zealand. In the 15 years of my nursing experience, I have worked in the clinical hospital (medical, surgical, obstetrics and gynaecology) with most of my years in public health/community rural nursing. In my early years of nursing, I was posted to a remote nursing station where I experienced the challenges of working as the sole health care officer responsible for 7 villages on a remote island, with no telephone (only radio telephone) or electricity in the villages. The other public health areas that I worked in were community health, school health, and reproductive health, before being promoted to a nursing manager position in 2013.

The title of this research—nurses' job satisfaction in Fiji—became a topic of interest for me when encountering first-hand the challenges of working alone in a rural maritime nursing station and a peri-urban facility with limited resources. Anecdotally, this resulted in feelings of dissatisfaction and, in part, informed my migration decisions. In addition, being promoted into a nursing management position gave insight into the difficulty of trying to improve the nurses' work conditions and associated job satisfaction. I saw this was due to the limited strategies and policies within the health care delivery systems that lacked clear understanding of the value of the nursing work.

1.2 Setting and Context

The research was set in the Republic Island of Fiji, in order to relate the experience of the Fiji nurses within the context of their cultural and political contexts and explore the nature of their workforce experience and behaviors.

Geography of Fiji

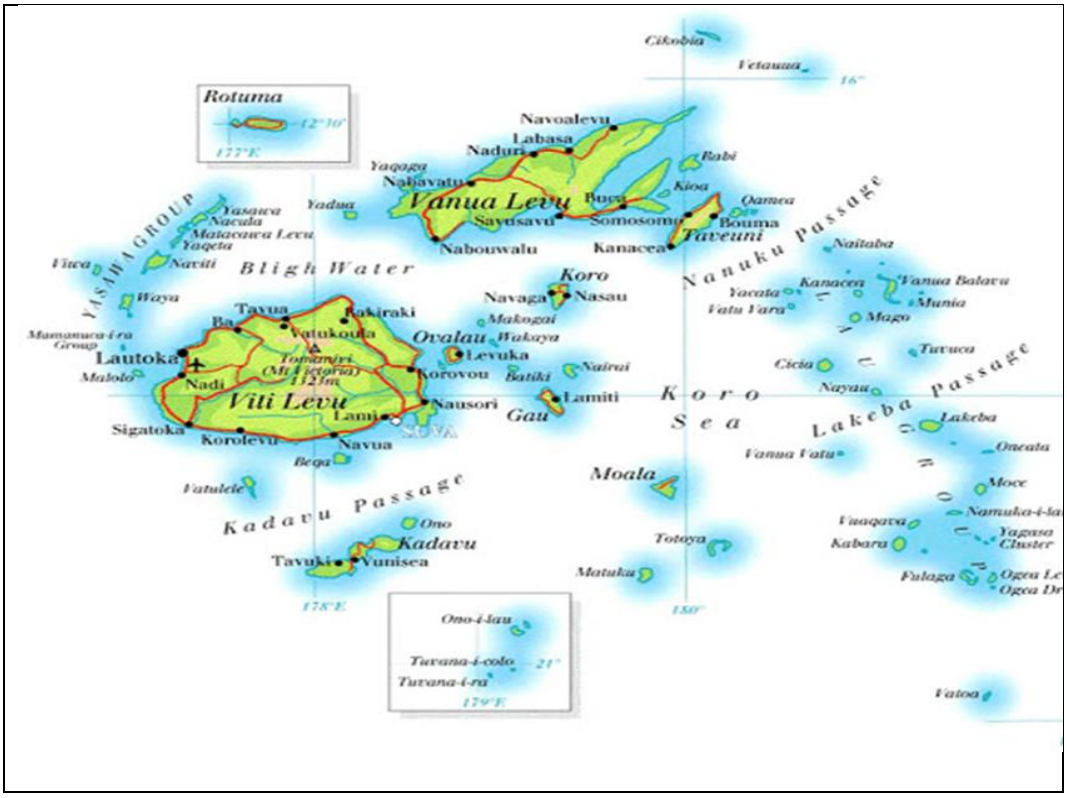
The island of Fiji is in the Oceania region and covers approximately 18,274 square kilometers (see Figure 1). It is a tropical island with an archipelago of more than 322 islands and 500 islets; however, only over 110 are occupied by the Fijian population. It is in the Western Pacific region with island neighbours; namely Samoa, Vanuatu, Niue, New Caledonia, and Wallis and Futuna. Tonga is one of the closest islands with links to the South-eastern parts of Fiji, and New Zealand located further south of Fiji (Fiji Bureau of Statistics, 2018).

The country is mostly made up of volcanic mountainous terrain that is covered by heavy tropical rainforest. Most of the mountains on the island are extinct volcanoes that have been dormant for many years. There are two main islands known as 'Viti Levu' which is the bigger island; and 'Vanua Levu' the smaller island. Together, the two islands share a land mass of

87% of the country, with the majority of the population occupying these two areas. The capital of the country is Suva, located southeast of Viti Levu, and is one of the largest centres in the South Pacific Island region. Initially the capital was located on one of the smaller islands in the Lomaiviti group called 'Levuka'; but was relocated to Suva in 1882 due to inadequate space for expansion on the island (Smith, 2006).

Figure 1

Fiji Map



Source: (netmaps.net/digital-maps/Fiji-island-map)

The highest mountain peak on the island is on Viti Levu which reaches up to 1,300 metres, though there are other higher mountains located on the South Island of 'Kadavu' and Northern Island of 'Taveuni'. The Western group of islands, also known as the 'Yasawa' and 'Mamanuca' chain of islands, is popular amongst tourists as it is well renowned for its white sandy beaches and clear blue oceans. The Eastern part of Fiji has a collection of islands 'Lau' and 'Lomaiviti' group—with the furthest island being 'Rotuma' located North of Fiji at approximately 500 kilometres. It is estimated that three quarters of the population live along the coastal area of Viti Levu, with the majority located on the coast of 'Nadi' and 'Sigatoka'; this may be linked to the establishment of the tourism industry in the western costal region with the sugarcane industry more towards the Lautoka and the Ba coastal area. The interior area of Viti Levu has a low population density mainly due to its rough geographical terrain

(Fiji Bureau of Statistics, 2018; Vudiniabola, 2011) which has implications for the delivery of rural and community nursing (elaborated in later chapters).

The capital of Fiji is Suva which is located southeast of Viti Levu and is known to be one of the largest centers in the South Pacific Island region. Initially the capital was located on one of the smaller islands in the Lomaiviti group called 'Levuka' but was relocated to Suva in 1882 due inadequate space for expansion on the island (Smith, 2006).

1.4 The People

The Fijian people of indigenous descent (Itaukei) are a mixture of Polynesian and Melanesian, and they are people who value family and continue to identify themselves with their tribe's clans and their ancestral lineage to their land. Though the origin of the Itaukei can be debated, with the legendary mythical belief that the people of Fiji are the descendants of the Chief who first landed on the Island and populated most of the country; studies suggest historical links of the Itaukei to the 'Lapita' people. The vague similarity in the language across the Pacific Islanders may be associated with the common myth that the Lapita people descendants are the true descendants (Tuwere, 2002). Further, social integration between Polynesian, Melanesian, and Micronesians have contributed to the Fijian people's ethnicity (Fiji Country Watch, 2016; Ravuvu, 1983).

It was the Tongans who called the island Viti (Fiji), and this name was adopted and established by the early Methodist missionaries. The missionaries also translated the English bible into the 'Bau' dialect, a language mostly used in the eastern part of Fiji. Though each province had their unique dialects, the 'Bau' dialect became the standard language used in the country until today (Vudiniabola, 2011).

In the 2020 Country Review published by Country Watch, it was stated that not much is truly known with regards the inhabitation of Fiji since the arrival of the early Europeans into the country more than 2,500 years ago. Although history records Abel Tasman as the first known European to discover the island in 1643 (Fiji Country Watch, 2020; Worldometer, 2020).

According to the World Population Review 2020, the population for Fiji is approximately 920,938 with two main ethnic backgrounds holding majority of the population for the whole country. The largest ethnicity in the country is the indigenous Fijians (55% of the population) who are mostly Melanesians with a mixture of Polynesian background. Fijians of Indian descent consist of 40%, and 5% are other mixed ancestry resulting from early arrival of the Christian missionaries who were mostly concentrated in the urban areas such as Savusavu (Vanua Levu). The indigenous Fijians are predominately Christians, with 78% being

Methodist; 8.5% Roman Catholic; and the rest Mormon, Seventh-day Adventist, Anglican, or Presbyterian. The ethnic Indians are 80% Hindu, 15% Muslim, and the remainder are Sikh or Christians (Fiji Bureau of Statistics, 2017; Worldometer, 2020). The Fijians of Indian descent were descendants of the Indian labourers who were brought into the country by the British in the 1800s (Worldometer, 2020). Studies suggest that today the Lapita people are the main population grouping in Fiji and are descendants of the people in the Pacific who colonised the Pacific Islands over 4000 years ago.

The latest growth rate recorded by the Fiji Bureau of Statistics for 2018 averaged 0.63% between 2017 and 2018, showing the population growth in Fiji to be steady and remarkable. The birth rates for the country, for the same period, are 18.2 births/1,000 population and a death rate of 6.2 deaths/1,000 population (Fiji Bureau of Statistics, 2017). This a great increase from reports showing a decrease in growth from 1% to 0.6% between the years 2000 and 2008. The reasons may be explained in the satisfactory family planning percentages, as recorded in the Ministry of Health Annual reports; and may also be linked to the constant migration and brain drain in the years following the 2000 coup (United Nations Population Program, 2008).

The Fijian People and the Vanua

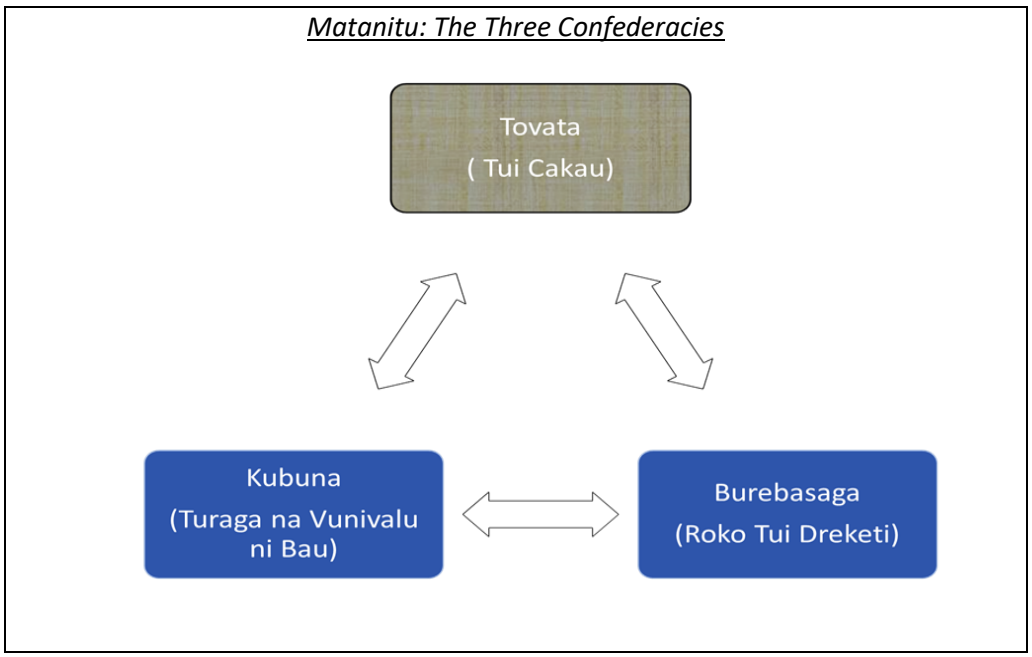
The definition '*Vanua*' is not limited to the island as a whole or the land area. It has deeper rooted meanings relating to the physical, social, and cultural aspects of the traditional ideology of the Fijian social structure. Vanua encompasses several '*Yavusa*' and '*Mataqali*' which have their specific roles in the community in ensuring the protection and wellbeing of the chief as the head of the Vanua. The structural set up of the Vanua works towards achieving harmony, prosperity, and, most importantly, solidarity; and has a strong influence on how Fijian people behave in their community as well as a sense of identity and belonging (Degei, 2007; Ravuvu, 1983).

Nabobo-Baba (2006) defined Vanua as a reference to the people as an extension of the land. The different connotations relating to Vanua translates to their relationship to the land and their defined territory including their fishing grounds, environment, and geographical unit. Many Westerners may not be able to comprehend how Fijians identify themselves with the land (Vanua) and its wide range of tangible factors, likening it to a socio-political organisation system that encompasses the different confederacy, their chiefs, and constituent groups (Nabobo-Baba, 2006; Tuwere, 2002).

The Vanua (Fiji Island) is divided into three main '*Matanitu*' (confederacies) which are known as '*Tovata'*, *'Kubuna'*, and *'Burebasaga*' (see Figure 2). Each *Matanitu* has their own paramount chiefly titles which are used in a traditional address or presentation of gifts in which the chiefly confederacy title will always be addressed first, followed by chiefly tribal titles. Each confederacy has several tribes (Vanua) underneath them, and all Fijian tribes have the same social structure system (Eräsaari, 2013).

Figure 2

Fijian confederacies



Fijian Social Structure

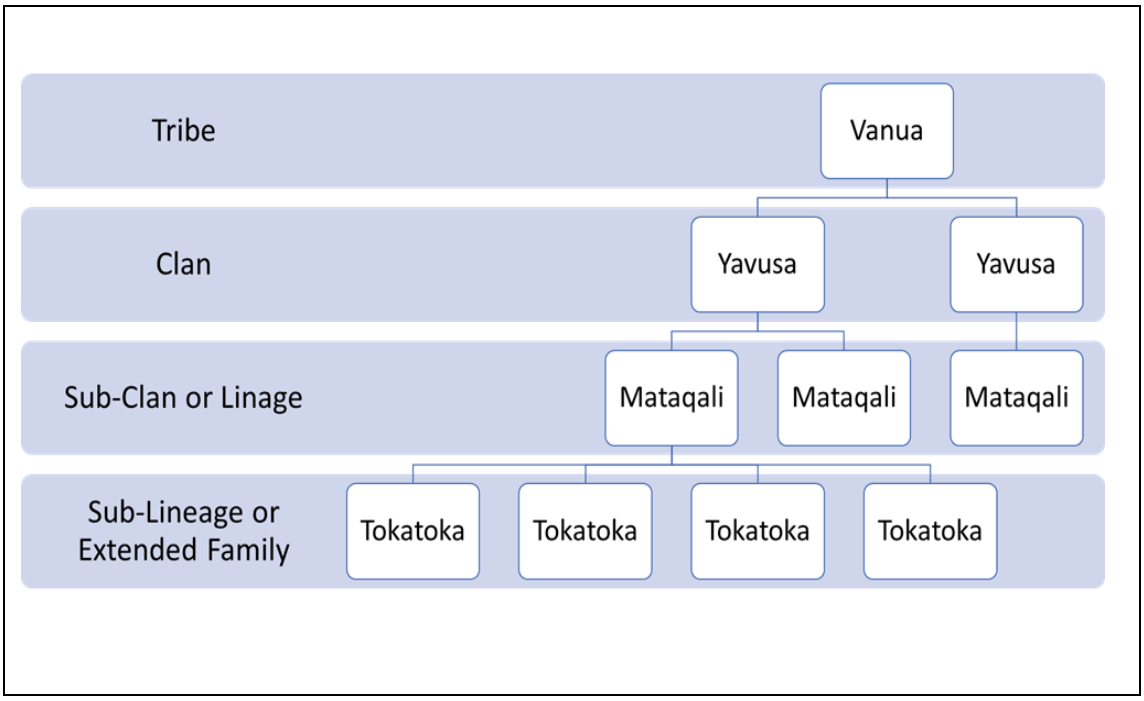
Indigenous Fijians originating from a Vanua or tribe will always introduce themselves by stating where they originate from by naming their Yavusa, Vanua, and Confederacy (Matanitu); not the urban centre where they might be living. It is imperative to understand the roles within Fijian society as to gauge the power relations within their culture. Though the culture may have been redefined by outsiders, themselves, or by the nature of time, it is still important to consider the critical role it plays with regards to how it impacts the political context, power relations, political constraints, and factors relating to incentives and motivation. Kinship and support have been the driving force in ensuring the Pacific people are socially protected when faced with social or economic crisis, thus making them quite resilient (Macpherson, 1999).

The cultural links within the Vanua structure articulates the kinship relationship amongst the people within the clan and is expressed as 'veiwekani'. Kinship is a cultural structure where individuals can identify with their indigenous family lineage and roles and assist in the sustaining of their communities (Macpherson, 1999).

The pyramidal structure below (Figure 3) allows for the visual understanding of the social structure within the community. The Yavusa is a chiefdom level and, as explained by Eräsaari (2013), the origin of a Yavusa may be traced down to a common male ancestor where several Mataqali sub-clans make up one Yavusa. The Mataqali branches out into smaller households or closely related family members known as the Tokatoka. Each Mataqali is allotted a specific area to reside in within the village compound (Eräsaari, 2013).

Figure 3

Fijian Social Structure



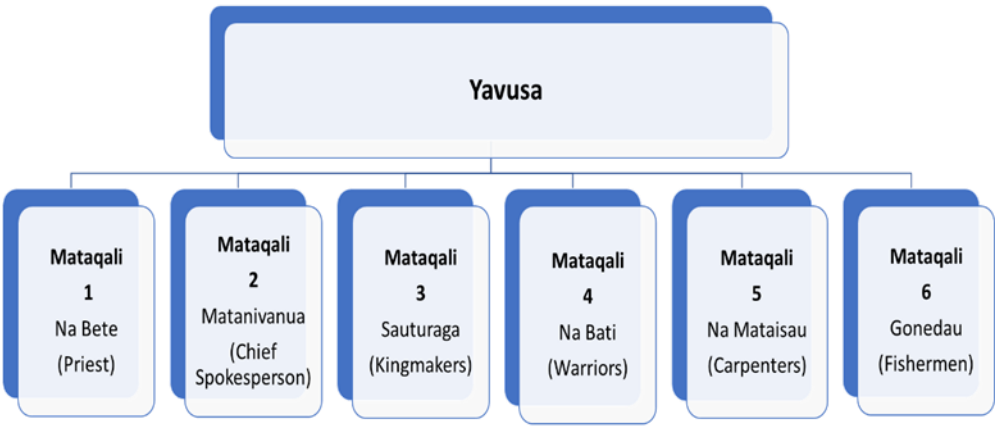
Source: Ravuvu (1983, p. 79)

The difference between the *Mataqali* and the *Tokatoka* (sub-clan) is that the *Mataqali* is mostly called upon according to their specific allocation of communal labour/role in the village. This is related to village affairs such as organisation of occasions like a wedding or task requested by the *Vanua* or chief. The *Mataqali* holds the responsibility of communal land ownership of its indigenous members and cannot give or sell their land without 60% approval from its registered members (Eräsaari, 2013). The *Tokatoka* are smaller household members that make up one *Mataqali*. The constituent groups or roles allocated within a

Mataqali are that of a clan leader *Turaga-ni Mataqali*, *Bete* (priest), *Matanivanua* (spokesperson/heralds), *SauTuraga* (king makers), *Bati* (warriors), *Mataisau* (carpenters), and *Gonedau* (fisherman). These six constituent groups/roles are not limited to just one *Mataqali*; for example, if a village/Vanua has six *Mataqali*, then each *Mataqali* will represent one of the constituent roles. If they have more or less numbers of *Mataqali*, then one may take up two or three roles with each unit having their own leader (*Turaga ni Mataqali*) (Eräsaari, 2013). The named constituent groups are illustrated in Figures 4 and 5.

Figure 4

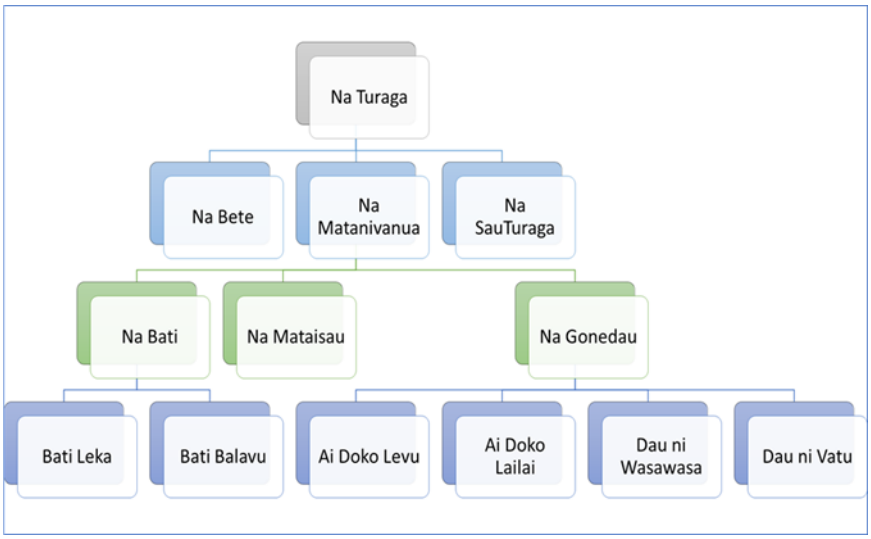
Distribution of Constituent Roles



Source: Eräsaari (2013)

Figure 5

Constituent Groups



Source: Ravuvu (1983, p. 77)

The Yavusa is a chiefdom position led by the 'Turaga-ni-Yavusa' who holds the chiefly title and is a person who is respected and holds over all the Mataqali leaders (*Turaga-ni Mataqali*), commoners, and village subjects.

SauTuraga – Holds the responsibility for keeping an eye on the chief's heirs and assesses them accordingly to determine whether they meet the criteria of taking up the chiefly post. Once agreement on the assessment is concluded, they then determine who should become the chief and carry out the installation protocols. They also play the role as the chief's advisors in the supervision of work carried out by the Vanua, deputized on behalf of the chief, and act during their absence. They, also ensure chiefly obedience is upheld.

Matanivanua – Known as the chief's heralds or spokesperson; they mostly play the role of the village diplomat and act as the link between the chief and commoners. The commoners, or any outsider, cannot speak directly to the chief; they have to go through the *Matanivanua* in order to seek an audience with the chief. Their traditional roles include drinking *Yaqona* (kava) after the chief in all traditional ceremonies (*Rabeta*), to reply and receive *i-sevusevu* (gifts, kava, tabua) presented to the chief, represent the chief and the people, and advise people on village code of ethics. They are known to be great orators.

Bete – The village priests who, before the arrival of the Christian missionaries, were associated with sorcery, medicine, and religion. They were known and identified through their supernatural powers in which they were believed to be ancestral Gods who have been possessed or reborn as men into the village clan. They were used to summon Gods in seeking success in war, good crop seasons, and safe voyages out in sea.

Bati – This warrior group is further divided into two specific groups: 1. *Bati Lekaleka* (short or close warrior) and 2. *Bati Balavu* (long or distant warrior). They both guard the land and the people (Vanua), with the difference in their role suggested by their names. *Bati Lekaleka* act more like the chief's bodyguard and stay close to the chief. *Bati Balavu* act as scouts and guard the boarders or boundaries of the *Vanua*. The warriors are always the first in line to accompany the chief to a war.

Gonedau – The village fishermen who hold the role of experts in their field and are experienced in fishing. They are tasked in ensuring fish is supplied to the chief, as part of the chief's nutritious diet, and gifting fish to the chief's visitors. In some villages, there are two types *gonedau*: 1. *Gonedau ni wasawasa* (fishermen of deep sea) and 2. *Gonedau ni vatu* (fishermen of the rock).

Gonedau ni wasawasa caught fish from the deep sea (travelled into the deep waters); whereas *Gonedau ni vatu* caught fish around the lagoons and reefs. The *Gonedau* were not all classified as fishermen, some were also sailors (*Dau ni veisokotaki*)—either 1. *Doko levu* (big pole) or 2. *Doko lailai* (small pole). *Doko levu* were experienced sailors, skilful in taking the chief and passengers out into the deep sea to voyage between islands. *Doko lailai* would sail the chief, or others, around the lagoon areas and usually areas close to the beach (Ravuvu, 1983).

Mataisau – Known as the carpenter or *liga ni kau* (hand for timber), pride themselves in the promotion of their handicraft skills in building canoes, boats, bure (house), and Tanoa. They attend to the maintenance and repair of buildings in the village, especially the chief's bure, and ensure adequate supply of firewood in the chief's kitchen (Ravuvu, 1983).

Understanding the Fijian social structure affords insight into the hierarchy of power and what society expects in terms of the role that one plays in the community. Though some of the designated responsibilities of the constituent groups are not applicable today, the principles behind the social structure still exist. For instance, when an indigenous Fijian is born, their birth certificate will state their inherited *Yavusa, Mataqali, Tokatoka, Matanitu*. This means they are registered into general office and into the Itaukei Land Trust Board (ITLTB) when certification of birth is processed (Tuwere, 2002).

Society plays an important role in shaping and building an individual's identity where, in the case of Fijian society, there is great emphasis towards the links within the Vanua and the communal way of living that is anchored deeply into their character and way of life. The links and strong connection to extended family, *Mataqali*, is focused on sharing and being

responsible for each other, with lesser emphasis on individual self or to the outside world. This impacts the indigenous Fijians who accept mostly whatever is offered in terms of development, money, or the economy. They may be resistant to address or question authority due to their cultural principle of distribution rather than accumulation (Ravuvu, 1983).

The commitment that binds a Fijian to their family or community is their kinship (*Veiwekani*). Even in modern time, or in a westernised society, a Fijian will always be pressured to maintain the *'bula ni veiwekani'* (kinship relationships). They have to reflect friendliness and hospitality in the way they act and behave and carry out the social obligation that is expected of them. This element is significant in understanding the Fijian identity with regards to leadership, relationship, and other factors that manifest their actions (Ratuva 2007; Tuwere 2002).

Fijians of Indian Descent

Most Fijians with Indian background are descendants of indentured labourers who were brought into the country in the beginning of 1879 to work on the farms. The 1860s attracted many planters/farmers into the country in the temporary cotton boom period with many trying different crops such as coffee, banana, and sugar. Many were unsuccessful due to labourer debt and not enough capital. The indentured labourer system was established due to the prohibition of indigenous Fijians being employed in the agricultural establishment, the unknown labour trade with the Polynesians, and Indians being an easy solution to meeting the shortage of workforce with cheap hiring rates as utilised by other colonised countries. The indentured labourer system continued between 1879 and 1916 with around 60,000 Indians migrating to the country. Though most were predominately descendants of the indentured labourers, some also came as free labourers working as colonial clerks, merchants, entrepreneurs, and traders (Lal, 1980).

The abolishment of the system in 1920 left the Indians contemplating whether to stay and make Fiji their work or return to India. In this era, they had outnumbered the indigenous Fijian population and other ethnic groups which threatened the survival of the indigenous Fijian. Undeniably, their presence and existence in the country influenced society in terms of economic impact, politics, and policies such as in education, and building the country to be a multi-cultural society. In 1947, agricultural community was established, with the sugar industry being the main contributor to the economy. Considering their domination in the sugar cane farming, Indians were only given land to operate as lease holders, not landowners, with the duration of the lease being mostly 10 years. The Fijians of Indian descent lived

primarily in the rural areas of the two main islands; and as their lease agreement expired, the migration from rural to urban areas was evident with some continuing the cycle as shopkeepers and traders in the small islands and rural areas. The urbanisation drift affords a better understanding of the structural health content of the country where the rural areas are mostly occupied by indigenous Fijians in villages and settlements, with very small numbers of Fijians of Indian descent remaining in rural areas (Lal, 1980; Vudiniabola, 2011).

Kai Loma (Part-European)

The early 19th century saw the arrival of European missionaries, including merchants, whalers, and traders. Sandalwood was one of the earliest trades recorded, followed by sea cucumber also known as 'beach de meres'. The civil war saw the establishment of cotton/fibre plantations following increase in cotton prices, and sugarcane farms were established later. These trades and Christianity missions saw an increase in the presence of Europeans in the country, including a small number of Solomon and Vanuatu labourers who were brought in to work. The existence of the Europeans came with the attachment to a dominant class who held great influence in colonial policy relating to racial segregation. European power came with prestige and privileges which included the roles of government officers, doctors, lawyers, and store owners. They mostly held commanding posts and had a higher living standard compared to other races (Lal, 1980).

The intermarriage between the early white settlers and the indigenous Fijians gave way to the lineage of part-Europeans who had bloodlines to both cultures, ethnicities, values and belief systems. The continuous generation of part-Europeans saw establishment of relations between both cultures and development of their own language. Though initially called '*half-caste*' as the mixture of the two races, they evolved and retained other identity titles such as part-European and 'Others', linking ties with the colonial government and their political motive of retaining superiority over the two races of Fijians and Indians. Though the part-Europeans did not have political authority or governmental influence, they were used in smaller administration roles to lessen the impact of colonisation and political dominance. This allowed many great opportunities for them as seen evident in nursing, where nurses were initially only European. Indeed, the first ever recorded qualified Fijian nurse in 1897 was not a full indigenous Fijian but a part-European (Osborne, 1998; Simpson, 1974).

Employment

In 2017 the last census showed the unemployment rate for the country was 7.6%; with 25.5% of the population living beneath the poverty line. The percentage of GDP used for public

health expenditure was 2%, education 5.6%, and military expenditure 1.47%. The main occupations in the country recorded in the census report were notably in the wholesale and retail area, manufacturing, and accommodation and food services. The salary distribution showed that 58.7% of the population were wage earners and 41.3% salary earners; with the average salary distribution of FJ$9,565.07 (US$4,404.30) for wage earners and FJ$30,519.28 (US$14,052.81) for salary earners. Overall, Fiji has an impressive literacy rate with 94% of the total population aged 15 years and over being able to read and write (Fiji Bureau of Statistics, 2017; Worldometer, 2020).

The Fiji economy, since colonisation, has followed the British colonial pattern of plantation/agriculture, and the introduction of the indentured labourers to work on the sugarcane fields. In terms of the country's economic overview, Fiji's is endowed with agriculture, tourism, mining, marine resources and minerals, making it one of the most developed economies in the Pacific. The main foreign exchange earners are sugar, tourism, and garments, but these have faced their equal share of challenges in terms of competition in the global market (Worldometer, 2020).

Independence

Fiji became part of the British colony in 1874; and gained back their independence on 10 October 1970. The country continued parliamentary democracy for 17 years following independence before it was disrupted by two military coups in 1987. The perception that the Indian community dominated the government led to the indigenous Fijians overthrowing the government that later led to future political turmoil. The two other coups that occurred in the country were in May 2000 which was a civilian coup, and a military coup in December 2006. Though there was a democratically elected Prime Minister and government in 2001, they were overthrown in 2006 by Commodore Frank Bainimarama who declared a military government upon Fiji until the elections in 2014, returning the country to democracy and order. The economic prospects of the country, though being the most developed in the South Pacific, remained uncertain with the military government elected to office (Worldometer, 2020).

Fiji was readmitted into the Commonwealth in 2001 following treason charges placed upon those that were responsible for the civilian coup in 2000 and the announcement of a democratic election in August 2001. This was short lived, as the country again faced the same sanctions from the Commonwealth countries in December 2006 and was suspended from the British Commonwealth in September 2009 due to the country's lack of progress towards

achieving democracy. On the global level, the country's economy has had a slow-moving growth, devaluation of the Fiji dollar occurred because of the crisis, and the country's debt is currently 50% of the GDP—high for a small economy like Fiji (Fiji Bureau of Statistics, 2017; Worldometer, 2020).

Historical and Contemporary Governance Systems

The government structure for the country has had reforms brought about by military coups that initiated these changes. Historically, Fiji's local government began in Levuka during the colonial era in 1877 before moving to Suva. Initially, the local government following the reforms of the 1987 coup, and the 1993 elected government, had a structure that included four distinct systems: Government administration, municipal administration, rural local authorities, and the Fijian affairs board. The government administration purposes were to organise government services to all four divisions of the country (North, Central, South, West), each having divisional commissioners and district officers. The municipal administration was more focussed on local government of land, housing, and public utility services. Rural local authority focused on areas outside urban boundaries such as villages; and the Fijian affairs board focused on promoting the Fijian culture and custom by governing all issues relating to Fijian affairs. This board was called the '*Great Council of Chiefs'*. Further, provincial council members are appointed to oversee and control the Fijian by-laws and building constructions conducted in the villages (Rahman & Singh, 2011)

However, following the military coup in 2006, the interim government put together a framework towards achieving good governance and a sustainable democracy. This included the abolishment of the '*Great Council of Chiefs'*, trade reforms, establishment of an independent anti-corruption commission, and reform of local government structure (Rahman & Singh, 2011)

The current government structure, implemented by the elected government, separates the state into three main branches: The Legislature (Parliament), the executive, and the judiciary. The parliament members are elected by, and represent, the people and the community in discussing issues that affect them, as well as scrutinise activities undertaken by the government. It has 51 members that belong to their respective political parties, with the majority of seats in parliament forming the government, leaving the rest to sit as the opposition to government. It is basically the legislative arm of the country responsible for making laws. The executive arm carries out the government administrations operations. The

cabinet comprises of ministers appointed by the Prime Minister, and they are the government's decision-making body. Each minister is assigned to a specific area in government. The Judiciary is the government's legal arm and takes up the responsibility of enforcing the law in the country. It is completely independent from both the parliament and executive administration (Parliament of the Republic of Fiji, 2019).

Health and Illness

Morbidity and Mortality

In 2020, the life expectancy for the country at birth was 70.44 years, though females tend to live longer with life expectancy of 73.1% compared to 67.9% for males. The infant mortality rate was 11.8 deaths per 1,000 births, with a fertility rate of 3.3%. The top causes of mortality in the country, as recorded by the 2017 census report, are diabetes, hypertension disease, ischaemic disease, other heart diseases, and cardiovascular diseases (Dearie et al., 2021; Institute for Health Metrics and Evaluation [IHME] Country Profile, 2019).

Non-communicable diseases (NCD) have been the major cause of death in the country since the 1990s with an increased number relating to cardiovascular. The prevalence of mortality for this disease alone increased from 20% to 45% between the years 1960 and 2010. There has also been significant increase in the prevalence of hypertension and diabetes (type 2) between the years 1980 and 2011, in accordance with the increase in the number of obesities in the country. This has initiated the country to activate public health programmes that target NCD through strategic planning target goals, with the hopes of reducing premature adult mortality and achieving improved wellbeing (Dearie et al., 2021; Linhart et al., 2016).

The mortality rate for infants and children under the age of 5years has decreased through the improvement of childhood programmes preventing deaths from infection and under-nutrition. The mortality trend for Fijians under 5 years saw a decrease from 25.9% in 1990 to 22.1% in 2019, with the main cause of mortality in this age category mainly being lower respiratory infection and neonatal disorders (IHME Country Profile, 2019).

Health Services

The health care system in Fiji is divided into four main divisions as outlined in the map below (Figure 6) as the Western, Central, Northern and Eastern divisions.

Figure 6

Fiji Map with Government Divisional Boundaries

Source: netmaps.net/digital-maps/fiji-political-map/

The Fiji Ministry of Health, in trying to improve the country's health care system, implemented two separate health reforms, with the first reform being attempted in 1999. The reform was delivered through the creation of three geographically divisions (North, West, Central), where the Central and the Eastern division were combined into a joint team sharing administration services. This health management reform was conducted with the aim of providing both clinical and public health in all four divisions, making services accessible to anyone in the country. Political instability, budget constraints, and lack of human resources contributed to the unsuccessful reforms, along with unavailability of staff to fill key positions in the health system. Thus, in 2004, the Ministry reverted to the initial centralised structure that had existed in 2001 (Mohammed et al., 2016).

The second wave of reform came in 2008 when Fiji implemented a pilot health service of recentralisation, like the first reform, along with the de-concentrating of general outpatient adult clinic to six of the main populated health centres within the Suva subdivision. The success of this pilot project initiated the third wave of reform in 2009 where decentralisation of the adult outpatients was rolled out throughout the country to all subdivisions. Structural positions were created to manage this new delivery services (Mohammed et al., 2016).

It is important to note that in relation to decentralisation, nursing leadership positions were abolished during the discontinuation of the reform period. The positions which were based at headquarters as the 'Director of Nursing' and two assistant nursing directors were established by AusAID during the 2001 reform. The nursing director position was the only one removed while all other health director positions remained. This would have resulted in nursing administration being supervised by either medical officers or non-medical personnel. The government unwillingly reinstated the position of the Director of Nursing in the country following threats of industrial action from the Fiji Nursing Association (FNA). Unfortunately, the assistant director positions were never reinstated (Vudiniabola, 2011).

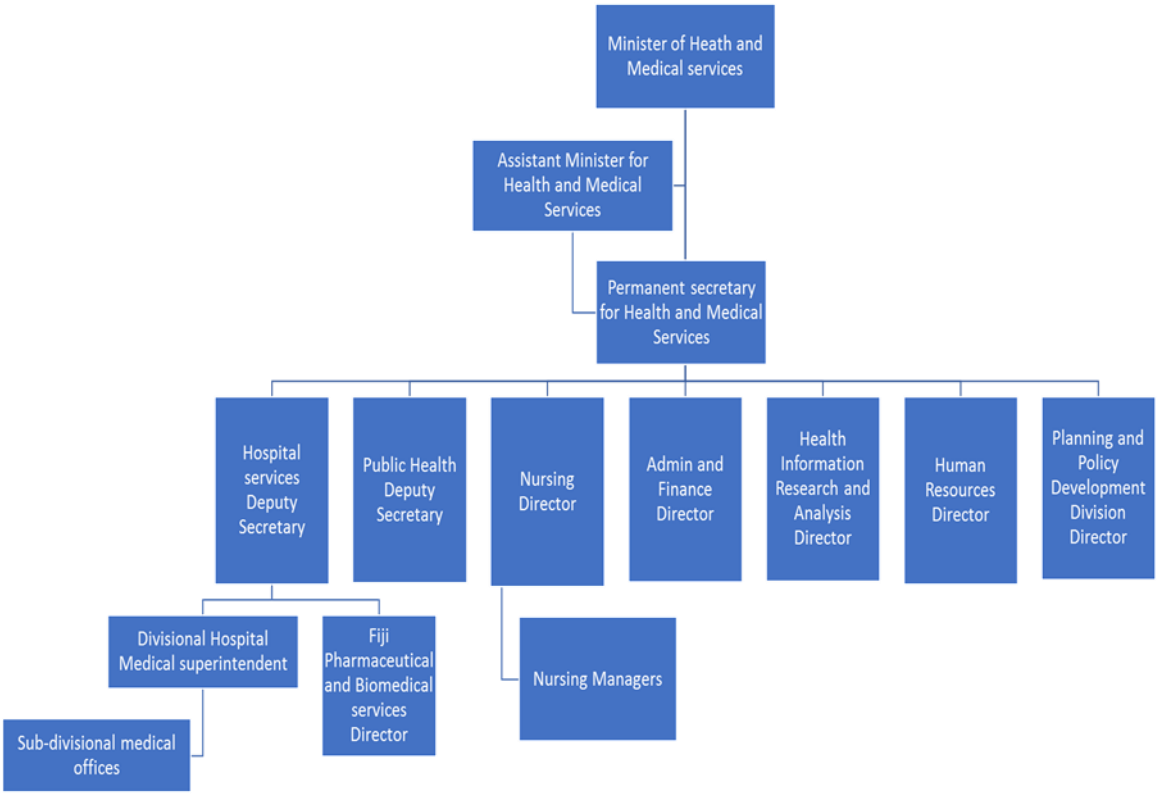
The geographical layout of the country has proven to be one of the challenging factors in the delivery of health services in the country through the dispersant of population from the maritime islands to the interior highlands of the country. Fiji's health care system is mainly financed by the Fiji government, and 70% of the health workers are paid by the government. Nurses represent almost two thirds of the total health workforce (Wiseman et al., 2017).

A brief overview of the current Ministry of Health and Medical Service's organisational structure is provided in Figure 7. The health services are provided throughout 207 health facilities in the country. Table 1 outlines the distribution of the facilities within the four divisions.

The health facilities are managed by the medical officers with the assistance of administrative and clerical staff, nursing managers, and other paramedic personnel such as dentists and health inspectors. The nursing station is solely managed by a district nurse located in an isolated area, who is expected to carry out a wide range of skills in both clinical and public health nursing.

Figure 7

Ministry of Health and Medical Services Organisational Structure



Source: Ministry of Health and Medical Services Annual Corporate Plan (2017, p. 14)

The health care settings of rural and urban health facilities are classified according to the population density and geographical setting of the population, which then defines the provision of the nursing workforce. Though population density in the country has increased over the years, it would be interesting to note if the workforce allocated to each facility has also increased or remained the same (Lasala, 2017).

Table 1

Health Facilities in Fiji

Health Facility	Central	Eastern	Western	Northern	Total
Specialised Hospitals/National Referral	2	0	0	0	2
Divisional Hospital	1	0	1	1	3
Sub divisional Hospital [level 1]	0	0	3	1	4
Sub divisional Hospital [level 2]	5	5	3	2	15
Health Centre [level A]	7	0	4	1	12
Health Centre [level B]	5	1	4	3	13
Health Centre [level C]	12	13	20	16	61
Nursing Stations	21	31	28	21	101
Total	5	50	3	4	209

Source: Ministry of health and Medical Services Jan-July 2018 Annual Report (2018, p. 20)

1.3 Development of the Nursing Profession

History of Nursing

Nursing in Fiji began through Ms. Wedderburn, a former student of Florence Nightingale. She was the first qualified nurse to arrive in the country in 1892. Ms. Wedderburn, who had received her nursing training in England, was the first Matron of the Colonial Memorial Hospital with a professional nursing qualification. Fiji is recorded in history as one of the only Pacific countries (apart from New Zealand) to which Florence Nightingale sent nurses.

Nursing began in 1892 in Levuka (Ovalau) and was pioneered by a group of women who had received no training but were supervised by a doctor. It was not until 1894 when the capital of Fiji was shifted from Levuka Ovalau to Suva, that a 70-bed colonial hospital was established and nursed by long term prisoners who, at the time, were supervised by an untrained matron. This paved the way for nursing education in the country.

European nurses were initially trained in 1893, but it was not until 1897 that Fiji finally saw the first qualified Fijian nurse—Ms. May Anderson—complete the full 3-year term training.

She went on to become the first locally trained matron for both colonial hospital (now known as the Colonial War Memorial Hospital) and the Lunatic Asylum (now known as the St. Giles Hospital) in 1902 (Usher, 2003). The 1900s was when Fijians were given equal status with overseas trained nurses, and training of Fijian girls began in 1901.

Currently, Fijian registered nurses have three main titles legislated by the Fiji Nursing Council which include 'general registered nurse', registered midwives', and 'registered nurse practitioner' (Fiji Government, 2011). The Fiji National University (FNU) has currently introduced a new curriculum for enrolled nursing, and in 2019 pioneered the new graduates of enrolled nurses which have rolled out into the health care system. Key milestones in the development of nursing in Fiji are portrayed by the World Health Organization (WHO)-Western Pacific region and midwifery databank in Table 2.

Table 2

Nursing Development Milestones

1892	Miss Wedderburn (friend of F. Nightingale appointed Matron of Colonial Memorial Hospital and started training European women as nurses
1923	Training continues. Training of Fijian as assistants commenced
1954	New Zealand training introduced to run alongside colony programme
1983	Suva and Lautoka Schools merge for 3 year-programme. New WHO-assisted curriculum introduced (Nadakuitavuki et al., 2004)
1987	School of Nursing in Suva expanded to accommodate approximately 400 students (Nadakuitavuki et al., 2004)
1990	Distance learning course by teleconference initiated to upgrade the skills of mid-level nurse managers (Stewart & Usher, 2010)
2003	Nurses and Midwives Board adopt nursing competencies based on the Western Pacific and South East Asia Region (WPSEAR) common competencies
2010	Fiji School of Nursing merges with Fiji School of Medicine to form the College of Medicine, Nursing and Health Sciences
2011	Nursing Decree 2011 passed. Fiji Nursing Council established and poised to take over responsibilities from the Nurses, Midwives and Nurse Practitioners Board Annual registration of all nurses and Midwives required

Source: Western Pacific Region and Midwifery Databank (2022)

The Nursing Workforce

Nursing as a profession includes diverse roles, geographical location, health facility distribution, service delivery, and specialists nursing domains. In 2017 nurses comprised 62% of the health workforce as reported by the Health Minister Rosy Akbhar in 2017 when she launched the first ever nursing strategic plan and scope of practice manuals (Ravuwai, 2017).

At the end of this thesis, Fiji nursing scope of practice has yet to be reviewed, is limited, and needs to be redesigned to encompass all the speciality nursing positions that have recently been created as expressed by the then former Chief of Nursing and Midwives, Margaret Leong, in an interview with the Fiji live media outlet during the nurse's world celebration day (Susu, 2020).

Nursing roles in Fiji have evolved over the years and many of the new nursing components mirror the Australian and New Zealand nursing positions, though are not as advanced into their specialist nursing domains. Clinical nursing is typically associated with secondary health care and medical interventions, whereas public health nursing involves preventative health care and health promotion. Health management is similarly associated with nursing leadership and non- clinical roles including lecturers, researchers, and contributors to development of health policies and patient health care management (Australia Nursing & Midwifery Federation, 2018).

Development of Nursing Education

Nursing education in Fiji initially began in 1955 using the Nurse' Ordinance regulation following the adaptation of the New Zealand nursing curriculum into the country. Later, from 1999, the Nurses, Midwives and Nurse Practitioners' Act regulated the education and practice of nursing in Fiji. The Fiji Nursing Council, in 2011, became the governing body that provided legislation towards nursing education and practice as according to the Fiji government Nursing Decree (Fiji Government, 2011; Vudiniabola, 2011).

Nursing in Fiji was provided by the Fiji government through a full scholarship scheme where students who took up nursing at the 'Fiji School of Nursing' (FSN) were bonded to the government for 3-years of service; equivalent to the number of years of study. The government resisted the recommendation of a school merger with the Fiji School of Medicine (FSM) in creating a School of Health Science for the University of the South Pacific because it needed to continue its authority over the school. This enabled the government to meet health services strategic plans of nursing shortages and migration in the country (Fiji Islands Education Commission/Panel, & Fiji Ministry of Education, 2000).

Though, globally, nursing education has moved forward into higher tertiary education such as in New Zealand and Australia, Fiji continued to have a diploma level nursing qualification. Despite refusing a merger with the FSM, the government agreed to upgrade the qualification. However, the Diploma in Nursing remained until the revision of the curriculums in 2004. The difference was that the 1983 curriculum (taught until 2006) was focussed on primary health

care, while the 2004 curriculum advocated a more competency-based curriculum. This has since changed following the FNU merger and a Nursing Undergraduate Degree was implemented into the curriculum in 2013. The 3-year bond for the new graduates meant that the experienced nurses were more likely to be moving offshore; however, the government also allowed for alternative cost sharing payments which enabled some students to avoid being bonded (Fiji Islands Education Commission/Panel, & Fiji Ministry of Education, 2000; Vudiniabola, 2011).

In 2010, following 116 years of FSN being the nursing education provider, they merged with the FSM following the government's decision of establishing the FNU. This was brought about through the merging of six government funded tertiary institutions (Fanine, 2009). The merger allowed for greater accreditation of tertiary qualification as well as providing academic professional development courses for post registered nurses as a form of incentive. Today the institution is known as the College of Medicine, Nursing and Health sciences (Fanine, 2009).

Before the merge with FNU, nurses were posted directly to hospitals and health centres following graduation. Nurses posted to divisional hospitals are fortunate to experience internship in all clinical nursing departments for the 1-year internship term before being posted to community health. The rest are directly posted to sub-divisional or rural health centres where they are expected to be competent in their nursing skills. Following the FNU merger, the new system requires new graduates to have a nursing registration exam before being awarded their nursing uniforms and posting. The internship period remains and soon after a year of supervisory clinical practice, the young nurses are posted to rural vacant postings.

Nursing Postings

In Fiji, the posting of nurses is conducted on an annual basis, usually coinciding with the graduation of the new nurses from university. Thus, "nurse posting" is the process that mainly occurs after new graduates are registered and assigned nursing positions within the Ministry of Health. Once registration is achieved, a 'posting' letter is given to advise the nurses on their new work station, and as new graduates they are sent off to the remote isolated facilities to begin their nursing career. The lucky few experience internships at divisional hospitals before being posted to the rural facilities (either inland or maritime).

Posting is not limited to the new graduates but extends to any registered nurses in the country who wish to change their work facility or area. Apart from the new graduates, who

in most cases do not have a choice regarding their appointed, the registered nurses who wish to change work area or facility are required to write a formal letter of request to the national posting committee for a transfer and will have to await their approval before any change can occur (Public Service Commission, 2011).

The national posting of nurses to any health facility is decided by the appointed Chief Nurse in consultation with the Director Nursing Managers, who makes selections according to priority of service needs. They are known as the National Posting Committee. Nurses posted to any health facility, especially to rural postings, are legally obligated to take up their post regardless of any objection. Appeals can be made but are usually unsuccessful, with a very few exceptions with genuine reasons for an appeal. Consequently, the establishment of the Open Merit Recruitment Selection (OMRS) has initiated a system of all civil servants being placed on contracts (Public Service Commission, 2018). The system will be further elaborated in the following paragraphs. Hence, an appeal on a posting may place a threat on the future renewal of the nurse's work contract.

New nurses posted to a rural isolated facility must adapt to cultural difference, familiarise themselves with a diverse health work force, and develop different approaches in the delivery of public health. This can be overwhelming for a new nurse with limited experience in community health. Nurses may tend to resign when appeal is rejected from the Ministry of Health or not complete the full term of service in the designated community. The career pathway for public health nursing is also unclear as management positions are limited. Conversely, the application for a promotion position does not take into consideration the years served in the community, even though working in isolation requires a great deal of management and specific skills.

Urban Nursing

Urban nursing in Fiji involves hospital nurses who work in either the divisional or the sub-divisional hospitals. The nurses have a broad range of skills such as being midwives, emergency (ER), Intensive Care Unit (ICU), and Coronary Cardiac Unit (CCU) specialised nurses. The ICU/CCU nursing skills are limited to the divisional hospitals; general nursing skills in other units such as surgical/medical/out-patients are practiced in both divisional and sub-divisional clinical settings (Ministry of Health, 2012; WHO, 2018). However, sub-divisional hospitals may work with limited clinical support team such as pharmacists, dental and laboratory support technicians.

Rural Nursing

Long and Weinert (1999) defined rural nursing as "the provision of health care by professional nurses to person's living in sparsely populated areas" (p. 258). The rural health facilities in Fiji are either in the maritime or in the deep highlands of the two main islands in the country.

Rural nursing is more focused towards preventative health care. District rural nursing in Fiji was initiated in the 1900s beginning with the training of the first local nurses. Initially, due to an increase in infant mortality in the districts, Fijian girls were trained because they had greater influence with pregnant women in the community in accessing hospital care (Usher et al., 2003). Thus, began the journey of district nurses.

District nurses are expected to perform both clinical and preventative health care nursing skills. The health centres are managed by either a medical officer or nurse practitioner and are the first level correspondents to nursing stations and the community. The higher-level urban health centres may have a support team of dentists, dieticians, pharmacists, and nurses. The lower grade health centres in more remote locations are on 24-hours stand-by with nurses taking up the role of maternal child health, out-patients, family health, school health, general/special out-patients, and assisting the medical officer in distribution of medication. The nursing station, operated by a single nurse, is assigned several communities in her designated area to provide all the services as well as 24hours on-call (Ministry of Health, 2012; WHO, 2018). Working in isolation, with no professional development opportunities, has been one of the many factors of dissatisfaction in rural setting (Delobelle et al., 2011).

Rural health facilities are usually operated by one medical practitioner and have a limited number of beds. Remote rural area facilities are operated solely by a nurse. In the absence of the medical practitioner, nurses take up the extended role of both medical officer and allied health workers such as a pharmacist, dietician, and counsellor (Hegney, 1996). Urban nurses are based at hospitals and work in specialised areas that require specific skills such as theatre nursing, emergency, ICU, and maternity.

Rural nurses working alone are sometimes required to be competent in skills relating to all areas of nursing such as paediatrics, maternal health, and emergency care assessments. The extended role can sometimes be conflicting, requiring them to work beyond their scope such as giving treatment which may not be within the polices and protocols that govern their practice (Sturmey & Edwards, 1991). This dilemma may also be an existing issue in Fiji in

which the nursing council board would hold the responsibility to legitimise such nursing practices, especially in the case of medication distribution.

Nursing Recruitment and Retention

It is important to understand nursing recruitment in Fiji as to gain a clearer view of the motivations and challenges the nursing organisation encounters regarding the retention of their workforce.

The recruitment and retention of nurses is a continuing challenge, especially for small island countries in the Pacific. This has resulted in nursing workforce shortages and increased workload on the remaining staff. Aiyub et al. (2013), retrospectively reviewed Fiji Ministry of Health's annual reports and the records of nursing registration. The descriptive study conducted between 2001 and 2010, reviewed the number of graduates from the nursing institutions in Fiji in comparison to the number of nursing vacancies in the organisation and the attrition amongst the nurses. It showed that resignation was the most widespread reason for the reduction of workforce. Though the data did not fully display the true picture of the nursing situation in Fiji, because of data being only available from 2007 onwards; the study concluded that nursing shortage was not only viewed as an issue of not having enough nurses as demanded, but may include other reasons such as the effective use of nursing resources (Aiyub et al., 2013).

Nursing Remuneration

Despite the difference in nursing domains of practice, the salary for all nurses in Fiji has been the same across the board irrespective of whether they work in the clinical setting or the community population-oriented setting. Nurses in the urban setting receive the benefit of working with a medical officer every day, working hours allocated according to their shifts, transportation availability, and well-deserved rest on days off. Rural nurses, however, are on call 24-hours a day, even on weekends/public holiday, have limited supply of treated water and electricity, and no shopping leave to allow them to restock food supplies. The remote and consolidated allowance awarded to district nurses is only 15.5% of their basic fortnightly salary (Public Service Commission, 2011). That small percentage substitutes for the long working hours and holidays.

The positive factors are that clinical nurses receive a night shift allowance of 10% basic salary, responsibility allowance (when being a general nurse but rostered to perform supervision duties), or consolidated (remote) allowance for district nurses. The allowance allocation has been the same for the last 10 years and is overdue for a review due to the increase in

standard of living (Public Service Commission, 2011). Negative factors that may need further discussion are the nurses' leave entitlements, and accommodation/housing and transportation allowance for rural district nurses.

Professional Development

Generally, the pathway to advancement of nurses relies on the years of service, experience, and management selection for further training. Post registration courses are fully sponsored by the government and thus selection criteria is at the discrepancy of the nursing leaders. The only post registration courses available at the FSN before the FNU was established were the 'Post Graduate Certificate in Public health', 'Post Graduate Diploma in Midwifery', and 'Post Graduate Diploma in Nurse Practice'.

Placements for advance training were limited, and nurses completing the trainings had an advantage in their nursing career path. The limited number selected for training leaves those not chosen to become dissatisfied with their supervisors and causes barriers in their professional practice.

In 2018, the government implemented an Open Merit Recruitment System (OMRS) for all Fijian civil servants as a transparent method of selection that would not discriminate, nor give priority to, any individual or groups. Appointed panel members who have completed training and been approved for recruitment selection may be selected from any government ministries (Public Service Commission, 2018).

The successful candidate is subjected to a contract of three years and the position is re-advertised after the term is completed. Thus, civil servant permanent work security has been replaced with the uncertainty of performance-based contract renewal. An editorial article in the Fiji Times by Mohan (2017), expressed views of an economist, who had stated that health professionals and teachers felt unfairly treated with regards to the contracts and OMRS process by the government of the day, in which the implications of this drastic change may affect the existing migration of professionals from these two sectors. The evolving changes of OMRS require nursing management positions to match required qualifications; thus, senior nurses may have skilled experience but promotion may be awarded to a less experience nurse holding more qualifications.

The Fiji civil services have been challenged over the years with regards to salary reforms and frozen wage earnings due to political crisis such as coups. Mrs Kuini Lotua, former FNA general secretary, in her statement addressing the 2010 South Pacific Nurses forum in Auckland, noted that nurses' last salary adjustment, as according to the standard of living for

Fiji, was conducted in 2005 (Nursing Review, 2010). This was short lived as, following the 2006 coup, the interim government declared a 10% pay cuts for all civil servants. The introduction of contracts with increased salaries for all civil servants before 2014 was not well received in the country as it left most of the employees disappointed with the uncertainty of their job security and the possibility of a non-renewal (Mohan, 2017)

Migration of the Nursing Workforce

Migration has been taking place for health care workers and nurses drawn by better working conditions. The research on the migration of skilled health worker was published by Rokoduru (2008), focusing on issues that affect women who were migrating to other Pacific Island countries such as the Marshall Islands. The women were mostly nurses and teachers who migrated due to unfair work conditions, restricted domestic labour market and human rights issues, which is influenced also with the decision of improving the welfare of their families (Rokoduru, 2008). In a Pacific wide study, Brown and Connell (2004) investigated the factors leading to migration and the intent to migrate from three countries in the Pacific namely Tonga, Samoa, and Fiji. In surveying 251 doctors and nurses, they were able to determine the factors that were most influential in the choices made. They discovered that return migration was also evident in the three countries; with Tongan nurses having higher re-migration salary in comparison to the re-migration salary of both Fijian and Samoan nurses. The study showed that though many nurses in the Pacific migrate due to higher salary, they also leave due to lack of professional development and better opportunities for their family and children. The survey also highlighted that in the named Pacific Island countries, the nurses were less likely to leave if they owned a house or business, with those owning a house being 16% less likely to leave the country. Income may not be the only cause of migration as the survey concluded that government work conditions, career structure, training with the latest equipment, as well as up skilling are all contributing factors towards the nurse's decision to leave (Brown & Connell, 2004).

1.4 Significance of this Study

In Fiji, the Ministry of Health (2014, 2015, 2016) in their annual reports aimed to provide quality and equitable health services to the people. Ensuring health organisational aims and objectives were widely promoted is often done without consideration of the impact on the morale of the nurses, their workforces, their workloads, the quality of leadership, opportunity for promotion, and public respect for the profession (Jenaro et al., 2011).

Importantly, Fiji has limited health infrastructure, with a lack of medical resources and delivery systems. Annual reports from the Fiji Ministry of Health from 2014–2017 showed a high number of nursing vacancies despite increases in the number of nursing graduates. These reports estimated that between 2014 and July 2017, nursing had the highest numbers of health personnel that were retiring (44%) and resigning (49%) (Ministry of Health, 2014, 2015, 2016).

The continuous increase in position vacancies has resulted in Fijian nurses working with a ratio of 1 nurse to 16 inpatients, and 1 public health nurse to more than 8,000 people. This is in stark contrast to the WHO recommended ratios of 1:1 for critically ill patients and 1:5 for other illnesses. The WHO also recommend a ratio of at least 5 nurses/midwives per 1,000 population in general hospitals, compared with the current ration in Fiji of 38/1000 nurse to population ratio (Egger et al., 2000; Ministry of Health, 2016).

The significance of this study will be gathering of first-time data on the working experience of Fiji nurses and their perception of the organisation, professional and personal factors that influence their job satisfaction.

What is Already Known

Currently, nursing turnover and associated workforce migration is on the rise globally and is predicted to grow exponentially (Booth, 2002; Nardi & Gyurko, 2013). Documented push and pull factors for this phenomenon include poor and insecure pay, higher salaries and better family living conditions abroad, workplace stress, lack of health infrastructure and associated resources, political circumstances, lack of staffing, and absence/paucity of leadership and supervision (Booth, 2002; Nardi & Gyurko, 2013). The insufficient and inadequate nursing workforce in Fiji was further supported by Yurumezoglu and Kocaman (2016), whose retrospective study of 799 nurses found that key contributing factors to the workforce shortage were burnout from excessive workload and limited numbers of staff. Fiji-trained registered nurses often seek improved working and living conditions abroad, which provide better job satisfaction and include personal and professional opportunities and better pay (Connell, 2010).

What this Research Aimed to Understand

This research aimed to explore both the tangible and intangible factors leading to job satisfaction that are experienced by Fiji nurses in specific nursing roles. I aim to use the empirical evidence gained towards providing nursing leaders, educators, and health workforce policy makers with a reference point from which strategies and policies can be

developed to resolve current barriers to nursing workforce satisfaction in Fiji; including, and not solely, the continuous migration of nurses to other countries for better pay and professional development.

Research Questions

What factors influence job satisfaction among nurses in Fiji that may lead to improving their work-related conditions?

Specifically, the research questions for this study in the context of Fiji are:

- To understand the meaning of job satisfaction for nurses.
- To understand personal, organisational, managerial, and professional challenges nurses in Fiji experience in their roles, and how they perceive these challenges impact on their job satisfaction.
- Recommend strategies that support improvement in work conditions for nurses in Fiji that lead to enhanced job satisfaction.

1.5 Thesis Outline

The thesis is structured into 11 chapters. Chapter One has described the setting and context of the study with an overview on the rationale to the selection of the research topic. The research approach was described and highlighted with the outline of the research questions. Chapter Two focuses on literature describing job satisfaction within the context of the Pacific and Fiji. Chapter Three introduces the methodology relating to the use of the Vanua research framework; and Chapter Four outlines the method, process of recruitment sampling, data collection, and analysis and rigour. Chapter Five overviews the findings through the analysis of the themes selected and gathered from the Talanoa face to face and group Talanoa interviews with the nurses, nurse leaders, and government officials. Chapters Six to Nine present the results according to the main themes relating to job satisfaction; and Chapter Ten critically presents the discussion framed by the research question and a review of the local and global literature. Chapter Eleven, the final chapter, includes the study's strengths, weakness, recommendations, and conclusion.

Chapter 2: Literature/Past Research Review

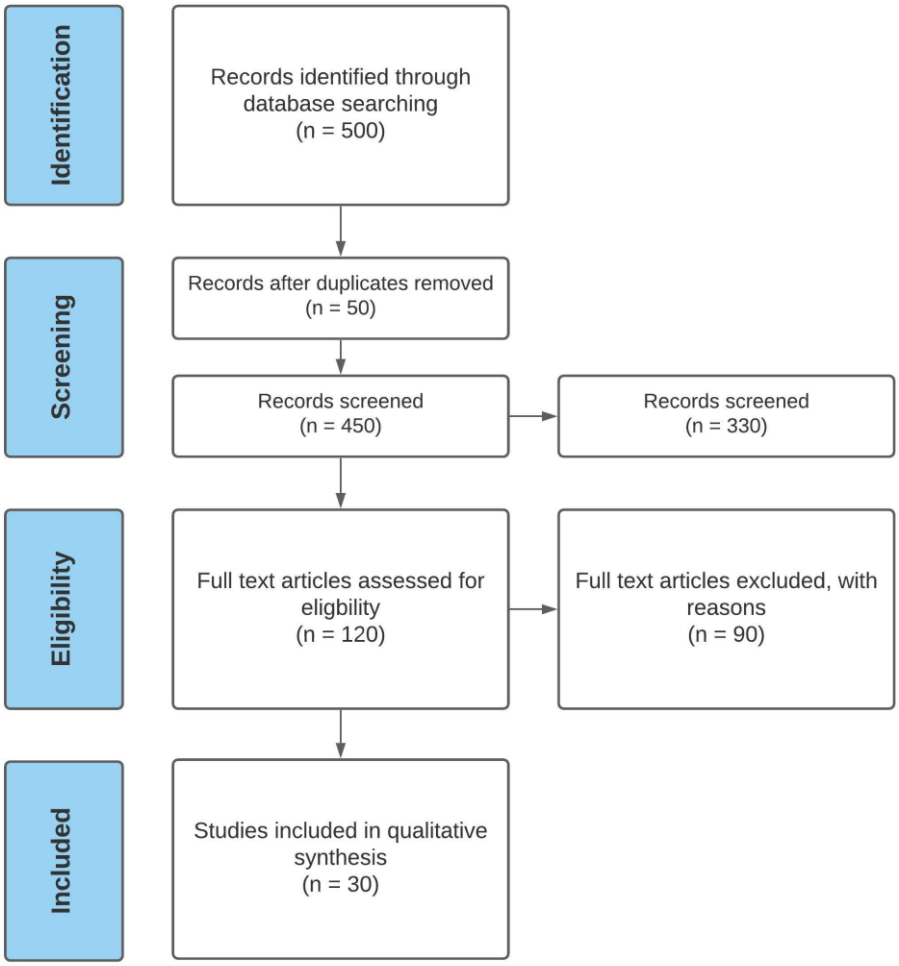
2.1 Introduction

This chapter examines the literature relating to this topic. Relevant literatures were gathered from four established databases: CINAHL, PubMed, EBSCO health database, and Google scholar; published over a 10- 12year (2009–2021) period. This extended period is due to limited studies being published in Fiji and the Pacific relating to nursing job satisfaction (search for literatures beyond this timeline will only be used when no other information is available or relatable to Fiji and the Pacific). The scope of this review used key search words that were used: ['work/job satisfaction' OR 'quality of nursing leadership' OR 'attrition and nursing migration'] AND ['workforce shortage' OR 'Fiji nursing context' OR 'workforce frameworks/policies/plans'] AND ['remuneration'] AND ['nursing' OR 'Pacific nursing culture']. Importantly, this literature review provides context for the development of the research questions. The integrated review adapted the preferred items and the PRISMA flow chart ensured that the required information and evidence are reported correctly.

The eligibility criteria for the inclusion of articles were full text articles only that were published between 2009 and 2021 with relevancy to the research questions. Given the limited number of studies conducted and published in Fiji, the integrated review expanded to include grey literature (Adams et al., 2017) such as government ministerial policies, reports, strategic plans, and frameworks to provide an integrated review. Though there were no geographical limitations, only articles that included causative factors to job satisfaction were considered. The articles that provided a possible conflict of interest or from a high socio-economic health care system were excluded ensuring articles selected were in line with the research question. The outcome after eliminating duplicates, abstracts, screening titles and the review of the full text resulted in 30 articles meeting the eligibility criteria for the inclusion. The PRISMA flow chart in Figure 8 summarises the four-step process of the eligibility criteria.

Figure 8

Flow diagram of the selection process and review process based on the PRISMA statement



(*Source:* Moher, Liberati, Tetzlaff, Altman & PRISMA Group, 2009).

The themes for the integrated literature review are grouped under the following headings: job satisfaction, definitions, and theoretical models of job satisfaction; managerial and leadership characteristics; organisational characteristics; workforce characteristics; and remuneration. The latter sections critique the Fiji context; that is, associated Fiji and Pacific based literature using the following headings: nursing migration, personal and professional factors; colonialism, power dynamics and women's role; urban and rural nursing; and, lastly, approaches to upskilling the Fijian nursing workforce.

2.2 Definitions of Job Satisfaction

Job satisfaction has been defined as "a kind of pleasant or positive affection state, which grows in the process of evaluating an individual's work experience" (Zhu, 2013, p. 294). Job satisfaction is, therefore, critical for the nursing profession because of its relationship with

roles, expected behaviours, nursing turnover, attrition, and retention, and how it affects the quality of healthcare delivery (Masum et al., 2016; Roelen et al., 2013).

To date, research on job satisfaction has been underpinned by motivational theories such as Maslow's (1943) hierarchy of needs, which links personal needs to organisational behaviours, as well as Herzberg's two-factor theory (Liu et al., 2016). However, these two motivational theories fall short in considering the value of work and workforce equity for nurses. Liu et al. (2016) argued that there is a need to broaden the definition of job satisfaction when studying the nursing workforce to extend beyond personal desires and motivation, and encompass nurses' self-perception of how they value their work and feel about their work conditions.

Job satisfaction is linked to an employee's emotional reaction towards their work conditions. Employees' attitudes depend on whether they are happy or satisfied with their working conditions. Jayasuriya et al. (2012) outlined factors relating to job satisfaction by examining interpersonal, intrapersonal, and extra-personal issues relating among nurses in rural Papua New Guinea (PNG). Measuring job satisfaction data were collected from 344 rural nurses in different provinces in PNG using self-administered questionnaires. The results offered insight into unique factors that affected job satisfaction in rural PNG compared with other developed countries. In PNG, work climate and leadership supervision were significant factors influencing job satisfaction, with most nurses being dissatisfied with poor teamwork and frustrated over the lack of nursing leadership supervision. The study highlighted those interpersonal factors were significantly related to job satisfaction and provided insights for developing strategies that could address improvements relating to nurses' personal and professional circumstances, rather than other recommendations such as improving health facilities and staffing shortages (Jayasuriya et al., 2012).

2.3 Theoretical Models of Job Satisfaction

The most valued asset in any organisation is the employees, and for any successful business organisation it is imperative that the employees remain satisfied and motivated. Studies (Alderfer, 1969; Ćulibrk et al., 2018) have analysed the development of motivation models and their application to a country's economy, and explored the nature of the relationship between the different characteristics of work motivation such as job satisfaction, organisational commitment, and work characteristics. One such study that investigated the relationship between work characteristics, job satisfaction, organisational policies and procedures, conducted in South-eastern Europe, revised existing models of motivation and

proposed models that mediate the effects of job satisfaction on organisational goals (Ćulibrk et al., 2018).

There are several existing models of work motivation. Maslow's hierarchy of needs theory evolved from Hawthorn's work and remains one of the most cited motivation theories (Denhardt et al., 2018). Other existing theories include Alderfer's ERG theory, the Achievement Motivation theory, Role Motivation theory, and the Motivation-Hygiene theory (Alderfer, 1969). Ćulibrk et al. (2018), explained that these mentioned theories only discover the needs of individual people and why they act or perform a certain way in an organisation, focusing on variables that fulfil their individual needs. Thus, they investigated more focused theories that influence motivation according to individual needs. Other theories identified that would work on motivation processors had some sort of limitation because they all contained different elements within the domain of work motivation theories. The performance product through the system of achievement and reward also affects job satisfaction and the theory models define the relation of job satisfaction and how it affects work characteristics and organisational commitment through policies and procedures (Ćulibrk et al., 2018).

Herzberg's (2008) two-dimensional factors theory contends that job satisfaction is linked to motivation and hygiene factors. Motivators for work satisfaction are associated with achievement, responsibility, receiving recognition, and work performed; and are associated with positive long-term outputs. Hygiene factors, such as salary, organisational policies, interpersonal relationships, and leadership, are considered to bring about short-term changes to work performance (Herzberg, 2008).

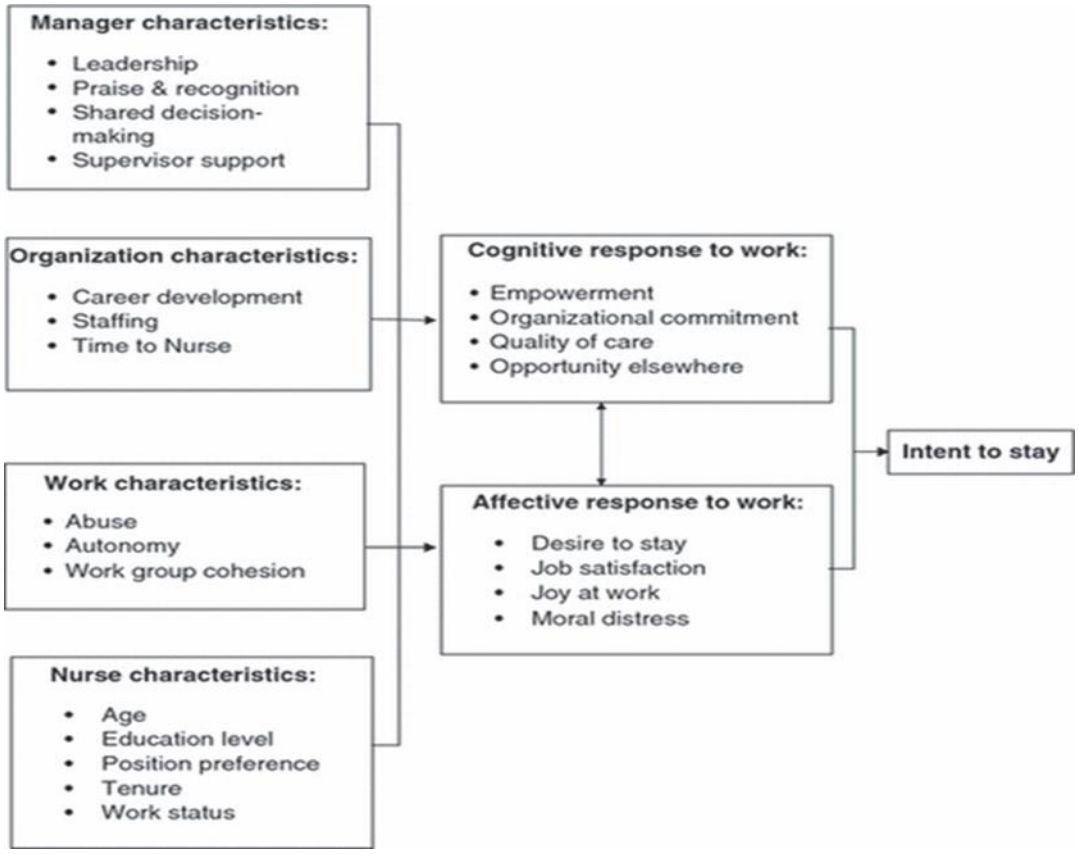
A more recent theoretical model that has been widely applied to the nursing workforce is Cowden and Cummings' (2012), 'Theoretical model of clinical nurses' intent to stay'. Their model was developed from a systematic review of the literature and outlined nurses' desire to remain in their current working positions. The model expanded on previous models by Alderfer (1969) in considering nurses' cognitive responses to work, such as job satisfaction and leadership. This theoretical model is presented in Figure 8 and shows key variables relating to nurses' intention to stay in their job. Subcategories included in the model are 'characteristic of leadership', 'organisation', and 'working and personal characteristics'.

The theoretical model by Cowden and Cummings (2012), postulates that nurses have a degree of desire to remain in their current working positions. However, cognitive responses (e.g., lack of empowerment, lack of organisational commitment, better opportunities

elsewhere) as well as work-related distress and other affective responses informed nurses' job satisfaction and intention to stay or leave (Cowden & Cummings, 2012).

Figure 8

Theoretical Model of Clinical Nurses' Intent to Stay



Source: Adapted from Cowden and Cummings (2012, p. 1652)

2.4 Managerial and Leadership Characteristics Informing Nurse Workforce Shortage

Internationally the shortage of nurses has resulted in many different studies and policies focused on leadership practices and the effect of such practices in creating an effective health workforce (Shaw, 2007). A study by Cummings et al. (2010), focused on the relationships between leadership behaviour and outcomes for nurses. That review showed there was a need for development and implementation of effective leadership strategies that positively impacted nurses' job satisfaction, especially because of worldwide nursing shortages (Cummings et al., 2010). The quality of leadership style is equally important to consider because attaining organisational goals is linked to employees' emotions which, in turn, are significantly influenced by management and leaders (McColl-Kennedy & Anderson, 2002). Platis et al. (2015) identified a relationship between the role of nursing leaders and attaining better work performance among staff. That study analysed 246 questionnaires relating to job

satisfaction and job performance completed by nurses and found that building nurses' confidence through respect and communication promoted increased job satisfaction.

The success of an organisation is influenced by both the individual and the organisation and Cherian et al. (2018) found that the relationship of nurses and job satisfaction is defined by a few characteristics such as organisational commitment. Their study focused on the job satisfaction of 380 nurses in Dubai through an exploratory design that examined the link between job satisfaction and the nurses' commitment. The results showed a definite link between commitment level and extrinsic job satisfaction level which would contribute to organisational success.

Job satisfaction factors precede an employer's performance irrespective of whether they are working in a private or public organisation. Factors such as how an employee feels are affected through named facets of job satisfaction such as feeling appreciated, being recognised, promotion, improved working conditions, remuneration, supervision/leadership, and policies/procedures available. When employees are satisfied with their work performance, work output is satisfactory, and their performance shows their commitment to their work. Pay, quality of leadership, and workplace satisfaction have been documented as positive influences for commitment from the employees (Suma & Lesha, 2013).

Reviewing the ratio between nurses and the population in different continents shows that Africa and East Asia portrayed the lowest average ratio (Buchan & Aiken, 2008). The result also highlighted that the definition of nursing shortage was not limited to people with nursing credentials but more likely to the lack of interest in working in the given conditions. One of main factors outlined in the study by Buchan and Aiken (2008) relating to workforce shortage was the lack of incentive structures and not enough career support for nurses. The study concluded that the way forward was for common countries, such as Japan and Europe, to design policy packages that address nursing shortages and their challenges, as this will allow countries to provide short- and long-term solutions (Buchan & Aiken, 2008).

The aim of an organisational commitment is to structure employees into achieving the organisation's goals and objectives through their emotional responses such as behaviour, beliefs, and attitudes that inspire loyalty and devotion to the organisation. The three different types of organisational commitment, as identified by Kaplan and Kaplan (2018), are: 1) affective commitment, 2) continuance commitment, and 3) normative commitment. Affective commitment is when employees feel like they have a sense of responsibility for the

success of the organisation and are emotionally attached to the values, goals, and needs of the organisation. These employees exhibit a positive work outlook and are more committed to achievement due to most of their needs being met (want to stay). The continuance commitment involves employees feeling guilty or the inability to leave because of fear of being judged because of the high cost of leaving, and thus employees feel trapped in the organisation (need to stay). The third, normative commitment, takes place when an employee joins an organisation that meets their expectation of the social work norms and code of conducts, thus inducing employees to make the decision that they must stay and join the organisation (Kaplan & Kaplan, 2018).

Organisational and managerial commitment focuses on the organisation and the attachment they have with employees; whereas job satisfaction focuses on the different tasks that employees carry out. The result of the study identified that there was no significant relation between the nurses' age and educational status in relation to job satisfaction. Organisational commitment and job satisfaction contribute to ensuring that health care services provide optimal services, and that extrinsic job satisfaction measures correlate with organisational goal measures (Cherian et al., 2018).

Nursing leaders are expected to be knowledgeable in performing their daily duties and act as advocates for their patients as well as the nurses, and support staff under their management. Tomey (2009) investigated the effects of nursing leadership on the work environment. Interestingly, the study highlighted that the quality of leadership may be measured by the work environment. An unhealthy workforce may reflect increased rates of absenteeism, non-performance of nurses, low morale, decreased organisational performance, and a high incidence of stress and accidents at workplace. These events are brought about by poor leadership styles, such as unsupportive leadership and lack of supervision, guidance and patience, as well as not giving employees the recognition that they deserve (Tomey, 2009).

The quality of nursing care as a function of patient outcomes was observed in a survey conducted by Adams and Bond (2000), which used the Ward Organizational Feature Scale to investigate associations between the organisation of hospital staff nurses and their personal characteristics and job satisfaction. Although work experience was a predictor of job satisfaction, this varied among hospitals, with nursing leadership style being the most important factor. That study also showed stress was a clear indicator of how nurses were unsatisfied with the burden of having more responsibilities, including the skill mix and communication with colleagues. Overall, the results showed that nursing characteristics (e.g.,

relationships with medical personal, workload, and the system in which they practiced) were associated with job satisfaction (Adams & Bond, 2000).

Organisational Characteristics

Leadership is a key organisational criteria strongly linked to the quality of the nursing work environment. A study that investigated the effects of nurse managers' transformational leadership behaviours on the outcomes of patient safety through a job satisfaction survey was conducted by Boamah et al. (2018). The study included 378 randomly selected nurses for a cross-sectional survey. Results highlighted that transformational leadership had strong links to the empowerment of individuals within a workplace and thus influenced job satisfaction of the nurses, which contributed to lower results of adverse occurrence in the workplace (Boamah et al., 2018).

Transformational leadership style is that where employees are motivated to achieve the organisational goals beyond what is expected of them because of the trust and respect relationship they have with their leaders. Transformational leadership consists of four core dimensions: 1) idealised influence, 2) inspirational motivation, 3) intellectual stimulation, and 4) individualised consideration. Overall, the transformational leadership style is linked to the nurses' attitudes and satisfaction behaviours, and the four dimensions create structure in empowering the work environment. The leadership behaviour that encourages empowering conditions of support and availability of resources in the workplace is associated with increased levels of job satisfaction from the employees (Boamah et al., 2018).

Organisational management and leadership roles contribute to the nature of the work environment. Pearson et al. (2008) evaluated different approaches used to spread nursing innovation in three hospitals. They suggested that a down-up leadership approach provided better options for spreading change to frontline staff and improving organisational strategies.

In their review of attrition of the health workforce in the United States, Lopes et al. (2017) stated that the shortage of nurses was related to several reasons including organisation migration, death, retirement, illness, and voluntary resignation.

In Fiji, continuous staff shortage has been identified as potentially preventing Fiji from achieving the Sustainable Development Goals of addressing health workforce shortages and meeting the needs of the population (WHO, 2016). Based on a review of published studies on health worker attrition rates since 2005, across different settings, Lopes et al. (2017) concluded that attrition may be used as a measure to gauge job dissatisfaction, as it was

often associated with unsatisfactory working conditions, lack of career opportunity, overwork, ineffective supervision, and uncompetitive pay. They recommended that for countries to make strategic decisions about the future of their health workforce and management, more focus should be directed to attrition-related data such as geography, health cadres, and facility types (Lopes et al., 2017).

The features of the organisation in association to job satisfaction may be understood through looking into the determinants or features that are associated with job satisfaction. This was reflected by a study published by Cohidon et al. (2019), who conducted a secondary analysis of the 2015 Commonwealth Fund International Health Policy Survey (CFIHPS) to identify how satisfied primary care physicians were practicing medicine. Using a four-point Likert scale, the results of the study showed that organisational characteristics associated with job dissatisfaction were having heavy workloads, changes in case managers, organisational changes, and stress (Cohidon et al. 2019).

Work dissatisfaction is a common issue experienced by high income countries that is linked to emotional commitment, stress, and heavy workload. The repercussion of this issue is individuals experiencing mental health breakdown like depression and burnout. Job dissatisfaction affects recruitment and retention of staff and compromises the quality of care delivered to patients. It is vital that the determinants of work dissatisfaction are understood as to enable organisations to address the challenges as they are identified.

The relationship between job satisfaction and job stress was published by Hosseinabadi and Etemadinezhad (2018), who, in a cross-sectional study of 406 female nurses from 6 hospitals in Babol, found that job stress was inevitable across all professions, and nurses seemed to be identified as encountering more stress in the workplace as compared to any other healthcare provider. The psychological, physical, and organisational problems associated with job stress range from having anxiety, depression, elevated blood pressure, cardiovascular diseases, musculoskeletal pain, absenteeism, and known quality in service delivery. Thus, job stress is an important organisational issue in relation to job satisfaction (Tadesse et al., 2016).

The ability for an individual to have increased self-confidence in their workplace with good communication skills; decreasing levels of psychological distress; and improved physical, social, and mental health amongst the nurses, promotes job satisfaction within a work environment. Other factors that may influence job satisfaction are policies and procedure, scope of practice, salary, communication, and personality characteristics. Hosseinabadi and Etemadinezhad (2018) outlined that when there is lack of attention focused on the needs of

the nurses in any given workplace, job stress is the outcome which negatively affects their work performances leading to job dissatisfaction.

The level of productivity may be improved and increased efficiently with better understanding of the relation between job stress and job satisfaction amongst the nurses. This information, in turn, may be able to guide managers and leaders of organisations to develop strategies that promote satisfaction and quality health care delivery. Thus, nurses' work security through the limited changes within their work area has also contributed greatly to the improvement of job satisfaction amongst nurses (Hosseinabadi & Etemadinezhad, 2018).

Elsewhere, a study exploring quality of work life among primary healthcare nurses in Saudi Arabia concluded that improving job satisfaction decreased staff turnover, increased productivity, and improved health services (Almalki et al., 2012). Such initiatives may be beneficial in addressing the situation among the Fijian nursing workforce. Previous studies highlighted that in Fiji, nurses are disrespected by the public in terms of their quality of care and poor professional attitudes (Eric et al., 2012). These factors, coupled with poor performance and anecdotal evidence of workplace dissatisfaction, are thought to be related to lack of resources and supervision, and provide complex challenges exploring and addressing nursing job satisfaction in Fiji (Molefe & Sehularo, 2015; Sriratanaprapat et al., 2012).

The retention of the nursing profession is dependent on an improvement of organisational strategies, including the quality of health care as well as understanding the nurses and the work that they perform (Jenaro et al., 2011). These authors concluded that increased knowledge of the nurses' professional wellbeing can increase retention in the organisation (Jenaro et al., 2011). Understanding the nursing workforce will allow better insight regarding their work satisfaction and reasons for leaving as emphasised by Henderson and Tulloch (2008) who highlighted that globalisation is inevitable and skilled health workers are bound to continue and venture out into more attractive working conditions. They identified that migration in Pacific and Asian countries was owing to health workers feeling neglected, through ineffective planning and policies, as well as limited health budgets in the health care system (Henderson & Tulloch, 2008).

Lu et al. (2019) investigated the impact of factors such as shift work, absence, leadership, job performance, organisational commitment, and incentives on job satisfaction. The results showed some of these factors had direct relationships with job satisfaction, such as work

environment, management, staffing and resources. That study concluded that though ensuring nurses were satisfied with their work may improve the quality of care provided and meet organisational needs, managers need to identify strategies that would specifically meet the needs of their own nurses, rather than adopting a 'one size fits all' approach (Lu et al., 2019).

Workforce Characteristics

Key factors related to the nursing workforce shortage, outlined by Buchan and Aiken (2008), were the lack of tangible incentives such as remuneration and insufficient career development opportunities. A suggested way forward was for developed countries (e.g., Japan and the European continent) to design policy packages that addressed nursing shortages and associated challenges, which would allow other countries to develop short- and long-term solutions (Buchan & Aiken, 2008). Although nursing workforce shortage significantly affects health care service delivery, Nantsupawat et al. (2017) recommended further research be directed towards guidelines that provided a healthy work environment with more attention towards policies and improving work conditions.

The promotion of primary health care nursing in undergraduate programmes allows exposure for nurses to decide on career opportunities. McKenna et al. (2015) investigated barriers and enablers to advanced nursing roles in Australia and noted that some barriers were the lack of attractiveness of the nursing role as a sound career; the uncertainty of a clear pathway to promotion; salary disparity in not recognising qualification, training, and different distinctive work area of acute sector and primary health care. Enabling the promotion of primary health care should be given as much recognition as clinical placements for pre-registered nurses and addressing organisational factors such as equipment and transport would greatly support the different nursing roles (McKenna et al., 2015).

Irrespective of which health facility nurses practice their clinical skills, ensuring they have satisfactory work conditions is equally important. This contrasts with the conclusion drawn by Baernholdt and Mark (2009) in which they stated that job satisfaction of nurses working in urban and rural units depends on the provision of a creative environment that has a good support system. They explained that this is mostly attributed to the characteristics of the nursing unit, which they listed as the support system received, the work environment, and the continuous support of autonomous nursing practices mainly in isolated rural settings (Baernholdt & Mark, 2009).

Hegney (1996) highlighted that rural nurses hold a higher level of responsibility. His study investigated the roles of nurses in Australia and stated that though urban and rural nursing have similar factors of practice, the impact of the diverse roles that rural nurses' practice, such as the different community needs, holds a higher level of responsibility as compared to urban nurses. Rural nurses also do not place complete emphasis on their shifts as compared to urban nurses, as working with rural communities requires providing all care until it is completed; sometimes working through paid or unpaid overtime (Hegney, 1996).

The fact is, when nurses are unhappy and not satisfied with the available work conditions, they are more likely to seek alternative nursing opportunities. As in most health care systems, nurses are the frontline in the delivery of effective health care services and are the main reason for staff inadequacy in the nursing field. Further exploring the barriers and enablers of nursing in Fiji will assist in understanding the influences behind the different roles of urban and rural nursing, and the scope of practice and the nurses' perception regarding their work, which may give light to the challenges they encounter (Buchan & Aiken, 2008).

In contrast with identifying future strategies for appropriate remuneration policies for both urban and rural nursing, the current workforce framework/policies and plans will be reviewed. Likewise, a look into the professional development system, the role of the health ministry, and existing pathways to promotion will assist in giving insight into the organisational structure.

2.5 Unique Context of Pacific and Fiji

Nursing Migration, Personal and Professional Factors

In a study relating to incentives and working conditions, Connell (2010) found that Fiji-trained registered nurses often seek improved working and living conditions abroad, which provide better job satisfaction and include personal and professional opportunities and better pay. Connell's (2004) study recruited participants using civil lists and snowball sampling. More than two-thirds of the sample was from the nursing field. Questionnaires (n=450) were distributed across eight countries—Samoa, Tonga, Cook Islands, Kiribati, Marshal islands, Fiji, Solomon Islands, Vanuatu—to measure reasons for migration. The survey highlighted key reasons for migration were dissatisfaction with work circumstances, job prospects, and the draw of family/community networks. The number of strikes conducted by nurses in the Pacific (mainly Samoa and Tonga) offered evidence of work dissatisfaction in the respective country. Garner et al. (2015) conducted a study in the Indian sub-continent and identified

relatable factors that influenced nursing migration. The results gathered from the 29 articles reviewed highlighted unsafe working conditions, salience of family (which was also part of attaining good marriage prospects for their children through migration), unjust political authority of power, and professional development (e.g., exposure to the latest knowledge, skills and technology) as some of the main factors that influenced migration. The study concluded that improving health policy would contribute to retaining nurses with the need for more research development and test programmes in ensuring nurses remain in the country (Garner et al., 2015).

Pool et al. (2013) explored the different perceptions of nurses and managers with regards to professional development. Their study highlighted six themes towards professional development selection between younger and older nurses, with the last theme of 'social status and self-esteem' indicating that nurses felt that selection of training was a reward only give to those recognised for their work (Pool et al., 2013). Though, over the years, only a lucky few have been selected, the 2010 merger to FNU has opened the gateway for nurses to purse higher training courses privately, at their own time and expense. Though the nurse's purse and attain training for their professional development, they are not remunerated for attending the specialised courses. However, Tukana et al. (2014) identified that community health nurses serving in isolated rural health facilities and maritime stations were mostly neglected from regular professional development trainings as compared to colleagues in urban and peri-urban facilities.

Colonialism, Power Dynamics, and Women's Roles in Fiji

The effects of post colonisation in Fiji have impacted the way and nature in which power has been inherited in the country, which operates within a culture-based hierarchy and a political hierarchy of power. Baker et al. (2011) argued that power is having the capacity to influence change brought about through features such as gender, knowledge, class and race. Ashcroft et al. (1998) explained that to understand relationships in terms of race or gender, we must also consider these relationships according to their contextual relationship with the colonial past. The power dynamics within the Pacific society may be classified into two stereotypical categories such as ascribed status, which is based on hierarchy (social hierarchy); and context status, which is based on egalitarianism and competition (Douglas, 2013). Hereditary leadership was evident not only in Fiji but also in other Pacific Island countries where the perspective of leadership, rank, and power synchronised with social interaction and authority. The chieftainship/hierarchy rank was common practice through the colonisation era and was a factor that influenced the introduction of social stratification and reflected the

monopoly of the privileged status of positions, and leadership offered to chiefs and their sons (Douglas, 2013).

The tradition of nursing in Fiji pre- and post-colonisation was limited to women who suited the role, given the ideal of females as healers and the missionary idealism of feminism (Akram-Lodhi, 2016). Tuner (1992) reviewed the rituals and societal hierarchy of the Fijian people and observed that the definition of hierarchy in Fijian society was dependent on age, seniority, and gender; and that the social system was implemented in cultural rituals. He explained that the hierarchy system, such as men holding more power, had been reproduced in daily practices and unconsciously carried over to people with political power (Tuner, 1992). Salzman (2005) published a paper on the implications of cultural trauma in the Pacific nations and wrote that the principle of human development and behaviour is influenced by ecological models which are classified as microsystems and macrosystems. Microsystems have direct interaction such as family, school, culture, or historical experiences that affect development and experience. Macrosystems work on a broader context such as patterned ideology or institutional norms that influence experiences and manifest behaviours defined through colonisation and cultural trauma (Salzman, 2005). In the case of Fiji nurses, these psychological effects may jeopardise their leadership role as traumatic cultural experience may be reinforced by their traditional role of being a woman in the society. The establishment of cultural power remains pervasive in modern leadership roles and continues the tradition of an inferior attitude towards women in a male-dominated society, where it is culturally acceptable for women to adhere to what they have been directed to do.

Stewart et al. (2006) studied the role of nursing leaders in Fiji and their contribution to a clinical governance framework. The authors contended that as they were almost solely women, nursing leaders in Fiji shared similar challenges faced by female leaders internationally. However, nursing leaders in Fiji were also challenged by issues relating to post-colonialism and the perception of society regarding the diminished role of females (Stewart et al., 2006).

Remuneration

The Civil Service is the official professional body in Fiji and involves the public service commission, including all professions that are employed and paid by the Fiji Government. The Ministry of Health is one of the government ministries that govern nursing according to their legislative policies and practices. Thus, all the Ministry of Health budget, health facilities, and nursing salaries are directly decided by the government.

The country's political structure and economy has paved the way for how nurses and civil servants are paid in Fiji. The Ministry of Civil Service has since developed a new government salary reform using salary bands for all civil servants. However, the Fiji civil service salary bands (refer Appendix A) are not specifically for nurses, but include all civil servants assessed in the same salary band. Band 'E' is mostly assigned to 'internship' nurses, who initially begin at step 1, before progressing according to their competency assessment. Band 'F' includes all registered nurses, and bands 'G' and 'H' include junior and senior supervisors (Ministry of Civil Service, 2017).

The Attorney General Mr Aiyaz Sayed-Khaiyum, in an interview with Fiji Sun newspaper, stated that the reform gave recognition to public civil servants with selection of a candidate to a position that would be based on merit without any discrimination (Vakasukawaqa, 2017). According to the new salary band distribution, nurses in Fiji have a starting salary of FJ$17,518 (NZ$12,514) for intern nurses and FJ$34,707 (NZ$24,793) for a senior nursing manager position. A Fiji registered nurse would have an overall average annual income of FJ$26,112.50 (NZ$18,653) and nursing directors an average salary of FJ$44,564 (NZ$31,834) (Ministry of Civil Service, 2017). In comparison, New Zealand nurses' starting salary for interns in 2017 was NZ$49,449 and now NZ$54,034, with the highest level of registered nurses (step 7) receiving a salary of NZ$83,186 (New Zealand Nurses Organisation, 2020; New Zealand Nurses Organisation, 2017). This gives an average salary of NZ$68,610 for registered nurses in New Zealand; although community mental health nurses, district nurses, public health and community nurses have a higher salary range (averaging around NZ$71,395.50). In addition, supervisors have a different salary allocation from both nursing levels, with an average salary of NZ$111,006.50 (New Zealand Nurses Organisation, 2020). The difference in average income between Fiji nurses (FJ$26,000 or NZ$18,504) and New Zealand nurses (FJ$96,753 or NZ$68,610) is clearly marked and cannot be compared (New Zealand Nurses Organisation, 2022).

The characteristics of workload, relationship with colleagues, and professional development, are all linked to the quality of their work environment and their renumeration. The challenges of meeting the patient's quality outcome, retention of nurses, and patient satisfaction are all critically determined by the nurse's level of job satisfaction (Boamah et al., 2018).

Andrioti et al. (2017) conducted a study with registered nurses in Cyprus. They contended that dialogue regarding identifying nurses' needs was necessary to improve work satisfaction. They identified job satisfaction as an integral component of retaining well-

qualified nursing staff. The study concluded that nursing staff continuously need encouragement through many avenues (e.g., professional development), recognition through improved renumeration to ensure performance was improved and quality health services could be delivered. Furthermore, they suggested management may need to implement plans and policies to ensure that nurses gain job satisfaction in their field of work (Andrioti et al., 2017).

In the Pacific, in 2011, the WHO conducted a policy review on the retention and recruitment of health workers. This included the status of retention efforts for various Pacific Island countries, and showed that Fijian nurses in rural areas should have an extra allowance to promote retention (Buchan et al., 2011). How such an allowance should be distributed among the different health professionals (e.g., doctors, nurses, allied health workers) and how new salary structures could be incorporated are issues that need further clarification. The continuous pattern of nurses leaving their positions commonly results in low morale among remaining nurses. A study conducted in the UK investigated barriers to job satisfaction and found that salary, relationships with work colleagues, management, work environment, and organisational policies were key factors (Coomber & Barriball, 2007).

Job Dissatisfaction

The number of strikes conducted by nurses in the Pacific (mainly Samoa and Tonga) is evidence of the work displeasure in the Pacific (WHO, 2004). Connell (2004) reported that the FNA conducted a survey in 2000 and reported that 88% of Fiji nurses noted the main reason for migration was the need to for an increase in salaries. Work dissatisfactions were related to increased workload without any recognition or income incentives, and the need to improve the welfare of the family lead to the decision of migration (Connell, 2004).

The training programme for nursing in Fiji is three years and, upon graduating and attaining registration, nurses are posted to fill in nursing established vacancy positions across the hospitals and health centres in the country. There is limited data to measure the attrition rate of nurses, though Aiyub et al. (2013) reported that in 2009 two thirds of the attrition rate was due to retirement coinciding with the government's new policy of setting the retirement age for all civil servants at 55 years. The nursing establishment positions for the Fiji nurses are 1,750. Interestingly, in 2005 the number of positions filled was 1,857 which exceeded the established number. In 2009, 170 new positions were established (Aiyub et al., 2013). Fiji's population has increased over the years; yet, nursing establishment has been progressively slow. This was acknowledged by the 2017 Minister for Health, Rosy Akbar, who

announced that the government was allocating US$1.68 million in the 2016-2017 national budget for recruitment of approximately 300 new nursing positions. This was with the aim of trying to meet Ministry of Health target patient to nurse ratio of 40 nurses per 10,000 patients by 2018. Fiji previously had a ratio of 22 nurses per 10,000 patients and has, over the years, moved up to 38 nurses per 10,000 patients (Mala, 2017).

In nursing leadership and improving health services in the Fijian context, Stewart et al. (2006) considered challenges associated with the constant shortage of nurses. Their study focused on strategies that were undertaken and implemented at the FSN as an education programme for leadership management. The objective was to increase knowledge about nursing management skills that would eventually translate into quality supervision of nursing care. This represented an effort to improve health outcomes in Fiji through upskilling nursing leaders. The outcome of improving service quality through leadership training was also a strategy to retain nurses in Fiji through professional development (Stewart at al., 2006).

The perceptions of practice that encourage good communication, team bonding, quality of care, and training sessions are measures of job satisfaction, and are affected when workload is overwhelming to the point that nurses are unable to perform basic communication and quality of care because of nursing shortage and frustration (Tamata et al., 2021). The negative impact on both the nurse and the patient, as the result of staff shortage, is a continuous challenge with other factors such as early retirement, nursing migration, and inadequate workforce policies and planning contributing to the nursing workforce shortage (Van der Heijden et al., 2019). The nursing shortage is an on-going issue among the Pacific Island countries and one of the main factors reported as contributing to this issue was poor policies (Abhicharttibutra et al., 2017; Barnett et al., 2010).

In summary, the quality of health care delivered in a particular country, nursing satisfaction, and the retention of the nursing profession, is highly dependent on the micro (personal), middle (professional), and macro (organisational) structure. Increased knowledge of the nurses' professional wellbeing and associated satisfaction may be used as a variable towards encouraging them to remain in an organisation (Jenaro et al., 2011). Understanding the nursing organisation and structure provides a lens to understand the value of work carried out; and thus, encourages a more realistic approach towards understanding the experience of job satisfaction or dissatisfaction and work conditions.

2.6 Summary

This critical review of the literature on nursing workforce job satisfaction and associated factors that result in staff retention, attribution and burnout is dependent on a number of personal, contextual, organisational, and professional factors; and a combination of these factors in turn affecting continuous nursing workforce migration.

In Fiji, the nature of these factors, and other possible factors, needs to be examined to better understand and address job satisfaction and retention in healthcare organisations. In reviewing the literature, presenting gaps include a lack of a definition of what job satisfaction means for nurses in Fiji; a paucity of recent data on the personal, organisational, managerial, and professional challenges that nurses in Fiji experience in the workforce; and how they perceive these challenges impact on their job satisfaction.

The extensive outward migration of nurses from Fiji, as elsewhere in the Pacific, is related to strong push factors such as few nursing specialist positions, lack of career progression pathways, lack of leadership, and lack of post graduate education opportunities. For Fiji to meet its predicated population health needs, evidence-based approaches that translate into management service and policy reform to retaining nurses in the health workforce system are urgently required. In the present study, addressing this gap in the literature will provide an evidence base to inform improved professional conditions that may increase job satisfaction and improve workforce retention, reduce net nursing migration flows and so improve patient and population health outcomes.

Chapter 3: Fijian Itaukei 'Vanua' Framework as a Theoretical Framework and a Methodology

3.1 Introduction

The Fijian Itaukei 'Vanua' framework represents the Fijian philosophies and methodology utilised in this thesis. This chapter outlines the research framework and sheds light on understanding the Fijian culture in relation to the principles of their society, and how it affects their behaviour (Ravuvu, 1983). Like the use of the Kaupapa Māori (Henry & Pene, 2001) and Tongan Kakala framing (Vaioleti, 2006), the decolonising of the Western methodology allows for epistemological acknowledgement of indigenous ways of sharing knowledge (Thaman, 2006). Nabobo-Baba (2008) stated that Pacific cultural epistemology provided the foundation for its methodological integrity. The use of the 'Fijian Vanua' research framework is implemented to investigate possible factors that influence job satisfaction of Fiji nurses. In turn, this may lead to the improvement of their work-related conditions and policies. The 'Vanua' framework, which uses Talanoa as an interview tool, allows for rich descriptions of experience of job satisfaction as perceived by urban and rural nurses in Fiji.

Study research questions:

- To understand the meaning of job satisfaction as perceived by nurses in Fiji.
- To understand the personal, organisation, leadership, and workforce challenges that nurses in Fiji experience in their roles, and how they perceive these challenges impact their job satisfaction.
- Recommend strategies that will support improvement in nurses' work conditions in Fiji and lead to enhancing job satisfaction.

3.2 Philosophical Framework of the Vanua

The philosophies surrounding the Fijian culture will allow insight into understanding the attitudes of the Fijian people, their culture, and the impact of globalisation; where change is inevitably resulting in the continuous shifting and evolving of culture. Change is in relation to how things are done, where some cultural practices are limited to specific provincial areas, and what is allowed to be done in society according to different levels and distinctive actions that may be carried out by certain groups; which may not be the true representation of the whole Fijian culture.

The customary practice deemed acceptable by the elders is the founding social principles that provide the structural framework in understanding the Fijian village, their beliefs and values, ceremonial rituals, and both the physical and social structure of Fijians. Comprehending how these social principles are applied will allow a better grasp to finding the real meaning behind why the Fijian people act and behave the way they do.

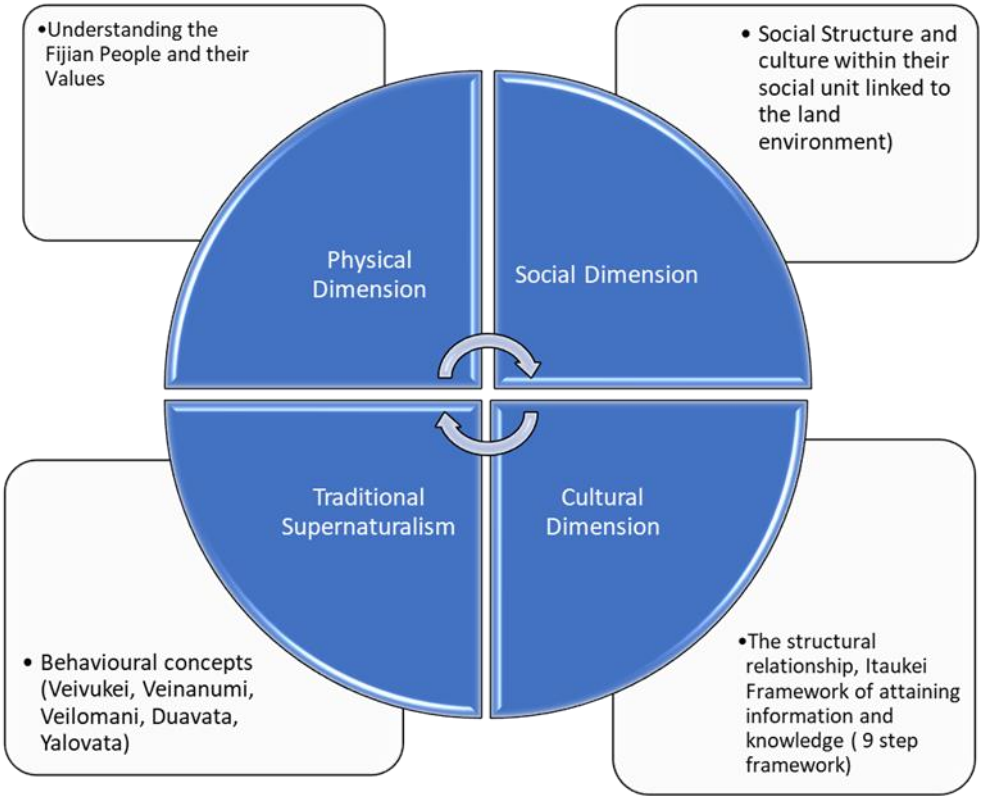
'Vanua' is a Fijian term that is not limited to its definition of land area but also includes the physical, social, and cultural element of the land and how they are inter-related. It is identified by its culture and tradition, the belief system for the main purpose of maintaining solidarity and attaining harmony and prosperity. Having a sense of belonging and identity allows for confidence and security, and gives a sense of belonging to a social unit. The endowment of supernatural power (mana) is manifested in cultural or traditional roles. For instance, the village spokesman, known as the herald (Matanivanua), has the gift of eloquent speech; the priest (Bete), has divine wisdom and guidance for leadership; warriors (Bati) have extraordinary strength; village carpenters (Mataisau) are able to build any structure like houses or boats; and village fisherman unit (Gonedau) can sense areas where there are bountiful fish in the sea. The Vanua is further defined into three main dimensions—physical, social, cultural—that determine how the Fijian people think and carry out activities, including traditional supernaturalism and their effect (Ravuvu, 1983). The characteristics of Vanua are depicted in Figure 9.

Physical Dimension

The physical dimension of the Vanua is the land (qele) and water (wai) which were divided amongst the different village tribes (Mataqali) for their hunting grounds or for gardening to sustain their daily living. This piece of land was passed on through ancestral generations until today where each land is registered under their tribe and a record kept with the Fiji ITLTB. However, all the land and sea/water, though registered under different Mataqali, still rightfully belongs to the tribal chief (Head of the Vanua); and even though previous practice allowed for a 5% rental income paid to the chief during Mataqali land lease payment, this practice has been abolished by the current government. The land and sea are not individually owned but duly belong to the Vanua as a whole.

Figure 9

Characteristics of the Vanua



The group of people or members of a group that are related socially or politically to one another may also be identified as a 'Vanua'. Thus, the Fijian people (members) are referred to as the Vanua (share common bonds). The presence of two or more groups will be differentiated by their traditional origin or label, and this does not affect the use of the word Vanua as separating larger groups into smaller groups. It may be continued to be used as reference to social group where members will have a common link and allegiance to an identified authority. Thus, although the country Fiji is addressed as the Vanua, other small clans in different provinces are also called Vanua with their distinctive tribal chiefs as the head of the Vanua (Ravuvu, 1983).

Traditionally, a member of a Vanua (different clan–Yavusa or Mataqali) would request entry when visiting or meeting with a different Vanua clan. This is done through the traditional welcoming or request of entry ceremony called '*sevusevu*'. It is practiced even when visiting different family members or smaller groups of people. In seeking permission from the chief to enter the Vanua, there is no direct contact with the head of the Vanua and the village herald (Matanivanua) is used as a mediator to communicate and present the sevusevu to the

chief. There cannot be any activity or progress of action until the sevusevu is accepted (blessings given). To ignore this protocol will bring great misfortune to the visiting individual or clan.

Furthermore, while Fiji is known as the Vanua, smaller groups such as the government or the Ministry of Health that share common links, values, and beliefs may also be referenced to a representation of a Vanua. Thus, in relating my research framework to the Vanua; the Fiji nurses are the embodiment of the Fiji Ministry of Health and a representation of a 'Vanua' with a recognised authority figure.

In conducting my research, the request of entry to the Ministry of Health (Vanua) required gaining permission and representation of the village herald (Matanivanua) as the chair of the research committee to present my research proposal to be assessed for approval.

Social Dimension

In understanding the physical aspect of the Vanua, the social aspects include the culture and the social unit linked to the land environment; for instance, the relationship between the people of the land and how they are socially structured, their relationship to each other, and their values and beliefs that embody how they carry out tasks and ways of doing things. The structure of the social units gives the people of the land a sense of belonging where they have control over what happens to their land. The land is a source life providing nourishment and food, and trees as shelter and protection from outside groups. Thus, the land is linked to the people and vice versa where they are related; deeming one useless and helpless without the other (Ravuvu, 1983).

The social structure of the Vanua allows understanding of how tasks are executed by assigned units or people. The hierarchy of the Ministry of Health represents the social dimension of the organisation (Vanua) and in understanding the factors relating to job satisfaction of Fiji nurses, the physical, cultural, and social dimensions are to be linked to how they carry out tasks in relation to their values.

Cultural Dimension

The cultural dimension includes how people think relating to their actions and how things are carried out. Beliefs and values are intertwined between different relationships that are established within the social system such as between two individuals or between an individual and their physical environment. The value system of the Fijian people is sharing; land is shared within the tribe and anything hunted on tribal land is always shared amongst the families within the Mataqali. Their survival is dependent on each other, creating a strong

biological bond that is enforced through socially living together and co-operating with each other. Their economy is based on subsistence living that is evident today, with Fijians taking up the responsibility or being obligated to look after and care for extended and blood relatives, irrespective of how they are affiliated to the family. The behavioural concepts that define their 'share and care' actions are embodied in the way Fijians live through social behaviours known as: '***Veivukei***' (offering a helping hand), '***Veinanumi***' (the act of being considerate), '***Veilomani***' (loving and friendly with one another), '***Duavata***' (togetherness), and '***yalovata***' (of the same spirit) (Ravuvu, 1983).

One of the principles of the Vanua framework is that the research should benefit the Fijian people (Nabobo-Baba, 2008). Understanding and valuing their system of the spirit of unity provides the open doorway for sharing knowledge or information.

Traditional Supernaturalism

The introduction of missionaries and religion into the country has resulted in Fijians being very religious people. This transition was made easy as the church structure mirrored the Vanua social structure making it acceptable for people to identify with it. This element is important to understand as religion has been one of the main influencers on the changes to the traditional social system and how it has impacted Fijian living today. "Any real understanding of the Fijian society, or attitudes or economic development of Fijian values and actions, must include an understanding of these supernatural beliefs" (Ravuvu, 1983, p. 85).

The Christian church is evident in every Fijian village and is a landmark built with pride. The Fijian people have deep beliefs in the presence of the spirit; whether it be religious spirit or 'mana' from the land and ancestral beliefs. This supernatural belief is used as a means of power, such as the same respect awarded to the chiefs in having the 'mana' of the land, is also given to the Church ministers as having the 'mana' from God. It could also be interpreted as using the concepts of 'Mana' and 'Taboo' as a means of control—both socially and politically—as both ideas give power (Ravuvu, 1983).

The blessings from the Vanua are important to progress, achieve success, and have a bountiful harvest or good health. The ethical approval or acceptance of the sevusevu is a doorway that represents blessings from the Vanua and give meaning of successful, enlightening, and authentic research.

The personality of the Fijian people is defined by several values and concepts, and their ideal behaviour is known as '***Vakaturaga***'. The definition of this '***Vakaturaga***' behaviour is

associated with characteristics or action and charisma that would be held in high regard and worthy enough to be in the presence of a chief. The '***Vakaturaga***' behaviour encompasses the followings actions: respect (*veidokai*), deference (*vakarokoroko*), compliance (*vakarorogo*), and humbleness (*yalomalua*). Fijian people are brought up with these common values, display these behaviours and qualities, and act a certain way when in the presence of elders, people with authority, superiors, or people in higher positions, especially chiefs.

The manifestation of this behaviour is important in understanding how Fijian people react in the presence of others, be it an individual or group response. It is being humble and respectful, where being quiet and speaking only when being spoken to is the appropriate norm. '***Vakaturaga***' requires great tolerance (*dau vosota*); that is, tolerating any hardship and easily forgiving anyone that may have challenged you. The '***Vakaturaga***' behaviour requires the welcoming of guests into the village or personal homes carried out in the form of a welcome ritual known as a '***sevusevu***' (presentation of yaqona or Piper methysticum), followed by offering of meals to the visitors and making them feel welcomed (*veidokai*).

When taking precautions not to insult guests or visitors through the actions of 'veidokai', the Fijian people will not carry out any activity that goes beyond their traditional boundaries and societal expectations. They will mostly seek permission for any proposed activity and consult with the people that are involved before taking action; this is termed as '***veirogorogoci***' (to consult with). The channel of communication between cultural and social ranks in society is respected, and to ignore it is disrespectful (veibeci). The speaking etiquette of 'veidokai' involves a soft, gentle, and hushed voice and being considerate of other people's feelings.

Thus, the philosophical framework of the 'Fijian Vanua' is the most appropriate methodology in which to structure this study and will be used to portray the methods of data gathering, the major themes for analysis, and the ethics of this study. The Vanua will also guide the interpretation and discussion of results. The framework will give more insight and understanding as to why Fijians comply and respect people in authority, where aggressiveness is discouraged, and concepts of their value system is upheld. The 'Fijian Vanua' framework allows for their worldviews to be reflected through their defined social and political structure, religious belief system, and inherited customary practices.

The Vanua indigenous framework allows for the identification of gaps in understanding of the different nursing roles in four areas of nursing in Fiji, as well as highlighting what would maximise their service potential. This study aims to explore the work experiences of Fijian nurses and gain knowledge and insights regarding their work expectations. Although there

have been studies focused on nursing and motivating factors globally, no studies have focused on the Pacific context and structure and identified differences in motivating factors for urban and rural nursing in Fiji. It is, therefore, important to choose a method that reflects the cultural context. Vaioleti (2006) noted that:

> Research methodologies that were designed to identify issues in a dominant culture and provide solutions are not necessarily suitable in searching for solutions for Pacific peoples, whose knowledge and ways of being have unique epistemologies, as well as lived realities. (p. 22)

The choice of the Vanua research framework aligns with my understanding that the nurses who will participate in this study will be mostly Fijians. It also coincides with the organisation and characteristics of the formal employee structure within the government, which relates to the management hierarchy of decisions being made by heads of department in a top-down approach. This may be similarly associated with the Vanua hierarchy structure of organisations, where members become passive recipients. This framework is a similar reflection of our own knowledge system and experiences.

3.3 The Fijian Itaukei 'Vanua' Framework

The Fijian Vanua research framework, developed by Nabobo-Baba in 2008, incorporates core principles that guide research design: 1) The research should benefit the needs of the Fijian people and the community, including the acknowledgement of Fijian protocols, cultural values, and philosophies regarding access to knowledge and processes of ethics in the Vanua context; 2) The researcher should be fluent in the Fijian language (dialect) to ensure deep understanding; 3) Verification of indigenous concepts should be addressed appropriately; 4) The primary researcher should be of indigenous descent to enable a deep understanding of the issues raised by the people and gain an 'insider view' of the situation; and 5) The researcher should address the social and cultural norms of respect and acknowledgement for the knowledge/information gained through elders and other sources in the Vanua structure. This may be achieved through the exchange of gifts, resources, and privileges awarded to certain groups as a token of appreciation (Nabobo-Baba, 2008).

In ensuring that the research benefits the community, the involvement of the local people and relevant stakeholders is encouraged throughout the research. Ensuring the validity of the research through feedback reports will give the researcher accountability, and mean that

relationships are maintained. Lastly, for the entry point to carrying out the research using the Vanua framework, it is important that prior approval and permission be obtained from the Vanua chief, village elders, village leaders, and government organisations before any research commences (Nabobo-Baba, 2008).

The Vanua research approach is a highly appropriate framework for this research, given the context of Fiji. I am a Fijian of indigenous descent and speak the language fluently. As a Fijian registered nurse and a citizen of the Republic Island of Fiji, I can assume the position of an insider researcher, gauging and understanding Fijian nurses' experiences, as well as reflecting on the structure of nursing in Fiji.

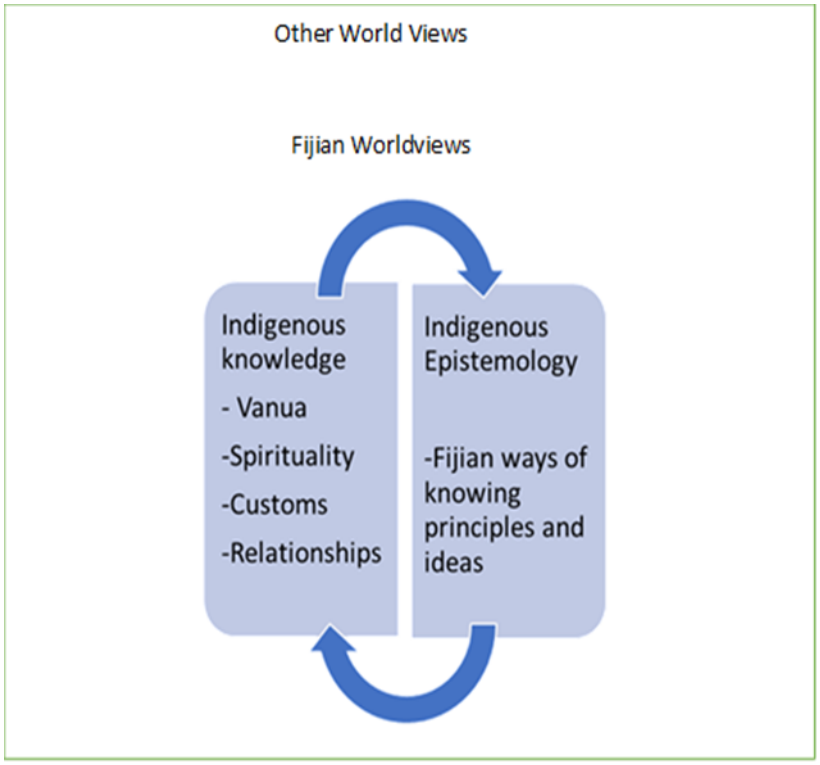
The culture and tradition of the Fijian people defines and dictates how they interact, as well as the protocols they follow with regards to communication, behaviour, and sharing of knowledge. A cross-cultural study conducted by Laverack and Brown (2003), in Fiji outlined that the social system operates in terms of behaviour with regards to cultural protocols. Therefore, the Fijian Vanua research framework has been identified as most appropriate for this research, as the framework itself will consider the language, knowledge, protocols, and values of nurses in Fiji (Arnolds & Boshoff, 2002).

The Vanua research framework is a theoretical approach that encompasses the Fijian worldview in terms of the way Fijian people live, interact and share knowledge which involves their culture, faith and values (see Figure 10). The Fijian worldview will be used as a guide throughout the process of data collection, analysis, and the interpretation and discussion of results.

The 'Vanua' represents the overall Fijian identity of the people living on the land (Vanua) and their relationship with the chiefs, the land, their spirituality, beliefs, the system in which knowledge is passed on, their cultural values and God. The framework acknowledges the Fijian system of having things done through the validation of their cultural philosophies, knowledge, and worldviews (Nabobo-Baba, 2008). Nabobo-Baba (2006) indicated that because the Vanua approach is grounded in the Itaukei indigenous epistemology, it allows us to holistically view the connection of the people, their land and spiritual dimensions (see Figure 11).

Figure 10

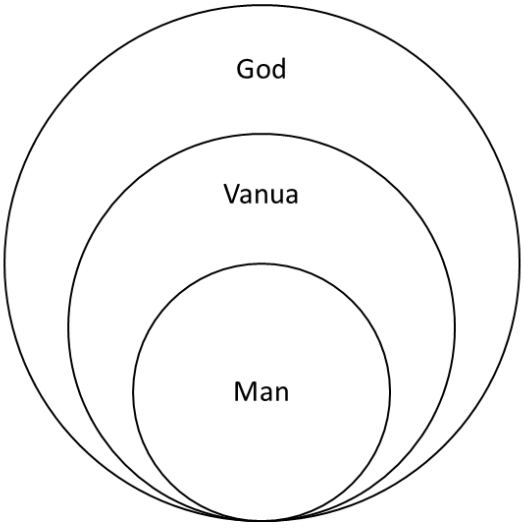
The Fijian Worldview



Source: Adapted from Nabobo-Baba (2006) and Vudiniabola (2011, p. 82)

Figure 11

The Fijian Indigenous Worldview of People

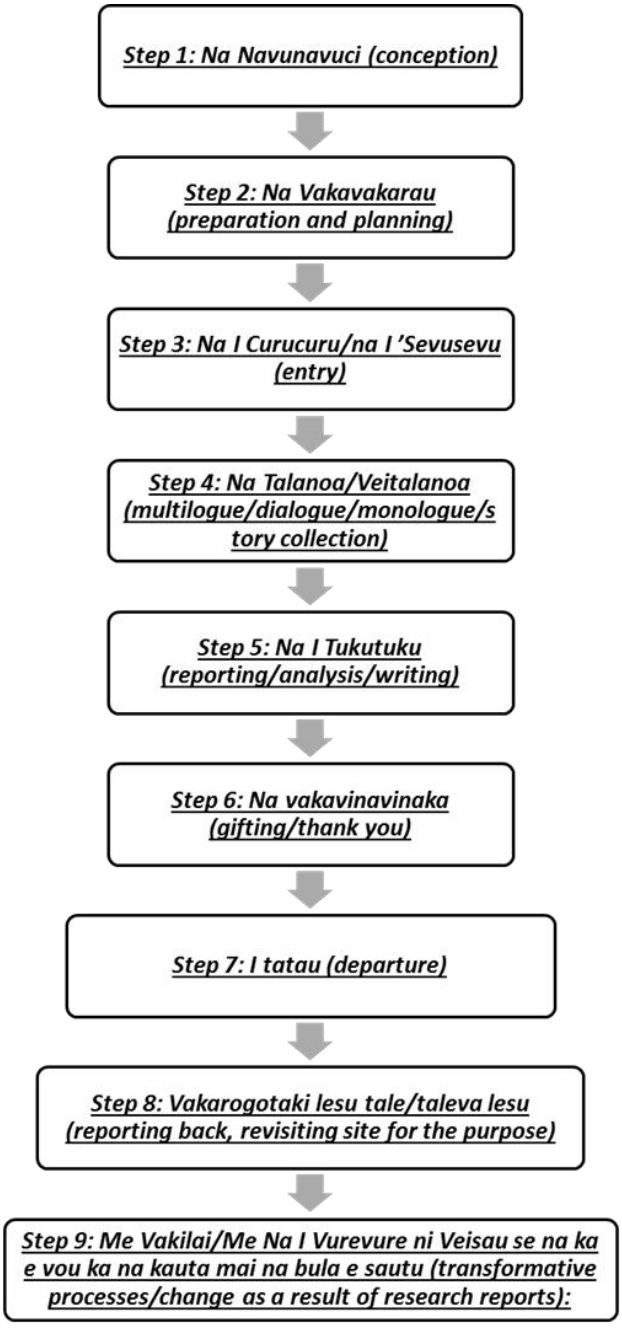


Source: Adapted from Vudiniabola (2011, p. 82)

Fijian protocols play an important role in the embodiment of their values and beliefs as evident in the continuous existence of their traditional ceremonies. The protocols in traditional ceremonies allow the reflection of worldviews into understanding the social and political structure that contributes to the unique Fijian way of life in relation to key ceremonies such as birth, death, and adulthood. The existing traditional approach or steps in the ceremonies are reflected in the research design (Figure 12).

Figure 12

Vanua Research Steps



Source: Vanua research steps adapted from Nabobo-Baba (2008, p. 147)

Step 1: Na Navunavuci (conception)

This stage represents theoretical planning of the research processes with regards to the identification of the research group (Fijian nurses), the research framing, conceptualisation of theories and ideas, and timelines and planned schedules. This stage was achieved through consultations with the institute that governs nurses in Fiji (Ministry of Health, Fiji). Other nursing stakeholders were consulted as to the relevance of the research (e.g., FNA FSN). The process of seeking approval and support from the relevant organisations was relevant before proceeding with other arrangements. Seeking permission for any proposed activity or consultation with the people that are involved before taking any action is termed as '***veirogorogoci',*** and this is part of the 'Vakaturaga' behaviour in the Vanua.

Step 2: Na Vakavakarau (preparation and planning)

The success of the research relies on the preparation and planning of the groundwork, which requires blessing from elders, chiefs, community leaders, relevant stakeholders, and government authorities. This is normal practice of showing respect and courtesy to organisational and community leaders, in which they give their blessings after being informed. The approval of the relevant persons of authority allows for easy exchange of information with research participants. An application to the Ministry of Health and Medical Service Research Committee was processed to request for ethical approval in carrying out the research within the organisation (requesting permission or entry). All activities were budgeted for, and a research timeline was planned around dates that were convenient to the research community, which involved consideration of important calendar events.

Step 3: Na I Curucuru/na I 'Sevusevu (entry)

Part of Fijian custom is the process of request to enter a Vanua, which includes the home, village, or community. Entry is usually in a form of the presentation of yaqona (kava), which is called 'I 'sevusevu'. In entering the Ministry of Health, a formal letter of approval was received from the research committee to conduct the research. In government institutions, where yaqona is forbidden, I 'sevusevu may be presented in other forms. Vudiniabola (2011) used a form of morning tea and gifts to the government institution (FSN) as her form of I 'sevusevu to gain entry to institution staff and seek permission to conduct her observations and interviews. In interviewing participants, the protocol of seeking entry or sevusevu was conducted with either the use of yaqona or a meal/refreshment before proceeding with the research process.

Step 4: Na Talanoa/Veitalanoa (multilogue/dialogue/monologue/story collection)

The tool used for the collection of information was Talanoa, with consideration of the protocols and rules of the use of Talanoa in the Vanua context. The conversation was mostly informal, allowing a friendlier tone and making the participants feel at ease. Though there are protocols relating to Talanoa, specifically what tone is used according to the hierarchy of the individual (chiefs and commoners use formal conversation tone), no level of hierarchy was enforced, and social status was disregarded (Vudiniabola, 2011). This was achieved through conversation of other relating topics before finally proceeding with the interview. As emphasised by Vaioleti (2006), Talanoa allows for easy exchange of information, which reflects true emotions and stories and allows for information gathered to better address Pacific issues.

Step 5: Na I Tukutuku (reporting/analysis/writing)

In considering the Vanua protocols, information gathered were recorded and analysed using the six phases of thematic analysis described by Braun and Clarke (2014). Reporting back results of the study allowed me to maintain the trust acquired from the community without compromising relationships. This contributes to maintaining the spirit of unity among the people of the Vanua. The research results will be reported back to the Ministry of Health and other nursing institutions as an acknowledgment for being part of the research.

Step 6: Na vakavinavinaka (gifting/thank you)

Fijian gifting is a token of appreciation and can occur between the researcher and the people that are being researched in both directions. It strengthens relationship between the two parties. As part of the 'Vakaturaga' behaviour, gifting contributes to the cultural protocol of being considerate and respectful of others. Therefore, as a token of appreciation, gifts were presented to all research participants, as well as the nursing organisations.

Step 7: I tatau (departure)

Just as there is an entry point into the research, there is also an exit point. This is the 'I tatau', which is the formal way of thanking the community and saying farewell. In the Fijian Vanua context, farewell is not the end, as a relationship has been established and will continue towards the future. Similar to what is conducted in the entry process (I 'sevusevu), the Yaqona is presented to the community for farewell; once accepted, an ongoing relationship is forged.

Step 8: Vakarogotaki lesu tale/taleva lesu (reporting back, revisiting site for the purpose)

As a sign that information shared by the community is valued, a feedback report signifies respect and appreciation for their contribution to the research. Feedback of the results gives recognition to the chiefs and people. It also serves the purpose of validation, as it allows the researched community to verify the results as a true reflection of information shared. The feedback report allows for transparency and honours the Fijian protocol of respect.

Step 9: Me Vakilai/Me Na I Vurevure ni Veisau se na ka e vou ka na kauta mai na bula e sautu (transformative processes/change as a result of research reports)

The research may provide information that allows change to be implemented to improve the status of the researched community, as well as influencing stakeholders on the implementation of the recommendations. Whether it will be used directly or indirectly as a tool for change, the research will contain evidence that may be used for future reference in implicating change and benefitting the community.

The Vanua reference framework will give the research methodology structure and support to answer the research questions, as well as considering the Fijian concepts of culture and communication protocols. This is reinforced by Nabobo-Baba's (2008), enlightening words with regards to the Vanua research framework:

> Vanua Research Framing is developed from within an organic Fijian context and legitimises Fijian ways of doing things—knowledge ways included—by validating Fijian language, knowledge, culture, worldview and philosophies. Furthermore, with Vanua Research Framing, Fijian clan, and culture-related concepts such as vanua (tribe), yavusa (clan), mataqali (sub-clan), tokatoka (extended family) and i valavala vakavanua (Fijian protocols and acceptable values and behaviours) become the defining principles of practice. These concepts provide the parameters of defining and theorising knowledge and engaging in action and reflection (praxis). Like Kaupapa Mäori theorising, Vanua Research theorising asserts greater cultural, socio-political, emotional, psychological, philosophical, and spiritual control for Fijians over their lives and changes to this. Vanua Research Framing should contribute to the enhancement and positive transformation of the lives of Fijians'. (p. 143)

3.4 Summary

This chapter has represented the Fijian philosophies and values, describing the application of the 'Vanua' framework as both an epistemology and a research methodology. The chapter also described the steps relating to the research design and how it was interpreted in a way that will enable the readers to follow how it is applied in the data collection method. The use of this methodological approach provides a greater understanding of indigenous forms of sharing knowledge and Pacific cultural epistemology relating to structure and ways of addressing Pacific issues and, in current research, the unique factors influencing job satisfaction amongst Fiji nurses.

Chapter 4: Methodology

4.1 Introduction

The previous chapter presented the Fijian 'Vanua' philosophies and how it was applied in the in the current research study. This chapter will describe how the 'Vanua' research framework steps/process was used in recruitment, sampling, data collection, analysis, rigour, and protocols for ethical consideration.

4.2 Research Setting

The research was carried out in Fiji primarily amongst Fijian registered nurses, as well as a small cohort of nursing leaders and government administration officials, with the decision to sample equally from the two major nursing settings of both urban and rural Fijian nursing. This was to enable a boarder and transferable exploration of job satisfaction amongst all nursing areas representing the diverse clinical settings in the country.

The Ministry of Health government nurses were selected for recruitment to the study because they hold a majority of nurse positions in the government with 65.8% of the 3,081 nurses registered under the Fiji nursing council, as compared to the private sector with 34.2% employment (Aiyub et al., 2013; Cokanasiga, 2020). Nurses graduating from the two main nursing schools are automatically absorbed in the Ministry after completion of the registration exam (Tanabe et al., 2019) as described in Chapter 2.

Nurses were recruited from two urban hospitals, which are the main divisional hospitals in the Western and Central division of Fiji. Nurses from the rural setting were selected from five maritime facilities and five interior located facilities on the main island of Fiji (Viti Levu). In a discussion paper by Cokanasiga (2020), the author highlighted how the public health nurses were resilient to the environment that they worked in; and how, over the years, they have trained and adapted to the lack of resources and shortages of staff. Though the nurses are trained to practice within their guidelines, they need to ensure that patients receive the best possible service that they can deliver, and this skill requires them to think outside the box in terms of service delivery. The public health nurses working in rural and remote rural areas encounter a complex working environment that challenges their practice, as compared to urban nursing in peri-urban and urban settings that have a system and safety support for their practice. Thus, the selection of nurses from both urban and rural spectrums offered a broad view of nursing practice and challenges. The setting was chosen following my

experience and familiarity with the work setting of nurses in Fiji and the ability to gauge on the ground experience of nurses in their different area of work.

The nursing leaders and government officials were also invited for a Talanoa group discussion as to gauge their leadership and management perspectives on the nursing roles and challenges in relation to the registered nurses.

Sampling Cohorts:

- General registered nurses
- Nursing (registered nurse) leaders
- Fiji government administration officials (Directors)

The selection of the three sampling groups allowed for a triangulated multi stakeholder perspective to address the research questions.

4.3 General Registered Nurses

Recruitment Process

The recruitment of nurses commenced in January 2020. Nurses that agreed to participate were given participant information sheets (Appendix B) with more detail description of the research as compared to the invitation flyer (Appendix C) which was distributed to health facilities via emails to nurses, and in face to face contact during the national nurses' tournament held in late 2019. Participants represented both urban and rural nursing in Fiji and though there were several nurses willing to participate, purposive sampling (Etikan et al., 2016) was conducted to ensure demographic and occupational diversity amongst the nurses was achieved.

Sampling

Purposive sampling was used to identify nurses that matched the inclusion criteria and who could provide the information required (Etikan et al., 2016). Selection criteria included both male and female nurses from the two nursing domains as gender allows for a better understanding of how the nurses disproportionately deal with the impact and social stressors in their different work environments (Reisner et al., 2015). The participants' age was also considered to include nurses with both more than and less than 10 years working experience in their different fields and areas of work so as to understand how age may have impacted emotional experience and other variables related to their nursing experience (Carstensen et al., 2011).

A) Registered Nurses

Purposive sampling, as used by Etikan et al. (2016), was employed using years of professional experience (recently graduated, over 10 years post registration). Purposive sampling focuses on demographic criteria of interest and provides added rigour for qualitative sampling method (Etikan et al., 2016).

Inclusion criteria

The criteria used in the selection of the nurses were:

- Registered nurse in Fiji (diploma or degree in nursing)
- Practising nursing within the Ministry of Health
- Worked in the selected nursing domain (urban, peri-urban, rural, remote rural)

Exclusion criteria

- Nurses that are council members of the FNA
- Nursing supervisors
- Nurse practitioners

These exclusion criteria were specified because council members may highlight views already recorded and published within their organisation. In addition, nursing supervisors have more administrative roles and nurse practitioners have a different working scope from general nursing. Their views may prevent a fair consideration to the research objective and influence the conclusion giving rise to bias (Pannucci & Wilkins 2010).

B) Nursing Leaders and Government Administration Officials

The recruitment of the nursing leaders and government officials were from the two main divisions—Central and Western—with invitation flyers distributed to them as an invitation to attend the focus group Talanoa.

B i) Nursing leaders (Talanoa Focus Discussion Group 1)

A convenience sample (Cristo et al., 2017) was used to recruit the nursing leaders.

Inclusion criteria

- Fiji registered nurses holding a supervisory position (team leader, nursing unit manager, nursing manager, team leader, nursing directors)
- Nursing supervisor with open work experience practising within the Ministry of Health (to allow for purposive sampling of nurses with different work experience and not limited to a required number)

- Worked in the selected nursing domain (urban, peri-urban, rural, remote rural)

Exclusion criteria

- Council member of the FNA
- Nurse practitioner

B ii) Government administration officials (Talanoa Focus Discussion Group 2)

A convenience sample of government officials included health government officers holding supervisory positions (health directors, divisional medical officers, chief nursing, nursing tutors, FNA representatives). The only exclusion criterion was being representative of a political party.

4.4 Developing the Interview Guide

The interview guide (Appendix D) was developed form the literature review in Chapter 2 using semi-structured questions through Talanoa. Though there is a structure to the discussion or interview, it is not strictly followed as it is a guide that explores the research question with the aim of collecting similar information from the participants (Kallio et al., 2016).

Approach to Talanoa Interview

- Participants were briefed on the purpose of the interview and ensured that they had fully understood all information written on the information sheet (Appendix B) such as participation being voluntary and that they may withdraw at any point during the interview. This was done face to face.
- Once accepted and consent form (Appendix E) signed, a 'I sevusevu' as part of the Vanua framework step 3, was presented to the participants before the interview began.
- Interviews were conducted in English as all nurses spoke the language fluently.
- Interviews were recorded using an audio device.
- Interviews were conducted in a neutral setting selected by the participant to ensure their comfort and maintain confidentiality (e.g., a restaurant, home, private work office).
- Indicative questions guided each interview which lasted between 30 and 45 minutes.

- After the interview, participants were thanked according to step 6 of the Vanua framework and were presented a gift as a token of appreciation for their participation.

- Step 7 of the Vanua framework of 'I tatau' which is the formal farewell, involved informing participants that they would be offered a copy of their interview transcript to cross-check and keep.

Approach to Talanoa Focus Group Discussions

- The first Talanoa focus group discussion presented nursing leaders with afternoon tea at a confined restaurant that prepared catering according to the participants request, located in the Central Division. The protocol guide was followed as per interviews and similar to focus group one.

- The second focus group discussion with respective nursing stakeholders (e.g., Fiji government health ministry representatives/managers, FNA, nursing school representatives) began with presentation of morning tea as the 'request of entry' due to the traditional requirement of kava (I 'sevusevu) being forbidden on some facilities. Clear explanations on the need for audio recording and who would have access to the information was explained to the participants. The discussion was held at Western Health Services in the Western Divisional office as it was a convenient location for all participants to attend. Participants were briefed on the purpose of the discussion and consent forms signed before proceeding. The discussion Talanoa group questions are attached in Appendix E.

- The moderator, myself, welcomed (Vanua) participants and ensured them that they had the opportunity to talk and the discussion lasted on average 90 minutes.

Ensuring the Content Validity of the Talanoa Interview and Talanoa Focus Group Discussion Guides

In ensuring that content validity was addressed, as part of step 4 of the Vanua framework of *Talanoa/Veitalanoa*, the semi-structured interviews of both nurses and leaders and government officials were discussed with nursing specialists in the field through a *Talanoa* discussion to ensure that the right questions were asked; thereby, eliciting maximum answers towards achieving the research questions. Consultation with senior nurses exploring their experience in the field, allowed the reconstruction of questions to ensure they were psychologically and emotionally safe to ask. These notes were kept as an audit trail of

decision making, serving to validate the research questions for the focus group discussions and individual interviews.

Piloting the Interview Guides

A pilot study was conducted with general nurses in the two rural and urban nursing areas (two nurses from each area) outside of the main study. This process allowed me to gauge if the questions were well understood, if the timing was appropriate, and modifications were made accordingly such as rephrasing questions to be more understandable and within the topic of discussion.

The limited number of nursing stakeholders and nursing leaders made it challenging to pilot test the focus group interview questions; however, *Talanoa* discussion was held with the Western Divisional nurse educator on whether the questions were relevant to the nursing administration and leaders. Changes made were in relation to focusing only on questions that were applicable to the administrative settings.

4.5 Ethics Confidentiality and Consent

Ethical approval was approved on 22 August 2019; Auckland University of Technology Ethical Committee (AUTEC) number 19/261 (see Appendix F).

Ethical Approval

Ethical approval was sought from AUTEC as well as Fiji Ministry of Health and Fiji education board ethical committees (Appendix G) before field work commenced. The application to AUTEC followed the processes of ensuring participant safety, consent, and confidentiality were addressed, and it made clear that participation was voluntary, and that participants may withdraw at any time.

In October 2019, I applied to the Fiji Ministry of Health and Medical Services for ethical approval through the Fiji National Health Research Ethical Review Committee (FNHRERC) for recruiting participants for the study (Appendix G). The application was done through the Ministry website and invitation for participants were planned to be distributed via invitation flyers (Appendix C) to all government health facilities inviting the Ministry of Health nurses to take part in the research.

The approval letter came in late November 2019 (FNHRERC number: 2019.98.MP) following the committee's monthly meeting (Appendix G) but, unfortunately due to the measles epidemic that swept through the Pacific Island countries, Fiji had to carry out a nationwide measles campaign which involved all of the nurses. This delayed the recruitment process as

nurses in urban areas were restricted to 12-hour shifts and rural areas had to work long hours, often late into the night, to achieve 95% immunisation of the Fijian population. All the nurses' annual and short leaves were postponed until January 2020 which is when recruitment of participants began.

Confidentiality

Confidentiality of the data as an important aspect in the ethical integrity of the research included having the information sheet presented to the participants and highlighting that all information collected during the research would only be used for the sole purpose of the study. Participants were allocated a code name or pseudonym. Interviews were held in a quiet safe environment where there were limited opportunities for disruption.

Participants were reassured that all answers would be kept strictly confidential and that the findings of the research would be reported without disclosing any information that could lead to them being individually identified. Forms were coded, including health facility location, ensuring nurses' information remained anonymous to all other nursing managers. Participant names and personal information will not be published in any form as maintaining participant confidentiality is of utmost importance in this research. Although the project was unlikely to cause any harm to the participants, the participant information sheet outlined potential risks such as emotional change/difficulties. As a member of the nursing organisation and a Fijian, I respected individual views and information shared by participants.

Consent Process

Verbal consent was gained before the start of the interview and through the acceptance of 'I Sevusevu' that was presented to the participants. This was followed with obtaining written consent. The sevusevu, as explained by Ravuvu (1983), is the Fijian protocol of requesting entry and gaining permission into the 'Vanua'. Participants were provided with all information and offered the opportunity to ask questions and voice any concerns before they committed to signing the consent forms. Their questions and concerns were answered and discussed truthfully. Participants were treated with respect and appreciation for their participation and commitment, and were reassured that they could withdraw their consent at any time. Participants were not coerced or pressured to complete the interview session and were reassured their right to not answer any given questions during the interview. All participants were treated with the utmost respect and all cultural protocols were followed throughout the Talanoa process.

4.6 Accessing the Participants

Participant Consent and Cultural Safety

This process followed the first three steps of the Vanua framework following seeking approval and requesting of information using the Vanua entry protocol of 'I sevusevu'. As explained earlier, the acceptance of the 'I sevusevu' is a sign of an approval of consent. As part of the research requirements, explanations were made to the nurse before they signed a consent form with all the details of the research outlined in the handout before any form of interview took place.

For confidentiality purposes, potential participants received an information sheet and consent form before the interview/focus group discussion which highlighted the research aims and stated that all information collected during the research would be used for the sole purpose of the study. Participants' names would not be recorded, and data would be collected using code names. All interviews were held in a quiet safe environment where disruptions were limited.

As part of the Vanua framework, permission was be sought from the leaders of government institutions (e.g., Ministry of Health) using two steps of the Vanua research framework.

Step 2: *Na Vakavakarau*: Planning and preparation for approval from Fiji's ethical committee, the Ministry of Health, nursing leaders, and other nursing organisations. On approval, planning moved to placing advertising posters to invite participation (Appendix B) at all relevant health facilities (Lautoka, Tavua, Suva, Nadi, Yasawa, Bua, Nausori). Identification of nurses from the different domains proceeded according to the inclusion and exclusion criteria, and arrangements to contact them were made either face-to-face or through a telephone conversation. One month was allocated for the selected participants to decide to participate; and, upon agreement, a scheduled date was allocated for the research interview.

Step 3: The 'Na I Curucuru': In the Fijian custom this is the process of request to enter a Vanua, which includes the home, village, or community; entry point for nursing after endorsement from Ministry of Health began with the I 'sevusevu' addressed to the Fiji nursing leader or 'chief nurse'. The chief nurse is the highest position within the nursing organisational hierarchy, and as a courtesy she was informed of the study. Although the acceptance of I 'sevusevu is a sign of an approval of consent, as part of the research requirements, explanations were made to each nurse before they signed a consent form, with all details of the research outlined in the participant information sheet.

Approach to Recruitment of Registered Nurses

Initial contact was conducted face-to-face through a meeting scheduled by the participant who had responses to the flyer that had been placed on the noticeboard of their health facilities. Phone contact was used for those in rural areas as my information details were listed in the invitation flyers to which the nurses could send me a text message for participation. I would call them following the message. Information was collected directly from participants by myself (as primary researcher), either face-to-face or via telephone.

Potential participants were given 1-month to consider the invitation and were given the option to inform me directly of their acceptance/rejection of the invitation to participate in this study through a phone call or text message. Following review of the inclusion and exclusion criteria, the consent form was signed by participants who accepted the invitation to participate. Follow-up phone calls were made when necessary to determine if potential participants had received the invitation to participate in the study, or to renew the invitation to those who had forgotten and follow-up on their availability.

Attrition

Purposive sampling drew on the nursing domains of urban, peri-urban, rural, and remote rural with the intention to recruit 20 nurses with the selection of 5 nurses per nursing area (domain) for a wider spectrum of nursing experience, and to allow for the refusal of some participants who had initially volunteered for the study. Two urban nurses refused due to personal reasons.

Approach to Talanoa interviews

Participants were briefed on the purpose of the interview to ensure that they fully understood the information provided, such as participation being voluntary, and that they could withdraw at any point during the interview. Once a participant had agreed to participate and signed the consent form, I ’sevusevu (as part of the Vanua framework, step 3) was presented to the participant before the interview began. Individual face-to-face interviews with participants were conducted in English, as all nurses spoke the language fluently. The interviews were recorded with participants’ permission using an audio device. The location of the interview was selected according to the participant’s preference in neutral settings where they felt comfortable and where confidentiality was maintained.

Most interviews took place in a quiet room in their health facility as the nurses did not want to travel; three preferred their home and two chose a quiet restaurant. Indicative questions were used to guide the interview, which on average lasted up to 45 minutes. After the

interview, the participant was thanked (step 6 of the Vanua framework) with the offering of a gift as a token of appreciation for their participation. This was followed by step 7 of the Vanua framework (I tatau), which is the formal farewell. Participants were informed that they would be offered a copy of their interview transcript to check and keep.

Talanoa Focus Group Discussions with i) Nurses Leaders and ii) Government administration Officials

Nursing leaders and government officials were also invited to participate through the advertisement flyers and were given 1-month to consider the invitation; this is in the understanding leadership positions need to schedule in events. I was informed directly of their acceptance/rejection of the invitation to participate in the study discussion through a phone call or text message. A follow-up phone call was made as necessary to determine if potential participants received the invitation, or to renew the invitation to those who may have forgotten and follow-up their availability. Once accepted, confirmation of the discussed venue was disclosed to the participant.

The focus group discussions with government officials (consisting of nursing stakeholders, Fiji Ministry of health representatives/managers, FNA, nursing school representatives), began with presentation of afternoon tea as a 'request for entry'. The afternoon tea was selected because both group discussions were conducted after lunch.

Discussions were recorded using two digital audio recorders, with clear explanations on the need for audio recording and who would have access to the information. As moderator, I ensured all the participants were encouraged and had an opportunity to speak. Discussions lasted between 90 and 120 minutes.

Language used

All interviews and focus discussion groups were conducted in English. The indigenous Fijian dialect was not used because Fiji has many provincial dialects, and one word may have a completely different meaning in a different province. English is the language and mode of communication used within the nursing profession, which has been brought about through the education system in the country.

Demographic Data

Demographics of Registered Nurses' Talanoa Interview

A total of 20 nurses were interviewed. Five were from remote rural nursing stations (3 female and 2 male) and included a community child nurse, community reproductive nurse, a community NCD nurse (special outpatients), and two zone nurses. All the nurses had a

diploma in nursing qualification and all, except for one, had attended the FNU (School of Nursing). The exception had attended a nursing school in Labasa.

The urban nursing domain included five peri-urban nurses ranging from different health departments in the sub-divisional hospital level that included (maternity, mental health, general-outpatients, child health, and diabetic health clinic). The remaining five urban nurses were based on the two main divisional hospitals that were from the ICU, children's hospital, ER, eye department, nephrology clinic, and special outpatients. In total there were 5 males and 15 females, and their ages ranged between 27 and 48 years.

Demographics of the Talanoa Focus Group Discussions

The two focus groups included one for nursing leaders (n = 4) and another for government officials (n = 5). They were all females in leadership roles and had between 5- and 10-years' experience in their respective roles. Both sets of focus group participants had background experience in leading or policy making in urban and rural nursing.

4.7 Talanoa

Protocols of Talanoa in the Interviews

Nabobo-Baba (2008) stated that the cultural epistemology of indigenous knowledge sharing is mostly dictated by culture and its values, and the tool that is most appropriate for encouraging shared knowledge in the Pacific context is the informal mode of Talanoa (Nabobo-Baba, 2008). The Talanoa and Kakala frameworks share the same concepts, which make them ideal in Pacific research. Although the use of Talanoa may be challenging, it is a trustworthy approach that makes Pacific people feel more involved and empowered (Vaioleti, 2006).

In the Fijian Vanua framework, the 'Talanoa' approach may differentiate according to social status; however, in this research, social status was disregarded allowing for an informal Talanoa conversation. Vudiniabola (2011) specified that when using Talanoa as a tool for interview, it is important that the process be structured in not allowing the participants or the context to becoming a barrier in the sharing of information. Talanoa was the selected tool for interview as it encouraged exchange of information in a two-way process while allowing me better insight into why participants respond accordingly, be it spontaneous or in-depth explanation. The nature of Talanoa is that it encourages open-ended natural

conversations with enough flexibility to encourage real answers towards the problem/issues involved (Vudiniabola, 2011).

Protocols of Talanoa in the Group Discussion

The Talanoa protocol for a group discussion may begin with the welcoming of the participants and following the Fijian village (Vanua) request of entry by carrying out the sevusevu which is the presentation of the yaqona or tea. The presence of the participants is acknowledged, and discussions are encouraged as participants proceed with the acceptance of the sevusevu 'and move towards voicing their concerned issues relating to job satisfaction from a management perspective.

I had to manage the Talanoa session directly as the context of the conversation had potential to become uncontrolled and digress to irrelevant issues and topics that lack continuity, affecting the time allocated for the discussion. In understanding Fijians' value on time, a little deviation may be allowed but conversation must be encouraged back to topic (Vudiniabola, 2011).

4.8 Analysis

Analysing the data is an important aspect in qualitative research, and the Vanua research framework provides guidance for interpreting data. This would be adopted from step 5, of the Vanua frameworks—Na I Tukutuku (reporting/analysis/writing)**.**

The concept of the Vanua is tied to nurses' perception of job satisfaction in Fiji; and critically analyses their views through the cultural lens of their land, values, and beliefs. This would allow better understanding of their behaviour in the context of the ideas that have been discussed in the previous chapters.

In qualitative research, methods that are developed to be culturally relevant better influence understanding on outcomes. The challenge encountered is ensuring rigour and trustworthiness is adapted for credibility, and Pelzang and Hutchinson (2017) stated that this may be achieved with researchers understanding how to position themselves appropriately, while working in collaboration with the participants in confirming any interpretations during the analysis of the data. This was practiced when issues were addressed while transcribing interviews and sorted prior to leaving the country. This action was consistent with the Vanua research framework step 7 of presenting the data back to participants for validation and acknowledgement (Nabobo- Baba, 2008).

The Fijian Vanua framework acknowledges and recognises that the word 'Vanua' relates to the universal whole, which includes the chiefs; their relationships with their people; ways of sharing knowledge, spiritual beliefs, relationship to the land; and their culture and values. The framework legitimises the way Fijians carry out a task. The task for this study is to organise themes embedded within the interviews that would relate to philosophies of the Vanua. The philosophies of the Vanua include the environment, beliefs, knowledge system, land, spiritual belief, culture, relationships, and God (Nabobo-Baba, 2006). Thematic analysis, guided by the six phases described by Braun and Clarke (2014), was used to identify themes embedded within the interview data that relate to philosophies of the Vanua. Thematic analysis is distinctively flexible and may be used in different ways to analyse data, such as experimental versus critical orientation to data. This relates to questions of individual experiences and their perception on factors and practices (Braun et al., 2013). Reflexivity allows for the application of thematic analysis through the six phases of data familiarisation, generating codes, constructing themes and reviewing them, naming the themes before finally processing towards reporting (Braun & Clarke, 2014).

Data were transcribed by myself due to the circumstances that affected the globe following the COVID-19 pandemic that led to me being stranded in Fiji. The coding of transcripts was conducted and assisted using Microsoft software to identify the phrases and assign them to different themes. The large amount of data required the use of the software tool (Microsoft excel) as it allowed clearer understanding and assistance in the data management.

Thematic Analysis

This section demonstrates how the concept of the Vanua is tied to nurses' perception of job satisfaction in Fiji; and critically analyses their views through the cultural lens of their land, values, and beliefs. This would allow better understanding of their behaviour in the context of the ideas that have been discussed in the previous chapters. The thematic analysis of the data provided allows the basis for the introduction of the research questions which are to understand: 1) the meaning of job satisfaction as perceived by nurses in Fiji; 2) the personal, organisation, leadership, and workforce challenges that nurses in Fiji experience in their roles; and 3) how they perceive these challenges impact their job satisfaction, and make recommend strategies that would support improvement in nurses' work conditions in Fiji that would eventually lead to enhancing job satisfaction. This chapter, combined with the concepts of the Vanua framework and philosophies, reports on how participants' narratives were analysed through the utilisation of Braun and Clarke's (2014) thematic analysis and sorting the data using their 6-step theme selection.

Thematic analysis (Braun & Clarke, 2012), is an analytical method that may be used on a wide range of theoretical frameworks. It is a method of identifying patterns and analysing the meaning of the qualitative data involved through the continuous shifting of their meanings while retaining the specific patterned discourses within the collected data (Braun & Clarke, 2012). The codes and themes generated from the relevant information derived from the research questions and the analytical process, aimed at capturing surface and underlying meanings within the data.

In relating to any research, the interviews (*Talanoa*), an instrumental method of collecting data, were pilot tested to ensure that the questions were in line with the research questions and to assess the process of the interview with the purpose of cultural sensitivity and content validity being achieved (Yeong et al., 2018). The pilot test allowed the simulation of an actual Talanoa session where consent was obtained and objectives explained, and the feedback allowed for the readjustment and refinement of questions asked that would decrease confusion and maximise response. The reviews of the two nurses working in similar fields and two managers who were experts in their area of work provided relevant feedback of discarding and modifying of questions. The interview protocol was used as a guide into ensuring a checklist was crossed before proceeding with the interview proper.

All Talanoa individual interviews and Talanoa focus group discussions were transcribed and manually coded, where the interviews were analysed in six batches: urban, rural, peri-urban, remote rural, focus group 1 (leaders), and focus group 2 (managers and directors). The coding of each batch was categories into themes with the details of the process (open coding analysis and interview process) attached in Appendix H. The additional adjustments to the research questions following the pilot interviews and consultation with the nurse educators/specialist were added to the interview and the process is outlined in Figures 13 and 14. The transcripts were analysed with the assistance of computer software, Microsoft excel, though most of the coding and comparing of the data were conducted manually. The coding of the 20 interviews by the nurses was aided by the 6-steps of the thematic analysis and model techniques of data familiarisation, generating codes, constructing themes, reviewing them, and naming the themes before the final step of reporting (Braun & Clarke, 2014). Emerging similar open codes were categorised, and mind mapping was used to map out the open codes and themes before theoretical coding was selected into the emerging categorises (see Figures 13 & 14).

Figure 13

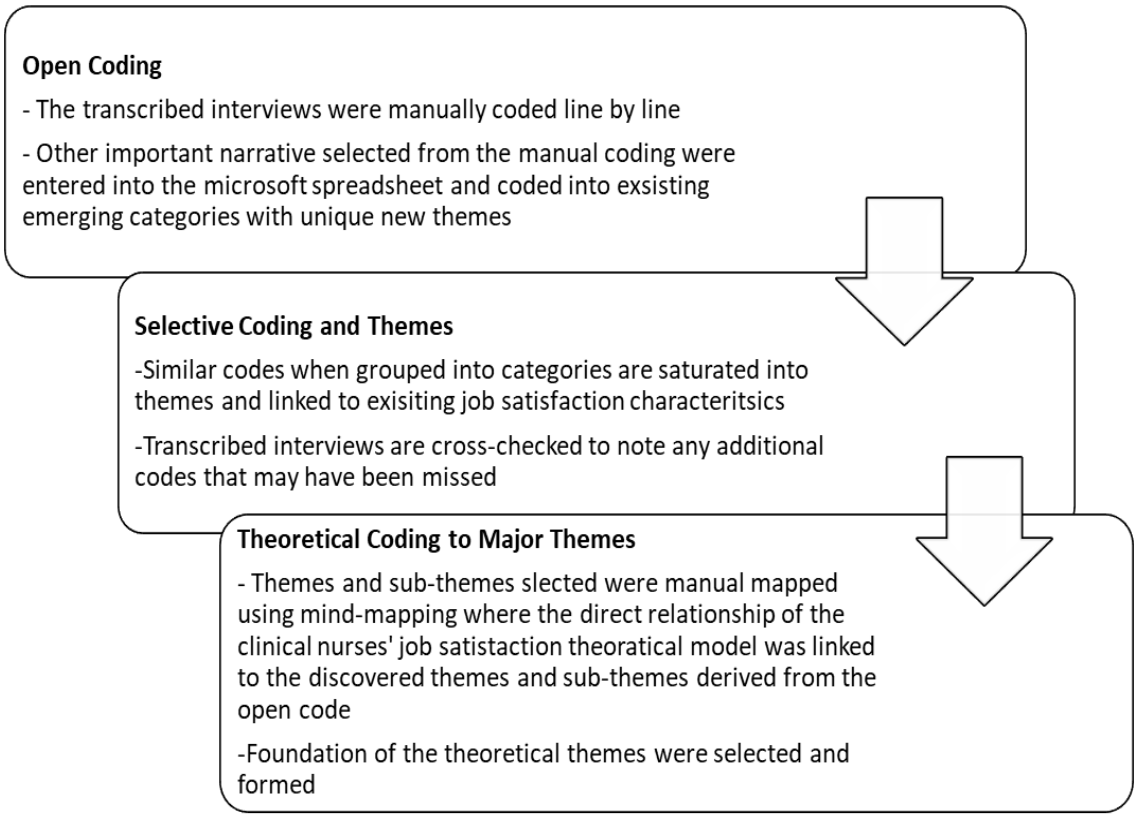
Thematic Analysis Process (Braun & Clarke, 2014)

Source: (Braun & Clarke, 2014).

The first process for step 5 of the Vanua Research design '***Na I Tukutuku'*** was the examination of all the transcribed interviews and discussion, recording the important relevant information received according to the spoken words of the participants. The semi-structured interviews conducted through *Talanoa* were guided by questions and discussions related to the research questions. Once similarities in the data narrative were grouped and coded, themes emerged and were categorised into the major themes relating to job satisfaction. The major themes were then referenced according to Cowden and Cummings' (2012), theoretical model of intent to stay. The outcome of the participants' response was coded with the significant concepts placed into subthemes before simplifying into relevant potential themes as shown in Table 3.

Figure 14

Data Process



The interview data gathered described the nurses' experience, and were interpreted with the understanding that the Fijian nurses were still guided by their subconscious beliefs in their indigenous worldviews and epistemology (Vudiniabola, 2011). The process was repeated when coding the two focus group interviews.

Table 3

Stage One of the Na I Tukutuku Process: Filtering Process for Transcript

Talanoa Question	Narrative (Transcript)	Codes	Sub Themes	Major Themes
Nursing Posting	**Participant 5**: 'Posted to a nursing station, but I was willing and volunteered to go because was single and saw it as an opportunity to visit a new place". **Participant 7**: "No, with my first posting I was single it was just a directive from the top to go your island.....No, I wasn't given any choice to appeal, was just told 'go to Kadavu', I packed all my things and went to Kadavu, I had no choice even though my home, my parents were in Lautoka you know, I thought they were going to post me to Lautoka but unfortunately I had to go to Kadavu, I had no choice".	•Made the most of the opportunity •Directive from the top •No Choice	**No Voice, No Choice**	**Authoritative Decision**

Mind Mapping Process

The overall structure of the themes and their connections to the relative characteristics were guided using a mapping diagram that highlighted the important connections of the themes to the nurses' intent to stay characteristics, which are organisation, management, work, and nurses' voice. The figure in Appendix H overviews the categorised data and potential conceptual links as mind mapped.

4.9 Rigour

Rigour was achieved through step 8 of the Vanua framework: ***Vakarogotaki lesu tale/taleva lesu (reporting back, revisiting site for the purpose)***. The validation of the data and

verification of discrepancies in information provided required revisiting of sites, facilities, and research participants. The reporting of the transcribed data back to participants allowed for the achievement of feeding back the information to the community, maintaining relationships, and ensuring information collected was accurate and credible.

Trustworthiness

Graneheim and Lundman (2004) stated that aspects of trustworthiness have been commonly described as concepts related to credibility, dependability, and transferability. In ensuring rigour of research is achieved, credibility will be determined using an indigenous Fijian framework to demonstrate the true picture of nurses' experiences in Fiji and incorporating the framework throughout the processes of approaching participants and gathering data. Pelzang and Hutchinson (2017) reflected on the position of researchers who conceptualised cultural elements into their research, and highlighted that to attain trustworthiness due attention on the principles of cultural relevance, contextuality, appropriateness, and flexibility were to be considered. This required the researcher to hold the position as an *indigenous insider* which allowed insight into the cultural understanding and beliefs of the participant, thus achieving cultural integrity and rigour (Pelzang & Hutchinson, 2017). As the primary researcher and an indigenous Fijian, I was able to gauge and understand Fijian nurses' experiences more accurately. The selection of nurses from different nursing domains (urban, peri-urban, rural, remote rural) increased the range of experiences captured to answer the research questions. Step 8 of the Vanua framework, which involves validating data and verifying discrepancies by reporting data back to participants, gave recognition to the aspect of credibility. Knowledge in relation to the sociocultural and political background of the research setting improves the cultural integrity of the study and ensures cultural credibility and rigour (Pelzang & Hutchinson, 2017).

In ensuring data are trustworthy and transferable, strategies that enhanced the validity of the data are quantity of time spent in the interview, trusting relationship with the participants, awareness of the research assumption, and interviewer bias which were achieved throughout the steps in the Vanua framework (Hamilton, 2020). Dependability may become challenging in a qualitative study; therefore, ensuring that the process of analysing the data is well documented will allow readers to identify with, and relate to, the findings and experiences shown. The cultural context and use of the Vanua indigenous framework may limit the extent of transferability; however, the characteristics of the participants (e.g., indigenous nurses) and the process of data collection and analysis using the framework may mean the findings are applicable to other Pacific healthcare perspectives. The results may be

epitomised from the cultural knowledge of the researcher and the participants, formulating evidence-based findings that reflects rigour in the ethos of cultural knowledge (Lock et al., 2021). The support of my supervisors helped guide me in upholding the principles of trustworthiness and ensured the results of the research emerged from the data and not my own conclusions and assumptions.

Openness to Bias

As a former nursing manager of a sub-division in Fiji, it may have been difficult to completely set aside all my knowledge of the Fiji health care system; however, this did not limit the research outcome but enriched it with my understanding towards the issues raised. Palaganas et al. (2017) highlighted reflexivity in research and how it may be impossible to separate the researcher and their topic as the acknowledgement of inter-personal factors gives more meaning to the research process. The authors stated that reflexivity is the process of understanding as well as gaining insight to information that affects and gives meaning to the research process (Palaganas et al., 2017).

4.10 Summary

The use of the Fijian 'Vanua' research framework in the collection of data facilitated the application of Fijian protocols such as greeting, meeting, gifting, and thanking the participants. The awareness of traditional knowledge allowed for decolonisation of methodologies for Pacific research and facilitated renewed knowledge on how Fijians apply and carry out tasks.

This chapter has provided an outline of the research method and epistemology for the methodology choice for this study. Furthermore, it has described sampling, recruitment processes, and the rationale for choosing the sample population of Fiji nurses, leaders, and government administration officials. Finally, the thematic data analysis and the application of rigour are presented in the following Chapters six, seven, eight and nine.

Chapter 5: Overview of Findings (*Na I Tukutuku)*

5.1 Introduction

This chapter represents step five of the Vanua research framework: Na I Tukutuku (reporting/analysis/writing) and addresses the research question of understanding the meaning of job satisfaction for nurses in Fiji, to understand personal, organisational, managerial, and professional challenges that nurses in Fiji experience in their roles, and how they perceive these challenges impact on their job satisfaction. Lastly, to recommend strategies that support improvement in work conditions for nurses in Fiji and lead to enhanced job satisfaction. An overview of the findings is presented, and the outline set for the next four chapters which are organisation characteristics, management and leadership characteristics, working environment, and nursing roles and responsibilities. Initially, the Talanoa interviews for the registered nurses and the Talanoa group discussion data will be presented as a diagram representative of the themes.

To frame this chapter, the Fijian Vanua is reviewed and adopted as being the hierarchical system of influence and power asymmetrical that predicates relationships having influence on the delivery of Fiji health care. The Fijian way of life, such as *'solesolevaki'*, is a lifestyle that encourages peoples' presence and contribution to whatever they are involved in, with the underpinning values of sociocultural obligations in their work structure. In a world where capitalism is promoted to individuals for personal gain and growth, this lifestyle conflicts with the modern era of evolving into obtaining progressive development. The Ministry of Health is governed by the '*matanitu*' (government or formal institution) with interwoven values in cultural practices such as the '*bula vakavanua*' (Fijian way of life); and though the Vanua leadership requires serving the people, the challenge is actions and leadership elements are ruled from a dictate perspective threaded through this chapter (Vunibola, 2020).

The hub of social capital within Fijian society is *'bula vakaveiwekani'* in the context of customary duties reciprocated with time and energy to maintain a good relationship important to satisfactory work and life blackness. This bond brings people together through trust and kinship in which monetary reward is not as important as the reward of reciprocated trust and relationship that is strengthened through Christian teachings (Nainoca, 2011).

The Fijian nursing workforce is vastly women; and, in Fiji, a woman's position in society, or in the workforce, may be explained through the sociological standards of institutional factors and social structure in their lives, including the determinant forces outside of the country in which they live, the cultural structure, and organisational policies (Hakim, 2016). Studies

have shown that the working environment has a significant effect on nurses' intent to stay and work satisfaction, which may require management to pay more attention to improving nursing work conditions through planning, effective management, and improvement of practices (Choi et al., 2013; Laschinger et al., 2001).

This chapter provide empirical evidence drawn from the thematic analysis of the Talanoa data into understanding the cultural system of practices associated with the decisions behind the strategic choices within the nursing organisation that has contributed to the overall health and wellbeing and satisfaction the nurses in Fiji (Meo-Sewabu, 2016). It provides first time evidence and meets an urgent need to present the multifaceted elements of the Fijian nursing workforce in relation to the Vanua framework in relation to their worldviews and cultural location.

Cowden and Cummings' (2012) framework for nursing job satisfaction provided general steerage for the allocation of themes identified but in no means influenced these. Though, overall, a western model, the supervisory team and I agreed that it mirrored the hierarchy of authority within the Vanua and portrays the representative of the overarching link between the whole Ministry of Health organisation and the Vanua structural organisation (see Figures 19 & 20). The link will be further discussed in Chapter 10.

Figure 15

Hierarchy of Authority Between Job Satisfaction Characteristics and the Vanua

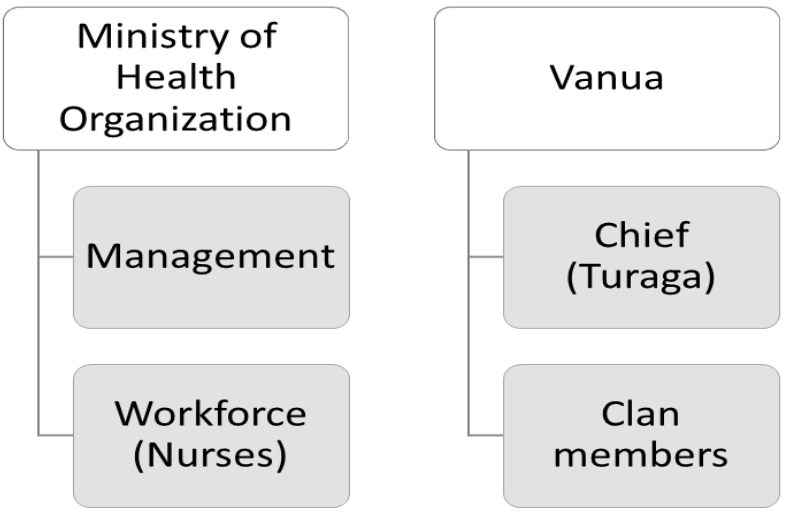
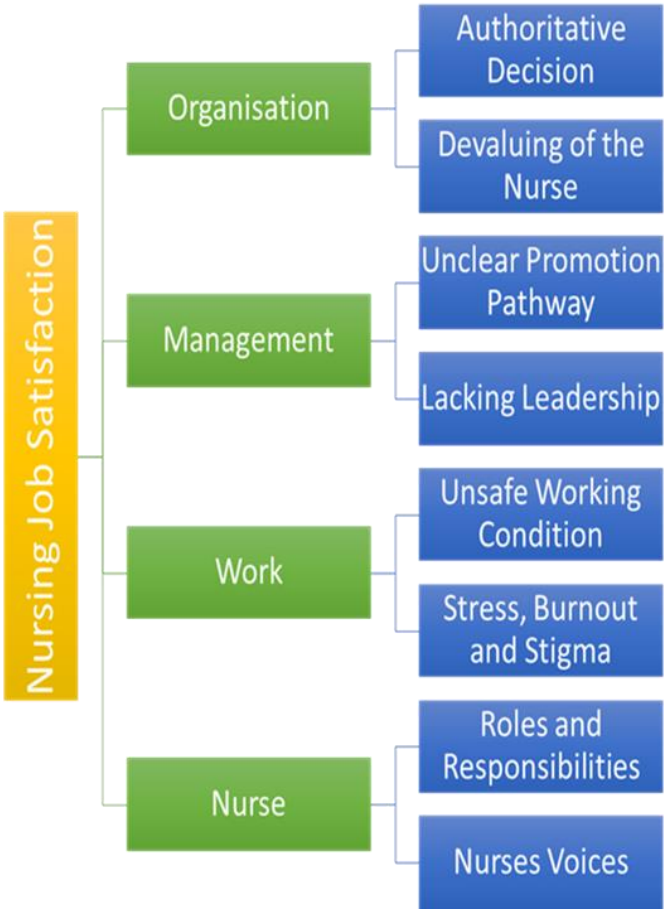


Figure 16

Overview of the Themes and Sub-themes Distribution According to the Hierarchy of Authority Decision making



5.2 Meaning of Job satisfaction in the Fiji context

i. Organisation (Vanua)

The main themes categorised were Authoritative Decision making and the Devaluing of the Nurses. Some of the sub-themes that emerged from the data were i) no voice no choice, ii) directive decision making, iii) powerless of the nurses to object to decisions made by management, iv) devaluing of nurses, and v) lack of recognition.

5.3 Authoritative Decision making

i. No Voice No Choice

The findings relating to the above theme apply mostly to nurses during their first posting, or after their internship in a divisional or sub-divisional hospital, where they are posted to health facilities without consultation. If they are single, the norm is that they are usually sent to any health facility according to management decision. The nurse's preference is usually

not considered, and the directive must be followed or they face the consequences of not adhering to the posting directives. The nurses voiced that they are not consulted on their posting areas and are just given directives of where to go once studies are completed:

> *No, with my first posting I was single it was just a directive from the top to go your island... No, I wasn't given any choice to appeal, was just told 'go to Kadavu', I packed all my things and went to Kadavu, I had no choice even though my home, my parents were in Lautoka you know, I thought they were going to post me to Lautoka but unfortunately, I had to go to Kadavu, I had no choice.* (Participant 7)

ii. Directive Decision Making

There are no specialised areas of work or acuity in Fiji; thus, when given a directive to move to a new working position or post that is either clinical or public health, the nurses have limited chances of appealing and may be punished or victimised if they challenge the decision made. The nurses receive an appointment letter when joining the workforce informing them of the health facility to which they will be posted. They may prefer certain health facilities due to family or area of work interest, but once a directive is given they have no choice but to follow through with the posting.

> *Like my experience was such that if I had refused the post its either they recommended us to go for counselling or suspension, it was like back then we did not have a voice... if not they will throw us further away from where we are currently posted*. (Participant 6)

iii. Powerlessness of Nurses

The data gathered from the interview revealed that these nurses did not have the ability to question authority and voice their concerns throughout the four different nursing domains, which relates to the cultural dynamics of women in Fijian culture having no power or voice in issues of authority. Cultural power is evident in the organisational leadership roles and is reflected in the information given during the interview.

> *Something we go through as an initiation process. Nurses do object… I feel they get victimised for objecting or appealing their post.* (Participant 2)

> *Well for now I think they are being restricted to appeal... most of their appeals have been declined e.g., in X facility 5 nurses appealed and only one was approved.* (Participant 16)

5.4 Devaluing of Nurses

i. Lacking Incentives and Rewards

Nursing turnover is on the rise in Fiji with more nurses seeking better work opportunities outside of the country. This creates job vacancies and the loss of experienced nurses. As outlined by the quoted nurse, migration, political situation, and frozen salary remuneration for nurses seems to be an on-going issue; but, as identified by the nurses, though these factors play a role in contributing to their working conditions, other professions have gained more attention with regards to incentives and rewards.

> *There are no incentives and there is no insurance or protection for us nurses in terms of risks. We go out there and we face these challenges and at times we get injured and end up in the situation that we are really deep in it that is hard for us to come out of. I've had a lot of colleagues who are sick, and the government doesn't even help, even our management as leaders they don't even see that there is a need to incentivise us or help us or protect us also from dangers, so I don't think so they can reach the target of quality or improvement at work, from my opinion. Like I said pay, increase our pay according to our IWP (Individual Work Plan).* (Participant 6)

ii. Lacking Remuneration

An integral component of retaining nurses is having desirable tangible motivation factors that would promote remaining in their working position. Motivational factors highlighted by the nurses that would encourage them to work and stay in the country related to pay incentives and improved management systems. These nurses sought recognition from both the Ministry of Health and their immediate supervisors for the 'hard work' that they carry out on a daily basis. The salary scale band introduced by the government includes different salary scales that increase as the band step move upwards (refer Chapter 1). Identifying the minimum and maximum salary received in each band, starting with intern nurses and moving up to management and director positions, the nurses voiced a lot of disagreement with the salary band and how it may not be applicable to the nurses as compared to other civil servant workers in the country. It was unanimous amongst all the nurses interviewed that the salary of nurses in Fiji was insufficient in comparison to the country's standard of living. They have voiced their disappointment and their continuous plea with the government to consider a pay-raise for the profession.

Okay salary band as a whole I'm glad it's gone up our salary has gone up, but I think they still have to pay us according to the roles that we play like the workload, look at me what I do at the clinic and look at what the other nurses do here. We are all midwives, so I see how many cases outside 60 even 70/80 on a Tuesday clinic, so the different roles – even when we are all midwives the different roles that we play. I think I'm the only midwife in Fiji that does a lot of things. (Participant 13)

Similarly, Participant 14 agreed stating that:

I feel it's not implemented; they have the band but we still waiting it's been three years now and the APA which was promised to us it's been a year now still nothing. The last increment was 2 years ago. (Participant 14)

iii. Lack of Recognition When Compared to Other Professions

In comparison to other health workers, such as the doctors, the nurses were quick to voice their disappointment regarding the unfair evolution of salary distribution. In 2016, doctors were offered a pay rise of around 45% to their base salary, while nurses were guaranteed only a 14% pay rise that would span over two years determined by the Annual Performance Assessment (APA) of the supervisors. This left the nurses feeling underappreciated and taken advantage of, as compared to other health professionals. Nurses undertake extra duties, fill vacant positions, and take up extra roles and responsibilities on top of their own position roles, which are not recognised by the government. The extra duties (e.g., roles like project officers) do not get recognition in terms of extra allowance. The nurses resorted to commonly using their own funds for professional development such as obtaining a degree and receive no increase in pay or allowance for the effort of attaining the extra qualification and skill.

No. We've been doing my APA assessment till now the salary remains the same. What I can say is that it has never worked so which means you do your IWP you get the annual assessment and then that's it. You don't get anything out of the assessment, so it has never worked, you just get assessed for performing the whole year and if you perform well or don't that's it, you don't get anything out of it. (Participant 13)

For my knowledge yes, it has contributed but apart from that nothing has changed, you go out and study and come back the system is still the same. There is no change at all the pay is still the same that's so unfair, the thing is I think they should look at that when you do extra studies because most of

the studies that we do now the Ministry is not sponsoring like before, now you have to folk out from your own pocket if you want to up skill your knowledge you go for studies. (Participant 2)

ii. Management and Administration (Chiefly Authority)

Leadership and the traditional ways of managing nurses were seen by these nurses to lead to inadequate unprecedented challenges that further hinder opportunities for career development. While more flexible management and leadership styles and improved work performance (Brewer et al., 2016) have been adapted in the past decade, these remain problematic. The data revealed two main themes in relation to management characteristics: unclear promotion pathway and lack of leadership components in management structures.

5.5 Unclear Promotion Pathway

i. Lacking Recognition

In attempting to achieve a promotion pathway that is more transparent and applicable to everyone, irrespective of race and gender, in 2018 the Fijian government introduced a new system called the OMRIS. The system is applicable to all government workers where a panel for interviewing and recruiting nurses would include other government ministerial personals. The OMRIS system, instituted in the interest of transparency, however, was not seen to be as effective as it should be by the nurses in the current study. The nurses voiced that the system of selection is open to anyone and thus poses the risk of hiring someone that had no knowledge of the position advertised. There is also the dilemma that the system goes through a job test where the recipient that scores the most points is awarded the position. In the case of practical nursing practice and theoretical knowledge, points are only awarded to those that have the knowledge but lack the skills. Experienced nurses who are highly skilled but lack the ability to express their work in written format are at a disadvantage for the opportunity of promotion.

I don't agree with it (OMRIS) because this is the only time that we will recognise our senior nurses. Open merit is something to me is not fair because we will like… the junior nurses with not much experience like they take up like if they take up the post to be the NUM for the hospital the department she doesn't have any, that officer doesn't have much experience than the one that is more senior then him and I feel sorry for the one that is

already holding the post and being demoted to go to the job test and didn't pass the job test. (Participant 11)

i. Lack of Recognition of Qualification and Experience

The OMRIS system screens people with the needed qualification, and the health care system in Fiji has progressed allowing professional development to be more accessible to younger nurses as compared to the senior nurses. The OMRIS system carries an advantage for younger nurses, with the promotion pool being more favourable towards promoting young nurses. Senior nurses interviewed found this situation unfair as they have more experience but, unfortunately, end up not meeting the criteria of having the appropriate qualification. These senior nurses and nurse leader Talanoa voiced that they would like to see a promotional pathway that included both the qualification and experience as the criteria for promotion.

With the open merit I just... I'm really not satisfied with the open merit thing because as they said you'll pay according to your performance and all but it's not how it is because when we rate us because we know ourselves, we know us better and some of our supervisors just sitting there in the office they hardly come around to see to observe what's really going on. (Participant 16)

5.6 Lacking Leadership

i. Cultural and Colonisation Influences

Clear cultural rituals in the criteria stipulated for leadership are reflective of the Fijian culture where the most adoptive style of leadership is a dictatorship and very hierarchical with dominant and subservient positioning inherent in communication patterns, matched by the Fijian Vanua social system of authority, seniority, and power in the community.

No, because in Fiji, no, because culturally we in Fiji we are not allowed to talk back to those in leadership. You are just supposed to learn and just I mean just hear what they say and follow out their orders, we are not allowed to talk back. (Participant 1)

ii. Lacking Nurses' Advocacy

Nurses identified that when they have good leaders who empower and encourage them in their working environment, it influences their performance in a positive way. They tend to enjoy their work and look forward to coming to work when working with leaders that mentor them. However, there have been incidents when their work environment becomes toxic and the only option they have is to resign. The dissatisfaction of working with a leader whom they

are not happy with has led to nurses not turning up for work and reporting sick due to pressure from management. Most of the nurses interviewed voiced that they were not happy with their leaders and would have preferred that they have the right training in managing them and the resources.

> *Because no one is recognising we have the skill that we have, what we go through every day and the people sitting up there they don't come down and appreciate us, like at least a thank you from them, thank you for the work. They don't do that so what's the use of staying in the Ministry of Health when no one is recognising us.* (Participant 5)

> *Yes, very much. 100% I believe that leaders they are the one I mean leaders in the organisation they are the ones are you know they decide they make the decisions but then you also have to be able to approach them.* (Participant 10)

iii. Workforce Environment (Clan Members)

Under this theme, a lack ability to gain a healthy working environment for Fiji nurses was evident as highlighted by the nurses during their interviews which, in turn, affected their mental and physical health.

5.7 Stress, Burnout, and Stigma

i. Nurses Welfare

Most nurses interviewed voiced that their nursing welfare was being overworked and this was not supported by supervisors' attitudes. Importantly, other associated issues were the stress and loneliness of working remotely, not having internet for phone connection, patient ratio, and lack of manpower.

The public health nurses who attend to remote island nursing stations voiced feeling lonely and on-call 24/7 every day in their station. Some nurses needed to attend 40-45 patients per nurse, meaning skipping lunch on a busy clinic day.

> *We usually see more than 100 children in a day, so there are about 4 of us, so the nurse-to-patient ratio is about roughly 30-40 per nurse.* (Participant 5)

> *So we are not seeing only 20 cases a day, we are seeing 40-50 cases a day per nurse, say if I work alone and my other colleague is not at work, I'll be seeing that much 40 to 30 so it's not according, so we are overworked with*

one manpower and that much cases, so I am not seeing a child 15-20 minutes which is supposed to be done, I am seeing a child 5 minutes to 10 minutes because I have to see the other cases. Sometimes I don't take up my lunch time or my teatime because I feel for the children, so I just have to clear the crowd before I go for a break, I don't even have time to go and drink water or to go to the loo (toilet). (Participant 3)

ii. Poor Mental Health

Mental health support is available but not practiced, and the nurses seek other ways of dealing with their mental health such as going to church. A few nurses explained that they are unable to communicate with any stranger how they feel because of the stigma associated with being Muslim further compounding their mental illness.

Actually, we have empowered pacific counselling centre here, but I have never seen any nurse going there may be due to stigma. No, but we have got... Reluctant because of stigma, because they think that it is in everybody's mind that if you are going there that you have issues and another thing is that we are working in one compound one area, so some of them might think that if I go there they might tell my friends and my Senior that I came for this issue and everybody will come to know my problem and that's why they are always reluctant. (Participant 12)

iii. Culturally Inappropriate Activities

Within the Talanoa session, nurse participants discussed how alcohol, especially consumed by women of a certain age, married with children, is viewed negatively within the Fijian culture. The expectation around women in society, especially nurses off duty as role models, is that they are not to engage in activities such as having a glass of wine, thus taking annual leave or sick leave for mental health reasons and engaging in de-stressing activities such as enjoying a glass of wine which may have supported their mental wellbeing, may lead to being victimized by management:

It is viewed, like what you said, viewed negatively in a cultural level, same thing with grog and especially with women of a certain age, and especially if you are married with kids (laughing while saying this). You know that kind of mentality 'oh, you know she is married, and she's got kids, why is doing this, shouldn't she be'... you know that kind of thinking will come up, and if you want to take time out with your friends it has to be you know it has to

be outside of your working hours and all this things like if I was to take a day for my mental health and I take my annual leave, I can't go on that day to go and drink grog...(laughing)... so it has to be outside of that actual annual leave that I would have to be taking care of my mental health. If I was to say go and drink grog on that particular day and somebody take my photo and put through social media, that's it!! I'd be victimized right then and there (laughing). (Participant 3)

5.8 Unsafe Working Conditions

i. Scope of Practice

The IWP is an outline of the individual's performance expectations and is submitted annually through a quarterly report as a means of outlining the individual nurse's accountability of their work plan—the 'how' and 'when' they will achieve their desired target goals. The IWP flows down from the Annual Cooperate Plan of the organisation to the divisional and sub-divisional cooperate plan before outlining the IWP of each nursing position. The achievement of the IWP will carry weight towards the overall performance of the organisation.

I think for rural nursing like the islands and villages, I think you have a very big responsibility like sometimes you work alone as a nurse compared to working in the peri-urban where it is closer to the hospital. Whereas for rural or for example the maritime you have lots of responsibility to carry out at your nursing and I think it's a lot where there no doctor, no one there I think it's a big responsibility that you have while you are out there. (Participant 15)

ii. Challenging Demands

The nurses voiced that numerous challenging demands related to needing to pay for transportation during emergencies and not getting reimbursed. The risk associated with transporting a patient across the maritime area with no supply of life-jackets is risky; yet, the nurses diligently perform this task. The isolated facility is mostly powered by solar panels, and on cloudy and rainy days the challenge would be going the night without power or the use of equipment that require power. Programme itineraries may be cancelled according to the weather as the sea is unpredictable and, lastly, nurses encounter lack of professional development opportunities.

We get swears for not providing the services, what can we do?... it's the Ministry that's supplying us with everything it's because of their own stupid

budgeting and whatever they have to order and all we are facing the brunt of it at grassroot, okay, we get swears every day because of what? Because limited resources, out-of-stock, we feel sorry for the community for the clients because they come to us, with the thought that they will come we will give them what they want, the thing is right now what the Ministry is trying to do it's trying to please the community, they are not looking at us the one that is providing the services trying to please the with whatever they announce in the radio saying things about the service and all but they are not providing us with whatever the communities need. What can we do, use our own money to buy things for the community and for the clients? (Participant 2)

iii. Lack of Resources, Infrastructure and Facilities

The maritime nurses explained that transportation was an issue with unavailability of boats in the islands to transport vaccine and medications. The lack of resources encountered ranged from non-replaced vaccine refrigerators, ECG machine, shortage of staff, transportation, and having the right equipment.

Okay, one of the major challenges, major challenge for being a clinic nurse in the maritime station, equipments... we do not have an ECG machine, we cannot take bloods and electricity, yeah, we only have solar only when the sun is hot solar will work if not then it just goes off. We have a dinamap but it only works with solar when solar is on. It can also be used with electricity, but our generator is not working... Oh, more than a year... not replaced. (Participant 8)

iv. Ministry of Health Expectations

Participants unanimously agreed that the Ministry of Health vision and mission— 'Health for ALL'—was unachievable due to challenges related to not being able to meet quality preventative health because of lack of resources. The community demands quality services, and the general population is used to being spoon-fed by the Ministry. Though the nurses want to do more, they are limited and challenged with not having the required resources that will help them achieve a quality health service.

It's really hard to say yes or no... yeah, I don't... well the way things look right now I don't think so it's achievable... Because of our, I think like most of my colleagues and I we sit down and we talk about our jobs and our pay and

amount of work, the expectations our supervisors have on us and given the limited resources because we want to do more but there's no resources so we can't really say we can achieve health quality. (Participant 10)

v. Professional Roles and Responsibilities

Nursing roles and performance is reflected through their skills, attitudes, traits, and motives, which are influenced by how work behaviour and competencies are assessed and managed (Zhang et al., 2001). The decision to stay or to migrate to other countries is linked to job satisfaction factors that comprise of challenges they encounter, position, and work opportunities. The data from the interviews highlight the nurses' voices and the description of their roles and responsibilities.

5.9 Very Demanding Roles and Responsibilities

i. Urban Nursing

There are four different nursing domains in Fiji—urban, peri-urban, rural, and remote rural—and each has different roles as described in Chapter 1. Urban nursing is mainly centred in divisional hospitals with special areas like ICU, CCU, and operating theatres run by specialist teams and doctors. Peri-urban is a lower grade hospital in that it does not have specialised departments (e.g., theatre, ICU) and, in most instance, serious cases are referred and transferred to divisional hospitals.

Okay core roles for urban nursing they have a certain time, they work 8-4 shifts a day and it's an 8-hour shift, in the health centre and in the hospitals it's just 8-hour shift but in rural nursing you work 8-4 but you are on-call 24-hours for emergency. So, when emergency arise and you get to, when you are called by the government, like for example what we are having right now is the measles campaign, you get to work beyond your normal hours and you have to be ready all the time that's what, yeah. (Participant 8)

ii. Rural Nursing

Rural and remote rural nursing are more in the field of public health nursing where nurses attend to the community, health promotion, and preventative health care nursing. Nurses are usually either in a health centre setting or nursing station setting where a sole nurse operates the health facility, carrying out the roles of both a clinical nurse and a public health nurse. Though more focused on public health, they also conduct clinical nursing relating to community out-patient services and treatment.

For the nursing stations in the remote areas are I think they mostly do everything from out-patients to immunisations child's clinic and the only thing I think that they don't do in the rural stations because it's just the nurse is that our obstetric and gynae cases are the ones we refer to the sub-divisional hospitals but otherwise we do mostly everything as nurses and for health centres in the urban settings is mostly out-patients, generally out-patients and sub-divisional hospitals we do other things nearly everything we still need to refer cases the serious cases to divisional hospital and divisional manages everything as the big hospital and three main ones cause they have all the equipments and everything to cater for all those cases. (Participant 2)

iii. Concerns Voiced (professional development, incentives, recognition)

Most of the nurses voiced that they funded their own post graduate training and nursing educators organised one-hour continuous nursing education (CNE) once a week in their various health facilities.

Overall, the most voiced working conditions that needed improvement, as suggested by the nurses, were the salary and work environment, and getting the recognition they deserve working as essential health workers in the country. Nursing establishment in the country needed to increase to cater for the population and nurses need to be more vocal with their grievances.

Working condition, the pantry where we eat, what we don't have proper changing room. See even the zone nurses there they change openly there, there is no changing room for them we go and crash in other rooms, crash in SOPD rooms and crash in that room and I think they should provide things like coffee and milo in the pantry and what else... yeah there's no privacy at all. Nurses working in remote ad maritime they need to get more pay because the other nursing domain they work comfortably where they are, in remote area they work hard, they walk, they go on horse backs, they go on flooded rivers they walk in the rain to get to deliver their services. (Participants 7 & 8)

Professional development in nursing was initially limited to a selected few, but now there are more nursing opportunities for professional development. Most nurses in the country pursue their professional development (i.e., post registration bachelor's degree) at their own

expense. There is limited support provided by the nursing organisation to fund and encourage attendance at professional development. The nursing council has introduced a 20-point system for evidence of professional development as a requirement for a nursing license renewal; though there is still limited training provided by the organisation.

5.10 Summary

This chapter connects the analysis of interview data to the research question, understanding the nurses' perspective on the meaning of job satisfaction; challenges to nursing roles. The job dissatisfaction factor themes that resulted from this process included: 1) Authoritative decision making; 2) Devaluing of the nurse; 3) Unclear promotion pathways; 4) Lacking leadership; 5) Unsafe working condition; 6) Stress, burnout, and stigma; 7) Roles and responsibilities of nurses; and 8) Nurses' voices.

The next four chapters: organizational characteristic, management and leadership characteristics, working environment and nursing role and responsibilities, outline the key themes and sub-themes gathered from the analysis through the testimonies and experience of the Fiji nurses, leaders, and government officials. The quotes are taken directly from the Talanoa interviews and presented to give rich, in-depth understanding of the nurses', leaders', and government officials' perceptions of job satisfaction.

Chapter 6: Organizational (Vanua) Characteristics

This chapter reflects on the second research question of understanding personal, organisational, managerial, and professional challenges that nurses in Fiji experience in their roles, and how they perceive these challenges impact on their job satisfaction. The analysis of the data that were collected from both Talanoa individual interviews and Talanoa focus group discussions summarises the themes extracted into the following three data chapters. The ethnic Fijian organisational culture and behaviour is examined with excerpts from the three different interview cohorts—registered nurses, nurse leader's government officials—triangulated to support the multiple stakeholder perceptions. The norms, values, and patterns of the organisation offer better insight into the research of understanding the challenges of how the organisational characteristics impact job satisfaction.

Table 4 is an example of how the themes were coded, themed, and compared across the interviews and the Talanoa group discussions. The complete table is attached in Appendix I for further reference.

The two main themes that were identified from the organisation characteristics interview questions were:

- Authoritative Decision Making
- Devaluing of Nurses

Table 4

Summary of the Tabulated Organisational Themes

Organisation	Summary – Code words from interview (Nurses Talanoa Interview)	Summary (coded words) (Talanoa 1 Leaders)	Summary (coded words) (Talanoa2 Government administration officials)	Possible Themes	Major Themes
Nursing Posting	•Made the most of the opportunity •Directive from the top •No choice	• It's always good that you go out to the communities • Always good that you go out and taste community nursing • Experience then expression of interest that you would like to come back to divisional	•Genuine reason should be considered •Should be a survey waiting to be done •Were they happy or how was their performance •Feedback to support your reasoning or decision	No Voice, No Choice	**Authoritative Decision**
Remuneration	•Working condition •Salary has been stagnant for so long •Huge gap between the work that we do and the amount that we are being paid •Job test is confusing •After job test the junior midwives had an increase in salary while the senior midwife's salary remained the same		• Salary should go with the standardised practiced • Nurse at work how they refer us to because doctors are still treating us like we're their servants • Nursing standard plus the establishment with regards to the Increase in population • Establishment goes with the working conditions • Mental leave • I'm not worried about the ones that are misusing it	• Remuneration Salary stagnant • Job tests confusing • Huge gap between workload and pay	**Devaluing of the Nurses**

			• Also, the working conditions in having the changing room/rest room on their own • Nursing work now is so heavy because in Fiji we are general nurses we are not specialised we do everything for public • Relationship between them and the leaders for them to be great leaders		
Annual performance appraisal (APA) system	•Doing a lot but not recognised •Boss doesn't like you or has something against you •It's up to them whether your pay goes up or remains the same •You should be in the good books of your supervisor •You don't get anything out of the assessment	• The service or meeting their needs especially the immediate needs that's quality • Quality patient care means equipment's, resources, staff personnel, delivery system but in this time there's a lot of challenges in defining this quality patient care and for us nurses we need to be well equipped with skills and knowledge and last the facilities infrastructure system should be up to standard in order to deliver the quality patient care in an efficient delivery system. • Resources in terms of quality care	• Fear that has been implemented by our leader • If you don't do this then its insubordination	• APA system • No results from the assessment, a lot of work is done but not reflected in the assessment	**Absence of Recognition (devaluing of the nurses)**

		• We're improvising with whatever resources focusing on customer care • Mostly resources that we cannot be getting consumable beyond our authority			
Motivational Factors	•Reward a nurse •A simple thank you •Give something a gift as an acknowledgement •Recognised for the hard work is enough •Pay like experience wise •No incentives •No insurance or protection for the nurses •Government doesn't even help if a colleague is sick •Pay according to IWP •Healthy working environment	• Before we were paid with night allowance so now even though they're still getting that night shift and they've reduced and when it comes to the 4th of 5th night, they start becoming sick • Overtime some are not getting paid and you know some nurses are cutting down on their overtime • They are not paid well • Passion to work even though they are paid or not paid • Overtime as I've said that nurses have changed the values and they have changed the ways if seeing things their taste and they	• Undervalued and invisible in the organisation • Leaves, establishment, salary not reviewed with specialised work areas • Consolidative allowance and that is one thing • Claim their hours of overtime • Need to write down the time they have been working	• Motivational factors • Acknowledgement, recognition, reward, insurance	**Incentives and Rewards (devaluing of the nurses)**

	are more concerned with wants than needs but they love to do overtime just to make money • Fair commitments so when overtime is limited some of them tend to be aggressive, get rebellious their respond is sick leave, refusing to do another overtime affects the teamwork its advantages and disadvantages at the end of today that question		

6.1 Theme 1: Authoritative Decision making

The Ministry of Health is the main authoritative domain that directs the management and supervision of nursing roles and responsibilities. They traditionally develop the structure of the health care services in the country and thus hold great responsibility for the dynamics of the nurses' work conditions in the county. The research questions sought to understand the meaning of job satisfaction for nurses; and understand personal, organisational, managerial, and professional challenges that nurses in Fiji experience in their roles, and how they perceive these challenges impact on their job satisfaction. The data were categorised into sub-themes and compared and contrasted with those of the nursing managers and leaders.

Sub-Theme 1: No Voice, No Choice

The national nursing posting is an expected annual activity that caters to the vacancy needs of nursing positions, and the assignment of nursing posts/positions to the new nursing graduates who have just been registered to practice in the country. The opportunity allows for the already practicing nurses to put forward their expression of interest in changing health facilities for various reasons, such as reunion with family, marriage, or a specialised area of interest. The research questions relating to the above theme were derived from questions relating to posting where the nurses are assigned their work area after graduation and registration. For most nurses in Fiji, their first posting, or after their internship in a divisional or sub-divisional hospital, is to health facilities without any consultation. Usually, if they are single, they are sent to any health facility according to management decision. The nurse's preference is generally not considered, and the directive must be followed or they face the consequences of not adhering to the posting directives.

In the interviews, almost all of the nurses expressed that they were directed to go to their posting facility after registration even though they did not want to, and that having the opportunity to appeal was not really an option.

> *No, with my first posting I was single it was just a directive from the top to go your island... No, I wasn't given any choice to appeal, was just told 'go to Kadavu', I packed all my things and went to Kadavu, I had no choice even though my home, my parents were in Lautoka you know, I thought they were going to post me to Lautoka but unfortunately, I had to go to Kadavu, I had no choice.* (Participant 7)

The nurses try to work around the system by looking for a replacement nurse who is more willing to take up the posting position. They would write in a replacement letter of agreement for an exchange basis or swapping of posts.

> *If they don't want to go???? (laughs)… I don't think… so, they wouldn't want to go, if they have a say… they have to go if they don't want to go, they have to get a replacement. If they willing to take up the post, then they have to go otherwise most of the time it comes from the management, so they have to go. They have no say.* (Participant 18)

The remaining participants expressed that nurses should adhere to the areas that they are posted to unless they have a genuine reason to appeal their posting.

The nursing managers in their focus group Talanoa discussion acknowledged that there was a need for the posting process to be improved but the idea of nurses respecting and adhering to where they are being posted resonated throughout the discussions.

> *I think they should get a choice to select the place because sometimes when we are posted at a station where we are not happy, we are forced to be placed there we might not perform that well. When we visit the stations some of the nurses are not doing very well maybe one of the contributing factors can be they're just posted there, just to do the work because they are posted there but they are posted somewhere else maybe closer to the family where they wanted to, maybe performance might change at a certain percentage.* (Official J)

> *I agree with Sister X we have to really see things that way. If they are taken into consideration if somebody appeals, then you take into consideration as to WHY they are appealing or if they don't have any other genuine reason then they should move because in the first place they agreed to be a nurse and I think it's a calling and I think with nursing it's an essential service and wherever you post them*. (Official J)

> *I feel that you know becoming a nurse it's not something that ...you are called… If someone comes to you the doorstep and says "hey come and act like a nursing" it's something that you know within you to come and do nursing and to come and help the people with that I feel that they should be sent to wherever they have to go. Don't object.* (Official A)

The nursing leaders who are relatively closer to the nurses believed that being posted to rural communities would benefit the intern nurses' or new graduates' nursing career because it would allow them to be more resourceful and cultivate skills of thinking outside the box.

> *From my point of view, like I was once a community nurse/rural nurse and then when coming to the hospital setting, I can see the difference between you know how you react towards your patients and sometimes I think you learn a lot being a community nurse. You know sometimes you don't have the resources and try to attend to your patients compared to being in the hospital where they just mainly depend on what's there and when it's not there they can mainly think outside the box compared to rural nursing.* (Leader C)

> *I mean for nurses appealing as an internship I mean it's always good that you go out to the communities and practice on community nursing so internship some we start from the divisional and it's always good that you go out and have a taste of community nursing. You know when you've had that experience then it's another expression of interest that you would like to come back to divisional or you continue in community nursing.* (Leader A)

Nursing leaders believed that nurses appealing the system of posting is related to progressive changing values within the nursing profession as the younger nurses are more inclined towards their career pathway in the early stages of their nursing career as compared to conforming to the older system of gaining community experience.

> *For my past experiences the older ones in the colonial area they have so much passion for nursing but in this 20th century, nurses have changed their values! They have their fixed mindset though they have gone through their experience in community health while they were in training, to them that's enough! So, when they join the workforce, they have their values, their goals in their career development, they have set their career pathways, so they believe in having clinical experience enough for them to take them to greener pastures, so they don't see the importance of going back to community and experience community health and do primary health care. So, in that concept they feel that appealing for their positions they have a good ground, good reason to do that they've gone past the experience, they might as well go for further greener pastures. So, they want to change their*

values, they look for better things better opportunities and that could be the reason why they are appealing to against the decision to do their tour in their nursing journey. (Leader B)

Sub-Theme 2: Directive Decision Making and Feeling Powerless

The leadership style reflected in the data points towards an authoritative leadership style where decisions are given as a directive without objections. This may be related to the effects of early colonisation or how the 'Vanua framework' of leadership has transcended into the modern role of authority and will be further discussed in the next chapter of findings. The inability to object or question the nursing leaders has left the nurses feeling intimidated and powerless, where they must resort to other measures of dealing with their situation themselves.

Like my experience was such that if I had refused the post its either they recommended us to go for counselling or suspension, it was like back then we did not have a voice... if not they will throw us further away from where we are currently posted. (*Participant* 6)

Okay that was management decision, you know when we misbehave and then we're thrown to the island (laughs....) Well, I was in ICU, paediatric ICU and then I left for Moala and of course being a new intern being mischievous and doing things that are not supposed to be done drinking, absenteeism so yes it was a management decision but when I went to Moala it was good, exciting when you work alone without any medical officers ...very interesting cases and the referrals. It was good and interesting staying in the Island for about 6 years. (Participant 20)

I did not have any choice for where I was posted to I was just given a letter to be posted and I went and you know I did not volunteer did not apply to go to those places I was just posted to those places from, from our in-charges from the managers that just posted us. I couldn't, I couldn't appeal you couldn't at that time appeal you just have to go, go with it, if the managers told you to go here you go there. If you are posted here, it just happens you have to go. It was more like authoritative you know it was more like an authoritative decision that you have to pack your bags and you go. (Participant 1)

The nursing leaders and managers, however, saw that the nurses needed to adhere to the directives given to them as all decisions made that way were at the nurse's best interest and would benefit them in their career pathway.

> *We are general nurses maybe you after being an experienced nurse then you get to be specialised. That's after you take interest and you do well for the starters but for a nurse when they start for me I believe that they should also go and be sent to a public health or district clinic so they can know the kind of services that they will range out compared to the clinics here and the judgement will be fair enough and they will say okay I love this and they haven't done the public health life, how would react with them and I feel that is unfair*. (Official M)

> *Because if they object to their first posting then the other colleagues will want to follow the same thing if they don't want to go to that place. Sometimes they listen to the opinion of others and they don't know that they are experiencing themselves to be a nurse in a particular area. You know they just hear their friends, "you don't come here because of this, you won't like it here" but it's better that they go and experience it how it goes, and you know the feedback from the clients so people can have a same personality. Rural attachment.* (Official T)

6.2 Devaluing of Nurses

Motivational factors that were highlighted by the nurses as encouraging them to work and stay in the country were mostly related to work conditions and management. Seeking recognition from both the Ministry of Health and their immediate supervisors for their hard work was highlighted in the interviews.

Sub-Theme 1: Lacking Incentives and Rewards

Nursing turnover is on the rise in Fiji, with more nurses seeking better work opportunities outside of country. This creates job vacancies and the loss of experienced nurses. When nurses are satisfied with their work environment and the work conditions (e.g., leave), they will feel less pressure to move out to other countries and would prefer to stay and work in Fiji provided the incentives to stay are appealing.

Like if you were to reward a nurse for her hard work and at the same time, she would perform better in terms of her performance, just a simple thank you, you don't have to you know give something a gift, just to know that you have recognised for the hard work that you are doing that is just its more than enough. (Participant 3)

Okay one of the things is like the nurses should be given the recognition into their work cause like, especially with their pay like in experience wise, experience wise and the qualification. (Participant 4)

I think the only time I was recognised was when we had a party… but then that was during a Christmas party, and I was very happy when me and my other IMCI nurse were awarded. At least somebody recognised our outfit that day, it really you know... you were given chocolates, at least that boost us telling us that our outfit for that day, somebody recognised that and for our other colleges our family planning nurse because she's always being punctual to work so she was recognised for that. (Participant 5)

Good working environment, healthy working environment, positive encouragement from our leaders they can get to at least appreciate our work and also good equipment's like resources and equipment and workload to be less we'll love our work. (Participant 14)

The challenges associated with nursing shortage are a global issue and the lack of incentives in the country is evident. The political situation and frozen salary remuneration for nurses seems to be an on-going issue but, as identified by the nurses, though these factors contribute to their working conditions, other professions have gained more attention with regards to incentives and rewards as compared to the nurses.

There are no incentives and there is no insurance or protection for us nurses in terms of risks, we go out there and we face these challenges and at times we get injured and end up in the situation that we are really deep in it that is hard for us to come out of. I've had a lot of colleagues who are sick, and the government doesn't even help, even our management as leaders they don't even see that there is a need to incentivise us or help us or protect us also from dangers, so I don't think so they can reach the target of quality or improvement at work, from my opinion. Like I said pay, increase our pay according to our IWP. (Participant 6)

The nursing leaders and nursing managers identified that removing incentives such as night allowance from the nurses' pay has directly affected their work performance but explained that their neglected performance could be due to their mindset and values being different and more focused on rewards rather than passion for nursing.

> *You know like before we were paid with night allowance, so this is one of... even though nurses were having a lot of night shifts it was okay because they were getting like $10... so now even though they're still getting that night shift and they've reduced and when it comes to the 4th of 5th night, they start becoming sick!! So, you know in overtime some are not getting paid, and you know some nurses are cutting down on their overtime it's maybe because they are not paid well and all, so we still have some propose on that when it comes to overtime, money, things, and all that. Then we have nurses who have the passion to work even though they are paid or not paid.* (Leader A)

> *So in regards to overtime as I've said that nurses have changed the values and they have changed the ways if seeing things because of their mindset, their taste and they are more concerned with wants than needs but they love to do overtime just to make money because of fair commitments so when overtime is limited some of them tend to be aggressive, get rebellious and their response is sick leave, refusing to do another overtime and facts the teamwork because they don't receive the money or they are not given another overtime so it's both sides... so it has its advantages and disadvantages but at the end of today that question surface (laughs) because they are more concerned about their values but they are not concerned about the passion.* (Leader B)

> *Bad way, like for some you can't take leave or sick leave roster if you have been doing overtime. They do overtime and the old roster they should never go sick leave or leave that was one thing I heard before and what say by the 3rd week you are sick so you can't overtime because you are really sick. It's been happening in the hospital, so it will affect a nurse's performance definitely.* (Official 1)

Sub-Theme 2: Remuneration Unpredictable and Confusing

A salary scale band was introduced by the government and categorises the nursing position level. Each salary band has a different salary scale that increases as the band steps move upwards. It identifies the minimum and maximum salary received in each band starting with intern nurses and moving to management and director positions. There was a lot of discussion regarding the salary band and how it may not be applicable to the nurses as compared to other civil servant workers in the country.

> *Retention of nurses in Fiji, nurses working condition... does salary count, then yes, the salary you have to increase the salary. It has been stagnant for so long now. I think ever since I joined it has been stagnant.* (Participant 9)

> *I think better pay, in terms, cause right now there is a huge gap between the work that we do and the amount of pay we are getting, so we are getting paid less and expected to do more with the limited resources we are given.* (Participant 3)

> *Last year, 2019, ours went up in 2019. So, we were all sitting on $28,000. After the job test then our salary increased last year February so all this while we were all sitting on $28,000, the job test results decide so after the job test... confusing. If a new graduate gets a higher job test mark she gets a higher pay, then you. That's why we were having all this issue in CWM most of the junior midwives getting higher salary then the senior midwives.* (Participant 13)

> *No, it's not effective that's why I said this my APA thing is so unfair its totally unfair, for me I just don't agree with this salary band and assessment that they are doing because it is sad if you are doing a good work and you are faithful to your work and your supervisor does not appreciate it when it comes to my APA it's the one that the supervisors like that will go up, like I said in the first place it's so bias and the assessment that they are doing is so bias.* (Participant 2)

> *Most of us sit on the same band actually, but on different steps, it would have to depend on the supervisor that assesses us so we can sit on the same band, but on that band there's 7 steps so you sit along any of the 7 steps you know depends on your superior so she would have to make the recommendation so my pay can be the same as somebody who did*

internship last year and became a fully fledge nurse this year our pay would be on the same level even though this is my eighth year in the service, the same thing would be for someone with 10 years in the service and pay would be the same thing, so it would depend on whoever is assessing us at that point in time just in comparison… …but it's been 2 years now where we've been assessed but still everything else is on hold, from what we have told is that you will be assessed and after that whatever your supervisor recommends the band she recommends, the step that she recommends for you that's where you will move, so it's either you will stay where you are or if she recommends for you to move up then you will move up. So basically, what happened is that we have been assessed and those that were recommended to move up, but there was no moving up, so we've basically been sitting where we have been sitting for the last 2 years… I think the doctors receive much better pay, much better than us, 4-5 times better than us, I think the doctors do get more than us, and most of the times we also do most of their work which I think that is quite unfair. (Participant 3)

An integral component of retaining nurses is having a desirable working condition that would motivate them to remain in their position. Motivational factors highlighted by the nurses that would encourage them to work and stay in the country were mostly related to pay incentives and management. They seek recognition from both the Ministry of Health and their immediate supervisors for the hard work they carry out daily. It was unanimous amongst all the nurses interviewed that the salary of nurses in Fiji was insufficient compared to the country's standard of living. They voiced their disappointment and their continuous plea with the government to consider a pay-raise for the profession.

I think it doesn't even come up to expectation, oh god, there are more things that we do here then the pay that comes in I think it doesn't meet at all, I mean if you compare to overseas has the equipments and everything but in terms of the patients, we have the same care that we give overseas but it's just the difference of how they serve their customers in terms of the care the positions that they do but at the end of the day it's the same kind of care we offer the patient comfort. (Participant 6)

What I can say? It's something that has been changed yeah it has been changed whereas we fall in the step and the band where the whole lot of

you go into that step, it's not that when you are specialised you sit on that I mean sitting on 30-40k, no. The only thing I mentioned are the midwives form 24k to 28k from 28k to 33k that's like the NUM salary, so it's a very big difference because it is specialised. Whereas for us ICU, ED other yeah, it's just the same salary. So, we fall in the same step same salary yeah same scale. (Participant 15)

No!! Even if I had to talk about this to the public I would say no because if you see the J.D. [job description] *of a nurse and compare it to the amount of work actually they're doing, there's afar difference in that, I don't think so nurses are paid according to that.* (Participant 19)

What can I say about open merit... Open merit is all about it's like open book, in the sense that it's open to everyone so like for us in maternity if you have the qualification so open merit is like when you have qualification for it you get it, but if you don't it doesn't really, this is what I think it doesn't really work, it's just merit your qualification it doesn't really look at your experience that's what I think, but so which means open merit I don't really like the open merit. (Participant 13)

The nursing leaders and managers agreed with the registered nurses that the salary band was confusing, and that remuneration needed to be reviewed to improve the morale of the nurses.

It's different with other workplaces like a clerk, casual labour but for a nurse you study to qualify to care for patients and to deal with the patients. For open merit it's open but to me it's not good because they'll get somebody inexperienced just because they passed that job test. Because if he/she is inexperienced the system suffers, the team suffers and it can bring conflict and affects the morale, affects work performances, behavioural of people. (Official C)

For me, being in the service for 30 years in the last system the title has been changed so I was a Matron in Service training and then got regarded and I was thinking on what grounds training is very paramount in any institution because you use your brain (laughs) you teach people, you educate people and provide opportunities for training... you are expected to be at the forefront when there's a new change, the change in the system where

there's a review in Policy, review of guideline and there's so many things in place… …My opinion it's more biased, there's a lot of discrimination and there's no good grounding for people to move up and they need to do a thorough analysis on how people should move up in regard to salary and creates a lot of tension among the nurses. It affects their morale. (Leader B)

To look at the salary band they did not consider some of the factors the number of years in the service, the experience, the qualifications okay if you have postgrads that should be added as a bonus and those are the things that should be overlooked and they did I don't the way it to amuse people or just political because the way they did it was just so sudden and some of the positions are just regarded like mine and some positions too… …Licensing is done by the Nursing Council, and you are given the license if you are competent so when you become competent the expectations is high so when you go up to the clinical area, they are looking at the figure because they are inexperienced and that created a lot of chaos amongst the nurses. (Leader D)

Sub-Theme 3: Lacking Recognition

In most cases, when there are vacancy posts, nurses' step into the position in an acting capacity. The extra duties are not recognised by the government and, therefore, do not get recognition in terms of extra allowance. Further, the nurses that pursue and fund their own professional development such as obtaining a degree, do not receive any increase in pay or allowance for taking the effort to attain the extra qualification.

No, I don't think so. It's so sad...too bad… Professional yeah maybe, because of my work experience and I have done some studies but it wasn't from the Ministry of Health it's from my own pocket. (Participant 19)

I will just give you an example I just attended only one training last year, and I was told from the boss to look for workshops on the internet, look it up and yes, you know to get my points and have my nursing license. I have to look it up. (Participant 1)

In funding their postgraduate studies, many nurses appreciate the extra knowledge attained from their qualification and voice how professional growth has been beneficial to them. Some, though, felt that the workshops do not make any difference. Apart from professional development, the nurses voiced that the extra qualification made no difference in their work

conditions as the Ministry of Health did not view their extra effort to improve their professional development as a merit for increase in their salary scale.

> *No, I don't think so I have been given recognition because pay just you know not my pay like the incentives I get is still the same from when I graduates. it just increased a little but not as much as we would like to have to meet whatever we are doing plus high living standards now right now in Fiji how cost of living. It's that high cost of living goes with our pay with increase our pay to match up with that high cost of living or high living standard.* (Participant 1)

> *Like for remote area nurses they just get 100 plus for looking after cases 24hrs, they are on-call hrs 24/7, okay, whatever cases comes after midnight they have to stand and see the case, but what do they get $130 or 100 plus a fortnight, you think that is enough that's not enough.* (Participant 2)

> *They need to improve the salary for our salary band and then they we get a job test and according to the job test you get paid, job test result. So, after the job test result some of us get $28,000 and some sitting on $30,000 some on $32,000 and $34... midwives so we basically do the same thing and some are more experienced than the others see, so according to your job test result you sit at that level you get paid so that's why this new salary band is ineffective.* (Participant 13)

> *For my knowledge yes, it has contributed but apart from that nothing has changed, you go out and study and come back the system is still the same. There is no change at all the pay is still the same that's so unfair, the thing is I think they should look at that when you do extra studies because most of the studies that we do now the ministry is not sponsoring like before, now you have to fork out from your own pocket if you want to up skill your knowledge you go for studies.* (Participant 2)

The nursing managers and leaders do to not promote verbal recognition which was reflected by the nurses in their disappointment towards their supervisors:

> *Because no one is recognising we have the skill that we have, what we go through every day and the people sitting up there they don't come down and appreciate us, like at least a thank you from them, thank you for the work.*

They don't do that so what's the use of staying in the Ministry of Health when no one is recognising us. (Participant 5)

No, I haven't had a nurse manager come up to me and tell me you are doing a good work you know continue doing really good work thank you for the hard work that you are doing out there in the nursing station. I have never had a manager to come and pat me in the back and tell me yeah that I am doing a great job and I don't think that happens. (Participant 1)

In comparison to other health workers, such as the doctors, the nurses were quick to voice their disappointment in the unfair evolution of salary distribution between the nurses and other health professionals. The doctors received a pay rise of around 45% to their base salary, while the nurses were guaranteed only a 14% pay rise spanning over 2-years. This had left the nurses feeling underappreciated and taken advantage of.

Just remained the same. No pay rise nearly all the nurses in Nadi have a bachelor's in nursing but still it's been the same. (Participant 11)

The nursing leaders agreed with the need to relook at policies and guidelines that give recognition to the nurses such as incentives that acknowledge their roles and the extra qualifications. However, the nursing managers explained that they have not been able to give the recognition that the nurses deserved because of the current system which threatens overall job security.

In terms of all these trainings and you come back with masters but then this obvious comes in place with open merits, you know the job holder positions … and when you come with masters and you don't get it you'll come back and sit as your old positions as an RN… so, there's no pathways in nursing. (Leader A)

There's no policy in place or a guideline for example you work for 10 years, and we will review your qualifications or 5 years, there's nothing in place. Nothing for nursing at all. It's only through a successful planning we motivate the people, identify the people that can move up that's through job training, exposure given the opportunity to relieve or take the position. There are no guidelines to say that in nursing that if you work for 5 years, we will review your position we will review your qualifications and we will give you incentives and nothing in particular has been in place. I think that's

one of the drawbacks in nursing because nobody even thought of that. People have educated themselves to go right up to masters but what is in place for us to challenge ourselves with this qualification "what is there for me" and it goes back to the counter. And it's just through observation or it has this to go because there's no platform but if they meet the criteria they move up and if they go for successful planning then they go for discourse, for them to go they achieve goals and objectives and they come qualified, they can fit into those positions. The culture was seniority and the one who's calling the shots but if you are in his/her blacklist then you are out!! (leader C)

The system is such that you cannot fight against it, you have to listen and take what they give coz if you fight, you'll take the foreign one. Like at the end of the day we are just meeting targets like there's no one to look after our concerns. (Official M)

6.3 Summary

The main themes discussed in this chapter were authoritative decision making and devaluing of nurses. The data collected allows insight and understandings into the challenges experienced by the nurses and how the administration body has influenced the leaders and managers towards addressing these challenges. The Vanua and the culture of the Fijian people provided a lens explaining why and how specific dialogue and actions took place, and the different perceptions between the nurses and the leaders. The next chapter reports on findings relating to management characteristics, which will be compared and contrasted in the form of triangulation to those of the nurse leaders and government administration officials.

Chapter 7: Management and Leadership (Turaga) Characteristics

The notion that management has an influence on job satisfaction and the outcome of work performance is well established (Kaur & Singh, 2019). However, the psychological mechanisms operating in the Fijian context and the Vanua are presented in this chapter through the highlighting of variables in their management processes. Though it is assumed that the commitment of the employees paves the way to the success of an organisation, the management of the organisation determines the productivity of the employees (Kaur & Singh, 2019).

Table 5 provides an overview of how the themes were tabulated and the triangulation of the interviews and the two Talanoa focus group discussions. The complete table is attached in Appendix J for further reference.

The two main themes that were identified from the management characteristics:

- Unclear promotion pathway
- Lacking leadership

Table 5

Summary of the Tabulated Management Themes

Management	Summary – Code words from interview (Nurses Talanoa Interview)	Summary (coded words) (FG Talanoa 1 Leaders)	Summary (coded words) (FG Talanoa 2 Government administration Officials)	Possible Themes	Major Themes
Pathway to promotion	• Promotion and performance are based on who you know • Pathway to promotion is very long, months before receiving the results • Don't understand the pathway • Go for the interview but no results • Need both knowledge and experience wise and qualification • Favouritism • They don't go with experience • Not through following the proper channel	• Unclear pathway between nursing experience and seniority and qualification • Unclear pathway on salary band • Unclear pathway on promotion process	• Open Merit System does not reflect all the nurses' working roles	• Unclear pathway, long process, favouritism, need to consider both knowledge and experience	**Unclear Promotion Pathway**

Recognition from nursing managers	• No nurse manager has come up to tell me that am doing good work • Never had a manager to come and pat me in the back • Some from previous supervisors • No one is recognising the skills that we have • Don't come down to our level and appreciate us • Not from the managers not from the Ministry	• Compromised working conditions, increasing customer complains • Lacking team building programmes to encourage team bonding and improvement of work performances	• The system is such that you cannot fight against it • Listen and take what they give cause if you fight, you'll take the foreign one meeting targets like there's no one to look after our concerns • Unfair working system for the nurse	• No recognition from nurse managers	**Lacking Leadership**

7.1 Theme 1: Unclear Promotion Pathway

Leadership and the 'traditional hierarchical ways of managing nurses' have led to unprecedented challenges that hinder workforce opportunities globally. The challenges encountered by organisations have resulted in transitioning to more flexible management and leadership styles that improve work performance (Brewer et al., 2016). The data revealed two main themes in relation to management characteristics: unclear promotion pathway and lack of leadership components from management.

Sub-Theme 1: Lacking Recognition

In attempting to achieve a promotion pathway that is more transparent and applicable to everyone, irrespective of race and gender, the government had introduced a new system called the OMRIS. The system is applicable to all government workers. A panel for interviewing and recruiting nurses includes other government ministerial personals. The OMRIS system, implemented by the government in the interest of transparency, is not seen to be as effective as it should be by the nurses.

> *I don't agree with it because this is the only time that we will recognise our senior nurses. Open merit is something to me is not fair because we will like… the junior nurses with not much experience like they take up like if they take up the post to be the NUM for the hospital the department she doesn't have any, that officer doesn't have much experience than the one that is more senior then him and I feel sorry for the one that is already holding the post and being demoted to go to the job test and didn't pass the job test.* (Participant 11)

> *We had a very big change I mean a very big, alarming story that happened here in X hospital. We had those who have been satisfied with the sitting on that 2 stripe (nursing leader) and then since it has been implemented the open merit, anybody can apply so they have been sitting there for 3 to 4 to 5 years enjoying that salary scale and …they have changed back to wearing blue (registered nurse) when they were red (nurse leader) and then they turned back (demoted) because of this open merit system.* (Participant 15)

The nursing leaders also voiced their dilemma with the OMRIS system in not recognising or considering that the older nurses may be at a disadvantage to writing as compared to new graduates. Thus, there is lack of understanding that having the knowledge and applying the skill to the procedure may need more assessment.

I think I totally disagree with this OMRIS in terms of experience like for senior nurses when it comes to this open merits some junior nurses are sitting above the senior nurses and this open merits they have all these criteria's where they are selected and they go onto job tests and one of the things that I disagree is job tests because focusing on whatever you jot down but then there's no skill test done, you know he/she might be good at jotting things down but when it comes to skills, you know if there could've been another skill test done in terms of the post holder you know after when they do the job test... so when you happen to be the meritorious one or even if you're not in that field but now it's whoever can get the job, with this is the open merit thing. So that's something that I'm not with this open merit's thing. (Leader B)

To look at the salary band they did not consider some of the factors the number of years in the service, the experience, the qualifications okay if you have postgrads that should be added as a bonus and those are the things that shouldn't be overlooked, and they did it to amuse people or just political, because the way they did it was just so sudden and some of the positions are just re-graded like mine and some positions too. (Official D)

However, the managers stated that in the end it is the national level (Ministry of Health) that makes the final decisions on issues of promotion and remuneration. The managers may assess the nurses but once it reaches national level it may be reassessed before any decision is made in accordance with promotion or pay increment.

It's the national level yes depending on the manager's recommendations they don't consider sometimes. …It's the managers as well like if they have given you the full competence then they will re-assess again like what is the use of assessing again. The way you fill the form I think and there's no feedback, communication is not there. (Official S)

When it comes to my APA it's the one that the supervisors like (favours) that will go up, like I said in the first place it's so bias and the assessment that they are doing is so bias, if we are in good terms you will be the one getting the increase in salary band, even when you don't do well, she can put up something there and you get a good salary band because it's the supervisor

assessing and from that the salary will change because of her assessment. (Participant 3)

Sub-Theme 2: Qualification and Experience

The OMRIS system screens people with the needed qualification, and the health care system in Fiji has progressed allowing professional development to be more accessible to the younger nurses. The OMRIS system is an advantage to the younger nurses, with the promotion pool being more favourable towards the promoting of young nurses. The senior nurses find this situation unfair as they have more experience but unfortunately end up not meeting the criteria of having the appropriate qualification. The nurses voiced that they would like to see a promotional pathway that included both qualification and experience as the criteria for promotion.

With the open merit I just...I'm really not satisfied with the open merit thing because as they said you'll pay according to your performance and all but it's not how it is because when we rate us because we know ourselves, we know us better and some of our supervisors just sitting there in the office they hardly come around to see to observe what's really going on. (Participant 16)

I would prefer maybe you work for 2, 3 years you apply for bachelor, you apply for masters, that's how you get promoted just by the trade. I would prefer the experience wise the number of years you have worked if you have more experience with the trade then, which is not just experienced alone, and it's not just trade alone it has to both go together you have to have experience with the trade. (Participant 9)

Traditional leadership was just really bad and they were so biased back then in terms of seniority, they do not listen to the other side of the story, that affects the nurses their performances, I might say this we had one team leader here before she actually growls at the nurses the performances is, was really bad and most of them wanted to complain but they were afraid at the same time because knowing that she's the boss she just might go and undermined the other bosses and then the bosses won't listen to the nurses. So, the bullying was there, victimisation was there it was just really bad. (Participant 6)

Most of the time when we have a meeting things that first come out from the supervisor's mouth is the negative parts of the work like 'you don't do this and you don't do that', 'you don't meet this', 'you don't meet this target', 'you don't do this', 'why are you doing this', so we don't really have those good recognition part of a positive from leader. (Participant 5)

Yes, maybe all supervisors should go through a management and leadership courses, all of them, it should be a must for a leader to go through that course because only then they will understand what's all in there for them to do in leadership and management of certain workplace. (Participant 2)

Though there were some nurses who felt that qualification and experience was necessary for management, some promotions were still following the old system of preferential selection and mentoring of nurses who displayed leadership skills without the needed qualification.

Okay before I know nurses get promotions through their work how they are working, what they are doing you know, I mean how their work is at the end of year, their performances. But now it's more like who you know. It's like you know it's more of like somebody if your boss you like likes another nurse even though that other nurse work isn't like as good as you, that nurse is picked for promotion. (Participant 1)

Not necessarily, yes with I think with this open merit system you need to getting some management qualification but with the roles I think leadership is a role that you have it in you, you know that you don't need a qualification to tell you that you are a leader, you show that you are a leader okay, by your action you know that this person is a leader just by what you do. (Participant 13)

The nursing leaders and managers outlined that as people in management, they felt the OMRIS system was flawed in the context that it did not give a true reflection of the work carried out by the nurses; and thus, induces conflict and low morale between nursing colleagues who are more skilled but did not receive the promotion.

With these open merits system, nursing is not open because we deal with patients' life and we cannot be compared with office workers who work with procedures, protocols, with systems because the way it is being practiced it does not actually identify who's skilful and the one who's knowledgeable so

its mode biased, it can be beneficial but on the other side biased. You cannot guarantee that the right person has been selected for the position because open merits system they have a selection for just that moment, people can get prepared well for that (job test), they can get interviewed or job test or presentations and anybody can do that but the way they implement it does not actually capture the most qualified person, because as we go up we can easily lose it and another challenge there is that how they format the fractions during job test. …Though they have independent bodies or independent referees, they are outside externally but what matters is that those who are in their departments or ministries have influence in the selection, so even though it's an open merit – the last say, the discretion still goes back to the immediate supervisor, and it forms a lot of questions. In this open merit we cannot complain about people, but we can only appeal about the system and about the process. It's different with other workplaces like clerks, casual labour, but for a nurse you study to qualify to care for patients and to deal with the patients. For open merit it's open but to me it's not good because they'll get somebody inexperienced just because they passed that job test. Because if he/she is inexperienced the system suffers, the team suffers and it can bring conflict and affects the morale, affects work performances, behavioural of people. (Leader C)

The professional development of the nurses with extra qualification was also discussed by the nursing leaders who acknowledged they were unable to give recognition for the extra knowledge attained; this was because there was no policy in the organisational system that awarded nurses for their achievements.

There's no policy in place or a guideline for example you work for 10 years, and we will review your qualifications or 5 years, there's nothing in place. Nothing for nursing at all. It's only through a successful planning we motivate the people, identify the people that can move up that's through job training, exposure given the opportunity to relieve or take the position. There are no guidelines to say that in nursing that if you work for 5 years, we will review your position we will review your qualifications and we will give you incentives and nothing in particular has been in place. I think that's one of the drawbacks in nursing because nobody even thought of that… (Leader C)

7.2 Theme 2: Lacking Leadership

The nurses identified that when they had good leaders who empowered them and encouraged them in their work environment it affected their work performance in a positive way. They showed greater tendency to enjoy their work and looked forward to working with leaders who mentored them. There were incidents mentioned in the interview of work environment becoming toxic for the nurses to work in, thus resorting to resignation as the only option.

Sub-Theme 1: Cultural and Colonisation Influences

The cultural rituals in leadership are reflective of the Fijian culture where leadership as dictatorship is commonly employed; reflecting the Fijian Vanua social system of authority, seniority, and power in the community. The nursing leaders in Fiji are promoted on merit basis, and some of the senior nursing management have been promoted after being mentored by their previous leaders on a seniority basis. Colonisation is evident through communication wherein subordinates are not allowed to question authority. The culture of respecting leaders and the effects of colonisation have influenced an unconscious feeling of fear in their working environment, resulting in nurses voicing their unhappiness with their leaders. Participants would have preferred that leaders receive the right training in managing them and the resources.

> *No, because in Fiji, no, because culturally we in Fiji we are not allowed to talk back to those in leadership. You are just supposed to learn and just I mean just hear what they say and follow out their orders, we are not allowed to talk back.* (Participant 1)

The interview data showed similarities with nurses not having the ability to question authority and voice their concerns throughout the four different nursing domains, which is related back to the cultural dynamics of women in the Fijian culture having no power or voice in issues of authority. The cultural power is evident in the organisational leadership roles, and is reflected in the information given during the interview.

> *Something we go through as an initiation process. Nurses do object… I feel they get victimised for objecting or appealing their post.* (Participant 2)

> *Well for now I think they are being restricted to appeal... most of their appeals have been declined e.g., in X facility 5 nurses appealed and only one was approved.* (Participant 16)

The nursing leaders when questioned about awarding nurses desired leave, such as mental health leave, talked about nurses abusing the leave rather than considering the nurses' health need and requesting time-off irrespective of their reasons. This may reflect how management leaders are influenced by work and performance culture.

> *Somehow or the other Director directs, and they will contribute to the organisation's objectives... at this time because of colonial system only the senior ones will take the cake, the junior ones will just tag behind and I believe that's the reason why they shift overseas because we could see the effect of colonialism because seniority is going to take the cake but there are other people who are more qualified and I can remember them, they were more qualified, they worked on their own and they developed on their own… if only they were given the opportunity and this new system of age of 55 you must retire, and they had to run down to take the right person for the post because they did not look at that in a long time. So, it's the new norms nowadays to recognise each individual, identify their area of interest and not everybody can get recognition... I mean some I can see can be very good educators, some are very good in research, if only it could be recognised earlier in the last 20 years, then everything would be better. So, it has impacted our positions, impacted the way that we behave, impacted the system and our career pathways.* (Official C)

> *It depends on what the issue an individual is going through so I think it would be best because every once in while it happens but sometimes it's like a routine to them so I think it would be good if it would does not happen to the frequent doers but otherwise, we are managing well.* (Official A)

> *Just like Madam has said, they have to look through it well and putting it into place but otherwise let's just leave it at that.* (Official B)

> *But right now, Family Care Leave nurses are already abusing it (laughs). They've already exceeded but the Family Care Leave is still coming and giving another mental problem to me (laughs).* (Official C)

Sub-Theme 2: Lacking Advocating for Nurses

Human resource are the most valuable assets in any given organisation, and thus effective management stimulates success through strategies that advocate for overall work satisfaction (Scanlan & Still, 2019). In management, possessing the relevant knowledge and

skills is pivotal for ensuring employees demonstrate effective performance that meets the organisation's goals and objectives. It is fundamental for managers to strategically develop processes that acknowledge dissatisfaction and challenge nurses' encounter, and may develop appraisals to reduce poor performance and assist with potential nursing development.

> *Because no one is recognising we have the skill that we have, what we go through every day and the people sitting up there they don't come down and appreciate us, like at least a thank you from them, thank you for the work. They don't do that so what's the use of staying in the Ministry of Health when no one is recognising us.* (Participant 5)

> *Yes, very much. 100% I believe that leaders they are the one I mean leaders in the organisation they are the ones are you know they decide they make the decisions but then you also have to be able to approach them.* (Participant 10)

> *I mean you can get a good pay but if your nursing leader or your manager is an asshole then no way, no way the nurses would want to stay... nurses managers' attitudes towards us, you know, if they say you are not good enough, that we don't do good, and also the work performance that they want us to achieve we won't be able to achieve it, if they don't do good themselves, if they don't perform well themselves in directing us. Organisation they are the ones are you know they decide they make the decisions but then you also have to be able to approach them.* (Participant 1)

The nurses expressed that managers lacked initiative to verbally acknowledge them for their hard work, with some mentioning that their manager has never patted them on the back to say, *'thank you'.* The nurse felt unappreciated by both managers and the Ministry in not being given any recognition, such as awards or certificate, to commemorate their hard work.

> *No, I haven't had a nurse manager come up to me and tell me you are doing a good work you know continue doing really good work thank you for the hard work that you are doing out there in the nursing station. I have never had a manager to come and pat me in the back and tell me yeah that I am doing a great job and I don't think that happens.* (Participant 1)

Ahh, so far yes from some previous supervisor, but so far, I'm not more into that but like for the 9th year for me it's just like the same old from the beginning till now. (Participant 4)

Because no one is recognising we have the skill that we have, what we go through every day and the people sitting up there they don't come down and appreciate us, like at least a thank you from them, thank you for the work. They don't do that so what's the use of staying in the Ministry of health when no one is recognising us. (Participant 5)

Only from my supervisors, only my supervisors… yes, they appreciate, but not from Ministry. (Participant 12)

Better working conditions and for the managers, our managers to try and take time to listen to our grievances, most of the time we take it up they just sit with our grievances, they do not try to help but... and they sort of take the Ministry's side again without fighting for us nurses. (Participant 8)

Though the managers and leaders explained that they have awards at the end of the year, recognition is usually focused only on the leaders of the unit, and has not evolved to giving awards to nurses.

Like for us we have this in-service committee and we usually come in groups, so the performance and in every month, we usually tell them that this group did best... you know coming in with attendance and then we have this nursing care plan where there's always updated because we usually audit. So, we have these groups... I mean focusing mostly on the groups and then the charge nurse (leader) are the ones that get recognised because of her good leadership you know the whole group follows but for Individuals we're still getting to that and in think we're always focusing on my APA. (Official B)

Recognising individuals. This is a difficult task because each individual is complex, they have different talents, different potentials, they have their own strengths and weaknesses, but we provide them opportunities to develop their potential. The main issue in getting their recognitions is that usually we personalise issues, we look at their weaknesses or their negative sides. We don't see their performance, the work they done and sometimes

it brings external influence and what they do is silent the workplace and we are doing because we are being judgemental, we are not positive on their performance and some people(nurses) have behavioural problems and some nurses because of their social life are being pushed aside. Those little things affect the managerial decisions. (Official C)

Like at the end of the day we are just meeting targets like there's no one to look after our concerns. (Leader 5)

7.3 Summary

The unclear promotion pathway accelerated by the lack of recognition from mangers and nurse leaders, who themselves often did not have the not qualification and experience, further challenges workforce planning. Though the nurses were able to point out some of the management issues that are influenced through colonisation, the leaders and managers acknowledged the lack of needed policies and interventions in this area. However, the different perspectives between the nurses and management (leaders and officials) were identified and how their response compared and contrasted with the job satisfaction themes. The next chapter reports on findings relating to the working environment of the nurses.

Chapter 8: Working Environment.

The work environment is associated with factors related to job satisfaction. Thus, understanding their levels of delivery may allow understanding of work satisfaction amongst Fiji nurses. The organisational function is linked to the management practice and work environment outcomes and the analysed data tabulated in Table 6 outlines the positive and negative behaviours related to the work environment that the nurses encounter (Li et al., 2020).

Table 6 overviews how the themes were tabulated in comparison to the nurse's interviews and the two focus group discussions. The complete table is attached in Appendix K for further reference.

The two main themes that were identified from the working environment characteristics were:

- Stress, burnout, and stigma
- Unsafe working environment

Table 6

Summary of the Tabulated Working Environment Themes

Working Environment	Summary – Code words from interview (Nurses Interview)	Summary (coded words) (FG 1 Leaders)	Summary (coded words) (FG 2 Government administration Officials)	Possible Themes	Major Themes
Challenges in meeting IWP	• Have to look for a boat for the vaccines • No refrigerator to store the vaccines • Damaged refrigerator replaced not supplied • Urban finish the shift forgets about the patient • Rural nursing takes their work home • Manpower, shortage of staff, nurses, shortage in everything • Medicine shortage • Have to walk for look for boat for shift clinics	• Nil protocols for working conditions provided such as short-change shifts or call-back policies • Limited resources	• Unsafe working environment	• Challenges in meeting IWP • No boats, no refrigerator in the maritime, late repair	**Unsafe Working Condition**
Care of mental health	• Talanoa session • Viewed negatively in a cultural level • Grog especially with women of a certain age • Married with kids	• Lack counselling and social support for the nurses and management team	• No mental health and work support	• Care of mental health • Victimised if you voice being tired, culturally inappropriate	**Stress Burnout and Stigma**

	• Mentality what married women should not do (e.g., have a glass of wine) • Take annual leave for mental health • Victimised if photo taken on de-stressing on a sick leave day • Family care leave available • Victimised if you voice that you are tired • Education • Pray • Watch a movie on a stressful day			• Married women cannot have time to themselves	
Resources	• Have not been receiving quarterly supply of medicine • Salary • Work condition • Patient ratio • Resources out of stock/ shortage of trays • No space • No manpower and resources	• Policies to be reviewed	• Poor working conditions (no resting place for nurses, no pantry, and breast-feeding rooms)	• Resources manpower, work condition, space	**Nursing Work Conditions (Unsafe Working Condition)**

8.1 Theme 1: Stress, Burnout, and Stigma

Though Nantsupawat et al. (2017), recommended that more research needed to be directed towards improving policies and work conditions, attaining a healthy working environment for the Fiji nurses is still a work in progress, as highlighted by these cohorts of participants during their Talanoa interviews.

Sub-Theme 1: Nurses Health and Welfare

The issues that were voiced repetitively in the nurse's interview were the lack of manpower in terms of nurse to patient ratio and the workload associated with performing multiple roles. Issues with management were also highlighted, with the lack of resources to cater to quality needs.

> *It's just being overworked at workplace some supervisors they don't understand us, we have work to do in the workplace we have families to look after and sometimes when they come, they are moody they put everything on us.* (Participant 2)

> *Overwork. A lot of work and no rest, it's just sometimes the work is just too much you are on your own in a station and you have this you have the dressings to do you have to roll your own swabs and cut your own lint and document all that, updated and then at the same time you have an emergency coming in and oh yeah general out-patients you have patients out there and you know you can't turn anyone away even after hours you are on call 24/7.* (Participant 10)

> *Overload, like sometimes like I said sometimes we work there in the clinic then we are told to pull the shift again somewhere where staff shortage or sometimes we have a lot of patients and one of our staff is sick they report sick and left with 2 nurses, you have to continue with your mental health clinic as well as your SOPD clinic.* (Participant 12)

> *Yes, if your employer is considerate, considers you or sees to the health and the happiness of the employees that's how I think we will be able to do a better job, but it's like your employer's nursing managers, they need to consider us with the communication challenges. sometimes we have grievances we cannot walk right up to the director of nursing to go and pour out our grievances to her we have to go through the channel but it's a pity*

that whatever we take up to the SDNM (sub-divisional nurse manager) remains there and nothing has been done… Maybe personal issues, maybe lack of training managers. (Participant 8)

Nurses also expressed that their working conditions and welfare, such as working in isolation and remotely, are not recognised in terms of remuneration when considering the challenges, they encounter.

Being isolated I have to work alone I don't have anybody else and any health care worker working with me and you know my family am isolated and isolated too from my family and I don't have the luxuries of like you know a nurse working in the hospital in the city you know, I don't have the luxuries for that and plus they have to I have to look after them even on my day off I am on stand-by for emergencies even on my day off you know and they come in patients come in sometimes 2 in the morning odd hours 3 in the morning late at night you know when you want to sleep and want to rest you there you need to attend to them there is no one else out there it's just you. (Participant 1)

Like the ratio is supposed to be 1:2,000, but my population I am looking after 6,832 and after I did my census for the whole four years then I completed my census for that for my X zone… When I came into zoning (Zone nurse) it was only a few of us and the other zone was vacant so we have to look after the rest of the zones, like 2 zones like 3 zones, like our zone and another 2 zone, like one nurse looking after 3 zone, there's like having 8,000 and 7,000 in population. (Participant 4)

It's $48 a fortnight (remote subsistence allowance) and no consolidated allowance and we get to buy our own food, get to buy our own fuel, we pay our own fare to come the island to mainland, and we travel by the Yasawa flyer ferry or sea bus. (Participant 8)

Roster is being done by our sister in charge and with the roster range is usually unfair because some of the time we've been working, an example would be for night shift we're given 5 straight nights so stressful and will be most of the time with one senior nurse will be working under the junior nurses which is really stressful as well, and we do have a tea room, we don't have a change room we use the toilet to go and change (laughs). We have

lockers but not a proper change room is what we don't have, and the tearoom we use it as a change room as well. (Participant 18)

The nursing managers and leaders agree that a nurse's performance is affected when their welfare and work conditions are not attended to. Not having the appropriate resting room or resources increases frustration, burnout, sick leaves, and low morale in the work environment. Consequently, the organisation's objectives are affected.

I would say yes, definitely affects the work performance of the nurses in terms of the facility that they have provided, the roster even and there are ways that we have seen that the facility has affected the work that's being done in terms of.... I feel that there's parts in the hospital that they don't have proper change rooms which is ICU, acute medical and we've also noticed that there are no proper tea-rooms like ICU even we have noted and there are areas too that we've done the rounds like nurses have told us that the type of rosters that they have been given and it has really affected their work and some have been rostered for 5 nights and they are not given proper day off and then working for 5 nights and not having the proper restrooms too. (Leader D)

For my experience for the last 4-years this is a battleground for nursing manager because in each unit we don't have the same number of beds and not all hospitals have speciality. So, for CWM it has expanded a lot in speciality in CCUs, they have different number of beds, they have acute wards and for Lautoka Hospital they don't have acute wards except for CCU and ICU. Medical unit and surgical they don't have acute Units, so they don't have same number of beds, so for the patient ratio differs also. If you hold the establishment is less means they have a bigger number patient ratio but if they have adequate staff establishment so your patient ratio will be mostly directionally proportional, but one thing that differs is the workload, the number of patients, the nature of work involved and the activities that's taken by the nurse to do... …if its specialised care then that means more time, more energy and increased workload but if the patients are stable patient nurse ratio would be not of a problem but in acute wards where there's a lot of sick patients nurse patient ratio would have to be considered because of the workload and the energy in the time involved because much

of the work though much of the basic work be done but to give the quality patient care that'll be questionable. We won't be able to meet our targets, achieve the outcomes because there'll not be many hands to do the work and it drains a lot of the energy on the nurses, nurses are vulnerable to be sick, stressed out, burned out because the patient nurse ratio not proportional and another factor that needs to be considered if there's a skill mix that will be great help senior nurses are there with a middle class and the new ones who have just joined in the force but if there are more young nurses it's going to be a burden. (Leader A)

Sub-Theme 2: Mental Health

Though counselling is available, nurses do not seek or utilise this service. They are reluctant to seek out counselling because it would be admitting that they need help. The culture and perception of the Fijian people is that they do not want to be seen as weak. The stigma associated with counselling and mental health is also a reason they do not seek counselling when needed.

I think its stigma. They go there 'oh she's stressed'… 'oh she went to see doctor so' in our workplace, our workmates they have become our family. Everyone in there would know that one nurse is going through a lot. You know like it's just within us but for a professional counsellor there no I don't think so. (Participant 20)

Actually, we have empowered Pacific counselling centre here, but I have never seen any nurse going there may be due to stigma. ...Reluctant because of stigma, because they think that it is in everybody's mind that if you are going there that you have issues and another thing is that we are working in one compound one area, so some of them might think that if I go there they might tell my friends and my senior that I came for this issue and everybody will come to know my problem and that's why they are always reluctant. (Participant 12)

For our department explaining our department to you will know about burn out. Yeah, nurses when they are sick, I'll just tell them to take a sick leave yeah to go on family care if their children are sick, they will just want to go home I know they are already burned out because of our turn out of patients.

Nurses go through the burnout a lot because of the stress because of the workload and the staffing shortage of manpower. (Participant 11)

There's no special counsellor for nurses, there's only for patients. Why there's no one for nurses because nurses are not bold enough to go straight to the counsellors in maternity unit or Pacific counselling because of stigma yeah so it will be good if we have our own counsellors for nurses in Fiji that would be so good. (Participant 14)

Nurses mentioned that they mostly deal with their work stressors through going to church and relying on their faith as their source of comfort rather than relying on a counselling support system.

I go to church you know and that helps me you know we don't have counselling systems, or you know base so we can have somebody to talk to. I am a nurse I give counselling advice but then who can I go to for counselling. (Participant 1)

One thing that really kept me going now in my nursing career is my faith if I would say that and mention that. I pray, most of the time my mum calls me up like she gets worried that am like in the middle of nowhere like in the rural. So yeah, well that's how I you know I drink grog.... yeah like I de-stress on days I try and relax my mind and I have my close friends I talk to them they understand and yeah just praying and trying to stay positive not see the bad side of it all the time try and see it from the patients and communities' side. (Participant 10)

Though mental health is an important variable that contributes to the nurse's performance, the nursing leaders explained that nurses have established means to address their mental health status, such as within their group of friends and taking family care leave. However, the leaders also mentioned that such strategies are abused by the nurses and thus they continue to question any form of leave taken.

The nurses have their own groups, so they have their own choices, they have their own way of planning together some are just in their little corners, some are very flexible, very vocal and they are able to share and currently the new leave that's being introduced is Family Leave. Family Leave is anything to do with family any urgency but in respond to your question in this point of

time... …No! The work is more important and if we're going to introduce that method then I don't know (laughs) but the current factors if they are faced with such situations like if they have some pending leave they can go and think about it and find solutions to their problems. So, their management comes in ...change of workplace or if they are interested in going into community, but those are some of the strategies that we use when the nurses are faced with issues, faced with problems. Mental health I think we should have something like that put in place. But people can also abuse it. (Leader C)

We have the 'Empower Pacific' so it's like a culture so if that person goes for things like that then that person cannot handle herself, it's the way they think and it's like a defeat or a sign of weakness. So, from the manager side hardly ever but maybe 1 in 20. First they will be counselled by the parties and then if it gets out of hand then we seek 'Empower Pacific' but hardly we get people to go to that agency maybe the stigma… but it's our culture because the way we are brought up that way, we are faced with so many challenges, unless we find that they are going through so much stress then if we see that it's affecting their work... then that indicates that they need help. Some they prefer the counselling with the union managers, I think it's because the way people view/interpretation. (Leader A)

Sub-Theme 3: Culturally Inappropriate

Though nurses would like to indulge in extracurricular activities to help alleviate stress, such as spending time with friends and enjoying activities outside of work, they are mindful of what society perceives as culturally appropriate. Therefore, they fear enjoying an activity, such as sharing a glass of wine, because of future judgement and being a victim of criticism.

It is viewed, like what you said, viewed negatively in a cultural level, same thing with grog and especially with women of a certain age, and especially if you are married with kids (laughing while saying this). You know that kind of mentality 'oh, you know she is married, and she's got kids, why is doing this, shouldn't she be'... you know that kind of thinking will come up, and if you want to take time out with your friends it has to be you know it has to be outside of your working hours and all this things like if I was to take a day for my mental health and I take my annual leave, I can't go on that day to

go and drink grog (laughing)... so it has to be outside of that actual annual leave that I would have to be taking care of my mental health. If I was to say go and drink grog on that particular day and somebody take my photo and put through social media, that's it!! I'd be victimized right then and there. (Participant 3)

Was a lot of drinking, I think that's the only thing we nurses do most of the time. We socialise to drink and party hard and get all those worries out. (Participant 6)

So yes, I manage my mentality with my family. My son I take him out to the movies or just for a dinner and of course with friend's grog session, never ending grog session. (Participant 20)

Maybe they are ashamed but most of us go to our supervisors like a person that we feel comfortable with or friends who are counsellors or 'Talatala' to get out our pastors and all to counsel us. As for me I have this prayer group and I feel comfortable with this pastor, so I normally share my problem with them, and he counsel me on some of my issues. (Participant 16)

The nursing leaders identified that the nurses resort to not seeking help because they are culturally brought up to not show any sign of weakness. Thus, they may prefer to confide in someone with whom they are more comfortable.

We have the 'Empower Pacific' so it's like a culture so if that person goes for things like that then that person cannot handle herself, it's the way they think and it's like a defeat or a sign of weakness. So, from the manager side hardly ever but maybe 1 in 20. First they will be counselled by the Parties and then if it gets out of hand then we seek 'Empower Pacific' but hardly we get people to go to that agency maybe the stigma or (...) but it's our culture because the way we are brought up that we are faced with so many challenges unless we find that they are going through so much stress then if we see that it's affecting their work... then that indicates that they need help. Some they prefer the counselling with the unit managers, I think it's because the way people view/interpretation. (Leader A)

8.2 Theme 2: Unsafe Working Conditions

The turnover intentions of the nurses may be controlled through the understanding of their work experiences, environment, job task, and resources. The demand from the nursing profession affects their performance, and the organisation has the responsibility for predicting feasible counter measures that assist in promoting a safe working environment. Unsafe working environment affects response to job satisfaction.

Sub-Theme 1: Scope of Practice

The accountability of dispensing medication at the nursing station level stems from a lack of manpower and not having a pharmacist at every rural station. Thus, the nurse takes up this responsibility and has to choose serving the patient over their scope of practice. Unsure if they are covered, nursing station nurses work alone and have no choice but to dispense either through prescriptions or general nursing knowledge.

> *No, it is not within my scope, even the fillings you know, they know, even the bosses they know, the managers they know that we are not suppose. It's not in my scope of nursing but still I, they know that I'm not supposed to be doing that but unfortunately, I have to do I because they won't be able to get another pharmacist assistant... man, I should say no to that, I shouldn't be doing it but who's going to do it.* (Participant 7)

> *It is not within the scope of nursing that's what I understand, we do it in say the nursing station, we do it because there's nobody else there to do it, say at nursing station level there is only one nurse and if I don't do it then who will? So basically, that's the whole reason why we do dispensing of medication even though it is not within our scope of nursing, but in terms of coverage that is something we do not know of we have been questioning that part but nothing has back to us in term of us being covered even though it is not in the scope of nursing.* (Participant 3)

> *I think for rural nursing like the islands and villages, I think you have a very big responsibility like sometimes you work alone as a nurse compared to working in the peri-urban where it is closer to the hospital. Whereas for rural or for example the maritime you have lots of responsibility to carry out at your nursing and I think it's a lot where there no doctor, no one there I think it's a big responsibility that you have while you are out there.* (Participant 15)

No, dispensing of medication is not part of our scope but that's it, due to, comes back to manpower. Usually dispensing is done by the pharmacist it's not under out scope as a nurse in some settings there is no pharmacist available, we do dispense but we don't know if we are covered or not if something comes up nothing in the book or protocol that says nurses are covered if something happened to patient because we are dispensing drugs to them. And well we feel unsafe doing it but, in the community, we have to do it otherwise they will go out with no medication and no use for doing the service if they don't take anything back home. (Participant 2)

First of all is like the workload especially the workload like to compare in hospital and the public health like the hospital them they just finish their shift and forget about their patients but in public health especially the zone once you finish with your work in day, you go home you take your work home with you their thinking again for tomorrow I have achieve all this because at the end of the year I have achieved my IWP. (Participant 4)

Manpower, shortage of stuff, nurses, shortage in everything, shortage in manpower and medicine, consumables are okay, problem in the transport, transportation, there's a lot of things that you know, a lot of factors that contribute towards not achieving the IWP's, there's a lot, a lot, a lot, am just naming a few (Participant 9)

In those cases, we will wait if any of the villagers are giving their boat then we'll... If there's none then we'll cancel or we'll walk... 45 minutes to one hour will all the luggage. (Participant 7)

The scope of practice is what protects and binds the nurses to the role they play within their nursing practice. The nursing leaders and managers understand some of the nursing scopes of practice are not carried out within legal boundaries, but they continue to see the practice because of public demand. Dispensing of medication is debated amongst the nurses, mostly amongst the public health nurses who work in the community without medical officers. The clinical nurses that work in the hospital have a standard operating procedure in which they follow patients' drug charts with the medication that is prescribed by the medical officer. The medication is pre-packed and dispensed to the patient by the pharmacist on discharge, and inpatient medication is charted on their medication forms. In terms of indemnity, the dispensing of medication in the community by the nurse is questionable because it is not

within their scope of practice, and they would be liable for their actions should wrong medication be given.

> *Like for public health there's a special nurse for that clinic SOPD and she looks after all these drug and I know it's not under our scope to give medication but when it comes to dispensing when there are people there for medication we can't wait for the pharmacist we will have to dispense and for that if we do something wrong we are not covered, there's no such thing to cover us if such things go wrong. So, you are dispensing at your own risk.* (Official S)

> *Yeah we do 1:1 but currently now we're doing extra duties they're not only doing ventilatory support we also doing Haemodialysis which is not we only catering for ICU patients but catering for acute cases who are coming from other wards so we have two things nursing ventilating and nursing haemodialysis patients even though we doing 1:1 but it's still some workload in looking after two critical patients at one time and it's a challenge.* (Leader A)

The scope of nursing is unclear and thus, as explained by the nursing leaders, needs to re-developed into a more specialised scope that clearly outlines the nurses' responsibility.

> *It will only be specialisation if the scope is carried out and the scope has to be carried out by the Nursing Council so even though we are doing the work we still under handled as ward nurses. We're still under-recognised and it requires a lot of work because of obligations.* (Leader C)

> *If we had to develop our scopes how will we carry out our own duties and every month of we would do scope practice, so there's a lot of things, one in scope and at the moment we've heard that FNU for the new students they are going to do honours so when they graduate they are graduating under speciality so that's like a bonus to the nursing society.* (Leader B)

Sub-Theme 2: Challenging Demands

Challenges in the delivery of quality health care regarding the work conditions of the nurses in Fiji are lack of resources, being over-worked and underpaid.

> *We get swears for not providing the services, what can we do?... it's the Ministry that's supplying us with everything it's because of their own stupid*

budgeting and whatever they have to order and all we are facing the brunt of it at grassroot, okay, we get swears every day because of what? Because limited resources, out-of-stock, we feel sorry for the community for the clients because they come to us, with the thought that they will come we will give them what they want, the thing is right now what the Ministry is trying to do it's trying to please the community, they are not looking at us the one that is providing the services trying to please the with whatever they announce in the radio saying things about the service and all but they are not providing us with whatever the communities need. What can we do, use our own money to buy things for the community and for the clients? (Participant 2)

Manpower, shortage of stuff, nurses, shortage in everything, shortage in manpower and medicine, consumables are okay, problem in the transport, transportation, there's a lot of things There's a lot of things that you know, a lot of factors that contribute towards not achieving the IWP's, there's a lot, a lot, a lot, am just naming a few. (Participant 7)

No, it doesn't have internet connection and there's no water coming from the clinic and that's the issue I have being raising ever since I went to Viwa. In the clinic I have to bring the water from the quarters… 10-20 meters… Carry the water from the clinic to the... I mean from the quarters to the clinic. (Participant 9)

Like I mentioned resources, lack of drugs like... water. Yeah water, sometimes because this is a clinic everything has to be cleaned, everything has to be and also, we need it to drink and eat. (Participant 10)

I think workload and kind of patients that we have, some patients they are very what can I say.... patients that are not patient, patients that always are always complaining and also the work environment especially with other staff that can't get along with other staff because of I don't know personal grudges that can also affect their them getting stressed. (Participant 13)

Nurses' work conditions, including not being paid allowance or overtime, has meant the nursing leaders and managers have seen a rise in absenteeism that affects the work progress in the organisation. The lack of resources and supply of proper equipment has overwhelmed the nurses thus affecting their service delivery.

I mean for PPEs we're always running out of that but then that's beyond our control so sometimes we are not really up to standard when we have all these outbreak cases coming on, all these micro bacterial cases that we need to nurse but for PPEs we still getting there so whatever things that are around like masks and gowns and all these we're still improvising sometimes but not in a sterile way what we're trying to provide you know this "high quality care" to patients so we still improvise whatever PPEs that are around even though we don't have a proper equipments. (Leader B)

You know like before we were paid with night allowance, so this is one of... even though nurses were having a lot of night shifts it was okay because they were getting like $10... So now even though they're still getting that night shift and they've reduced and when it comes to the 4th of 5th night, they start becoming sick!! So, you know in overtime some are not getting paid, and you know some nurses are cutting down on their overtime it's maybe because they are not paid well and all so we still have some propose on that when it comes to overtime, money, things and all that. Then we have nurses who have the passion to work even though they are paid or not paid. (Leader A)

The relationship of managers to the colleagues. If you got good relationship then okay and if you don't it like when you are wanting to finish your work, she has something against you, she doesn't accept anything you do and that is difficult. (official M)

Lack of resources right until now we haven't been receiving our quarterly supply of medicine and that's not quality because when the patients come we don't have enough, not enough, we don't have any supply available for them. So, we like advise them on other things like go up to the hospital if they have it here then yes good, I not they have to buy it... that's not quality don't you think so? ...And other things not only medicine also family planning commodities, like they might come for injections even sometimes they want to come for Jadell/papsmear there's not enough pills, not, there's not enough, there's nothing available for them. (Participant 7)

Sub-Theme 3: Lack of Resources

The maritime nurses voiced their concerns with limited resources such as needing boats to secure vaccines, no refrigerator to store the vaccines as damaged refrigerators are not replaced. Manpower, shortage of staff, medicine shortage, having to walk to look for boat for shift clinics, spoon feeding patients are just some of the mentioned challenges with resources raised by participants. Further, incidents with unavailability of medication have led to increased number of complaints from the public to higher management.

> *Okay, one of the major challenges, major challenge for being a clinic nurse in the maritime station, equipments... we do not have an ECG machine, we cannot take bloods and electricity, yeah, we only have solar only when the sun is hot solar will work if not then it just goes off. We have a dinamap, but it only works with solar when solar is on. It can also be used with electricity, but our generator is not working... Oh, more than a year... not replaced.* (Participant 8)

> *That's a very good question, the Ministry of Health's vision is a healthy population and delivering quality of whatever they want, okay, how can you deliver quality service when there are no resources things are getting out of stock, they come to us we are the ones at grass root level, and we get all the blame from the public and the community.* (Participant 2)

> *Manpower, shortage of stuff, nurses, shortage in everything, shortage in manpower and medicine, consumables are okay, problem in the transport, transportation, there's a lot of things that you know, a lot of factors that contribute towards not achieving the IWP's, there's a lot, a lot, a lot, am just naming a few.* (Participant 7)

> *Right now in X hospital we are faced with the out of stock of PPEs and resources and medicine, now we have not doing what we are wanting to do for example because of the shortage of trays in the theatre like the cataract trays... we have the manpower but because of the shortage of equipment's we cannot adjust to so many cases in a day and you can see the theatre in Lautoka hospital it's there's no space, manpower and instruments.* (Participant 14)

The consumables, drugs, and change room were some of the resources mentioned by the nursing leaders and managers that needed to be addressed. The nursing leaders highlighted

that the lack of resources was one of the contributing factors to increasing stress levels amongst the nurses as they would have to search for what was available and manage whatever was available to them.

> *You know one thing that's stopping us from achieving the Ministry of Health's goal and whatever they put is manpower (resources) and the supply of stocks. We can't go and see the community if there are shortage of nurses, medications like what we are currently facing! We are waiting for 2nd quarter, 3rd quarter, very tired. No drugs, how can they do their outreach out into the community If they are not taking anything. It all comes from up there how they manage it.* (Official A)

> *I have a change room, but it only accommodates for the nurses' lockers and at least they should armchairs or couches because sometimes when the nurses pull, I mean at least should be given an hour to go rest but since there is none they will just sit around in the pantry and the condition of the pantry is not good and it really affects their work.* (Leader A)

> *I think it's the facilities, the storerooms, and at least tea rooms for them to come and rest.* (Leader B)

> *You know some things that really affects the nurse's performance and stresses out is the consumables. I know it's beyond our control but the thing is when you work and it's almost 70% that during your 8-hour shift you go looking around for things and the turnovers is very fast… you're still looking after this patient and another one comes in and the same you're looking for in that patient, the same thing you'll get for that other patient and as a nursing manager that is quite challenging.* (Leader A)

Sub-Theme 4: Ministry of Health Expectations

The Ministry of Health vision and mission was unanimously agreed upon by participants as being unachievable due to the challenges relating to not being able to meet quality preventative health because of lack of resources. The community demands quality services, and the general population is used to being spoon-fed by the Ministry. Though the nurses want to do more, they are limited and challenged with not having the required resources that will help them achieve quality health service.

It's really hard to say yes or no... yeah, I don't... well the way things look right now I don't think so it's achievable... Because of our, I think like most of my colleagues and I we sit down and we talk about our jobs and our pay and amount of work, the expectations our supervisors have on us and given the limited resources because we want to do more but there's no resources so we can't really say we can achieve health quality. (Participant 10)

There is no such thing as providing the quality care. First of all, we are not provided with the resources like I said before in terms of boosting our performances we don't even get much money to accommodate those things, they don't consider our health as health workers but their just so selfish just to meet up the target that they want but they ignore the people whose life's of those that are actually doing the work for them so we are actually just the frontline being thrown under the bus and they don't care our welfare, our health and stuff like that. (Participant 6)

The Ministry of Health's vision is a healthy population and delivering quality of whatever they want, okay, how can you deliver quality service when there are no resources things are getting out of stock, they come to us we are the ones at grass root level, and we get all the blame from the public and the community. (Participant 2)

The nursing leaders and managers acknowledged that the expectations of the Ministry of Health were challenging due to the lack of resources which has led to unavoidable complaints against the nurses.

Like the complaints from the customers are uncountable and unavoidable but the complaints have been raised about the nurses but little do they know that the things that they need is not actually there and that's the reason why care has been compromised like care is not delivered up to standard and patients are complaining about it, like the unavailable of consumables and these nurses tend to run around from wards towards asking for it and the customers tend to think that nurses somewhere else waste time or just loiter around or maybe just out doing their business not knowing that these nurses are going around just to look for these consumables. (Leader D)

You know now they can terminate you on the spot, you know they can implement that. The Government of the day if this particular Minister is not

happy with you, they can fire you on the spot. You go home on the spot. So, there's a risk regardless of all the years you've been working. People have their petitions they want to, but they are afraid. Very afraid. Because there's nothing you know to back us up... "Be careful or you'll turn 55 tomorrow" somebody always says this... So overall your job is just not secure with this Government we must think of a backup plan. I used to remember my dad telling us siblings to all work in the Civil Service because it was a secured job but now it's no more. Civil servant we are at the worst time. Servant of the Government and you must listen to what the Government says. Like a puppet. (Official A)

For example, public health nurse. Okay, a good nurse will come to you with a monthly itinerary. She comes with her monthly itinerary and there's shortage of nurses in other health centres, who do they call? The managers… asking for reliever for that health centre. How will they achieve what's in their itinerary of what they have planned for that month? Shortage of nurses… So yeah that is a challenge. Transport. Availability of the transport. They cannot go out to conduct report tracing or to because of unavailability of transport. (Official B)

8.3 Summary

The findings from this chapter present the above-named factors of nurses' welfare, mental health, and cultural appropriateness as causes of stress with 'workload' being the key factor that was repeated amongst the nurses, officials and leaders who were interviewed. The unsafe working condition relating to their scope of practice and lack of resources is challenged by the organisational expectations. The next chapter reports on findings relating to the nurses roles and responsibilities.

Chapter 9: Nursing Roles and Responsibilities

Nurses are labelled the backbone of the health care system; yet, they are also one of the institutions that are underappreciated, influenced by many factors (EE, 2018). Job satisfaction has been defined and associated with how employees like or enjoy their work; and their behaviour, attitudes, and feelings they have towards their work as seen in more detail from chapter one (Ahmed et al., 2013; Kumar et al., 2013). The data tabulated in Table 7 outlines the participants findings on nursing roles and responsibilities and perception of association with job satisfaction in the urban and rural Fijian nursing locations.

Table 7 overviews how the themes were triangulated across the Talanoa interview and the two Talanoa focus group discussions. The complete table is attached in Appendix L for further reference.

The two main themes that were identified from the job satisfaction characteristics interview questions were:

- Complex roles and responsibilities
- Need to hear nurses' voice

Table 7

Summary of the Tabulated Job Satisfaction Themes

Job Satisfaction	Summary – Code words from interview (Nurses Talanoa Interview)	Summary (coded words) (FG Talanoa 1 Leaders)	Summary (coded words) (FG Talanoa 2 Government administration Officials)	Possible Themes	Major Themes
Understanding of the nursing roles	•Urban has hospitals/ Divisional settings •Peri-urban sub divisional hospitals •Health centres and nursing station are more remote areas •Health centres rural •Nursing stations remote rural	• Rural nursing works with far much lesser resources as compared to urban nurses and thus have developed the ability to think outside the box	• Public health, it's like a big job for them more preventative rather than the curative is like a routine work • A public health nurse does a lot • She's alone • Hospital nurse is a curative measure • Public health nurse is a preventive	• Understanding of the nursing roles, Urban is divisional and sub-divisional clinical settings, rural is remote community setting	**Roles and Responsibilities (Fiji Nursing)**

Related factors	• No creche room • Doing much more then what we are being paid for • Expected to do more because of the demands from the Ministry • We work with whatever resource we have now that's way above our pay grade • Recognised in what roles such as walking in the sun during the 8 hrs community shift work for those living in difficult geographical terrain and mostly being chased by dogs while surveying the community • No recognition • Things that are not allowed can be included in the scope of practice (e.g., dispensing of medication and IV cannulation)	• Don't have the potential to be fully equipped to face the challenges because they are still new to the workforce • The new ones they are going to be stressed out they won't be able to have the energy, stamina during low situations and it can be the source of stress and the source of conflict among the group because things like unfinished job incomplete job vulnerable to errors/mistakes that can happen	• Medical insurance should be included as well for the welfare of the officers • Organisation looks after the staff as a family, the family care should be there in terms of medical support pay can't be deducted they can't afford it • That's why the nurses said no because they were asked to pay when • Salary is already not enough	• Other important factors • No creche room, no recognition, improve scope of practice, measure pay according to workload, leadership training, provide counselling services	**Nurses' Voices**

9.1 Complex Roles and Responsibilities

Continuous nursing migration is evident globally, with many documented factors associated with job dissatisfaction in country or origin. Nursing performance is reflected through skills, attitudes, traits, and motives, which are influenced by how work behaviour and competencies are assessed and managed (Zhang et al., 2001). The decision to stay or migrate is linked to job satisfaction factors that comprise the challenges they encounter, position, and work opportunities. The data from the interviews highlighted the nurses' voices and the description of their roles and responsibilities.

Sub-Theme 1: Urban Nursing

There are four nursing domains in Fiji—urban, peri-urban, rural, and remote rural; and each has different roles. Urban nursing is mainly centred in divisional hospitals with special areas like ICU, CCU, and operating theatres that are run by specialist teams and doctors. Peri-urban, while still a hospital, does not have specialised departments (e.g., theatre, ICU), and, in most cases, serious cases are transferred to divisional hospitals.

> *Okay core roles for urban nursing they have a certain time, they work 8-4 shifts a day and it's an 8-hr shift, in the health centre and in the hospitals it's just 8hr shift but in rural nursing you work 8-4 but you are on-call 24-hours for emergency. So, when emergency arise and you get to, when you are called by the government, like for example what we are having right now is the measles campaign, you get to work beyond your normal hours and you have to be ready all the time that's what.* (Participant 8)

> *Okay so in the urban areas like the hospitals it's like a curative place it's my expertise in nursing is how to get a patient to be well, he is already sick he's lying there in the hospital bed and so on my nursing care to give my best ability to give whatever the doctor has ordered you know for the to cure the patients. Like in peri-urban health centres it's also it's part of the hospital it's like where you also have to ...so you have to at the peri-urban health centres you have to like offer the same roles that the hospital s but a much lower level like in most cases when the patients come in and they are very sick they are sent to the hospitals form the peri-urban and then the rural or remote rural nursing it's a quiet afar away where we look after mostly the well. Those who are well we look after maternal child health we look at all the injuries and accidents and we also do IMCI or integrated management of*

childhood illness and we also do ....health promotions and do home visits and do community awareness and nearly everything we do all of it we even do the maid's job we clean up our own houses and our stations we do promotions what the health inspectors do, we actually do everything in the remote rural nursing. (Participant 1)

Okay, urban like they work, urban nurses work according to doctors plan, so whatever the doctors plan for the nurses they work according to that's from my understanding, peri-urban sub divisional that's for nurses, a bit more like the urban the doctors are still in control and we work under them so we do the plans we implement their plans and the peri-urban are health centre levels, there are doctors and nurses too they have to listen to doctors for the plans and work accordingly and for remote rural nurses work alone, like they are their own managers. For example, if there is a severe case they have to discuss with the doctor, even they are not trained with IV cannulation you'll have to cannulate if your area medical officer tells to cannulate and put up a fluid, no am just saying there's no one there's no doctor there it's just them alone. Even if you are not trained with procedure like cannulation or giving IV medications which is not within our scope... unless and until we are trained, in nursing stations in the remote rural you'll have to do it for the sake of the patient's life. (Participant 5)

They'll just look after this number of patients and you know at the starting of the shift, they do their NCP, and they make sure that the end of the shift, the NCP has been addressed. So, if it's not done in this shift next shift takes over. (Leader A)

Sub-Theme 2: Rural Nursing

Rural and remote rural nursing are more into the field of public health nursing where they attend to community, health promotion, and preventative health care nursing. They are usually either in a health centre setting or nursing station setting where a sole nurse operates the health facility carrying out the roles of both a clinical nurse and a public health nurse. Though more focused on public health, they also conduct clinical nursing relating to community out-patient services and treatment.

For rural, rural would have to be the health centres around, well health centres in general, in public health, and for remote rural, remote rural would

be those out in the maritime nursing stations whereby the nurses are 'jack of all trades' they basically do everything there and whenever they encounter a case that they cannot handle then they will refer to say the urban or divisional hospitals. (Participant 3)

Divisional is much easier everything is there everything is provided, I mean the doctors are there, sub-divisional too I think, but the rural ones I think they are the ones carrying all the hard times in providing the services because most of the things are not there, even the if they happen to refer cases it depends on the – they use the radio telephone – and it depends on the weather and you know technical things to get across to mainland, discuss their cases, the transportation in the islands they have to come by boat. The outer areas they have arrange you know where the ambulance cannot reach, and they have to come down on horse backs. (Participant 7)

The roles of the nurses, okay, in terms of the clinical knowledge and skills here in the hospital setting we have other departments other doctors other medical from different cadres so they actually help you in terms of clinical on how they approach situations but when you get to be thrown into a rural setting the ideas of survival of the fittest, it's how you survive there and how you manage things with whatever resources that is available. For me to treat an asthmatic it was manual pump kind of machine so I have to press I have pump from my leg and supply the patient, but then if I do not have any Ventolin then I have to stay alert… …the only form of communication back then in the rural in X facility was through radio telephone (RT), but then it was a cold night usually in the interior the dues are very heavy that it can disrupt the transmission so the RT was down, there was no reception that I could call no phone line no mobile so it was hard for me to communicate and the transport rarely comes in at night, so I did not know how to transfer her to any, the nearest health centre was about 45-minutes to 2-hours by horse so if I had to walk it might take me 5-hours with a labouring 17 year old like that I really didn't know if I could. The only thing I did was to pray and try my best to deliver the baby… she managed to deliver so that was the greatest challenge I faced and the difference between the cares I have to go through in terms of the clinical setting and the rural. (Participant 6)

The nursing leaders and managers, in comparing urban and rural nursing roles, agreed that though urban nursing was more clinical, the role of rural nurses seem to be defined as being more resilient in dealing with harsher working conditions and meeting health target goals.

> *Quality patient care, to me it's well defined by the patient. It can have a lot of meanings, it can be the duty care, the service or meeting their needs especially the immediate needs that's quality to them but in a broader perspective quality patient care means equipment's, resources, staff personnel, delivery system but in this time there's a lot of challenges in defining this quality patient care and for us nurses we need to be well equipped with skills and knowledge and last the facilities infrastructure system should be up to standard in order to deliver the quality patient care in an efficient delivery system.* (Leader A)

> *So public health, it's like a big job for them, more preventative rather than the curative unlike hospitals curative is like a routine work or a protocol to follow that where's public health nurses must go out of their box to meet their targets, meet their activities and I believe that the work in public health is more demanding than a curative.* (Official R)

> *From my point of view, like I was once a community nurse/rural nurse and then when coming to the hospital setting I can see the difference between you know how you react towards your patients and sometimes I think you learn a lot being a community nurse. You know sometimes you don't have the resources and try to attend to your patients compared to being in the hospital where they just mainly depend on what's there and when it's not there they can't mainly think outside the box compared to rural nursing.* (Leader C)

9.2 Theme 2: Need to Hear Nurses' Voices

Job satisfaction and associated variables may be divided into extrinsic factors—salary and work benefits; and intrinsic factors—professional progress with the desired recognition from employers (Kabeel & Eisa, 2017). Though the variables of work and management characteristic are associated with job satisfaction, the exploration of the data analyses from the Fiji nurses' interviews may consider other variables that are applicable to the country of.

Sub-Theme 1: Concerns Voiced (Professional Development, Incentives, Recognition)

Professional development in nursing was initially only limited to a selected few, but now there are more opportunities. Most nurses pursue their professional development like post registration bachelor's degree at their own expense. There is limited support provided by the nursing organisation to fund and encourage attendance at professional development. The nursing council has introduced a 20-points system for evidence of professional development as a requirement for nursing license renewal. Though there is limited training provided by the organisation and nursing educators organise one-hour CNE once a week in their various health facilities, most of the nurses voiced that they funded their own postgraduate training.

Overall, the most voiced working conditions needing improvement, as suggested by the nurses, were the salary and work environment, and getting the recognition they deserved for working as essential health workers in the country. Remuneration to reflect the roles and responsibilities that is outlined in their IWP, and the need to recognise nurses working in isolation who are not compensated for undertaking extra working roles and managing a health facility all by themselves.

> *Imagine nurses are not getting risk allowances that's one thing, people who are working in the stress ward, St Giles, Tamavua Hospital should be getting risk allowances. People who are looking after isolation cases, risk allowance should be given to them, why not!? When the allocation is there. I feel sorry for my nurses because they are exposing themselves to things that they can always deny or not to do and they are buying is with these G.O. (General Orders) and the policies and procedures of the Ministry of Health without looking in the gaps that have created to allowances that they're supposed to be receiving. So, I guess I think they should pull up their socks cause that's when we'll see a lot of nurses requesting transfer from this work endowment.* (Participant 19)

Nurse managers expressed the same concerns mentioned by the nurses regarding the limitations and challenges they face as leaders and managers working in the health care services in Fiji. Manager A expressed that targets are unrealistic because of the work load and the need for nursing to evolve into a more specialised care where skills and tasks are considered.

> *The number of patient, the nature of work involved and the activities that's taken by the nurse to do... if its specialised care then that means more time,*

more energy and increased workload but if the patients are stable patient nurse ratio would be not of a problem but in acute wards where there's a lot of sick patients nurse patient ratio would have to be considered because of the workload and the energy in the time involved because much of the work though much of the basic work be done but to give the quality patient care that'll be questionable… …We won't be able to meet our targets, achieve the outcomes because there'll not be many hands to do the work and it drains a lot of the energy on the nurses, nurses are vulnerable to be sick, stressed out, burned out because the patient nurse ratio not proportional and another factor that needs to be considered if there's a skill mix that will be great help senior nurses are there with a middle class and the new ones who have just joined in the force but if there are more young nurses it's going to be a burden. (Official A)

You know something that we could focus on is the nursing degree, we have three steps ...we have interns, intermediate level then we come to the senior so in terms of salary if we can recognise that in nursing degree so they have come through interns, so things that they have to do like the basics and then they come into intermediate where need to, into ECLS, protocols, policies and all that and when you're in the senior level you're part of mentoring, coordinating or help in facilitating so when it comes to salary if it can be recognised the nursing degree maybe then and then you know it comes the qualifications the post grad where they sit on and that can be part of increasing your salary I'm sure there won't be any dilemma going on in terms of nursing salary and that's where your skills, your competency comes into and if you could always focus on your nursing career because we have those three steps and maybe if we implement those when it comes to salary, I'm sure you'll know where you stand. (Leader C)

I think medical insurance should be included as well for the welfare of the officers. If something happens to the officers what will happen? They just have to struggle on their own/fundraise. Like we say our organisation looks after the staff as a family, the family care should be there in terms of medical support like it's not internal or anything but in overseas if there's a need, they should set a funding for it's not only 5,000/15,000 just the airfare to be given, it should fully cover the cost or something. (Leader M)

Leader D, in her statement, clearly explained that the burden of working with limited resources affects the nurses and the population in not having their needs met. The reality would be that as much as they, the nursing leaders, would like to anticipate working in a fully equipped environment, the challenge to deliver quality service will always be hindered by the limited resources.

> *To reflect that one now to the past, the system that we have in this pointing time we are nursing the sick population. The sick population demands structure, facilities, resources, money, policy and the Government support ...as we speak now we are promised with resources. Patient turnover is very fast and patient is very sick and hospital condition is very bad and if we have good working conditions there's not enough resources people will stay and this is contradicting and if we increase the number of nurses compared to the last year lucky if we have more but now we have (starts counting) 1-8 nurses and we don't have the resources and we don't have the consumables or the supplies... the workload is increasing day by day, population is very sick, high incidents of NCDs but our working conditions, our allowances are not input... meal allowance they've taken away, long service leaves they've taken away, rate one rate 2 and it's just a straight allowance... …if they decide to better our working conditions to work on a Saturday, work on a public holiday or 2 shifts in a 24-hours and enough consumables, enough supplies, improve infrastructure and the nurses will stay because we have our own needs also, patient has its own needs , system has its own needs, we have our own needs and if it's not met we will leave to places where our needs can be met.* (Leader D)

9.3 Summary

This chapter has sought to answer the research question regarding understanding the nurse's perspective of job satisfaction and challenges in their nursing roles and responsibilities.

The themes from the two Talanoa focus group discussions were triangulated with those from the nurses' data to compare and contrast the key differences between the nurses', leaders', and government officials' perspectives. Highlighting complex roles and the need to hear nurses' voices. The next chapter critically discusses the findings in relation to how the research questions were addressed and where they are situated in the local and international

literature. Highlighted in particular, will be unique and novel findings, that situate the current thesis as making a significant contribution to new knowledge on nurses job satisfaction in a developing context.

Chapter 10: Discussion

> *When a child is born to a family in the indigenous Fijian settings, he/she is called '**luve ni vanua'**, meaning that all the people, the land, culture, and traditions are responsible for nurturing the child. During the child's christening in church, it is a norm for the congregation to stand up and promise to assist in the upbringing process. These promises are broken on many occasions when people continue to follow the **'individualised and laid-back lifestyle'** of the village… ...**solesolevaki** contributes to this social safety net when individuals feel out of place from the systems that influence their lives… …**Solesolevaki** is also; **'karua ni vuvale'** (a second family), **'neitou koronivuli'** (our village school), or **'I vesu ni neimai veiwekani'** (strength of our kinship).* (Vunibola, 2020, p. 198)

10.1 Reflection on the Research Questions

The main research questions sought to understand the meaning of job satisfaction for nurses; the personal, organisational, managerial, and professional challenges that nurses in Fiji experience in their roles, and how they perceive these challenges impact on their job satisfaction; and recommend strategies that support improvement in work conditions for nurses in Fiji, leading to enhanced job satisfaction. The four main characteristics that affect and influence job satisfaction are related to the research question as outlined in Table 8.

The organisational characteristics relating to the Vanua identified two main themes—Authoritative decision making and Devaluing of nurses. The nurses voiced that they had 'no voice no choice' which stems from years of dictation leadership styles that are culturally supported and influenced by British colonisation; and has influenced the role of women, the economy, and the structure of the health care system (Stewart, 2007). Furthermore, the Vanua hierarchy system is a governance level that demarcates the lines of authority awarded to those with high traditional status such as chiefs. In today's modern time, the perception of high status is different, where the importance of wealth, academic and social status is equally as important as traditional status (Brison, 2007; Nainoca, 2011).

The Talanoa interviews gave insight into the Fiji nurses' need for more autonomy in their working environment, though in the Talanoa focus group discussion nursing leaders and government administration officials testified to falling back onto older more authoritarian

leadership styles. British colonisation informs how nurses have come to accept their passive behavioural colonisation within the health care system, as discussed by Participant 6 who stated that if she had made the choice to refuse her nursing posting, she would have to face the consequences of being suspended or posted further away to an isolated nursing health centre.

Table 8

The Research Questions and How They Were Addressed Within the Thesis

	How it is addressed in the chapters
Question 1: To understand the meaning of job satisfaction for nurses in Fiji	Chapter 7-10 presented findings on the nurse's meaning and experience relating to job satisfaction that provided context to the meaning of job satisfaction as integrated with colonialism, nursing migration and professional factors. Relating to the connections to the 'Vanua' that is elaborated in Chapter 3, testimonies of nurse's experience, and those of the managers are quoted in Chapters 6-9 that describe their understanding to the meaning of job satisfaction through the organisation, management, workforce and nursing responsibilities.
Question 2: To understand personal, organisational, managerial, and professional challenges that nurses in Fiji experience in their roles, and how they perceive these challenges impact on their job satisfaction	The personal, organisational, managerial, and professional themes and sub-themes of the cultural imbedded influences of the Vanua related to the cultural social structure and hierarchy of power, as described in Chapters 6-9, allow insight into the experience of the challenges encountered according to the variables that influence job satisfaction and discussed in relation the factors in Chapter 10.
Question 3: Recommend strategies that support improvement in work conditions for nurses in Fiji and lead to enhanced job satisfaction	The findings detailed and outlined in Chapters 7-10 present the structured themes described by the nurses and connected to the Vanua philosophies step 9 to provide recommendation as a way to understand the complex cultural nursing context in the country and assist in addressing key recommendations to be presented in Chapter 11.

10.2 Organisational and Managerial Barriers to Job Satisfaction

In Chapters 7 and 8, nurses discussed management characteristics; for example Participant 20 explained that they had no choice and were recommended for suspension if they questioned authority. It is important to first consider the practice context within their cultural identity and how they interact in comparison to a broader worldview understanding of experience and practices. The country's history stems from a rich colonial background and globalisation has influenced their model of care integrated with both Western and cultural practices. The heavy dependence on foreign aid in the country has encouraged acceptable ideologies of Western development and associated objectives, without recognising the indigenous process of understanding within the local context of their work practice (Saxton, 2019).

The "Pacific way" has been employed, at times, as an instrument of social and political control by indigenous elites. The Pacific way places strong emphasis on the virtues of stability, tradition, and, by implication, on the value of 'traditional' chiefly rule. Despite much of the rhetoric against colonialism from the South Pacific political elites, these same elites have been said not only to lead a lifestyle that mimics that of their former colonial rulers, but also to "exploit their own people" (Lawson, 1996, p. 4), sometimes even worse than their colonial masters before them.

Indigenous knowledge is valued, and some of the concepts may be applied in today's knowledge system as emphasised by Durie (2004) who stated that it may open opportunities for gaining new knowledge that influences important health management decisions. Stewart (2007) investigated the clinical governance framework of the roles of the nurses in Fiji and highlighted that the structure of the Fiji Ministry of Health was socially constructed within the bureaucratic structure of social constructionism rooted from the history of colonisation. He also noted that nursing leadership skills, work conditions, with migration and retirement patterns impacted clinical governance (Stewart, 2007).

As outlined by Participant 1 (Chapter 6) nurses were given directives to take up postings without consultation (as outlined in Chapter 1) and were not given a chance to appeal. The issue faced by the nurses in Fiji, in relation to being given such directives and the feeling of powerlessness to act against the decisions, has been shown to result from socio-cultural expectations, as well as hereditary and chieftainship leadership (Douglas, 2013). European missionaries introduced the monopoly of privilege given to people with position, a status reflected in cases of social stratification and the pacification of other office holders (Douglas,

2013). Thus, in a uniquely cultural setting like that in Fiji, the nursing leaders justify their decisions on how they evaluate people through their personal understanding and religion cultural values, demonstrating characteristics of pluralistic conservative style of management decisions (Byrne & Bradley, 2007).

The authoritative leadership style that has translated from the nurses being interviewed has reflected nurses' feelings of discouragement and having low morale; thus, the organisation may need to objectively reassess performance in relation to professional and cultural values (Ukaidi, 2016).

The impact of hierarchy, gender, politics, and colonialism were highlighted by Stewart (2007), who explained that the passive demeanour of the Fiji nurses was not merely influenced by colonisation but through the impact of women in the country where they are expected to not talk back and await instructions from the doctor or nursing leaders (Leckie, 2000).

The introduction of Christianity in Fiji has also been a key characteristic of Fijian identity and is expressed through key roles in nursing such as the role of a woman being submissive to their husbands and to authority. This Christian morality is connected to their indigenous identity (Leckie, 2000); thus, nurses, in their grievances, are encouraged to seek solace through prayer and fellowship rather than voicing their need for having better working conditions (Stewart, 2007).

As outlined in Chapter 8 by Participant 10, the Christian belief system and the traditional belief ('*Kalou-vu'* ancestor god) are interwoven in the traditional Vanua setting where the bible is concerned with universal Christian aspects of honesty, love, and respect; and the mythical roots of the 'Kalou-vu' is linked to darkness, illness, and death. Thus, misfortunes and tragedies are blamed on the power of the spirit ancestral gods which can only be battled by the 'Bible God'. Hence, when hardships, challenges, and other tragedies unfold, the expected traditional and Christian response is to pray (McNamara & Henrich, 2018).

The political turmoil, with the three coups that occurred between 1987 and 2000, saw the deterioration of the country's economic status and placed questions on the existence of indigenous paramountcy. The hostility between the political leaders and the reoccurrence of the seizure of government, places questions on the country's democracy leadership that has been intricately woven in facets of the organisations, ministries, and society in the country (Prasad, 2008).

10.3 Devaluing of Nurses

Lacking Incentives and Rewards

Lacking incentives—both tangible and intangible—featured in the findings, as well as women's status in the community and health profession. In Chapter 7, Participant 14 expressed that having a good environment and positive encouragement from leaders would encourage them to love their work. The work environment is important as it affects a nurse's physical and mental wellbeing and resonates with the development of innovative behaviours. Mahgoub et al. (2019) investigated the relationship between the work environment and innovative behaviour, and showed that though incentives and rewards do influence dimensions of the nurse's performance, it is the organisational structure and dimensions of the work environment that greatly improved behaviour.

Universally, the common goal for health care outcomes is providing quality care which has been widely advocated by the WHO (2006) through ensuring there are motivated health workers to deliver quality health care. Aninanya et al. (2016) noted that motivation can be both intrinsic and extrinsic, with intrinsic factors leading to personal satisfaction and extrinsic motivation gained from external rewards. The intrinsic motivators are from a sense of achievement in making a difference in a patient's life or a sense of pride for providing the services needed; and extrinsic motivators are more towards recognition from authorities for the work performed, financial rewards, gifts, or verbal words of praise for the work achieved. Work motivation is important as the characteristics of a worker without motivation are linked to negative attitudes to clients, absenteeism, lateness, staff turnover, poor practice, and migration of nurses to greener pastures (Aninanya et al., 2016).

These factors contribute to the nurse's performance and feeling of self-worth as described by Participants 4 and 5 (Chapter 7) who stated that just to be given recognition verbally a 'simple thank you' would improve their performance; and when they were given chocolates during a Christmas party award it was a memorial moment of being recognised and appreciated.

Thus, the key to improved work satisfaction may lie in the benefit of understanding the incentives that encourage a more motivated group of health professionals who are inspired to work harder in delivering quality health care. The discovery of incentives must be advocated for by Fiji nursing leaders for it to be adopted by the organisation such as paying unused annual leave. Nurse managers need to understand implementation of rewards that

may be able to conceptualise the whole nursing process for Fiji nurses who culturally lack the empowerment to voice their much-needed recognition and reward.

In respect to wellbeing and recognition, the grey literature of a doctoral thesis, Meo-Sewabu (2016) discussed the concept of 'culturally embedded agency' and explored how the cultural constructs of health and wellbeing of Fijian women may lead to the development of policies that incorporate indigeneity goals, nurse's cultural wellbeing and empowerment.

Power, as highlighted, is inherently awarded to men; and women gaining power seemingly threatens man's sense of control. A woman's status has been defined in society through religion, colonisation, cultural imperialism, and traditional settings where her value is measured in reference to the man's identity. In the Vanua setting, the woman's role or identity is linked to the kitchen; the kitchen illustrating their position and responsibility as having the domestic role of looking after the family and the children. Thus, to take control away from man is an obstacle itself for Fijian women's empowerment. They prefer dealing with issues using the 'power within' concept of spiritual commitment and taking their grievances to God with prayer. To empower women, tools of empowerment need to be identified to achieve change (Meo-Sewabu, 2016).

> a shift from instrumental notions of empowerment as something a woman does or does not have and instead focuses on the processes by which women come to perceive themselves as able to act, and the condition under which they do so within the contexts of particular social and cultural systems. (Dolan et al., 2021, p. 38)

Lack of Remuneration is Confusing

Among the many factors that influenced nurses' dissatisfaction, and ultimately their intention to leave, is their personal and emotional responses to current working conditions. The stagnation of salary remuneration of the Fiji nurses has been brought about by the economic political instability of the country (Mohammed et al., 2016). The introduction of the open merit system amongst all civil service workers (government workers) has left most nurses confused as it is based on a points system (job test) rather than the skills of the nurse who is applying for the vacant position, as highlighted by nurse Leader C in the Talanoa (Chapter 6). Other areas, like clerical officers, are casual labourer; whereas a nurse is a professional who undergoes 3-years strenuous study in order to qualify to look after patients. Thus, the open merit system welcomes inexperienced individuals into a position for which

they are not qualified or have limited experience to hold. This brings conflict with the more experienced nurses and affects the overall morale and behaviour of the team.

The remuneration framework in the country is adopted across the public system and has had profound issues that are important to be understood in order implement change in the human resources management policies. The introduction of the new salary band reform in 2017 is based on an open merit system that assigns salary steps based on competency assessments by supervisors (Ministry of Civil Service, 2017). It is a system that has been highly criticised by the study participants as confusing because the system only gives attention to the qualification of the nurses; and, as explained by Participant 13, in the maternity unit any midwife may apply for leader position though there are experienced midwives with a lower qualification that do not get the same opportunities. Further, as stated by one nurse, the system seems biased to nurses favoured by the nursing supervisors who have a greater chance of quickly climbing up the salary band (Participant 3, Chapter 7).

The open merit system was implemented between 2018 and 2019 following the allocation of the new salary bands for the nurses through their APA, which does not consider the extra roles, qualification, and positioned performed; or the lack of resources and work environment encountered. The nurses voiced that since its implementation, there has not been any change in their salary band and salary has remained the same following an increment two years ago. The nurses are assessed by their superiors using APA and the increments are awarded according to the recommendation given by their nursing leaders. The system seems biased by the nurses as those that are favoured by the nursing supervisors have a greater chance of quickly climbing up the salary band (Participant 3, Chapter 7).

Participants 2, 3, and 13 stated that the salary band was confusing and discriminative compared to the doctors' salary, with medical officers receiving four to five times more salary even though the nurses perform some of their roles and responsibility. The social status of nursing in Fiji, as compared to doctors and paramedics, is profoundly imbalanced in favour of the doctors as the doctors in Fiji have a separate ministry (Ministry of Civil Service) and budget (apart from the Ministry of Health budget), that is responsible for their salary band and issues such as allowance and overtime (Ministry of Civil Service, 2016). In the 2017 government budget, the doctors received a 56-81% pay rise, while the nurses were to receive a 25% salary increment according to their APA (Ravula 2016; Tabua, 2017). The implementation of the separate strategies and wage disparity may be viewed from the perspective of the attention awarded to these different healthcare professions. The factors

relating to socio-demography such as gender and socio-economic status are relatively interpersonal and may be influenced by culture, gender and tradition as seen in the current wage disparities between health professionals. The traditional gender norm may also be challenged with the incorporation of nurses being mostly women and a patriarchal ideology that they should be paid according to the labour market of feminine jobs (Chattier, 2013).

Participants interviewed in the one to one Talanoa and group Talanoa discussions comprised 90% females, and reflects heavy gender imbalance and stigma by association of nursing being a career choice for females in Fiji. The nursing profession in Fiji has been predominately females since the formal implementation of the nursing professional training into the country in 1955 (Vudiniabola, 2011). A career choice is influenced to a larger degree by financial remuneration, although studies have shown that gender has also been strong determinant amongst the nursing profession (Hasan et al., 2010; Wu et al., 2015). The factors relating to higher income for professions perceived to be more prestigious than nursing, irrespective of education and patient outcomes, may need to be addressed with a change in perceptions relating to career choice. The Vanua as described in Chapter 3 allows the understanding of variability of culture and the status of women in society; however, the choice of nursing as a profession must be influenced by financial remuneration that is reflective of the profession and not gender status in society.

Among the many factors that has influenced nurses' intent to leave, the personal and emotional response to working conditions is one the driving forces behind satisfying the nurses' needs. Studies such as the one conducted amongst the nursing staff in Cyprus, a low resource setting similar to Fiji, revealed that monetary incentives were an intrinsic factor for motivation towards attaining job satisfaction (Lambrou et al., 2010). The personal needs of an individual may be fulfilled through either intrinsic or extrinsic rewards which are derived from being acknowledged or rewarded to feeling satisfied and prideful of the job/work that is being conducted. The nature of the systems, whether hospital policies or the country's economic status, place pressure on management and the adjustment of their workforce (Lambrou et al., 2010).

Lack of Recognition

The nurses' response to their reasons for leaving or wanting to leave (intent to leave) was highlighted in their Talanoa when asked if they were awarded any recognition from the Ministry for their nursing roles and contribution to the Ministry of Health Fiji. The response

from Participant 19 was that no sort of recognition was awarded to them despite their long years of service and funding their own studies to upgrade their skills.

The nurses' perception on lack of recognition from the organisation and management (Chapter 7) is a determining factor that influences a nurse's decision to leave. When they feel that they are not being supported through policies that do not have the legislative requirements to support the roles carried out such as overtime/allowances, and with a management team that seldom acknowledges all the work that has been done, their view of the organisation is negatively impacted—the environment carries great impact on the nurse's desire to stay (Tuckett et al., 2015).

Professional development is linked to a nurse's career satisfaction in their growth and practice. The Fiji nurses voiced that nursing courses available at universities are not funded and that they must fund their own training to gain the skills that they need in delivering quality health care. The only funded training in the country is the 'postgraduate diploma in midwifery' that is sponsored by the Australian government (AUSAID), and other short workshops and training when funding available. There are no training resources available online for CDP and nurses must find other means of attaining their CDP points for license renewal.

Training and development are considered one of the important components in job satisfaction, as well as retention strategies that promote a healthy work environment and gives recognition to the importance of a nurse's professional development. The commitment to quality care must coincide with growth in nursing practice and education funding and pay associated with qualification and skill must be accredited to ensure optimum quality care (Price & Reichert, 2017).

Participants 1 and 5 suggested that the nurses in Fiji were skilled in the services that they performed but are just not appreciated with a simple 'thank you' and, hence, the decision to leave the Ministry is easier because they are not recognised. Participant 1, in all her years of nursing experience, explained that not once has she encountered a manager that would verbally commend her on the work done nor offer physical acknowledgement, such as a pat on the back.

High quality care is one of the main expected outcomes in any health organisation; thus, work environment factors need to be geared towards supporting the health care workers' environment to promote high quality care. Work environment factors are reflective of leadership behaviour, nurses' input, participation towards health organisation strategies and

policy, staffing, resources, and workload (Zúñiga et al., 2015). Nurses in Fiji, as reflected from the interviews, are subjected to long working hours, lack of support from management, extra roles and responsibilities, unhealthy work environments, and low professional status. It is important to understand that a satisfied and content employee promotes improved health outcome; therefore, it is necessary to understand the nurses' need for recognition within their work environment and adjust improvements that are applicable to their settings (Er & Sökmen 2018).

It is important to note the wave of decentralisation in the Fiji health care system that has occurred over the years, starting in 1999 to present, leading to dispersal of power and authority through the health care system and the attention that had been given to nursing management within the leadership organisation. Mohammed et al. (2016) outlined the three phases of movement between the decentralisation and recentralisation in the country.

The organisational structure during the first wave of decentralisation between 1999 and 2004 had three main director positions that lead each of the three divisions—Central, Western, Northern. The directors were each assigned a general manager position for both community health and the hospital. In 2008, following recentralisation, the organisation structure for the health ministry was reconstructed to contain a permanent secretary under which lie seven main positions including the cooperate services, health programmes and training, curative health services, health information planning and infrastructure, pharmaceutical and biomedical supplies, primary health services, and health systems standards. The second wave of decentralisation in 2009 saw the re-distribution of the organisation structure to having only main positions after the permanent secretary (hospital services, public health and administration and finance); with divisional positions and pharmaceutical/biomedical services reporting to hospital services, and divisional and national programmes to public health. Surprisingly, with the third rearrangement of the Ministry of Health structure, nursing is placed in the structure under the Administration and Finance post in alignment with human resources, health information and planning and policy (Mohammed et al., 2016). It was not until the 2017 organisational structure that national nursing leader was recognised as a director post and one of the seven health directors in the ministry (hospital services, public health, nursing, administration and finance, health information and research, human resources and planning, and policy development) (Ministry of Health and Medical Services Annual Corporate Plan 2017/2018).

Thus, in the first two organisational health workforce structure reforms, nursing was not included. The second wave of decentralisation placed nursing on the fourth hierarchy level to administration, with the latest organisational structure placing a nursing director position alongside other directors. However, the nursing director position was only unwillingly reinstated following FNA threats for industrial action (Vudiniabola, 2006). In 2018, though the organisational structure remained the same, the nursing title for the Director of Nursing was changed to Chief Nurse and Midwifery officer with the nurse managers retitled to Divisional Directors of Nursing (DON).

Though the nursing managers highlighted reporting to the nursing director, the findings show in reality that they report under the medical officers and medical superintendent within their divisions which has led to confusion regarding communication lines. The president of the FNA, Dr. Vudiniabola (2020), stated in her South Pacific Nurses Forum (SPNF) country report that one of the challenges faced by nurses was that they felt isolated from their Chief Nurse and Midwifery Officer (Director Nursing). This is because of the unclear communication lines of supervision and responsibilities of the nursing directors at divisional level structure as implemented by the government. The main concern highlighted by the Fiji nursing organisation is that this unclear line of responsibilities has rendered the nurses powerless and subservient to doctors (Vudiniabola, 2020).

The organisational, management, work environment themes, as outlined in Chapter 6, reflect the experiences of the nurses, and their managers gave insight into their work environment experiences with authority. A recent systematic literature review on the state of nurse work environments found nurses to be more satisfied with a healthier work environment with subsequent improvement in the health care organisation (Wei et al., 2018). In the review, when nurses felt cared for, their behaviour in the workplace showed lower scores of fatigues, burnout, and stress; and higher scores of job satisfaction and work relationship. Extrinsic and intrinsic factors would have to be achieved for an employee to feel valued and empowered, including communication, having learning opportunities, personal benefit (incentives), and reduced workload and stress (Wei et al., 2018).

Unclear promotion pathways

The nurses explain the dilemma of experience and qualification that is the job test associated with the position vacancy. This is with regards to the re-advertisement of all nursing management positions in which some of the nursing leaders who have had years of experience in management lose their position to junior nurses who have the qualification

and scored higher points in the test. The dilemma is: would skills and experience in clinical nursing compensate with knowledge from a new graduate.

In Chapter 8, Participant 15 explained the open merit system and the incident that occurred in her work area that saw the demotion of some nursing leaders who were in supervisory positions being reverted to the position of a registered nurse because of this new promotional system. The promotion pathway that has been introduced to civil servants, including the nurses, is the OMRIS, which is the ministerial system of selection for vacancy positions. There was mixed reaction with regards to this new promotional system; both from the nurses and the nursing leaders and managers.

A job tests the correlation between the four variables of knowledge, experience, skills, and abilities; that is, cognitive ability to reason, plan, and perform with excellent performance that is gathered from their knowledge (Hunter, 2017). Their ability to work under any circumstance is extended to their experience and skills to efficiently meet the work aims and requirements. The principle behind this OMRIS system is to ensure that there is consistency in the recruitment and selection of people in the civil service. The OMRIS policy was derived from the Fiji constitution (S123, (i) (I, ii)) defining the values of the public service system and that recruitment and promotion should be based objectively and fairly relating to merits of education, character, and experience (Fiji Civil Service, 2017). Nursing Manager B (Chapter 8) noted that she did not agree with the open merit system because the criteria for selection were based on a 'job test' system that focused only on knowledge and did not consider the skill set of the officer. This allowed junior nurses to take up leadership positions because they had the advantage of better writing skills compared to senior nurses. Nurse Leader B explained that the promotion occurs meritoriously even if the applicant has never worked in the nursing field applied for; thus, making it possible for anyone, even with no experience in the field, to take up the position.

This was explained by Nurse Manager D (Chapter 7) who stated that the salary band did not take into consideration number of years served in the ministry and qualifications, such as nurses having post graduate studies. The idea of the nurse's extra qualification being ignored rather than recognised as a bonus to the profession was amusing for Nurse Leader D who explained that the introduction of the new salary band may have been political as the positions remained the same and were just re-graded to new titles.

The open merit system is implemented with the salary and wages guideline in civil service that requires a job evaluation to ensure the remuneration is based on position requirements

that are defined in the job/role description. In every salary band there are seven steps, and the bands are alphabetically ordered starting with Band A to Band O (total of 15 bands). In the recruitment process, contracts are offered between steps 1 and 3, with a gradual increase in steps according to APA results (Fiji Civil Service, 2021). The guideline only pays according to the position. Thus, if the person holding the position attains a higher qualification there will be no increase in pay or additional remuneration added to the position (Appendix A, Salary Band).

The APA has been repeatedly voiced by nurses as a system that is biased. Participant 3 stated that salary increase will only occur according to the supervisor's assessment. The APA assessment is conducted by the management or nurse leader which can be biased or influenced by other factors and may affect how a nurse moves up the salary band steps (Banai et al., 2004). Leadership qualities focus on supporting employees reach their goals through implementation of a positive environment and rewards for goals achieved. The influence of behaviour and attitudes of nursing leaders in Fiji were described by participants as biased and lacked the support to acknowledge the hard work that they had completed, which made them feel unappreciated. The values or criteria nurse leaders use to justify their decisions are influenced by personal and cultural values; wherein culture is integrated into the personal values of people, and this has great influence on management leadership styles (Banai et al., 20014; Byrne & Bradley, 2007).

The Fijian cultural stereotype of the dictator leadership (Ravuvu, 1983) may be seen in management where the organisational operations of promotion and position assessments within the salary bands has meant leaders have been ineffective to individually draw sufficient task requirements that give more recognition to the nurses' work positions. Thus, the cultural values of Vanua (see Chapter 3) may be a contributing factor to the laxity of effective outcome form the managers through barriers of having a conservative relationship that adheres to whatever has been dictated.

Role of Qualifications and Experience

Though the nurses suggest that this may be a result of management not having the right skills and training on how to manage and encourage workers, management understood their shortcomings and realised that support training in management needed to be implemented to better cater to the nurses' needs and work performances. Nurse Manager C expressed this by stating that nurses needed to be recognised individually drawing from their different strengths and weaknesses, and thus provide opportunities to develop their potential. The

main challenge highlighted by Nurse Manager C was that nursing leaders have the tendency to personalise issues. Nurse Leader X acknowledged the need to encourage nursing leaders to gain the right skill and training in management which can be achieved with the right support.

The role of a nursing leader in management is frequently demanding and involves multidimensional roles with the ever-changing dynamics of health care and educational studies. The leadership style predominately practiced in most organisations, including nursing, is the transformational leadership style which focuses on building relationships that motivates and transforms beliefs and behaviour (Giddens, 2018). Transformational leadership characteristics influence, motivate, stimulate, and consider the employees' views, thus invoking a relationship built on trust and integrity. When leaders can inspire their employees and consider their opinions, it engages the workers to be motivated to working hard in meet organisational goals. Alternatively, transactional leadership follows the concept of effort and reward, where good performance is rewarded, and bad performance is disciplined. Leaders using a transactional leadership style are more like monitors that look for mistakes and intervene only when objectives are not met. The difference between these two leadership styles is important to consider when understanding styles of influence applicable to any workplace (Boamah & Tremblay, 2019).

The Pacific people's concept of selflessness, which is embedded in their identity, reflects their Christian beliefs of connecting with God and divinity, and has been interrelated with cultural elements of traditional values and incorporated into decisions and development (Tamasese et al., 2010). The application of the principles of respect, and how it is reciprocated, allows insight into understanding the communication principles of the Fijian worldview within the context of the Vanua. The indigenous framework of status, gender, age, and clan governs the approach of communication and behaviour in community which contributes to the elements of leadership and authority (Cammock et al., 2021).

The leadership style affects the nurse's performance and Participant 6 (Chapter 7) shared this experience by stating that traditional leadership style was biased in terms of seniority where two sides of the story are never considered. Thus, bullying and victimisation from nursing leaders and senior nurses was evident. Participant 5 also expressed that the nursing leaders were very negative with comments and compliments targeted against what nurses did wrong and did not achieve.

10.4 Lacking Leadership

Nursing leaders may gain better understanding of how to manage their nurses if given the right course of training, as expressed by Participant 2 (Chapter 8). The results from the nurses in the Talanoa interview identified that the nurses felt underappreciated and that their leader's leadership style resonates towards a more transactional leadership where they are monitored and punished when organisational goals are not met. This has led to dissatisfaction with the management, with the cultural barrier of not being able to voice their needs or challenge authority.

The indigenous approach to the role of power and traditional norms patterned into the nurse's environment gives contradictory views to the role of management in trying to counter challenges to the status quo of respect (*vakarokorokotaki*) and the traditional norms of seniority and its power dynamics, while attaining respect and creating a fair working environment conducive to everyone. Though cultural norms allow the understanding and interpretation of leadership structure within the Vanua, there is emphasis by the nurses for better work conditions and management that is diverse and prioritises services through health research. Traditional leadership styles for Fiji nurses, though embedded in cultural practices, may face challenges of attitudes from junior nurses who have the knowledge and capabilities to challenge the customary perceptions of how things are usually done. Thus, the need to consider experience in management leadership and the right management training and qualifications that ensures the development of nursing progresses with the modern time (Ahmad, 2002).

There is a need for nursing leaders to be competent in professional management and leadership development as to influence an effective team. A vital guide for managers is having the intellect to understand behavioural approach to emotional and cognitive developments of nurses and developing a relationship that has empathy and teamwork. Thus, development of leadership competencies is vital for future application with the inclusion of the development of leadership programmes (Boyatzis, 2011).

Cultural and Colonisation Influence

Participant 1 (Chapter 7), explained that in Fiji people are culturally not allowed to talk back to their leaders; they have to respectfully adhere to what they have been directed to perform with no resistance. Nayacakalou (1975), in his book regarding Fijian leadership, discussed the distinguished patterns of leadership levels in the country. The hierarchical step in society is defined by distinct groups which is the way the Fijian cultural structure is arranged. Thus,

understanding the Fijian Vanua structure considers how traditional and modern organisation has been interlocked. In the British colony era, 1874, Queen Victoria commanded Sir Arthur Gordon (the first governor of Fiji) to govern the country according to their (Fijian) ancient custom. Those principles and European influences have allowed the absorption of traditional precedents that has evolved into the leadership criteria and socio-political framework in the country (Nayacakalou, 1975).

In examining Nayacakalou's contribution to anthropological literature, Tomlinson (2006), expressed how Nayacakalou referenced the status and role of the chiefs was generated from experience with colonialism. The British did not produce the Fijian chiefly system, but they did institutionalise it through placing fixed positions of privilege being awarded to chieftainship rather than recognition of ability to perform. In this modern era, the cultural social structure and colonialism effects have become intertwined with modern political dynamics and institutional organisation, which will be challenging to change and preserve at the same time (Tomlinson, 2006). The leadership in Fiji is infrequent, as explained by Brenneis (1980), and though there is an understanding of the symbol of a power relationship in a Fijian administration, the bureaucratic and chiefly concerns hinge on individuals that are pluralistic to the circumstances of change involved (Brenneis, 1980).

The nurses in Fiji understand this level of respect and authority and thus are reluctant to question authority as part of their cultural values and way of life (*Na I tovo vakaviti*). The participants' responses show experiences and interaction with their leaders and how their cultural values are still internally applied.

Surprisingly, the nursing leaders and government administration officials are aware of the process of seniority and colonisation and explained how they had neglected to develop a system that gave recognition to the nurses who self-developed their skills and upgraded their knowledge by paying for their own studies. If this was considered, then nursing would have evolved into creating better career paths with a decrease in the numbers of nurses leaving. Nurse Manager C stated that the colonial system only gave opportunities to senior nurses to progress forward in terms of study opportunities and development. This has discouraged junior nurses who, after attaining extra qualification, have had the tendency to leave their jobs because of lack of recognition. The opportunity to excel is not equally distributed in the system and Nurse Leader C explained that had it been recognised many years back, a clearer career pathway would have been developed.

The Fijian indigenous structure of order and organisation involved rituals that were symbolic and inspired by warriors, priests, deities, and allies that empowered a chief. The British hierarchy was culturally different, with an arrangement that was top-down with one ruling class that involved Christianity, civility, and the work discipline (Kaplan, 1989). The benefits of the civilisation that was introduced by the empire and the colony was that civil order was attained under God and Queen, and Fijian custom resonated their order of structure towards this British custom of rule. This has remained an inevitable problem with nationalism and the struggling class, with implications towards traditional practices and colonial leadership practices (Kaplan, 1989).

Lack of Advocacy for Nurses

The Fijian social structure is undoubtedly operated through a hierarchal system where traditional rituals are performed to acknowledge or emphasise the connections to the Vanua or the relations to a status within the cultural group. In Fiji, the order of rank is through birth and, as much as this offers inequality and instability, the categorised groups and relationships are honoured with due respect given to the seniors. The Fijian notion of hierarchal relationships has placed them in conflicting situations where habitual practices have become a norm, and a violation of the social relationship may be observed as disrespect or a threat to the established cultural social organisation. However, changing economies and other governmental factors have placed this social category of rank into question through not tolerating the unfair distribution of power and inferiority (Arno, 1979). The results reflect the issue that nurses feel as though they are not represented enough by their managers in addressing their need for better working conditions or improvement within their work environments as expressed by Participant 8 who said that the nursing leader and health ministry refuse to pay attention to their grievances.

The dilemma with nurses is that their established relationship within the health ministry has been static, with policies and establishments being neglected to be reviewed on a regular basis. In a media article, Lata (2014) wrote that the then Director of Nursing, Silina Waqa, was in a discussion for the scope of nursing to be reviewed and submitted for endorsement to cabinet. Despite the years and decades that nursing had been available in the country, the article highlighted that only in 2014 had a draft of the scope for nurse practitioners, educationist, registered nurses, and registered midwives been developed with consultation for the document. The scope of practice—the set of procedures and actions that define the boundary of practice—had begun review in 1999 for the administration and management of nursing in the health care service. This scope of practice authorises the services that nurses

have been trained to do and is an important component to the development of nursing in the country (Lata, 2014). In a Fiji newspaper article, Susu (2020) wrote that the health ministry chief nursing and midwife Margaret Leong, in her speech during the world nursing celebration, stated that the Fijian nursing scope of practice should not be limited and should support nurses in their advanced roles. This brings into question the advocacy of nursing management into the development and consistent review of nursing practice in Fiji, as between 2014 and 2020 both national nursing leaders were still advocating for reviews.

In Chapter 8, Official C explained that there was no policy or guideline in place that reviewed a nurse's portfolio. An example she gave was that a nurse could have worked for 10 years in the health ministry without any review of her qualification. Only through successful planning are nurses exposed to opportunities, as there is nothing in place to guide or incentivise a review of service and qualification. The drawback in nursing is that they have moved on with paving the way to getting more qualifications, such as masters in nursing, but there is no platform that recognises this achievement and successful planning will always be geared towards seniority rather than a system that considers all areas for success.

The results show the nurses voicing that their nursing leaders and managers gave little recognition to the work that they have done nor advocated for improvement in their working conditions. It is important to note that though being placed in a position of power as nursing managers and leaders, they are still, respectively, women. The gender norm embedded in the country is generated from cultural norms that may restrict women from challenging authority or becoming vocal with their liberal views. Chattier (2013) noted that the opportunity structure for both men and women was different, where women were seen in the private sphere while male in the public sphere. Though educated women may close the gap of inequalities, the cultural patriarchal gender norm in Fiji has not altered the power in relationships, as men are still viewed as head of the family both culturally and religiously. The attitudes and behaviours of the educated woman is constructed within her social organisation with the traditional beliefs of what is expected of her; this influences choices and preferences to naturalise hierarchy where it becomes deeply embedded causing resistance to change and following the expected norm (Chattier, 2013).

Though the affirmation of cultural identity is gathered from the elements of tradition which objectifies the way people are expected to communicate, the ideological character of power would have to shift through dialogue. The challenge would be to try and modify beliefs that conversations would need to be placed into institutions that enlighten managers and nursing

leaders into strengthening their ability to lead effectively rather than follow the identification or stereotyping of women according to contemporary traditional customs and beliefs (Norton, 1993).

10.5 Working Environment

Stress, Burnout, and Stigma

Nurses' Health, Welfare and Role Complexity

The interviews consisted of nurses from four different backgrounds. As explained earlier, rural nursing involves public health where nurses are located or work in health centres and in isolation at remote nursing station. The quality of service provided by the health care system heavily relies on the health care workers that are providing the services. Though training and development have been conducted within the health care system, the human resources relating to the welfare of the nurses remain the least developed, as voiced by the nurses being interviewed in this research. In Chapter 9, Participant 8 discussed how employees would perform better if they were happy with their grievances being directed to the right channel and to the right people that would deal with them accordingly.

The catchment area for Fiji is spread through the geographical terrain of the interior highlands to the maritime islands dispersed throughout the region. Thus, work areas that are more densely populated are equipped with more resources and staff, and the provision within the divisions is influenced by the level of need by a facility (Wiseman et al., 2017). This would explain why more attention is directed to the urban health facilities as compared to the rural health facilitates regards the distribution of manpower and resources (Wiseman et al., 2017).

Participant 1 (Chapter 9) explained that when she worked alone, she was isolated from her family and the luxuries of working in the city. She was stressed from being on-call for 24-hours and not having enough rest because patients were coming in to see her during odd hours of the day and emergencies late at night. One of the key issues brought out by rural nurses is the challenges encountered while working in isolation with unusual working hours. They are the sole health worker in the area, either in the maritime or inland, and are expected to carry out all clinical screening (general and special outpatients, maternal and child health, obstetrics and gynaecology, management of childhood illness, reproductive health and dispensing of medication), public health screening, surveillance, and health education. This is on top of their 24-hour on-call for any emergency, since they live on the premises located

within the community and are compensated with very little in terms of remuneration. Participant 8 explained that they only receive FJ$48 a fortnight for the remote subsistence allowance despite catering their own food, fuel, and boat fare to travel to the main island.

The nurses' work condition impacts their performance. A study by Tamata et al. (2021) outlined that the physical health of nurses is greatly affected from work overload and long working hours that adds pressure to both the nurse and her family. The physical exhaustion impacts work performance resulting in the decrease of quality care delivered that aggravates stress and burnout (Tamata et al., 2021). The work capacity of the nurses, both in urban and rural nursing, are stretched thin which is not a surprise considering nursing shortage is a global issue. The WHO (2013) had estimated that by 2035, the demand for shortage of health care workers would have increased to 12.9 million.

The demographic challenges, difficult work conditions, and unusual working hours make public health nursing in Fiji admirable as the nurses work through the difficulty they encounter while still trying to accommodate the organisational objectives. The themes gathered from the interview express the shortage in nursing ratio, limited resources, with vacant posts. Participant 4 is currently looking after a population with the ratio of 1 nurse to a population 6,832. The nursing vacancy sometimes requires them to look after 2 to 3 zones at a time, increasing their nurse to patient ratio of 1 to sometimes 8,000.

Participant 10 (Chapter 9) noted that the role of nurses in having multiple tasks including rolling and cutting their own swab supplies, documentation, and up-to-date care for patients, means a lot on their plate. Interestingly, in their latest revision for disease classification the WHO (2018) officially classified job burnout as an occupational condition. Job burnout and stress exists in urban and rural nursing in Fiji and the safety of these nurses, both mentally and physically, is to be managed through attracting attention to the general occupational welfare. Work condition and environment influence performance, productivity, and patient safety. Inevitably other factors within the organisation, such as lack of support, and personal factors that lead to low morale and motivation, as well as lack of nursing opportunities to advance their work practices contribute to job burnout. The risks associated with environmental work stresses require adequate policies and strategic planning to focus on improving the health system and issues that affect nurses' decision to leave (Wang & Wang, 2021).

The negative effect burnout has on an individual is that it reduces productivity, and increases absenteeism and the risk of psychological issues such as anxiety and depression (Peterson et

al., 2019). The urban nurses expressed the same sentiments relating to challenges in the work environment with Participant 18 explaining that unfair rostered shifts and having no proper facilities for nurses add to their stressful work conditions. The rosters are prepared by the nursing leaders and it is usually the norm for night shift to be rostered on five straight days with no facilities such as tearoom or restroom to accommodate the night shift nurses on their breaks.

The interviews with the urban and peri-urban nurses brought out issues of being overworked and understaffed with managers who demand more, yet offered no compliments for their hard work. The challenge for motivation and improving performance in a developing country is to understand what would enhance their job satisfaction with crucial importance to cultural domains and social dimensions. Innovative engagement may need to be conducted amongst the nurses to give insight into the management of positive ways that improve their work environment. This would require generating and dealing with complex ideas that may require nurses to contribute towards developing innovative solutions within their cultural work environment (Mahgoub et al., 2019).

Challenges to Mental Health

Mental health is a mental or behavioural disorder that affects different groups of people in society and is linked to other medical conditions. The WHO estimated that around one third of people that seek out medical services have somehow had an undiagnosed mental disorder (Bloom et al., 2012). A health care professional's state and quality of mental health is influenced by their work environment and impact on their emotions. Globalisation demands that workers are driven towards meeting organisational goals with intensity that involves rapid decisions with increased workload, and health workers are no exception. Their work area involves encountering people on a regular basis. Mental health has an impact on the emotional health of health care workers, such as nurses, due to their role, the tension when quality care is not delivered, and lack of management support to address their frustration within the context of their work area (Koinis et al., 2015).

The work situation of the nurses, as addressed earlier, highlighted the environmental stresses that they encounter and have had to endure over the years such as working in isolation and staff shortage with limited equipment. The consequence of the pressure on emotional health is expressed by studies that show that continuous stress may subject nurses to alcohol abuse or heavy smoking (Koinis et al., 2015). The Talanoa discussion with the nurses regarding the outlets used in dealing with stress, burnout, and their emotional mental health issues

reflected the limited access nurses in Fiji have to receiving the psychological and mental support needed in dealing with stress and burnout.

Participants 1 and 10 resorted to their faith when dealing with work stress and were disappointed that there are no counselling services available to nurses. Participant 10 also relaxed her mind by calling and talking to family. The reliance on God is rooted in Fijian identity because the traditional image of being a good Christian illustrates positive beliefs of encouraging supernatural interventions in their lives (McNamara & Henrich, 2018). The '*Power from within'*, as explained by Meo-Sewabu (2016), concerns Fijian women's spirituality and it is the strength and power which comes through a commitment to their spiritual being that has allowed them to deal with the realities of their daily lives. The spiritual being in their lives is their God whom they rely on through daily prayer. The belief system of God and religion is an important component of the Fijian culture with connected links to the *'Vanua'* and its resources (McNamara & Henrich, 2018).

Though most of the rural nurses were unaware of an available counselling facility, the urban nurses knew that there was a counselling service available called 'Empower Pacific' that provided services to hospital patients and staff if needed. Though this service was available, the nurses voiced that they were not accustomed to fully utilising the service because it was against their nature to admit that they needed help and the stigma associated with seeking counselling services. This was explained by Participants 12 and 20 who reported that the nurses were most probably reluctant to use the service because of stigma that the rest of their colleagues will judge them for having issues and not being able to deal with their problems personally. Nursing leaders also noted the availability of the service 'Empower Pacific', though they have never seen any nurse utilise the service. The facility is located within the hospital premises and the belief that nothing will be kept confidential likely underpins nurses' refusal to use the professional services.

The Fijian people are culturally wired to handle things on their own as explained by Leader A (Chapter 8). To seek help is to declare defeat which is a sign of weakness. The increase in the amount of stress that the nurses are faced with cannot be denied as it affects their work. Leader A suggested that the interpretation of counselling services needs to change so that the nurses can access the services. The stigma of mental health illness within the context of the Vanua is associated with the stereotype that mental illness is a punishment from God who is the main caretaker of the land (McNamara & Henrich, 2018), and the cultural judgement of being weak with negative attitudes against people who experience

psychological distress and depression (Emmer et al., 2020). Thornicroft et al. (2007), defined stigma as experiencing shame and disapproval brought about from being rejected. Stigmatisation, associated with mental health, can occur through three levels: intrapersonal, that is the internalisation of stigma (individual); interpersonal, the misinformation or lack of knowledge relating to mental health (society); and structural, inadequate mental health facilities or services with poor discriminatory policies (health system) (Javed et al., 2021).

The culture of not admitting when help is needed is internalised from Fiji nurses' cultural indigenous values and system of beliefs connecting them to the land (man, Vanua, God) and that blessing is received when values are upheld (Vudiniabola, 2011). The belief is that "where they fail to pursue 'the straight path' (na gaunisala dodonu), sickness and misfortune may result, and Fijians must then turn to traditional healers or clinic" (Kaplan, 1997, p. 501). Thus, factors relating to culture determine their attitudes, protection of family reputation, early intervention, and the desire to maintain their personal dignity, all of which contributes towards their decision on whether to seek help or treatment (Gopalkrishnan, 2018).

Integrating faith-based units with mental health services could be a way forward for nurses to confide in a service that creates a pathway for them to seek the outlet they need in addressing stress, work place challenges, and culturally sensitive interventions such as domestic violence for improving their mental health and closing the gap between discrimination and stigma (Javed et al., 2021).

Pressing Cultural Expectations

Apart from their own intervention of dealing with work related stress and burnout through their faith-based religions, some of the nurses sought other forms of stress relief such as drinking alcohol (Kava) which is considered culturally inappropriate. Participant 3 explained that culturally, women, especially married women with children, are not allowed to treat themselves. The cultural mentality is that she is expected to look after her husband and children and not take time with her friends outside working hours or drink alcohol. The nurse would be victimised by her nursing managers or community if she is seen out with friends rather than looking after her family. Participant 20 adhered to the status quo of managing her mentality by taking her son to the movies.

The controversy of Fijian women drinking Kava and alcohol was always going to be subject to debate. Meo-Sewabu (2015) noted that the cultural integrity of a Marama iTaukei (Fijian woman) was to encompass all the components of being of service (dau veiqaravi), maintaining harmony in relationships (Veiwekani), maintaining outward physical reflection

(Kena I rairai), and spirituality (Bula vakayalo). These cultural worldviews of women have been passed down through the generations and have conceptualised how society views women to be always on good form, showing no sign of weakness (Meo-Sewabu, 2015). Lynda Tabuya, a female parliamentarian elected into government in 2018, was no exception to these expectations. She was criticised for her appearance in the opening of parliament for wearing a tight-fitting modern dress. An educated lawyer who earned her place in government was still criticised by members in parliament and society by being a headline in the papers (Bolanavanua, 2018).

The relation with people and trying to maintain the peace (yalomatua; yalo meaning spirit and matua meaning older) is seen as someone achieving a sense wisdom (Nabobo-Baba, 2006), which adds pressure on the nurses in dealing with their stress and fear from management and society of being victimised if they were to resort to other forms of stress relief such as winding down the day with a glass of wine. Therefore, there is more pressure on Fijian females to adhere to their gender obligations of serving without complaint (Meo-Sewabu, 2015; Nabobo-Baba, 2006; Ravuvu, 1983).

10.6 Unsafe Working Environment

Limited Scope of Practice

The nurses in Fiji work according to their IWP that aligns with meeting the organisation's target outcomes derived from the annual cooperate plan. The nurses' different approach to motivation distinguishes how well they achieved the task that they set out to complete. Ryan and Deci (2017) explained that tasks were more likely to be achieved if employees enjoyed their work. They described that autonomy, competence, and a sense of belonging are the basic psychological needs to motivation and contributed to the nurse's work output (Ryan & Deci 2017). The quality and persistence of the actions performed is driven by an individual's self-determination, influenced by their work environment and motivation (Klein, 2019). Thus, when nurses are faced with an unclear scope of practice and are obligated to achieve unrealistic work goals with limited resources, their motivation and competency to compete the allocated work goal will be affected.

The nurses explained the challenges they encountered in not being able to meet their IWP due to lack of resources and carrying out responsibilities that were outside their scope of practice like dispensing medication to patients that come into clinic (otherwise the responsibility of the pharmacist). Participant 7 explained that she takes up the responsibility because there is no one else available to do the role, even though she is well aware that it is

outside her scope. Participant 3 also faced with the same dilemma and feared who would take responsibility should anything go wrong.

Interestingly, Nurse Leader C (Chapter 9) explained that only until the nursing council recognises the work and obligations carried out by nurses can a specialised scope be created that gives accountability to the work carried out by the nurses. This was agreed upon by Nurse Leader B who stated that developing a scope of new nursing positions was needed as new graduating nurses are moving towards a more specialised era. The nurses and nursing leaders are well aware that they are performing duties outside their scope of practise (e.g., dispensing of medication). Though the nurses are more than capable and knowledgeable of the prescribed medication, only pharmacists are designated to dispense medication; and the safety of the nurses comes into question in terms of indemnity in situations where an error should occur with the dispensed medication.

Challenging Demands and Resources

There is no internet at the facility where Participant 9 works, neither is there water in her clinic. She has to carry water from her nursing quarters to the clinic which is 10-20 metres in distance. This is the same experience for Participant 10, who also expressed that the limited supply of water made it difficult for her to clean her clinic let alone have access to clean drinking water. Availability of water, energy, waste management, hygiene, and sanitation are essential in the establishment of safe and adequate environmental conditions for health facilities, including standards for ensuring correct precautionary measures to prevent cross-infection and protect the community (Cronk & Bartram, 2018).

Interestingly, though some nurses voiced that they were working in environments that had limited water supply, they were resilient in working towards achieving their IWP and meeting targets set by the organisation. However, the safety of the community and the health worker is placed into question relating to a work environment that could potentially be a source of transmitting an infection outbreak.

The progress of the health care system suggests that there should be equity in medical resources. Unfortunately, there are still issues regarding shortage of medical supplies in both the clinician and primary health care services as revealed by the nurses who sometimes had to pay for their transportation in attending to an emergency (Zhang et al., 2017). Participant 1 voiced that if there was an emergency in another village she had to pay for the transportation with her own money and sometimes had to pay for fuel in order to take an emergency case to mainland, without any reassurance that the money spent would be re-

reimbursed. Another frustrating encounter told by Participant 1 is the unavailability of key equipment such as a vaccine refrigerator to store vaccines for meeting immunisation targets.

Providing quality care is a challenge, with Participant 6 calling the Ministry selfish in ignoring the nurses' work conditions and giving them unrealistic targets to meet with limited resources. Participant 6 went on to explain that health care workers were the frontline in health care delivery but most of the nursing welfare is ignored. There are no incentives such as insurance for nurses or protocols in place that protect their practice of care and Participant 6 expressed that they feel like they are just thrown under a bus. The capacity of a system to support and deliver quality healthcare is limited due to lack of resources, shortage of staffing, skillset to deliver the required services, and infrastructure to deliver the care needed. It can be overwhelming for nurses considering the surge of events from natural disasters to pandemics that has occurred in the country (Bornstein et al., 2021) and challenged the health care services. Nurse Leader B highlighted that there was a shortage of PPEs, such as masks and gloves, that was beyond their control, especially during the pandemic and nurses had to improvise with whatever was available to them. The lack of resources also contributes to lack of quality care delivery, and unavailability of resources prevents nurses from performing to the best of their ability. Medical risks and unsafe working environment cause stress and impacts the nurses' physical health with effects on their family and social relationships. Increased workload with limited resources significantly hinders the quality of care delivered, leading to burnout, and increases the probability of nurses leaving the profession (Tamata et al., 2021).

Ministry of Health Expectations

The expectation of delivering quality care to the whole country, as stated in the Ministry of Health's mission and vision goals, requires clear evidence-based policies that ensure the response from the health care workers meet these expectations. Ensuring there are adequate and motivated health care workers is essential as human resources are the main framework in the health care system. Development of policies that propose change are to recognise that equality to both the services delivered and the staff that provide it are considered, with the inclusion of retention intervention and workforce planning to be considered a priority (Antonazzo et al., 2003).

The nurses and nursing leaders highlighted the reality that they encounter working in a healthcare system that demands quality care but lacks the measures to improve the already existing suboptimal work conditions. The work conditions mentioned by the nurses are the unavailability of a crèche for nursing mothers (nurses) returning to work after maternity leave to breastfeed their children, proper resting facilities such as a staff room or change room, and lack of resources such as transportation. A child is required to be exclusively breastfed for six months, as required by the Ministry of Health; yet, as Participant 3 explained, given the lack of a crèche, the nurses who are breastfeeding would have to either get a babysitter to bring in their child to work when hungry or express milk and leave it at home to be given to the child. Participant 11 described that in the facility that she works they do not have any tearoom or changing room. They had been given a room which is a consultation room and converted it into a changing room.

Understanding the factors that affect the work conditions of the nurses, from their perspective, may assist in the redesign of a work environment that can positively improve job satisfaction and nurses' intention to stay. There is a need for policy makers to investigate the variables of nursing turnover and job satisfaction in the country so as to promote retention. There may be the obvious factors for a challenging work environment such as transportation and under deserved facilities, but incentives can supplement these shortcomings.

10.7 Roles and Responsibilities of the Posting

Urban Nursing and Rural Nursing

Urban nursing, as explained by Participant 5 (Chapter 10), is mostly nursing according to the doctor's plan of care, whereas rural nurses manage their cases alone, only discussing with a medical officer during emergencies. The nursing leaders noted that rural community nurses were seen as more capable and competent when placed in a clinical hospital setting due to their resilience adopted from overcoming challenging work conditions. Rural nursing, though unique, is challenging, working in isolated communities where their needs and practice safety needs to be reviewed and valued for the responsibilities that they have had to compromise such as IV cannulation. The dilemma is that when faced with circumstances such as delivery, which is the midwives' scope of practice, the rural nurse has to carry out the procedure as per their professional judgement. Their practice is affected by weather conditions that demands nursing expertise across all fields of health care from paediatrics, obstetrics, to

emergency intervention; thus, policies need to be relooked at in terms of considering the workload carried by rural nurses while striving towards improving work conditions in public health nursing (Lea & Cruickshank, 2015).

As described in Chapter 1, the country is divided into four main divisions (Central, Western, Northern, Eastern) and each division has sub-divisional health facilities that come under their health boundary. There are five sub-divisions in the Central division, six in the Western division, and four each in the Northern and Eastern divisions. The main role of rural nursing is preventative health care and health promotion, with priority translated to health care programmes from the '*Public Health Act 2002*'. These programmes include NCDs, reproductive and family health, health promotion, control of communicable diseases, and environmental health (WHO, 2011). The remote rural nurses who work in isolation hold the responsibility of undertaking all these health programmes of preventative, curative, and rehabilitative services with limited acknowledgement.

The demographic characteristics of urban nurses are that they are more clinically based at divisional and sub-divisional hospitals. Job satisfaction, in correlation to nursing turnover, recognises that work balance with professional development and opportunities are indications for turnover intentions amongst nurses (Li et al., 2019).

The significant difference in roles and responsibilities between urban and rural nursing in Fiji, as described by the participants, focuses on the two extreme services of primary and secondary health care. Though there is diversity in workload and responsibilities, they face similar challenges of having limited resources and heavy workload. The notion that work place environment promotes job satisfaction, gives an opportunity to compare the roles of the two nursing domains and their overall significance (Aloisio et al., 2018).

The challenges in the different roles are explained by Participant 6, who drew on her experiences of working in a remote rural facility in Fiji. Rural nurses work remotely, often alone, unlike urban nurses who have medical officers and equipment to assistant them. Limited resources in rural facilities, such as manual machines, unfavourable phone reception, and no transportation, are daily challenges that rural nurses encounter. Their perseverance to work under these harsh environments, with no recognition such as financial incentives, is admirable. Other rural nurses also noted transporting emergency patients across the maritime sea with no life jackets, being on-call for 24-hours, and receiving normal pay, as well as working beyond their scope of practice since they work in isolation and are expected to do everything. Participant 7 explained an encountered experienced in the rural area where

the approach was survival of the fittest. The challenges ranged from treating asthmatic cases with a manual pump, and labouring mothers late at night with no communication except through radio telephone, 2 hours by horse or 5 hours of walk in case of an emergency to the hospital.

The usual practice, described by Nurse Leader A (Chapter 10), is that care is ordered by the doctors and administered and documented by the nurses. The usual routine and practice are that first dose of IV medication is always administered by the doctors and the remaining course of medication is administered by the nurses. Health service delivery in a clinical practice is reflective of urban nursing where their scope of practice is based on bedside nursing and secondary diagnostic nursing care. The core factor of their nursing care is nurse to patient care and ensuing that patients are satisfied with the services that they provide, while working with other multidisciplinary health workers such as doctors, dieticians, physiotherapists, laboratory technicians and many more. Their roles include admission, treatment, and individual care, and interacting with the patient and their families. The challenges faced by urban nurses are patient complaints that undermine their reputation and medical officers that are unappreciative of their skills. Quality improvement needs to be perceived from the nurse's perspective and valued for the limited staff ratio and work load they perform, as this is sometimes neglected because of the power hierarchy between doctors and nurses in the community (Buchanan et al., 2015).

The urban nursing structure shows the roles the clinical nurses carry out in a hospital setting. Though the sub-divisional hospital is a smaller version of the divisional hospital, the roles they carry out are essentially the same as compared to the rural nurses who do different roles for each designated programme. There are different wards and, except for midwives who are a specialised position, all other positions are general nurses where nurses can be placed and rotated to when needed.

Advocacy

The strategic policies and plans that may be modified according to the work environment of each country would need to take into consideration the intervention that is applicable within their organisation. However, the nurses' voices need to be considered as they are important and critical to the Fiji health care system. Outlined below are some of the nurses' voices on factors commonly brought up as challenges faced and factors of dissatisfaction including remuneration to reflect different roles and responsibilities, which Participant 3 described as a gap between what the nurses did and the value of their paid work. Their IWP did not

consider the different roles that were performed and specialised nursing areas such as emergency and ICU were not recognised to be placed in a different salary band (Participant 6). Lack of recognition and workload were commonly voiced (Participant 6) in the form of unreasonable patient ratios with outdated policies that disallow nursing from moving forward. The workload and limited resources challenged the nurses working in the rural community who conduct both clinical and preventative health nursing without any recognition to their area of work (Participant 10). Lack of recognition for nurses working in isolation was also raised. Participant 19 noted that nurses who work in high-risk environments such as a psychiatric facility do not receive any risk allowance. This is the same for nurses who work in rural community or in high-risk wards. The country's general order and policies do not state anything specific relating to these work conditions, and such gaps would have to be addressed. Participant 6 described the barriers encountered (e.g., lack of communication in the rural areas and availability of a reliable source of clean water) that needed to be addressed.

Nursing turnover and shortages is a concern shared worldwide and is greatly associated with low levels of job dissatisfaction. The factors that affect nurses' job satisfaction have been highlighted in previous chapters, with studies (Al Maqbali, 2015; Dilig-Ruiz et al., 2018; Lu et al., 2019) indicating factors such as workload, lack of recognition, financial remuneration (salary and benefits), and burnout. These factors encompass the overall components of their work environment and the experiences they perceive from it. Though job satisfaction factors continuously fluctuate, Lu et al. (2019) mentioned that employment factors and organisational factors such as rotating shifts, stress and exhaustion from work, burnout, lack of resources, staffing ratio, and teamwork were all important for the nurse's job satisfaction.

10.8 Summary

The organisational and managerial barriers to job satisfaction are featured through nurses feeling undervalued for lack of rewards and incentives. The emotional response to their working condition is related to the confusing renumeration salary bands with unclear promotional pathways. The cultural and colonisation influence on leadership highlights the unequal distribution of power relations in administration that has influenced the lack of advocacy for nurses. Their working environment is challenges with organisational health expectations while their scope of practice is limited and unclear. Nurses have described experiences relating to the need to be recognised, supported, empowered, and valued as

they make up the largest percentage of healthcare workers both in Fiji and globally (WHO, 2011, 2016).

Chapter 11: Recommendation and Conclusion (Me Vakilai/Me Na I Vurevure ni Veisau)

This chapter fulfils step 9 of the Vanua framework (*Me Vakilai/Me Na I Vurevure ni Veisau se na ka e vou ka na kauta mai na bula e sautu (transformative processes/change as a result of research reports).* The findings from this research have highlighted the perceptions of job satisfaction for nurses in Fiji through identifying the challenges that they encounter within their organisation, management, and work characteristics.

The question remains, since the establishment of nursing in Fiji in the early years, why has the evolution of the profession, in comparison to other countries such as New Zealand, not progressed with the same advancement and potentially addressed key factors leading to nursing job satisfaction concerns. Nursing education began in Fiji in 1893 and developed into a nursing diploma programme with the assistance of the WHO in 1983 (Usher et al., 2003; Vudiniabola, 2011). It was not until 30 years later, in 2013, that the Bachelors in Nursing programme was finally introduced into the country by the FNU (Fiji Government, 2013). Understandably, the challenges encountered by many developing- or low-income countries are training and retaining their nurses who eventually migrate for better working conditions (Aiyub et al., 2013).

The media, on two separate occasions, published interviews with FNA President Dr Alisi Vudiniabola, who discussed the reasons for the mass resignation of nurses from Fiji following the COVID-19 pandemic. Dr Vudiniabola expressed that the nurses were resigning because of fatigue, lack of compensation, and stress brought on by limited manpower. Though the health system was 'falling apart', as stated by Dr Vudiniabola, the permanent secretary for health Dr James Fong could not respond to the nurses' issues; rather, simply commented that they were working with the chief nurse towards resolving the nurses' grievances (Nacei, 2022). In a separate interview with the Fiji Times Media, Dr Alisi Vidinabola expressed again how disappointed she was with the two doctors who represented the health ministry minister and permanent secretary in making decisions that did not consider the endless workload nurses had to endure during the COVID-19 outbreak in the country (Chaudry, 2022).

The overarching theoretical model of clinical nurses' satisfaction or disatisfaction, and the Fijian Vanua indigenous framework, provided the interpretive paradigms as guidelines to the interpretation of the data collected. Data were collected through the Vanua methodology (qualitative), using the tool *Talanoa* in interviews and focus group discussions where three

different samples were grouped to triangulate the data within the Vanua framework towards addressing the research questions. The Vanua framework dictated the research processes conducted on the ground, using its protocols and ethics of knowledge (Nabobo-Baba, 2008), because knowledge is linked to the epistemology of the people such as their culture and values.

These worldviews of the Vanua framework and philosophies were considered alongside the critical analyses of the job satisfaction factors of nurses in Fiji. The interview information and focus group discussions were thematically analysed and grouped into the four characteristics of the clinical nurses' intent to stay theoretical model. Cowden and Cummings' (2012), theoretical model guided the formulation of the research questions as it considers the nurses' cognitive response to work such as job satisfaction.

The empirical evidence gathered from the participants established meaning and experiences of job satisfaction. The findings will assist policy makers to understand the complex nursing establishment in a country that has been neglected through the evolution of educational programmes, organisational roles of management, budgeting position of nursing staff establishment, and limited involvement in health care service development (Aiyub et al., 2013).

11.1 Improve Remuneration and Working Conditions

The need to improve the nurses' salary has been consistently voiced throughout the Talanoa interviews with the participating Fiji nurses, and the main factor for their dissatisfaction is that their salary is not matched to their roles and responsibilities. The improvement of remuneration and working conditions to reward promotion pathways would contribute towards reducing migration and improving the Fiji health care system. The majority of the nursing graduates in Fiji are females (Aiyub et al., 2013), which brings to light gender awareness with key focus on improving women's work conditions and pay as discussed in Chapter 10. Leckie (2005) noted that the FNA represented a union that was proactive since the late 1970s in fighting the exploitation of women and their pay which, till today, has not been matched by their different political representatives. Surprisingly, Leckie noted that the FNA was one organisation that would dominate in numbers with the amount of Fiji nurses, but they (the nurses) would not speak much and would just remain quiet, with only a few dominating the union meeting and making the decisions. The unsuccessful nurses strike in 2007, saw resistance from the government to listen to the nurses' grievances and the Fiji

Nursing Association continues to fight the silent battle of advocating for the nurse, as described in Chapter 1 (Chaudry, 2022)

The view of women in the Pacific who continue to be marginalised within their culture is a reality that has to be considered. This brings to light many factors of customary hierarchy and patriarchy within Fijian society. Despite being educated, the stereotype relating to women and their Christian values significantly cut through the advancement of nursing in the country (Meo-Sewabu, 2015). Fijian women have come to accept their position in society as it embodies their culture of maintaining relationships across all sections (Ravuvu, 1983). Though modern Fijian society is slowly evolving, nursing will only propel forward and be well represented within the organisation if they take up the challenge to educate themselves on the colonial discourse that has impacted their profession (Ravuvu, 1983).

11.2 Empowering Nursing Leaders Through Management Training

Data showing lack of knowledge in management leadership were outlined in Chapter 7. Leadership training should start at the tertiary curriculum level for all nursing students, either as course material available online or through face to face training workshops which would empower the nurses with the knowledge of self-awareness and advocating for better conditions.

A leadership and management training that gives perspective to the experiences of Fijian nurses as women within the whole Ministry of Health organisation would serve to change leaders' visions on the value of their role and responsibilities with examples on women empowerment workshops. Organisations are transformed when leadership can recognise the critical factors that need to be addressed and have the cultural competence and intelligence to relate to the conflicting issues. Leaders, when placed in a position of power, are responsible for the welfare of their subordinates and thus need to influence change with traits of professionalism grounded in Western views of equity. That does not mean that they abandon their culture, but more that they have the ability to critically understand and incorporate effective leadership frameworks. Nursing leaders cannot continue to give in to the indigenous perspective of respect, but must reflect on measures that demand the change that is needed (Park et al., 2018).

11.3 Review the Scope of Practice

In Chapter 9, participants described how their individual work plan encompassed additional roles that they were accountable for such as dispensing of medication in isolated facilities, well above their scope of practice. The Fiji nursing scope of practice needs to be regularly reviewed to ensure the safety of the patients and legislate nurses' practice of care in accordance with their education and area of practice. Nursing speciality is on-going in Fiji; apart from the scope of nursing manuals for general nursing of registered nurses, there have only been two other manuals launched that legislate their speciality roles—nurse practitioners and nurse midwives. The paradigm move towards nursing specialisation in Fiji will shift once there is development of a nursing scope that would encompass new roles such as enrolled nursing, emergency or intensive care nursing, and a licence that defines the role of practice and standardises professional practice which encompasses nurses' legal responsibilities protecting and guiding them to what they can and cannot perform. The creation of new roles and titles cannot be done without first understanding the boundary of practice and the nature of the nursing task needed (Schluter et al., 2011; White et al., 2008).

The competency of nurses in delivering quality care is regulated through the provision of their scope of practice. Understandably, the nursing shortage has contributed to nurses taking on responsibilities beyond their scope, such as dispensing of prescribed medication at health centres. The limitation within the nursing scope was expressed by the former Chief of Nursing Fiji, as described in Chapter 1, where new nursing speciality positions were still not included in the nursing scope.

The reclassification and renewal of regulation of nursing roles and scope of practice will allow the development of accredited educational programmes and opportunities, clear confusion of overlapping roles when faced with situations such as in maritime nursing, reduce uptake of responsibilities to other health cadres, and pave the way for clear career paths for the nurses. Nurses in Fiji are remunerated equally, even when performing different nursing roles, because their general scope of practice is the same; a nurse being on-call 24-hours every day, an ICU nurse, and a sub-divisional general ward nurse who looks after two patients are remunerated equally irrespective of different skill, workload, or qualification. This was highlighted by Participant 6 (Chapter 8). The lack of opportunity to advance their professional development in a specific area of practice and gain recognition for it causes low morale (Tamata et al., 2021). The scope of practice needs to be reviewed to recognise the diversity of roles and, once it progresses into defining specialised roles, it may allow policies on salary

remuneration and geographical population density to be developed in line with services provided, and a remuneration value for the responsibility undertaken.

The scope of nursing practice must give recognition to the need for professional development that may allow the advancement of nursing into specialised fields and remunerate according to their roles, responsibilities, and workload. It paves the way for nurses to have a clear career pathway that highlights their role without being subjected to responsibilities that are beyond their scope.

11.4 Review Nursing Establishment (Vacancy Number) and include Nurses in Health Policy Planning

The allocation of manpower is determined by the workforce establishment (established vacancy number) and works within allocated facility numbers. Participant 6 (Chapters 8 & 9) expressed that workload was one main challenge in achieving the organisational goals and the management's allocation of manpower is sometimes biased. Considering that the Fiji population, and concurrently burden of illnesses, has increased since 2017, the nurse to patient ratio is due for review as workload continues to increase with no growth in nursing establishment. If not considered, nurses will continue to voice concerns of overwork and shortage of staff when, in reflection to their established positions, they are completely filled with no vacancy needed.

Health policies manage work conditions, compensation, health infrastructure, and many other governing rules. The recognition of nurses' presence or non-presence in the policy arena has not gone unnoticed, with nurse representatives very recently questioning decisions made without the consultation of the nurses or how it may affect them (Nacei, 2022). The current hierarchical power relationship between the nurses and doctors is suggestive of medical and cultural authority, and the nurses compensate because of their subordinate status of being medically inferior in knowledge and the demeanour of women being subjective to authority (Hughes, 2010). The executive version of the Fiji Ministry of Health and medical Services National Strategic Plan 2016-2020 document shows, at the back, the name list of the people consulted for the published document; out of 97 health professionals, only one was listed as a nursing profession—the manager nursing Lautoka (Ministry of Health & Medical Services, 2016/2020).

Key forums or a board need to be established to ensure nurses are included in decision makings of health care and that they are not completely left to the mercy of doctors and other health care workers who dictate what is expected from them. Collaboration and partnership are key in relation to clinical governance and nursing needs to be well represented. Critical enlightenment needs to go to this area of interest as portrayed by the nursing leaders where the Chief of Nursing, Midwifery, and Nurse Practitioners is unclear of her channels of communication within the Ministry of Health and her nursing directors. This is again evident in the recent COVID-19 pandemic where no nursing representative from the ministry advocated for the nurses' challenges; rather, this was done through the FNA representative (Vudiniabola, 2020). This conceptualising of the process of gender and power will identify key elements which can influence organisational change and buffer against traditional modes of communication and other social dynamics. However, it is important to note that overcoming discriminatory practices against gender, nurses, and medical authorities need to construct and provide insight to the many productive ways health care services may be improved. Participating in governing organisational policies may adhere to giving the nursing profession the recognition it has always requested and rightfully earned (Hughes, 2010).

When the nursing establishment and health policies are reviewed and better aligned this will ensure that manpower is addressed accordingly to the workforce demand and that nurses are included in policy and health care delivery services, rather than being ignored and expected to achieve unrealistic health outcomes.

11.5 Review of the Nursing Curriculum

Chapters six and seven reflected on the nurses' perception of their submissive behaviour towards authority. This brings in effects of cultural traditions and colonialism which points to gaps in the curriculum relating to cultural competency, professionalism, political awareness and advocacy. The nursing curriculum urgently needs review as it imposes nursing ideologies that feature foreign values commonly colonial and westernised values that do not truly align with Fijian centric approaches to care delivery and responsibility. Highlighting the health perspectives of indigenous values with congruent cultural competency models at all levels. If the curriculum, may serve to suggest empowering nurses to be more aware of their behaviour, and more assertive that has been characterised by the colonising effects through their delivery of care. Development, through change and reform, may require a dynamic

programme that integrates the complex and constant change in the country. Academic and technical development that advocates for nursing management, leadership, and resilience training programmes at both undergraduate and post graduate specialism levels as the general nursing curriculum practices are the main vehicles for the process of change from colonial influences. Importantly integration of indigenous knowledge will ensure health practices are delivered via an approach that is comfortable to both receiver and provider.

11.6 Leadership Management to address the Mental Health of all Health Professionals

Participants in Chapter 8 expressed the lack of services available for mental health support, which is critically important considering the stressful working environment that the nurses are exposed to on a daily basis. The nursing leaders and management, such as the Chief Nurse in Fiji, could develop and implement policies designed to cater to the mental health of nurses, such as mental health leave days, and put in place a support system to cater to the needs of the nurses, such as having a reliable counselling service or a health app-based approach. Training of nursing leaders into developing strategic plans for mental health and work life balance self-assessment needs to be undertaken ensuring equal attention is awarded to each nurse professionally without bias and prejudice.

The university nursing schools in Fiji could implement curriculums that educate nurses, and allied health professionals with the skills to deal with mental health issues, and management courses for leaders on management competency in addressing underlying issues relating manpower shortages and mental health. Empowering nursing leaders and developing management behavioural programmes will work towards addressing authoritative leadership that encourages nurses to work in an environment that motivates them to be more productive. Leaders, when empowered, will advocate for the improvement of nurses' work conditions in terms of finally finding their value and worth within the Ministry.

11.7 Strengths

The current research featured the Vanua Model and the Fijian Vanua Research Framework that was adapted as the methodology and used throughout the research. Indigenous knowledge, when integrated with western worldviews, leads to strengthening two different perspectives that would pave the way to advocating and producing better outcomes

(Kealiikanakaoleohaililani & Giardina, 2016). The Vanua research model allowed the translation of the Fiji nurses' voices, with in-depth meaning into understanding the connection between their relationships, values, culture, knowledge system, and spirituality. The protocols validated the acquisition of knowledge and information that gave raw insight into the context of nursing in Fiji (Nabobo-baba, 2008). The research was also supported by both the Fiji government and the Fiji Nursing Association which highlights the importance of understanding the experience of nurses in relation to job satisfaction in the country.

The use of the Vanua framework together with Cumming and Cowden's (2012) theoretical model for nursing job satisfaction guided the discussion, and enabled the robust process and internally consistent process to address the key research questions while linking the findings of the three cohorts of participants to the Vanua framework and concepts.

The ability to carry out Vanua framework step 8: Vakarogotaki lesu tale/taleva lesu (reporting back, revisiting site), though the COVID-19 pandemic limited my ability to travel home to present my findings and report back the transcription of the interviews. Instead, I was able to email the participants a copy of their transcribed Talanoa interview for the purpose of validation. Though most of them did not respond to the email due to the complexity of the Covid landscape taking place in Fiji, this form of feedback report to the nurses ('Vakarogotaki') allowed me to show my appreciation and value their contribution to my research.

Other strengths were the engagement of three cohorts – registered nurses, leaders, government administration officials, which enable robust rigor through triangulation of stakeholder groups, as well as potential for later widespread dissemination of my findings through all sectors of the nursing administration systems in Fiji and the Pacific.

In addition, purposively sampling across areas of employment- remote rural, peri urban, urban, and rural enabled further credibility and transferability of the findings.

This research study in relation to the nurses in Fiji and job satisfaction is the first of its kind to be carried out in the country and highlights the influence culture, beliefs system, power imbalances, role pf women and colonisation. Indigenous knowledge, when integrated with western worldviews, leads to strengthening two different perspectives that would pave the way to advocating and producing better outcomes on the evolution of nursing in the country and, ultimately, job satisfaction and dissatisfaction (Kealiikanakaoleohaililani & Giardina, 2016).

11.8 Limitations

Fiji is an island that has had adverse political instability with a unique mix of democracy; thus, the introduction of the research through the Vanua needed to be diplomatic without directing attention at the government or any exploitation of political parties within the nursing governance (Lane, 2012).

The study experienced a number of limitations in the process of data collection as there was a measles outbreak in Fiji between October and December 2019 delaying the participant interviews because nurses had to work on the mass measles campaign (Kaspar et al., 2020). This was followed by the first ever COVID-19 case to be reported in Fiji on 19 March 2020, as part of the global pandemic that saw New Zealand close its borders to the country (Kant et al., 2021). Being an international New Zealand student stuck in Fiji due to border closure limited my resources to analysing data because internet in the country was limited and expensive, I lacked study space, and student allowance was halved because I was working out of country and I was thus unable to print.

It took exactly one year before the New Zealand border was opened to PhD students and, upon my return, New Zealand reported its first COVID case in August (Tretiakov & Hunter, 2021), bringing the country into lockdown. Library resources have been limited with the inability to complete writing in a study environment that is conducive to learning. The university was closed and mental stress and anxiety was high during this period. I questioned my ability to finish the thesis.

The use of the 'Vanua' indigenous framework, though a privilege and an advantage for an indigenous researcher, required substantial time to translate the meaning and concepts of the Talanoa conversation that were enriched with overwhelming details of the nurses' experience.

The number of nurses, leaders, and government officials who were recruited to participate in the study through snowballing sampling was small. There is a need for further research in relation to job satisfaction of nurses in the Pacific.

11.9 Conclusion

This final section will review the key factors influenced job satisfaction among this cohort of nurses in Fiji and will be followed by a summary in the context of the research questions which were:

- To understand the meaning of job satisfaction for nurses in Fiji.
- To understand personal, organisational, managerial, and professional challenges nurses in Fiji experience in their roles, and how they perceive these challenges impact on their job satisfaction.
- Recommend strategies that support improvement in work conditions for nurses in Fiji, leading to enhanced job satisfaction.

The areas for further research, and suggested areas of improvement and recommendation, along with the concluding statement, will be presented at the end of this chapter. First evidence generated to contribute to developments to the improvement of nurses' work conditions will be considered.

11.10 Research Influence

The key influence of this research journey began with my personal experience. As one of the youngest nursing managers in Fiji, responsible for the biggest sub-division in the Western division, I encountered multiple barriers in attempting to improve the nurses' work conditions. I had to consider the complexities of the personal layers of responsibility I held in terms of my position in the social structural hierarchy of power, cultural identity, spirituality, and perceptions of the nurses; as well as the nurses' views on the definition job satisfaction with meaning give to statement by Thiong'O (1993) as:

> Culture embodies those moral, ethical and aesthetic values, the set of spiritual eyeglasses, through which people view themselves and their place in the universe…. Language as a culture is the collective memory bank of people's experience in history. (p. 14)

The concept of job satisfaction has been widely researched (Al Maqbali, 2015; Lu et al., 2019) and it is, indeed, a critical issue within any health organisation. However, in encountering the barriers towards improving productivity among these Fijian nurses and leaders, the broader aspect of trying to understand organisational implications that encompass their environment and identity needed to be understood and evaluated before any development could contribute to change. The literature that reflected on nurses' job satisfaction within the

Pacific, on relevancy of their cultural understanding , was very limited. Thus, the need to represent the nurses' voices from the cultural lens of their own definition of job satisfaction and give value to why they spoke and behaved the way they did; thereby, shining an understanding onto the reasons why the nurses' work conditions have not improved to date despite changes in the health care system.

The 'Vanua' framework methodology was the ideal fit as it was able to give meaning to the complex system of the health institution in the country, and offer insight into indigenous knowledge-based philosophies and cultural standards that are believed and still practiced by nurses (Nabobo-Baba, 2006). The nurses' values have revolved around the Fijian context of valuing relationships and talking about issues, such as the challenges they encounter in their roles, would denote disrespect to the leaders (Nabobo-Baba, 2006; Vudinibola, 2011).

Summary of the Key Findings

The first key finding is that the bureaucratic ideologies and conservative leadership protocols within the 'Vanua' have become a conflicting dilemma and barrier when operating in the western environment of change within the Ministry of Health. The research questions of understanding the meaning of job satisfaction for the Fiji nurses primarily reflected participants' unique and significant disappointment with nursing management. Though other factors were highlighted that contributed to their job satisfaction, their overall attitude indicated the complex concepts of having 'no voice' and the complex professional expectations they are subject to without key consideration to their realities of their working environments.

Indigenous Fijians' culture and tradition is guided by 'Vanua' protocols and processes, and is solidified through their Christian values and ethos of the land. Identifying the values of the 'Vanua' enables nurses to be empowered to be agents of change.

Second, job satisfaction was categorised into organisational and management characteristics as the two main features that affect job satisfaction. The context of the imbalance of power and authority in leadership was observed within the complex Fijian hierarchy which places high value on tradition. Even in the modern era, traditions are commonly inevitably manipulated to fit into the current situation of socio-political groups that continue to give power and prestige to whomever holds the position of authority (Sayes, 1984). The historical and contemporary devaluing of nurses though a global issue identifies the personalised

management style adopted by the organisation and nursing management in Fiji, as elsewhere.

Understandably, a healthy working environment with satisfied nursing staff results in quality patient care due to nurses that engage, retain their position, do not migrate, and demonstrate improved work performance. The psychological impact associated with the current nurses' work environment stems from confusion relating to the organisational structure, stagnant remuneration, lack of recognition and qualification, and lack of mental health support outlined in Chapters 6, 7, 8, and 9. The application of pressure on nurses to conform to the demands and underlying issues are related to work stress are associated with the multidimensional phenomenon of power and women in Fijian society who are marginalised as passive victims to change (Meo-Sewabu, 2016).

Third, the work characteristics and job satisfaction of the Fiji nurses were examined through their experience in the broader work environments (urban and rural nursing). The nursing educational development has been progressively slow with the transition to a bachelor's degree programme only recently implemented in 2016 (Hassan, 2016), with no options available for local online short courses except for the WHO (2015) sponsored online programme (POLHN) for Pacific health workers. The nurses encounter job stressors and burnout as a result of having an overstretched workforce capacity, that includes having an unclear scope of practice on responsibilities undertaken, inadequate policies and personal support for working conditions, and stigma associated with emotional mental health issues due to cultural barriers. The Fijian nurses' working conditions demanded high quality care with very limited resources, and this was seen by these nurses to contribute to low morale and decisions to move out of the Ministry. The relationship between the nature of job satisfaction and working environment has implications on the nurses' attrition rate and the challenges identified should provide a pathway for opportunity for change within the country.

Nursing migration is inevitable, as reflected upon in Chapter 1, and the factors relating to nurses making the decision to leave is driven significantly by their dissatisfaction with their working environment as well as other factors outlined in chapter one, such as the betterment of their careers and protects their family options. The Fijian remuneration ratio is vastly lower than that offered by other countries like New Zealand (as discussed in Chapters 1 & 2), but findings from the research in Chapter 8 suggest that nurses are more willing to consider

staying if given the right recognition in terms of improved working conditions such as paid leave, risk allowance, and increase in nurse/patient ratio.

Lastly, the findings from the research allow the transfer of generalised challenges encountered by this cohort of Fijian nurses within the context of their developing country to that of other Pacific nursing workforces, based on a comprehensive review of their understanding of the definition and meaning of job satisfaction. Internationally, countries have differing definitions and expectations of job satisfaction depending on their level of development. To accurately evaluate the situations Fiji nurses are faced required an understanding of their socio-political and cultural backgrounds as outlined in this thesis.

Though there are many varying levels and factors related to work satisfaction, similar results to the working conditions through the organisational, management, and professional commitments, give insight to the role content and challenges of nurses universally (Al Maqbali, 2015). The issues highlighted are related to understanding the association of job satisfaction and its significance to the delivery of quality health care in the country that may work towards achieving a deeper understanding of designing measures that assist in the retention of nurses. Thus, to understand the meaning of job satisfaction and the customary meaning behind the decisions made through the evolution of nursing in the country will enable the development of nursing in Fiji that integrates the cultural and western policies of change for the improvement of the nurses' work conditions.

11.11 Contribution to Literature and Suggestions for Further Research

This research adds knowledge to an understanding of the culture and identity of the Fijian people, and Fijian nurses in particular the related concepts pertaining to the nurse workforce such as leadership, women's roles, and the colonial rule that contribute to job satisfaction and add motive to migration for a better life. The cultural practices are emphasised through communication that has been modified through dialogue between different groups as seen by senior (leader) and junior (general) nurses. The cultural beliefs of the participants shape their practice models which makes the service system both unique and dominating at the same time. Fijian women's social values were brought to light in understanding their duties within the 'Vanua' and in the context of modern society. The traditional ideology that women are excluded from decision making and non-representation in strategic planning investigates the impact of gender, education, and power within the relations that nurses are stereotypically just for females. More research that drawn from these concepts of nurses and gender roles in the community is needed.

A larger qualitative study needs to be conducted to engage a wider perspective of nurses generated from larger scale random sampling could contribute to the data collected in this study for further understanding and recommendations into improving job satisfaction and nursing standards in the country.

A qualitative study or descriptive survey of patients and their relative's perception of nursing may be conducted to identify the stigma associated with nursing in Fiji, which may further inform job satisfaction, as well as nursing as a career choice and the service outcomes for nurses.

The scope of nursing in Fiji has always been limited to generalised nursing roles and there is an unknown timeframe for a shift to nursing specialisation, though government representatives in their media interviews comment on ensuring nurses' careers are paved towards that direction (Hassan, 2016). The New Zealand district health board has a 103-page document—nursing and midwifery Multi-Employer Collective Agreement (MECA)—that outlines the employment terms and conditions with clear definitions to their roles (New Zealand Nurses Organisation, 2017). Fiji may work towards developing a similar document for their nurses with the right support and research towards progressing nursing in the Pacific.

Concluding Statement

The journey through this research has allowed me to recognise my role as an indigenous Fijian nurse working as a young manager in the country. The barriers encounter within the Ministry of Health in the early years of my career were influenced by a lack of policies and strategies, with static management decisions indicating that nothing could be done. The commitment to deal with the issue meant I had to place myself in a position where the complexities of being seen as a woman is given little attention but linked to someone that is productive enough to influence change. Fiji is a country with culturally embedded roles and strategies that are exercised by women who are classified as being oppressed (Meo-Sewabu, 2016). This research was selected not out of personal interest alone but as an obligation to the nurses of Fiji who have been oppressed and neglected for so long, and have worked in silence for many years without receiving proper attention.

Leadership is a responsibility and I have been blessed to receive the opportunity many nurses in Fiji only dream of, pursing a PhD while being only the fourth nurse in the country to do so.

I do not take my privileged position lightly and weigh the responsibility of using it to improve nursing standards and work conditions for the nurses in Fiji. I may not have any cultural status of chiefly bloodline, as I am a commoner, nor do I have any social status having a prominent family background. What I do have is that I am educated, I am indigenous, and hopefully that will be enough to generate the noise required to give nurses in Fiji the workplace satisfaction and public recognition they long deserve.

References

Abhicharttibutra, K., Kunaviktikul, W., Turale, S., Wichaikhum, O. A., & Srisuphan, W. (2017). Analysis of a government policy to address nursing shortage and nursing education quality. *International Nursing Review*, *64*(1), 22-32. https://doi.org/10.1111/inr.12257

AbuAlRub, R., El-Jardali, F., Jamal, D., & Al-Rub, N. A. (2016). Exploring the relationship between work environment, job satisfaction, and intent to stay of Jordanian nurses in underserved areas. *Applied Nursing Research*, *31*, 19-23. https://doi.org/10.1016/j.apnr.2015.11.014

Adams, A., & Bond, S. (2000). Hospital nurses' job satisfaction, individual and organizational characteristics. *Journal of Advanced Nursing*, *32*(3), 536-543. https://doi.org/10.1046/j.1365-2648.2000.01513.x

Adams, R. J., Smart, P., & Huff, A. S. (2017). Shades of grey: Guidelines for working with the grey literature in systematic reviews for management and organizational studies. *International Journal of Management Reviews*, *19*(4), 432-454. https://doi.org/10.1111/ijmr.12102

Ahmad, W. I. (2002). The trouble with culture. In D. Kelleher & S. Hillier (Eds.), *Researching cultural differences in health* (pp. 202-231). Routledge.

Ahmed, S. M., Tolera, M., & Angamo, M. T. (2013). Assessment of job satisfaction among pharmacy professionals in south-west Ethiopia. *International Journal of Pharmaceutical Sciences and Research*, *4*(6), 2351. https://doi.org/10.1186/s40545-021-00356-1

Aiyub, S., Linh, N., Tayler-Smith, K., Khogali, M., & Bissell, K. (2013). Nurses graduating in Fiji between 2001 and 2010: Sufficient supply for Fiji's health service demands? *Public Health Action*, 3(1), 63-67. https://dx.doi.org/10.5588/pha.12.0067.

Akram-Lodhi, A. H. (2016). *Confronting Fiji future* (Chapter 8). The Australian National University.

Al Maqbali, M. A. (2015). Factors that influence nurses' job satisfaction: A literature review. *Nursing Management*, *22*(2), 30-37. https://doi.org/0.7748/nm.22.2.30.e1297

Alderfer, C. P. (1969). An empirical test of a new theory of human needs. *Organizational Behavior and Human Performance*, *4*(2), 142-175. https://doi.org/10.1016/0030-5073(69)90004-X

Almalki, M. J., FitzGerald, G., & Clark, M. (2012). The relationship between quality of work life and turnover intention of primary health care nurses in Saudi Arabia. *BMC Health Services Research*, *12*(1), 314. https://doi.org/10.1186/1472-6963-12-314

Aloisio, L. D., Gifford, W. A., McGilton, K. S., Lalonde, M., Estabrooks, C. A., & Squires, J. E. (2018). Individual and organizational predictors of allied healthcare providers' job satisfaction in residential long-term care. *BMC Health Services Research*, *18*(1), 1-18. https://doi.org/10.1186/s12913-018-3307-3

Alotaibi, J., Paliadelis, P. S., & Valenzuela, F. R. (2016). Factors that affect the job satisfaction of Saudi Arabian nurses. *Journal of Nursing Management*, *24*(3), 275-282. https://doi.org/10.1111/jonm.12327

Andrioti, D., Skitsou, A., Karlsson, L., Pandouris, C., Krassias, A., & Charalambous, G. (2017). Job satisfaction of nurses in various clinical practices. *International Journal of Caring Science*, 10(1), 76-87.

Aninanya, G. A., Howard, N., Williams, J. E., Apam, B., Prytherch, H., Loukanova, S., Kamara, E. K., & Otupiri, E. (2016). Can performance-based incentives improve motivation of nurses and midwives in primary facilities in northern Ghana? A quasi-experimental study. *Global Health Action*, *9*(1), 32404. https://doi.org/10.3402/gha.v9.32404

Antonazzo, E., Scott, A., Skatun, D., & Elliott, R. F. (2003). The labour market for nursing: A review of the labour supply literature. *Health Economics*, *12*(6), 465-478. https://doi.org/10.1002/hec.737

Arno, A. (1979). Conflict, ritual, and social structure on Yanuyanu Island, Fiji. *Bijdragen tot de Taal-, Land-en Volkenkunde/Journal of the Humanities and Social Sciences of Southeast Asia*, *135*(1), 1-17. https://doi.org/10.1163/22134379-90002568

Arnolds, C., & Boshoff, C. (2002). Compensation, esteem valence and job performance: An empirical assessment of Alderfer's ERG theory. *International Journal of Human Resources Management,* 13(4), 699-719. https://doi.org/10.1080/09585190210125868

Ashcroft, B., Griffiths, G., & Tiffin, H. (1998). *Key concepts in post-colonial studies*. Routledge.

Australia Nursing & Midwifery Federation. (2018). *Nurses & Midwives' Pay Check: A Quarterly Publication Providing A comprehensive Analysis of Wages for Nurses and Midwives, 17*(2), 6-8.

Baernholdt, M., & Mark, B. A. (2009). The nurse work environment, job satisfaction and turnover rates in rural and urban nursing units. *Journal of Nursing Management*, *17*(8), 994-1001. https://doi.org/10.1111/j.1365-2834.2009.01027.x

Baker, L., Egan-Lee, E., Martimianakis, M. A., & Reeves, S. (2011). Relationships of power: Implications for interprofessional education. *Journal of Interprofessional Care*, *25*(2), 98-104. https://doi.org/10.3109/13561820.2010.505350

Banai, M., Reisel, W. D., & Probst, T. M. (2004). A managerial and personal control model: Predictions of work alienation and organizational commitment in Hungary. *Journal of International Management*, *10*(3), 375-392.

Barnett, T., Namasivayam, P., & Narudin, D. A. A. (2010). A critical review of the nursing shortage in Malaysia. *International Nursing Review*, *57*(1), 32-39. https://doi.org/10.1111/j.1466-7657.2009.00784.x

Bloom, D. E., Cafiero, E., Jané-Llopis, E., Abrahams-Gessel, S., Bloom, L. R., Fathima, S., Feigl, A.B., Gaziano, T., Hamandi, A., Mowafti, M., O'Farrell, D., Czaltin, E., Pandya, A., Prettner, K., Rosenberg, L., Seligman, B., Stein, A. Z., Weinstein, C & Weiss, J. (2012). *The global economic burden of noncommunicable diseases* (No. 8712). Program on the Global Demography of Aging.

Boamah, S. A., Laschinger, H. K. S., Wong, C., & Clarke, S. (2018). Effect of transformational leadership on job satisfaction and patient safety outcomes. *Nursing Outlook*, *66*(2), 180-189. https://doi.org/10.1016/j.outlook.2017.10.004

Boamah, S. A., & Tremblay, P. (2019). Examining the factor structure of the MLQ transactional and transformational leadership dimensions in nursing context. *Western Journal of Nursing Research*, *41*(5), 743-761. https://doi.org/10.1177/0193945918778833

Bolanavanua, S. (2018, 27 Nov). My dress symbol of modern woman: Lynda. *Fiji Sun News Online*. https://fijisun.com.fj/2018/11/27/my-dress-symbol-of-modern-woman-lynda/

Booth, R. Z. (2002). The nursing shortage: A worldwide problem. *Revista Latino-Americana de Enfermagem*, *10*(3), 392–400. https://doi.org/10.1590/s0104-11692002000300013

Bornstein, S. L., Elton, L. G., Kennedy, F., Sosefo, M., Daniel, P., Sanau, E., Nason, R., & Mitchell, R. D. (2021). Rising to the challenge: The emergency nursing response to COVID-19 in the Pacific. *Australasian Emergency Care*, *24*(1), 1-3. https://doi.org/10.1016/j.auec.2020.09.005. Epub 2020 Oct 1.

Boyatzis, R. E. (2011). Managerial and leadership competencies: A behavioural approach to emotional, social and cognitive intelligence. *Vision*, *15*(2), 91-100. https://doi.org/10.1177/097226291101500202

Braun, V., & Clarke, V. (2012). Thematic analysis. In H. Cooper (Ed.), *APA handbook of research methods in psychology: Research designs* (pp. 57-91). American Psychological Association.

Braun, V., & Clarke, V. (2014). What can "thematic analysis" offer health and wellbeing researchers? *International Journal of Qualitative Studies on Health and Well-Being*, 9. https://doi.org/ 10.3402/qhw.v9.26152

Braun, V., Tricklebank, G., & Clarke, V. (2013). "It shouldn't stick out from your bikini at the beach": Meaning, gender, and the hairy/hairless body. *Psychology of Women Quarterly*, *37*(4), 478-493. https://doi.org/10.1177/0361684313492950

Brenneis, D. (1980). Leadership in Fiji. *American Anthropological Association*, 18-20.

Brewer, C. S., Kovner, C. T., Djukic, M., Fatehi, F., Greene, W., Chacko, T. P., & Yang, Y. (2016). Impact of transformational leadership on nurse work outcomes. *Journal of Advanced Nursing*, *72*(11), 2879-2893. https://doi.org/10.1111/jan.13055

Brison, K. J. (2007). *Our wealth is loving each other: Self and society in Fiji*. Lexington Books.

Brown, R. J., & Connell, J. (2004). The migration of doctors and nurses from South Pacific Island Nations. *Social Science & Medicine*, 58(11), 2193-2210. https://doi.org/10.1016/j.socscimed.2003.08.020

Buchan, J., & Aiken, L. (2008). Solving nursing shortages: A common priority. *Journal of Clinical Nursing*, *17*, 3262-3268. https://doi.org/10.1111/j.1365-2702.2008.02636.x

Buchan. J., Conell, J., Rumsey, M., & World Health Organization. (2011). *Recruiting and retaining health workers in remote areas: Pacific Island case-studies.* World Health Organization. https://apps.who.int/iris/handle/10665/44547

Buchanan, J., Dawkins, P., & Lindo, J. L. (2015). Satisfaction with nursing care in the emergency department of an urban hospital in the developing world: A pilot study. *International Emergency Nursing*, *23*(3), 218-224. https://doi.org/10.1016/j.ienj.2015.01.001

Buykx, P., Humphreys, J., Wakerman, J., & Pashen, D. (2010). Systematic review of effective retention incentives for health workers in rural and remote areas: Towards evidence-based policy. *Australian Journal of Rural Health*, 18(3), 102-109. https://doi.org/10.1111/j.1440-1584.2010.01139.x

Byrne, G. J., & Bradley, F. (2007). Culture's influence on leadership efficiency: How personal and national cultures affect leadership style. *Journal of Business Research*, *60*(2), 168-175. https://doi.org/10.1016/j.jbusres.2006.10.015

Cammock, R., Conn, C., & Nayar, S. (2021). Strengthening Pacific voices through Talanoa participatory action research. *AlterNative: An International Journal of Indigenous Peoples*, *17*(1), 120-129. https://doi.org/10.1177/1177180121996321

Carstensen, L. L., Turan, B., Scheibe, S., Ram, N., Ersner-Hershfield, H., Samanez-Larkin, G. R., Brooks, K. P., & Nesselroade, J. R. (2011). Emotional experience improves with age: Evidence based on over 10 years of experience sampling. *Psychology and Aging*, *26*(1), 21-33. https://doi.org/10.1037/a0021285.

Chattier, P. (2013). Does schooling and work empower women in Fiji? Or have gender inequalities persisted and why? *Global Change, Peace & Security*, *25*(1), 61-76. https://doi.org/10.1080/14781158.2013.758097

Chaudhary, F. (2022, 8 Jan). Duty of care. *The Fiji Times Online*. https://www.fijitimes.com/duty-of-care-2/

Cherian, S., Alkhatib, A. J., Aggarwal, M., & Cherian, S. (2018). Relationship between organizational commitment and job satisfaction of nurses in Dubai hospital. *Journal of Advances in Social Science and Humanities*, *4*(1), 36373-36400.

Cherif, F. (2020). The role of human resource management practices and employee job satisfaction in predicting organizational commitment in Saudi Arabian banking sector. *International Journal of Sociology and Social Policy, 40*(7/8), 529-541. https://doi.org/10.1108/IJSSP-10-2019-0216

Choi, S. P. P., Cheung, K. I. N., & Pang, S. M. C. (2013). Attributes of nursing work environment as predictors of registered nurses' job satisfaction and intention to leave. *Journal of Nursing Management*, *21*(3), 429-439. https://doi.org/10.1111/j.1365-2834.2012.01415.x

Cohidon, C., Wild, P., & Senn, N. (2019). Practice organization characteristics related to job satisfaction among general practitioners in 11 countries. *The Annals of Family Medicine*, *17*(6), 510-517. https://doi.org/10.1370/afm.2449

Cokanasiga, L. (2020). Public private partnerships: Are they a healthy investment model? Lautoka and Ba Hospitals- Fiji A Case Study. *Pacific Network on Globalisation*, *Dawn Discussion Paper, 22*.

Connell, J. (2004). The migration of skilled health professionals: From the Pacific Islands to the world. *Asian and Pacific Migration Journal*, 13(2), 155-177. https://doi.org/10.1177/011719680401300202

Connell, J. (2010). *Migration of health workers in the Asia Pacific region*. Human Resources for Health Knowledge Hub, School of Public Health and Community Medicine, University of New South Wales.

Coomber, B., & Barriball, K. (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. https://doi.org/10.1016/j.ijnurstu.2006.02.004

Cowden, T. L., & Cummings, G. G. (2012). Nursing theory and concept development: A theoretical model of clinical nurses' intentions to stay in their current positions. *Journal of Advanced Nursing*, *68*(7), 1646-1657. https://doi.org/10.1111/j.1365-2648.2011.05927.x.

Cristo, M., Saerang, D. P., & Worang, F. (2017). The influence of price, service quality, and physical environment on customer satisfaction. Case study Markobar Cafe Mando. *Journal EMBA: Jurnal Riset Ekonomi, Manajemen, Bisnis dan Akuntansi*, *5*(2). https://doi.org/10.35794/emba.v5i2.15962

Cronk, R., & Bartram, J. (2018). Environmental conditions in health care facilities in low-and middle-income countries: Coverage and inequalities. *International Journal of Hygiene and Environmental Health*, *221*(3), 409-422. https://doi.org/10.1016/j.ijheh.2018.01.004

Ćulibrk, J., Delić, M., Mitrović, S., & Ćulibrk, D. (2018). Job satisfaction, organizational commitment and job involvement: The mediating role of job involvement. *Frontiers in Psychology*, *9*, 132. https://doi.org/10.3389/fpsyg.2018.00132

Cummings, G., MacGregor, T., Davey, M., Lee, H., Wong, C., Lo, E., Muise, M., & Stafford, E. (2018). Leadership styles and outcome patterns for the nursing workforce and work environment: A systematic review. *International Journal of Nursing Studies*, *85*, 19-60. https://doi.org/10.1016/j.ijnurstu.2018.04.016

Dearie, C., Linhart, C., Rafai, E., Nand, D., Morrell, S., & Taylor, R. (2021). Trends in mortality and life expectancy in Fiji over 20 years. *BMC Public Health*, *21*(1), 1-14.

Degei, S. (2007). *The challenge to Fijian Methodism-the vanua, identity, ethnicity and change* [Unpublished doctoral dissertation]. The University of Waikato.

Denhardt, R. B., Denhardt, J. V., Aristigueta, M. P., & Rawlings, K. C. (2018). *Managing human behavior in public and nonprofit organizations*. CQ Press.

Dilig-Ruiz, A., MacDonald, I., Varin, M. D., Vandyk, A., Graham, I. D., & Squires, J. E. (2018). Job satisfaction among critical care nurses: A systematic review. *International Journal of Nursing Studies*, *88*, 123-134. https://doi.org/10.1016/j.ijnurstu.2018.08.014

Delobelle, P., Rawlinson, J. L., Ntuli, S., Malatsi, I., Decock, R., & Depoorter, A. M. (2011). Job satisfaction and turnover intent of primary healthcare nurses in rural South Africa: A questionnaire survey. *Journal of Advanced Nursing*, *67*(2), 371-383.

Douglas, B. (2013). Rank, power, authority: A reassessment of traditional leadership in South Pacific societies. In *Across the great divide* (pp. 47-86). Routledge. https://doi.org/10.4324/9781315079233

Durie, M. (2004). *An Indigenous model of health promotion*. 18th World Conference on Health Promotion and Health Education. http:/temata.massey.ac.nz/doc/Health Promotion and Health Education.pdf

EE, E. (2018). Job satisfaction among nurses working in mansoura university hospital: Effect of socio-demographic and work characteristics. *Egyptian Journal of Occupational Medicine*, *42*(2), 227-240.

Egger D., Lipson, D., & Adams, O. (2000). *Achieving the right balance: The role of policy-making processes in managing human resources for health problems. Discussion paper 2.* World Health Organization.

Emmer, C., Bosnjak, M., & Mata, J. (2020). The association between weight stigma and mental health: A meta-analysis. *Obesity Reviews*, *21*(1), e12935. https://doi.org/10.1111/obr.12935

Er, F., & Sökmen, S. (2018). Investigation of the working conditions of nurses in public hospitals on the basis of nurse-friendly hospital criteria. *International Journal of Nursing Sciences*, *5*(2), 206-212. https://doi.org/10.1016/j.ijnss.2018.01.001

Eräsaari, M. (2013). *"We are the originals": A study of value in Fiji* [Unpublished doctoral dissertation]. University of Helsinki.

Eric, L., & Biaukula, V. (2012). Patient waiting time in GOPD and SOPD at Nadi Hospital 2012. *Fiji Journal of Public Health,* 1(2), 27-32.

Etikan, I., Musa, S. A., & Alkassim, R. S. (2016). Comparison of convenience sampling and purposive sampling. *American Journal of Theoretical and Applied Statistics*, *5*(1), 1-4.

Fanine, S. (2009, 30 Nov). Health Ministry bids farewell to nursing school. *Fiji Sun Online*. https://fijisun.com.fj/2009/11/30/health-ministry-bids-farewell-to-nursing-school/

Fiji Bureau of Statistics. (2017). *Fiji population and housing census*. Retrieved from http://ghdx.healthdata.org/organizations/fiji-bureau-statistics

Fiji Bureau of Statistics. (2018). *Fiji population and housing census*. Retrieved from http://ghdx.healthdata.org/organizations/fiji-bureau-statistics

Fiji Civil Service. (2017). *Open merit based recruitment and selection guideline*. Retrieved from http://www.education.gov.fj/wp-content/uploads/2018/09/Open_Merit_Based_Recruitment_and_Selection_Guideline-1.pdf

Fiji Civil Service. (2021). *Job evaluation and civil service remuneration guideline.* Retrieved from http://www.mcs.gov.fj/guidelines/JESCRGuideline2021.pdf

Fiji Country Watch. (2016). *2016 country review*. Retrieved from http://www.countrywatch.com/content/pdfs/reviews/B393L3ML.01c.pdf

Fiji Government. (2011). *Nursing decree 2011.* Retrieved from https://www.health.gov.fj/wp-content/uploads/2014/09/17_Nursing-Decree-2011.pdf

Fiji Government. (2013). *New nursing program to boost Fiji's health reform*. Retrieved from https://www.fiji.gov.fj/Media-Centre/News/NEW-NURSING-PROGRAM-TO-BOOST-FIJI%E2%80%99S-HEALTH-REFORMS

Fiji Government. (2017). *Fijian civil service salary bands*. Retrieved from www.fiji.gov.fj/getattachment/3287c799-961b-410b-8421-ff00d4a24e80/FIJIAN-CIVIL-SERVICE-SALARY-BANDS.aspx

Fiji Islands Education Commission/Panel, & Fiji Ministry of Education. (2000). *Learning together: Directions for education in the Fiji Islands*. Government of Fiji, Ministry of Education.

Garner, S. L., Conroy, S. F., & Bader, S. G. (2015). Nurse migration from India: A literature review. *International Journal of Nursing Studies*, 52(12), 1879-1890. https://doi.org/10.1016/j.ijnurstu.2015.07.003

Giddens, J. (2018). Transformational leadership: What every nursing dean should know. *Journal of Professional Nursing*, *34*(2), 117-121. https://doi.org/10.1016/j.profnurs.2017.10.004

Gopalkrishnan, N. (2018). Cultural diversity and mental health: Considerations for policy and practice. *Frontiers in Public Health*, *6*, 179. https://doi.org/10.3389/fpubh.2018.00179

Graneheim, U. H., & Lundman, B. (2004). Qualitative content analysis in nursing research: Concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today*, *24*(2), 105-112. https://doi.org/10.1016/j.nedt.2003.10.001

Hakim, C. (2016). *Key issues in women's work: Female diversity and the polarisation of women's employment*. Routledge-Cavendish.

Hamilton, J. B. (2020). Rigor in qualitative methods: An evaluation of strategies among underrepresented rural communities. *Qualitative Health Research*, *30*(2), 196-204. https://doi.org/10.1177/1049732319860267

Hasan, S. S., Chong, D. W. K., Ahmadi, K., Se, W. P., Hassali, M. A., Hata, E. M., Hadi, M. A., Sridhar, S. B., Ahmed, S. I, Yeah, L. B., & Efendie, B. (2010). Influences on Malaysian pharmacy students' career preferences. *American Journal of Pharmaceutical Education*, *74*(9), 166. https://doi.org/10.5688/aj7409166.

Hassan, R. (2016). New degree program for nurses. *Ministry of Health & Medical Services online*. Retrieved from https://www.health.gov.fj/new-degree-program-for-nurses/

Havea, E. H., Wright, F. T., & Chand, A. (2020). Going back and researching in the Pacific community. *Waikato Journal of Education*, *25*(1), 131-143. https://doi.org/10.15663/wje.v25i0.788

Hegney, D. (1996). The status of rural nursing in Australia: A review. *The Australian Journal of Rural Health*, 4(1), 1-10. https://doi.org/10.1111/j.1440-1584.1996.tb00180.x

Henderson, L., & Tulloch, J. (2008). Incentives for retaining and motivating health workers in Pacific and Asian countries. *BioMed central Human Resources for Health*, *6*(18), 1-20. https://doi.org/10.1186/1478-4491-6-18

Henry, E., & Pene, H. (2001). Kaupapa Maori: Locating indigenous ontology, epistemology and methodology in the academy. *Organization*, *8*(2), 234-242. https://doi.org/10.1177/1350508401082009

Herzberg, F. (2008). *One more time: How do you motivate employees?* Harvard Business Review Press.

Hosseinabadi, M. B., & Etemadinezhad, S. (2018). Evaluating the relationship between job stress and job satisfaction among female hospital nurses in Babol: An application of structural equation modeling. *Health Promotion Perspectives*, *8*(2), 102-108. https://doi.org/10.15171/hpp.2018.13

Hughes, A. (2010). The challenge of contributing to policy making in primary care: The gendered experiences and strategies of nurses. *Sociology of Health & Illness*, *32*(7), 977-992. https://doi.org/10.1111/j.1467-9566.2010.01258.x

Hunter, J. E. (2017). A causal analysis of cognitive ability, job knowledge, job performance, and supervisor ratings. In F. Landy, S. Zedeck, & J. Cleveland (Eds.), *Performance measurement and theory* (e-ed., pp. 257-266). Routledge.

Institute for Health Metrics and Evaluation (IHME) Country Profile. (2019). *Fiji*. IHME, University of Washington. http://www.healthdata.org/fiji

Javed, A., Lee, C., Zakaria, H., Buenaventura, R. D., Cetkovich-Bakmas, M., Duailibi, K., Ng, B., Ramy, H., Saha, G., Arifeen, S., Elorza, P. M., Ratnasignham, P., & Azeem, M. W. (2021). Reducing the stigma of mental health disorders with a focus on low-and middle-income countries. *Asian Journal of Psychiatry*, *58*, 102601. https://doi.org/10.1016/j.ajp.2021.102601.

Jayasuriya, R., Whittaker, M., Halim, G., & Matineau, T. (2012). Rural health workers and their work environment: The role of inter-personal factors on job satisfaction of nurses in rural Papua New Guinea. *BMC Health Services Research*, *12*(1), 156. https://doi.org/10.1186/1472-6963-12-156

Jenaro, C., Flores, N., Orgaz, M. B., & Cruz, M. (2011). Vigour and dedication in nursing professionals: Towards a better understanding of work engagement. *Journal of Advanced Nursing*, *67*(4), 865-875. https://doi.org/10.1111/j.1365-2648.2010.05526.x

Kabeel, A. R. A., & Eisa, S. A. E. M. M. (2017). Relationship between job satisfaction and professional identity among psychiatric nurses. *Egyptian Nursing Journal*, *14*(1), 9-16. https://doi.org/10.4103/2090-6021.206939

Kallio, H., Pietilä, A. M., Johnson, M., & Kangasniemi, M. (2016). Systematic methodological review: Developing a framework for a qualitative semi-structured interview guide. *Journal of Advanced Nursing*, *72*(12), 2954-2965. https://doi.org/10.1111/jan.13031

Kant, R., Varea, R., & Titifanue, J. (2021). COVID-19 vaccine online misinformation in Fiji: Preliminary findings. *Pacific Journalism Review*, *27*(1/2), 47-62. https://doi.org/10.24135/pjr.v27i1and2.1189

Kaplan, M. (1989). Luve Ni Wai as the British saw it: Constructions of custom and disorder in colonial Fiji. *Ethnohistory*, *36*(4), 349-371.

Kaplan, M., & Kaplan, A. (2018). The relationship between organizational commitment and work performance: A case of industrial enterprises. *Journal of Economic and Social Development, 5*(1), 46-50.

Kaspar, A., Pifeleti, S., & Whitfield, B. C. (2020). The measles emergency is over, but the crisis continues–a call to action for the Pacific Islands. *Journal of Global Health*, *10*(2), 020301. https://doi.org/10.7189/jogh.10.020301

Kaur, R., & Singh, B. (2019). Do CEO characteristics explain firm performance in India? *Journal of Strategy and Management, 12*(3), 409-426. https//doi.org/10.1108/JSMA-02-2019-0027

Kealiikanakaoleohaililani, K., & Giardina, C. P. (2016). Embracing the sacred: An indigenous framework for tomorrow's sustainability science. *Sustainability Science*, *11*(1), 57-67.

Klein, M. (2019). Self-determination theory: Basic psychological needs in motivation, development, and wellness. *Sociologicky Casopis*, *55*(3), 412-413.

Koinis, A., Giannou, V., Drantaki, V., Angelaina, S., Stratou, E., & Saridi, M. (2015). The impact of healthcare workers job environment on their mental-emotional health. Coping strategies: The case of a local general hospital. *Health Psychology Research*, *3*(1), 1984. https://doi.org/10.4081/hpr.2015.1984

Kumar, R., Ahmed, J., Shaikh, B. T., Hafeez, R., & Hafeez, A. (2013). Job satisfaction among public health professionals working in public sector: A cross sectional study from Pakistan. *Human Resources for Health*, *11*(1), 1-5. https://doi.org/10.1186/1478-4491-11-2

Lal, B. V. (1980). Approaches to the study of Indian indentured emigration with special reference to Fiji. *The Journal of Pacific History*, *15*(1), 52-70. http://www.jstor.org/stable/25168407.

Lambrou, P., Kontodimopoulos, N., & Niakas, D. (2010). Motivation and job satisfaction among medical and nursing staff in a Cyprus public general hospital. *Human Resources for Health*, *8*(1), 1-9. https://doi.org/10.1186/1478-4491-8-26

Lane, J. E. (2012). Fiji: What kind of nilitocracy? *Japanese Journal of Political Science*, *13*(3), 401-417.

Lasala, K. (2017). Nursing workforce issues in rural and urban settings: Looking at the difference in recruitment, retention and distribution. *Online Journal of Rural Nursing and Health Care*, 1(1), 8-24. https://doi.org/10.14574/ojrnhc.v1i1.499

Laschinger, H. K. S., Finegan, J., Shamian, J., & Wilk, P. (2001). Impact of structural and psychological empowerment on job strain in nursing work settings: Expanding Kanter's model. *Journal of Nursing Administration*, *31*(5), 260-272. https://doi.org/10.1097/00005110-200105000-00006

Lata, S. (2014). Scope of practice for nurses reviewed. *FBC online news*. Retrieved from https://www.fbcnews.com.fj/news/scope-of-practice-for-nurses-reviewed/

Laverack, G. R., & Brown, K. M. (2003). Qualitative research in cross-cultural context: Fijian experience. *Qualitative Health Research*, 13(3), 333-342. https://doi.org/10.1177/1049732302250129

Lawson, S. (1996). *Tradition versus democracy in the South Pacific: Fiji, Tonga and Western Samoa* (No. 2). Cambridge University Press.

Lea, J., & Cruickshank, M. (2015). Supporting new graduate nurses making the transition to rural nursing practice: Views from experienced rural nurses. *Journal of Clinical Nursing*, *24*(19-20), 2826-2834. https://doi.org/10.1111/jocn.12890

Leckie, J. (2000). Women in post-coup Fiji: Negotiating work through old and new realities. In A. H. Akram-Lodhi (Ed.), *Confronting futures in Fiji* (pp. 178-201). ANU Press.

Leckie, J. (2005). The complexities of women's agency in Fiji. In B. S. A. Yeoh, P. Teo, & S. Huang (Eds.), *Gender politics in the Asia-Pacific region* (pp. 168-192). Routledge.

Li, N., Zhang, L., Xiao, G., Chen, J., & Lu, Q. (2019). The relationship between workplace violence, job satisfaction and turnover intention in emergency nurses. *International Emergency Nursing*, *45*, 50-55. https://doi.org/10.1016/j.ienj.2019.02.001

Li, X., Zhang, Y., Yan, D., Wen, F., & Zhang, Y. (2020). Nurses' intention to stay: The impact of perceived organizational support, job control and job satisfaction. *Journal of Advanced Nursing*, *76*(5), 1141-1150. https://doi.org/10.1111/jan.14305

Linhart, C., Tukana, I., Lin, S., Taylor, R., Morrell, S., Vatucawaqa, P., Magliano, D., & Zimmet, P. (2016). Continued increases in hypertension over three decades in Fiji, and the influence of obesity. *Journal of Hypertension*, *34*(3), 402. https://doi.org/10.1097/HJH.0000000000000807

Liu, Y., Aungsuroch, Y., & Yunibhand, J. (2016). Job satisfaction in nursing: A concept analysis study. *International Nursing Review*, *63*(1), 84-91. https://doi.org/10.1111/inr.12215

Lock, M. J., Walker, T., & Browne, J. (2021). Promoting cultural rigour through critical appraisal tools in First Nations peoples' research. *Australian and New Zealand Journal of Public Health*, *45*(3), 210-211. https://doi.org/10.1111/1753-6405.13097

Long, K. A., & Weinert, C. (1999). Rural nursing: Developing the theory base. Scholarly *Inquiry for Nursing Practice: An International Journal*, *13*(3), 113-127.

Lopes, S. C., Guerra-Arias, M., Buchan, J., Pozo-Martin, F., & Nove, A. (2017). A rapid review of the rate of attrition from the health workforce. *Human Resources for Health*, *15*(1), 21. https://doi.org/10.1186/s12960-017-0195-2

Lu, H., Zhao, Y., & While, A. (2019). Job satisfaction among hospital nurses: A literature review. *International Journal of Nursing Studies, 94,* 21-31. https://doi.org/10.1016/j.ijnurstu.2019.01.011

Macpherson, W. (1999). *The Stephen Lawrence inquiry* (Vol. 1). Stationery Office Limited.

Mahgoub, A. E. F., Mostafa Shazly, M., & Mohammed El-sayed, S. (2019). Relationship between work environment and innovative behavior among staff nurses. *Egyptian Journal of Health Care*, *10*(3), 64-77. https://doi.org/10.21608/ejhc.2019.48124

Maslow, A. H. (1943). A theory of human motivation. *Psychological Review, 50*(4), 370.

Masum, A. K. M., Azad, M. A. K., Hoque, K. E., Beh, L. S., Wanke, P., & Arslan, Ö. (2016). Job satisfaction and intention to quit: An empirical analysis of nurses in Turkey. *PeerJ*, *4*, e1896. https://doi.org/10.7717/peerj.1896

McColl-Kennedy, J. R., & Anderson, R. D. (2002). Impact of leadership style and emotions on subordinate performance. *The Leadership Quarterly*, *13*(5), 545-559. https://doi.org/10.1016/S1048-9843(02)00143-1

McKenna, L., Halcomb, E., Lane, R., Zwar, N., & Russell, G. (2015). An investigation of barriers and enablers to advanced nursing roles in Australian general practice. *Collegian*, *22*(2), 183-189. https://doi.org/10.1016/j.colegn.2015.02.003

McNamara, R. A., & Henrich, J. (2018). Jesus vs. the ancestors: How specific religious beliefs shape prosociality on Yasawa Island, Fiji. *Religion, Brain & Behavior*, *8*(2), 185-204. https://doi.org/10.1080/2153599X.2016.1267030

Meo-Sewabu, L. D. (2015). *'Tu ga na inima ka luvu na waqa': (The bail to get water out of the boat is in the boat yet the boat sinks): Yhe cultural constructs of health and wellbeing amongst Marama iTaukei in a Fijian village in Lau and in a transnational Fijian community in Whanganui, Aotearoa* [Unpublished doctoral dissertation]. Massey University.

Meo-Sewabu, L. (2016). 'Na Marama iTaukei Kei Na Vanua': Culturally embedded agency of indigenous Fijian women-opportunities and constraints. *New Zealand Sociology*, *31*(2), 96-122.

Ministry of Civil Service. (2016*). Annual report 2016-2017*. Fiji Government. http://www.parliament.gov.fj/wp-content/uploads/2021/12/192-Ministry-of-Civil-Service-Annual-Report-2016%E2%80%932017.pdf

Ministry of Civil Service. (2017). *Fiji civil service salary bands*. Fiji Government. www.fiji.gov.fj/getattachment/.../FIJIAN-CIVIL-SERVICES-SALARY-BANDS.aspx)

Ministry of Health. (2012). *Ministry of Health annual report*. Government Printer.

Ministry of Health. (2014). *Ministry of Health annual report*. Government Printer.

Ministry of Health. (2015). *Ministry of Health annual report*. Government Printer.

Ministry of Health. (2016). *Ministry of Health annual report*. Government Printer.

Ministry of Health & Medical Services. (2016/2020). *National strategic plan 2016-2020 executive version*. Government Printer.

Ministry of Health & Medical Services. (2017/2018*). Annual corporate plan*. Government Printer.

Moher, D., Liberati, A., Tetzlaff, J., Altman, D. G., & PRISMA Group*. (2009). Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. *Annals of internal medicine*, *151*(4), 264-269.

Osborne, G. (1998). *Kai Loma: An exploratory study of ethnic identity among young part-Europeans in Fiji.* [Unpublished Master of Arts dissertation].

Park, S., Jeong, S., Jang, S., Yoon, S. W., & Lim, D. H. (2018). Critical review of global leadership literature: Toward an integrative global leadership framework. *Human Resource Development Review*, *17*(1), 95-120. https://doi.org/10.1177/1534484317749030

Parliament of the Republic of Fiji. (2019). *Fiji systems of Government*. Retrieved from http://www.parliament.gov.fj/

Pearson, M. L., Upenieks, V. V., Yee, T., & Needleman, J. (2008). Spreading nursing unit innovation in large hospital systems. *Journal of Nursing Administration*, *38*(3), 146-152. https://doi.org/10.1097/01.NNA.0000310726.66160.d0

Pelzang, R., & Hutchinson, A. M. (2017). Establishing cultural integrity in qualitative research: Reflections from a cross-cultural study. *International Journal of Qualitative Methods*, *17*(1), 1609406917749702. https://doi.org/10.1177/1609406917749702

Peterson, S. A., Wolkow, A. P., Lockley, S. W., O'Brien, C. S., Qadri, S., Sullivan, J. P., Czeisler, C. A., Rajaratnam, S. M. W., & Barger, L. K. (2019). Associations between shift work characteristics, shift work schedules, sleep and burnout in North American police officers: A cross-sectional study. *BMJ Open*, *9*(11), e030302. https://doi.org/10.1136/bmjopen-2019-030302

Platis, C., Reklitis, P., & Zimeras, S. (2015). Relation between job satisfaction and job performance in healthcare services. *Procedia-Social and Behavioural Sciences*, *175*, 480-487. https://doi.org/10.1016/j.sbspro.2015.01.1226

Pool, I., Poell, Rob., & Cate, O. T. (2013). Nurses' and managers perception of continuing professional development for older and younger nurses: A focus group study. *International Journal of Nursing Studies*, *50*(1), 34-43. https://doi.org/10.1016/j.ijnurstu.2012.08.009

Prasad, A. (2008). Moving beyond "ethnic" conflict in Fiji: From colonization to the coup of 2006. *International Journal of Social Economics, 35*(2), 951-962. https://doi.org/10.1108/03068290810911480.

Price, S., & Reichert, C. (2017). The importance of continuing professional development to career satisfaction and patient care: Meeting the needs of novice to mid-to late-career nurses throughout their career span. *Administrative Sciences*, *7*(2), 17. https://doi.org/10.3390/admsci7020017

Public Service Commission. (2011). *General order*. Fiji. Retrieved from aifsa-fj.met.gov.fj/qa/Administration/Procedure/Go_Master.pdf

Public Service Commission. (2018). *Fijian civil service open merit recruitment and selection*. Retrieved from http://www.psc.gov.fj/images/2017/OMRS%20Guideline%20April%202018%20%20(2).pdf

Rahman, M. H., & Singh, S. (2011). Towards strong local governance: Current reform scenario in Fiji. *International Journal of Public Administration*, *34*(10), 674-681. https://doi.org/10.1080/01900692.2011.587993

Ratuva, S. (2007). Na kilaka a vaka-Viti ni veikabula: Indigenous knowledge and the Fijian cosmos: Implications on bio-prospecting. In *Pacific genes & life patents: Pacific indigenous experience & analysis of commodification & ownership of life* (pp. 90-101). Call of the Earth Llamado de la Tierra and The United Nations University Institute of Advanced Studies.

Ravula, A. (2016). All doctors employed by government to get pay rise from January 1st, 2017. *Fijilive Online*. Retrieved from fijilive.com/news/All-doctors-employed-by-governement-to-get-pay-rise-from-January-1st-2017-9r25ks/.

Ravuvu, A. (1983). *Vaka i Taukei: The Fijian way of life*. Institute of the Pacific Studies.

Ravuwai, I. (2017). First nursing strategic plans and scope of practice manuals launched. *FijiVillage Live*. Retrieved from https://fijivillage.com/news/First-Nursing-Strategic-Plans-and-Scopes-of-Practice-Manuals-launched-25ks9r

Reisner, S. L., Conron, Scout, K. J., Baker, K., Herman, J. L., Lombardi, E., Greytak, E. A.,Gill, A., M., Matthew, A. K., & GenIUSS Group. (2015). "Counting" transgender and gender-nonconforming adults in health research: Recommendations from the Gender Identity in US Surveillance Group. *Transgender Studies Quarterly*, *2*(1), 34-57. https://doi.org/10.1215/23289252-2848877

Riley, K., Middleton, R., Wilson, V., & Molloy, L. (2021). Voices from the 'resus room': An integrative review of the resuscitation experiences of nurses. *Journal of Clinical Nursing*. https://doi.org/10.1111/jocn.16048

Roelen, C. A. M., Magerøy, N., van Rhenen, W., Groothoff, J. W., Van der Klink, J. J. L., Pallesen, S., Bjorvaten, B., & Moen, B. E. (2013). Low job satisfaction does not

identify nurses at risk of future sickness absence: Results from a Norwegian cohort study. *International Journal of Nursing Studies*, *50*(3), 366-373. https://doi.org/10.1016/j.ijnurstu.2012.09.012

Rokoduru, A. (2008). 11 Transient Greener Pastures in Managed, Temporary Labour Migration in the Pacific. *The International Migration of Health Workers*, *10*, 172.

Ryan, R. M., & Deci, E. L. (2017). *Self-determination theory: Basic psychological needs in motivation, development, and wellness*. Guilford Publications.

Salzman, M. (2005). The dynamics of cultural trauma: Implications for the Pacific nations. In A. J. Marsella, A. A. Austin, & B. Grant (Eds.), *Social change and psychosocial adaptation in the Pacific Islands* (pp. 29-51). Springer.

Saxton, K. A. (2019). *The white is right? The challenge with defining social work in Fiji* [Unpublished doctoral thesis]. Western Sydney University.

Sayes, S. A. (1984). Changing paths of the land: Early political hierarchies in Cakaudrove, Fiji. *The Journal of Pacific History*, *19*(1), 3-20. https://doi.org/10.1080/00223348408572477

Scanlan, J. N., & Still, M. (2019). Relationships between burnout, turnover intention, job satisfaction, job demands and job resources for mental health personnel in an Australian mental health service. *BMC Health Services Research*, *19*(1), 1-11. https://doi.org/10.1186/s12913-018-3841-z

Schluter, J., Seaton, P., & Chaboyer, W. (2011). Understanding nursing scope of practice: A qualitative study. *International Journal of Nursing Studies*, *48*(10), 1211-1222. https://doi.org/10.1016/j.ijnurstu.2011.03.004

Shaikh, A., Bisschoff, C. A., & Botha, C. J. (2017). Identifying factors to measure managerial and leadership competence of business school educated managers. *International Review of Management and Marketing*, *7*(5), 140.

Shaw, S. (2007). *Nursing leadership*. Blackwell Publishing.

Simpson, W. S. (1974). *The part-European community in Fiji*. South Pacific Social Sciences Association.

Smith, L. (2006). *Uses of heritage*. Routledge.

Sofer, M. (2007). Yaqona and the Fijian periphery revisited. *Asian Pacific Viewpoint*, 48(2), 234-249. https://doi.org/10.1111/j.1467-8373.2007.00342.x

Sriratanaprapat, J., Chaowalit, A., & Suttharangsee, W. (2012). Development and psychometric evaluation of the Thai nurses' job satisfaction scale. *Pacific Rim International Research*, 16(3), 175-191.

Strategic Information and Developments. (2010). *Fiji. A 'spy' guide* (Vol. 1). International Business Publications.

Stewart, L. (2007). *How does a clinical governance framework contribute to the changing role of nurse leaders in Fiji?* [Unpublished doctoral dissertation]. James Cook University.

Stewart, L., Usher, K., Nadakuitavuki, R., & Tollefson, J. (2006). Developing the future nurse leaders of Fiji. *Australian Journal of Advance Nursing*, 23(4), 47-51.

Sturmey, R. I., & Edwards, H. E. (1991). *The survival skills training package: Community services and health workforce in rural and remote areas: Needs and recommendations study*. Commonwealth Department of Community Services and Health.

Suma, S., & Lesha, J. (2013). Job satisfaction and organizational commitment: The case of Shkodra municipality. *European Scientific Journal*, *9*(17). https://doi.org/10.19044/esj.2013.v9n17p%25p

Susu, A. (2020). Leong: Scope of practice for nurses shouldn't be limited. *Fiji Times News Online*. Retrieved from https://www.fijitimes.com/leong-scope-of-practice-for-nurses-shouldnt-be-limited/

Tabua, S. (2017). Nurses receive pay increment. *FBC News Online*. Retrieved from fbcnews.com.fj/news/nurses-receive-pay-increment/.

Tadesse, D., Ashagre, M., & Tefera, B. (2016). Job related stress among nurses working in Jimma zone public hospital, South West Ethropie. *BMC Nursing, 15,* 39. https://doi.org/10.1186/s12912-016-0158-2

Tamasese, T. K., Parsons, T. L., Sullivan, G., & Waldegrave, C. (2010). *A qualitative study into Pacific perspectives on cultural obligations and volunteering.* Pacific Section and the Family Centre Social Policy Research Unit.

Tamata, A. T., Mohammadnezhad, M., & Tamani, L. (2021). Registered nurses' perceptions on the factors affecting nursing shortage in the Republic of Vanuatu Hospitals: A qualitative study. *Plos One*, *16*(5), e0251890. https://doi.org/10.1371/journal.pone.0251890

Thaman, K. (2006). Acknowledging Indigenous knowledge systems in higher education in the Pacific Island region. In V. Meek & C. Suwanwela (Eds.), *Higher education, research, and knowledge in the Asia-Pacific region* (pp. 175-184) Palgrave/Macmillan.

Thiong'O, N. W. (1993). *Moving the centre: The struggle for cultural freedoms*. James Currey.

Thornicroft, G., Rose, D., Kassam, A., & Sartorius, N. (2007). Stigma: Ignorance, prejudice or discrimination? *The British Journal of Psychiatry*, *190*(3), 192-193. https://doi.org/10.1192/bjp.bp.106.025791

Tomlinson, M. (2006). Reflexivity, tradition, and power: The work of RR Nayacakalou. *Ethnos*, *71*(4), 489-506. https://doi.org/10.1080/00141840601050684

Tretiakov, A., & Hunter, I. (2021). User experiences of the NZ COVID tracer app in New Zealand: Thematic analysis of interviews. *JMIR mHealth and uHealth*, *9*(9), e26318. https://doi.org/10.2196/26318

Tuckett, A., Winters-Chang, P., Bogossian, F., & Wood, M. (2015). 'Why nurses are leaving the profession… lack of support from managers': What nurses from an e-cohort study said. *International Journal of Nursing Practice*, *21*(4), 359-366. https://doi.org/10.1111/ijn.12245

Tukana, M., Kamunaga, M., Waqa, S., & Glandon, G. (2014). Rapid assessment of the health care on air radio broadcast (2012). *Fiji Journal of Public Health, 3*(1), 1-7.

Tuner, J. W. (1987). *Blessed to give and receive: Ceremonial exchange in Fiji.* University of Pittsburgh-of the Commonwealth System of Higher education. Retrieved from https://www.jstor.org/stable/3773658

Tuner, J. W. (1992). Rituals, habitus and hierarchy in Fiji. *Ethology, 31*(4), 291-302. https://doi.org/10.2307/3773421

Tuwere, I. S. (2002). *Vanua: Towards a Fijian theology of place*. Institute of Pacific Studies, University of the South Pacific.

Ukaidi, C. U. A. (2016). The influence of leadership styles on organizational performance in Nigeria. *Global Journal of Human Resource Management*, *4*(4), 25-34.

United Nations Population Program. (2018). *World population prospects*. *The 2008 revision*. United Nations.

Usher, K., Rabuka, I., Nadakuitavuki, R., Tollefson, J., & Luck, L. (2003). Nursing and the development of nursing education in Fiji. *Australian Journal of Advanced Nursing*, 21(3), 28-31

Vaioleti, T.M. (2006). Talanoa research methodology: A developing position on Pacific Research. *Waikato Journal of Education,* 12, 21-34.

Vakasukawaqa, A. (2017). Salary boost for civil servants. *Fiji Sun*. Retrieved from https://www.press.reader.com/fiji/fiji-sun/2017/20170208/282355449484596

Van der Heijden, B., Brown Mahoney, C., & Xu, Y. (2019). Impact of job demands and resources on nurses' burnout and occupational turnover intention towards an age-moderated mediation model for the nursing profession. *International Journal of Environmental Research and Public Health*, *16*(11), 2011. https://doi.org/10.3390/ijerph16112011

Vudiniabola, A. (2011). *The Fijian diploma of nursing curriculum: An Indigenous case study of a curriculum change* [Unpubished doctoral thesis]. Massey University.

Vudiniabola, A. (2020). *Unique Fiji - Yesterday & today*. SPNF Country Report 2020. Retrieved from http://www.spnf.org.au/pdfs/FIJI_SPNF_Country_Report_2020.pdf

Vunibola, S. (2020). *'E da dravudravua e na dela ni noda vutuni-i-yau': customary land and economic development: Case studies from Fiji.* [Unpublished doctoral dissertation]. Massey University.

Wang, B., & Wang, Y. (2021). Job burnout among safety professionals: A Chinese survey. *International Journal of Environmental Research and Public Health*, *18*(16), 8343. https://doi.org/10.3390/ijerph18168343

Wei, H., Sewell, K. A., Woody, G., & Rose, M. A. (2018). The state of the science of nurse work environments in the United States: A systematic review. *International Journal of Nursing Sciences*, *5*(3), 287-300. https://doi.org/10.1016/j.ijnss.2018.04.010

Western Pacific Region Nursing/Midwifery Databank. (2022). *Country: Fiji*. Retrieved from https://docplayer.net/14607748-Western-pacific-region-nursing-midwifery-databank.html

White, D., Oelke, N. D., Besner, J., Doran, D., Hall, L. M., & Giovannetti, P. (2008). Nursing scope of practice: Descriptions and challenges. *Nursing Leadership-Academy of Canadian Executive Nurses,* *21*(1), 44-57. https://doi.org/10.12927/cjnl.2008.19690

Wiseman, V., Lagarde, M., Batura, N., Lin, S., Irava, W., & Roberts, G. (2017). Measuring inequalities in the distribution of the Fiji Health Workforce. *International Journal for Equity in Health*, *16*(1), 1-8. https://doi.org/ 10.1186/s12939-017-0575-1

World Health Organization. (2006). *The world health report 2006: Working together for health*. Author.

World Health Organization. (2011). *The Fiji Islands health system review*. WHO Regional Office for the Western Pacific.

World Health Organization. (2013). *Global health workforce shortage to reach 12.9 million in coming decades*. Author.

World Health Organization. (2015). *Pacific Open Learning Health Net: improving Pacific health care through e-learning handbook* (No. WPR/2015/DPS/001). WHO Regional Office for the Western Pacific.

World Health Organization. (2016). *World health statistics 2016: Monitoring health for the SDGs sustainable development goals*. Author.

World Health Organization. (2018). *ICD-11 for mortality and morbidity statistics (2018).* Author.

World Health Organization and Ministry of Health. (2012). *Health service delivery profile.* Retrieved from http://www.wpro.who.int/health_services/service_delivery_profile_fiji.pdf

Wu, L. T., Low, M. M. J., Tan, K. K., López, V., & Liaw, S. Y. (2015). Why not nursing? A systematic review of factors influencing career choice among healthcare students. *International Nursing Review*, *62*(4), 547-562. https://doi.org/10.1111/inr.12220

Worldometer. (2022). *Fiji population 2020*. Retrieved from https://www.worldometers.info/world-population/fiji-population/

Yeong, M. L., Ismail, R., Ismail, N. H., & Hamzah, M. I. (2018). Interview protocol refinement: Fine-tuning qualitative research interview questions for multi-racial populations in Malaysia. *The Qualitative Report*, *23*(11), 2700-2713. https://doi.org/10.46743/2160-3715/2018.3412

Yurumezoglu., H., & Kocaman., G. (2016). Predictors of nurses' intentions to leave the organization and the profession in Turkey. *Journal of Nursing Management*, *24*(2), 235-243. https://doi.org/10.1111/jonm.12305

Zhang, T., Xu, Y., Ren, J., Sun, L., & Liu, C. (2017). Inequality in the distribution of health resources and health services in China: Hospitals versus primary care institutions. *International Journal for Equity in Health*, *16*(1), 1-8. https://doi.org/10.1186/s12939-017-0543-9

Zhang, Z. X., Luk, W., Arthur, D., & Wong, T. (2001). Nursing competencies: Personal characteristics contributing to effective nursing performance. *Journal of Advanced Nursing*, *33*(4), 467-474. https://doi.org/10.1046/j.1365-2648.2001.01688.x

Zhu, Y. (2013). A review of job satisfaction. *Asian Social Science*, *9*(1), 293. https://doi.org/10.5539/ass.v9n1p293

Zúñiga, F., Ausserhofer, D., Hamers, J. P., Engberg, S., Simon, M., & Schwendimann, R. (2015). Are staffing, work environment, work stressors, and rationing of care related to care workers' perception of quality of care? A cross-sectional study. *Journal of the American Medical Directors Association*, *16*(10), 860-866. https://doi.org/10.1016/j.jamda.2015.04.012

Appendices

Appendix A: The Fiji Ministry of Civil Service Salary Band. (Approved June 2017)

Band	Step 1 Transitional	Step 1	Step 2	Step 3	Step 4 Mid	Step 5	Step 6	Step 7
A		8,849.10	9,529.80	10,323.95	11,345.00	12,025.70	12,819.85	13,840.90
		4.60	4.95	5.37	5.90	6.25	6.66	7.19
B		10,339.99	11,135.38	12,063.32	13,256.40	14,051.78	14,979.73	16,172.81
		5.37	5.79	6.27	6.89	7.30	7.79	8.41
C		12,081.69	13,011.05	14,095.31	15,489.35	16,418.71	17,502.97	18,897.01
		6.28	6.76	7.33	8.05	8.53	9.10	9.82
D		14,428.13	15,537.98	16,832.82	18,497.60	19,607.46	20,902.29	22,567.07
		7.50	8.08	8.75	9.61	10.19	10.86	11.73
E	17,518.41	19,041.75	20,506.50	22,215.38	24,412.50	25,877.25	27,830.25	30,515.63
F	20,163.22	22,528.74	24,261.72	26,283.53	28,883.00	30,615.98	32,926.62	36,103.75
G	23,942.76	28,605.45	32,038.10	34,707.95	38,140.60	40,429.04	43,480.28	47,675.75
H	28,155.85	34,760.31	37,434.18	40,553.70	44,564.50	47,684.02	51,249.18	56,596.92
I		43,296.63	46,627.14	50,512.74	55,508.50	59,394.10	63,834.78	70,495.80
J		51,132.98	55,066.28	59,655.14	65,555.10	70,143.96	75,388.37	83,254.98
K		59,945.18	64,556.35	69,936.05	76,852.80	82,232.50	88,380.72	97,603.06
L		67,830.20	73,047.91	79,135.24	86,961.80	93,049.13	100,006.07	110,441.49
M		74,710.90	80,457.89	87,162.71	95,783.20	103,445.86	112,066.34	124,518.16

Appendix B: Participant Information Sheet

Date Information Sheet Produced:

26/05/2019

Project Title

Exploring Job Satisfaction of Nurses in Fiji

An Invitation

Bula Vinaka,

My name is Kesaia Tawa Nawaqaliva and I am currently a student at Auckland University of Technology pursuing my Doctoral Degree in Philosophy. I would like to invite you to be part of my research in exploring the motivating factors for nurses in Fiji. The information gathered in this research will hopefully be used by the Fiji Government and Fiji Nursing Organization as a reference for strategic and policy planning towards improving nurses working conditions and salary incentivise. Whether you choose to participate, or not, will neither be an advantage nor a disadvantage to your nursing career.

What is the purpose of this research?

This study anticipates providing nurse leaders and health workforce policy makers with empirical data from which strategies and policies can be developed to help resolve nursing workforce concerns in Fiji, including the continuous migration of nurses to other countries for better pay and professional development. The study results are intended to inform an improvement of both tangible and intangible aspects of job satisfaction, including the community value placed on the work nurses perform, workforce productivity and health service delivery in Fiji.

How was I identified and why am I being invited to participate in this research?

The research investigates job satisfaction of nurses through the comparison of performances from the two main nursing areas which are described as the urban and rural nursing. The criteria outlined for selection focuses mainly on nurses working in the two named areas and have work experience in the field with at least a Diploma/Degree in Nursing qualification. Not included in this research are Nursing supervisors, Nurse Practitioner and Council members of the Fiji Nurses association.

You have been selected because you have accepted the invitation to participate and also because your experience and the geographical location of your work facility

coincides with the research criteria. Your participation will maximise the information needed in meeting the research questions.

How do I agree to participate in this research?

Your participation in this research is voluntary (it is your choice) and whether you choose to participate will neither be an advantage nor disadvantage to you. You can withdraw from the study at any time. If you choose to withdraw from the study, then you will be offered the choice between having any data that is identifiable belonging to you removed or allowing it to be continued and used. However, once the findings have been produced, removal of your data may not be possible.

A consent form will be attached to the end of this information sheet for your agreement should you wish to participate in this research

What will happen in this research?

The research will use the Vanua framework as this will allow the identification of gaps in understanding the different nursing roles in the four areas of nursing in Fiji; as well as highlighting what would maximise their service potential.

The study will explore your work experiences with the hopes to gain knowledge and insight into providing a platform to understand the expected performance of the different nursing areas. The research would also allow true insight into the work that is carried out at ground level, and its association with other factors that would contribute to a more satisfied work force. It would allow country leaders to have a reference towards developing strategies and policies to help resolve nursing issues in Fiji such as the continuous migration to other countries for better pay and professional development.

The face to face interview will be conducted at a location of your choice or a safe environment where you would feel most comfortable to attend. The data collected will only be for the sole purpose of this research.

How will my privacy be protected?

There will be no written names involving you or any other participant, but instead each data will be collected using different code names. Interview would be planned to be held in a quiet safe environment where there would be limited number of disruptions.

In the event of experiencing discomfort or psychological disturbance from the interview, you will be referred to an independent counselling agency for post-interview support. The independent counselling agency is a non-government organization and does not charge for services provided.

The counselling agency is called ‘Empower Pacific’ located at Suva and Lautoka; Ph: 679 7769224

Will I receive feedback on the results of this research?

Yes. As part of achieving credibility with regards to data analysis, feedback of the transcribed interview will be presented back to the participant for verification and confirmation that all information transcribed is accurate and true.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the **Project field Supervisor**, ***Mrs Iloi Rabuka***, email address: iloir@unifi.ac.fj

Phone number: + (679) 664066 / (679) 7452170

Primary Supervisor: *Dr Sandra Thaggard, email address: Sandra.thaggard@aut.ac.nz, phone number*: +64 0274821516

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, Kate O'Connor, *ethics@aut.ac.nz* , +64 921 9999 ext 6038.

Whom do I contact for further information about this research?

Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the research team as follows:

Researcher Contact Details:

Kesaia Tawa Nawaqaliva

knawaqaliva@yahoo.com/ +64 2102963539 /+6798095917

Project Supervisor Contact Details:

Dr Sandra Thaggard

sandra.thaggard@aut.ac.nz

Approved by the Auckland University of Technology Ethics Committee on *type the date final ethics approval was granted*, AUTEC Reference number *type the reference number*.

Appendix C: Invitation to Participate

July 4th, 2019

To whom it may concern

Ni sa Bula Vinaka,

We write to invite all Fijian registered nurses currently working in the Fiji Ministry of Health to take part in our research project. Our research project is about exploring urban and rural nursing roles in Fiji. The different roles of urban and rural nursing in Fiji have always been misunderstood with more attention directed toward the clinical nursing field. This prompted an interest to understand the different work performance of nursing positions which may offer leaders a reference point from which strategies and policies can be developed to help resolve nursing issues in Fiji.

If you are interested to be a willing participant, please contact the Primary Researcher Contact Details:

Kesaia Nawaqaliva knawaqaliva@yahoo.com ph. +679 80951232 or +64 2102963539

This research will provide a platform for nurses and nursing leaders, to understand the work performance of the different nursing positions.

We will need about half an hour to an hour of your time to *Talanoa*. We will provide refreshments and compensation for travel expenses. You will be informed of the findings when we are finished through a catered for dissemination evening. The date and the venue will be given to you closer to the time. If you prefer we can send you out a written copy.

For further information, let Kesaia know through a txt to her phone or email address as noted above.

We look forward to your participation

Vinaka vaka levu

Kesaia Nawaqaliva.

Appendix D: Participant Consent Form

Project title: ***Exploring Job Satisfaction of Nursing in Fiji***

Project Supervisor: ***Dr Sandra Thaggard***

Researcher: ***Kesaia Tawa Nawaqaliva***

○ I have read and understood the information provided about this research project in the Information Sheet dated __/ __/ ____

○ I have had an opportunity to ask questions and to have them answered.

○ I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.

○ I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.

○ I understand that if I withdraw from the study then I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, once the findings have been produced, removal of my data may not be possible.

○ I agree to take part in this research.

○ I wish to receive a summary of the research findings (please tick one): Yes○ No○

Participants signature .....

Participants Name : (Optional).....

Participants Contact Details (if appropriate) :

……..

Date:

Approved by the Auckland University of Technology Ethics Committee on type the date on which the final approval was granted AUTEC Reference number type the AUTEC reference number

Note: The Participant should retain a copy of this form.

Appendix E: Semi Structured Talanoa Questions

The Fiji Nursing Workforce:

1.When did you graduate as a registered nurse and from which institute?
Let us discuss the areas you have worked in and the experiences you have gathered from over the years from each of those field.
b). Were you posted to your current position or volunteered to take up the post, and what has your experience being like since taking up the current posting?

2.How would you describe the difference between urban, peri-urban, rural and remote rural nursing?

3.Can you explain the different core roles for each of the different nursing domain? In answering this question, you can relate to organizational Objectives and vision.
b) are the objectives achievable and why?
c) Explain meeting your individual work plan (IWP), can you discuss these factors from your personal experiences?

4.How do you manage the work capacity in your facility?

5.Some of the common experiences of nurses are burnout and stress due to staff shortages. Can you identify some of the reasons for this experience?
Nursing Recruitment and Retention:

6.There are times when factors will either motivate you or cause dissatisfaction in your work performances. Do you agree that motivational factors measure a nurse's performance, if so, can you discuss some of this factor?

7.Do you feel that you are given any recognition for the work that you perform? If yes-
How has the recognition been presented?

8.In your personal experience, do you feel you have had a personal and professional growth working in the MOH?
b) what other ways do you feel may encourage nurses to remain?

9.Can you describe the nurses current work conditions and how has it influenced the nurses work performances? Such as allowances and leaves, and when have they been last reviewed?

10.Can you list some of the main challenges in delivering quality health services, ranking them to which one comes first? Please also explain the reason for the ranks.

Ministry of Health Workforce and Framework

11.Can you discuss the pathway to promotion, and please discussion your views on the selection criteria?
Such as whether qualification and experience should be considered or should mentoring of a successor suffice?
What other qualification do you hold apart from your Nursing Diploma?
b) having extra qualification or less contributed to more opportunities?
If yes? How-

If No? Why?

12.Have you been offered training and workshops to improve your skills and how often are they been offered?

13.How would you compare your salary and allowance to your colleagues in other nursing domains?
b) and compared to other health personnel working within the organization?

14.Discuss your views on the new government salary scale band, is it effective and do you feel you are paid according to the role that you perform?

15.Mention and discuss some of the things that may affect your performance at workplace?

16.Nursing leadership roles can be very challenging. Do you feel they contribute employees' performances, or not? Please discuss according to qualification and leadership skills.

17.Discuss one Nursing Policy that you feel can be improved to assist in the retention of nurses in Fiji

Appendix F: AUTEC Approval

22 August 2019

Sandra Thaggard
Faculty of Health and Environmental Sciences

Dear Sandra

Re Ethics Application: **19/261 Exploring job satisfaction on nursing in Fiji**

Thank you for providing evidence as requested, which satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEC).

Your ethics application has been approved for three years until 21 August 2022.

Standard Conditions of Approval

1. The research is to be undertaken in accordance with the Auckland University of Technology Code of Conduct for Research and as approved by AUTEC in this application.
2. A progress report is due annually on the anniversary of the approval date, using the EA2 form.
3. A final report is due at the expiration of the approval period, or, upon completion of project, using the EA3 form.
4. Any amendments to the project must be approved by AUTEC prior to being implemented. Amendments can be requested using the EA2 form.
5. Any serious or unexpected adverse events must be reported to AUTEC Secretariat as a matter of priority.
6. Any unforeseen events that might affect continued ethical acceptability of the project should also be reported to the AUTEC Secretariat as a matter of priority.
7. It is your responsibility to ensure that the spelling and grammar of documents being provided to participants or external organisations is of a high standard.

AUTEC grants ethical approval only. You are responsible for obtaining management approval for access for your research from any institution or organisation at which your research is being conducted. When the research is undertaken outside New Zealand, you need to meet all ethical, legal, and locality obligations or requirements for those jurisdictions.

Please quote the application number and title on all future correspondence related to this project.

For any enquiries please contact ethics@aut.ac.nz. The forms mentioned above are available online through http://www.aut.ac.nz/research/researchethics

Yours sincerely,

Kate O'Connor
Executive Manager
Auckland University of Technology Ethics Committee

Cc: knawaqaliva@yahoo.com; Eleanor Holroyd

Appendix G: Fiji Ethical Approval

Fiji National Health Research and Ethics Review Committee

MINISTRY OF HEALTH AND MEDICAL SERVICES

Date: 25/11/2019

Ms Kesaia Tawa Nawaqaliva
Health & Environmental Sciences
New Zealand

Project Title: "Exploring Job Satisfaction of Nurses in Fiji".

FNHRERC Number: 2019.98.MP.

Primary Investigator(s): Ms Kesaia Tawa Nawaqaliva, New Zealand.

Primary- Supervisor(s): Sandy ThaggardHealth, New Zealand.

Dear Ms Kesaia

This is to inform you that the Fiji National Health Research Ethics Review Committee (FNHRERC) has granted scientific, technical and ethical **approval** to your proposal titled *"Exploring Job Satisfaction of Nurses in Fiji"*.

As the Principal Investigator, it is **your responsibility to ensure that all the people associated with this particular project area aware of the conditions of this approval and copy of the final report is also submitted to the Ministry of Health and Medical Services at the conclusion of your project for our records.**

The following conditions apply to your approval. Failure to abide by these conditions may result in suspension or discontinuation of approval and/or disciplinary action.

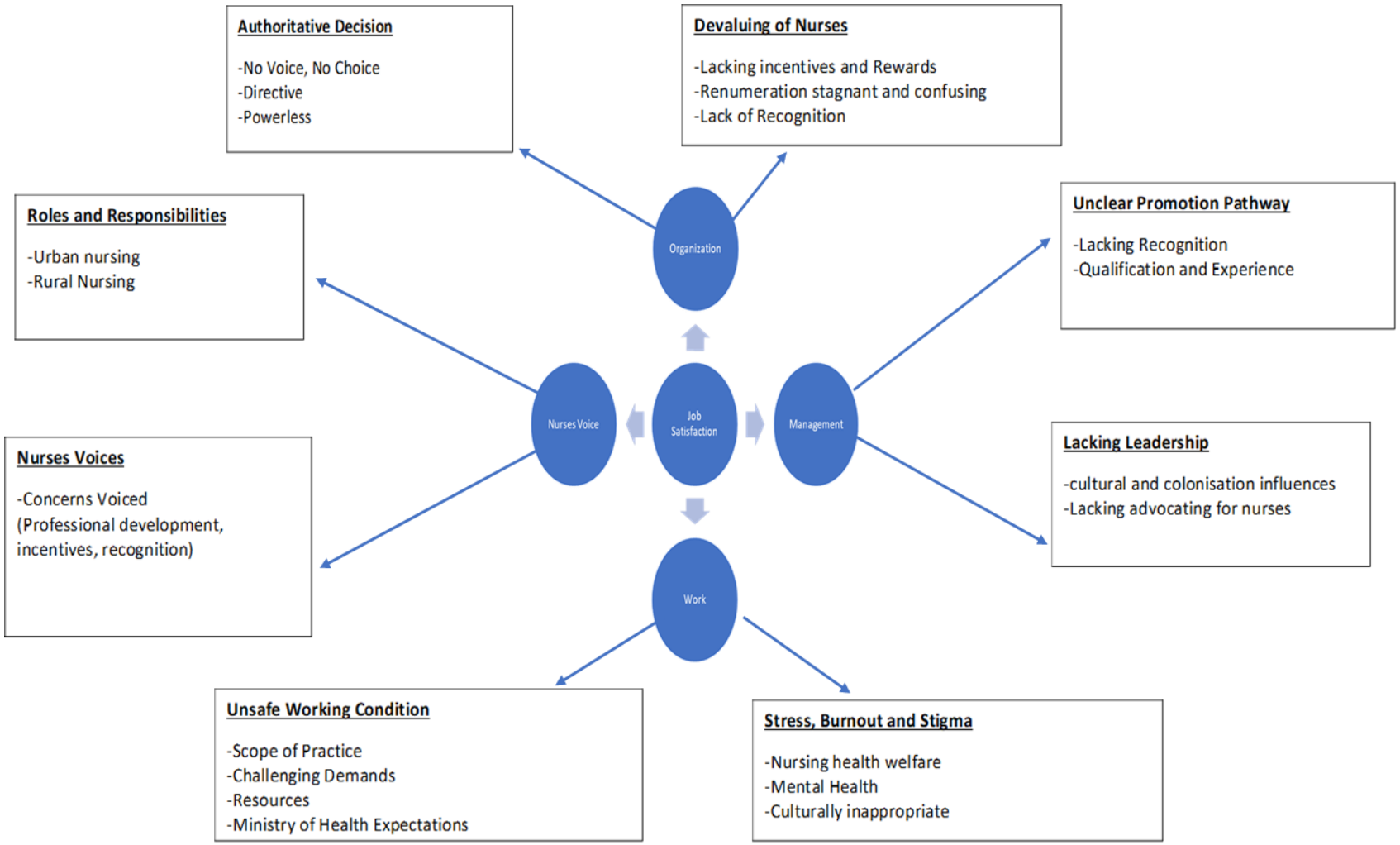
1. **Variation to the project:** Any subsequent variation s or modifications you may wish to make to your project must be notified formally to the Chair, FNHRERC for further considerations and approval. If the Chair considers that the proposed changes are significant, you may be required to submit a new application for approval of the revised project.

2. **Incidence or adverse events:** Researchers must report immediately to the Chair FNHRERC anything which may affect the ethical acceptance of the protocol including adverse effects on subjects or unforeseen events that may affect continued ethical acceptability of the project. Failure to do so may result in suspension or cancellation of approval.

3. **Monitoring:** Projects are subject to monitoring at any time by the Committee.

4. **Annual/Final Report:** You must submit a progress report at 6 months of your study and an annual/final report at the end of the year or at the conclusion of the project if it continues for less than or more than a year. Also you are to present the evidence back to the participating institutions.

Appendix H: Mind Mapping Process



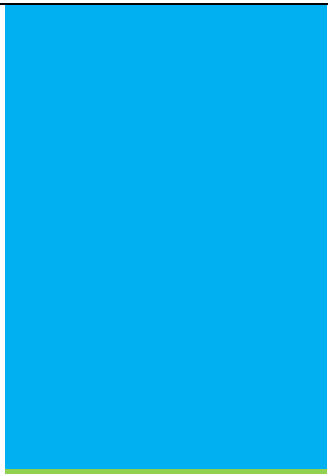
Appendix I: Tabulated Organizational Themes

ORGANIZATION	Summary – Code words from interview (Nurses Talanoa Interview)	Summary (coded words) (FG 1 Talanoa Leaders)	Summary (coded words) (FG 2 Talanoa Government Officials)	Possible Themes	Major Themes
Nursing Posting	•Made the most of the opportunity •Directive from the top •No Choice	-it's always good that you go out to the communities -always good that you go out and taste community nursing -experience then expression of interest that you would like to come back to Divisional	•genuine reason •should be considered •should be a survey waiting to be done •were they happy or how was their performance •feedback to support your reasoning or decision	No Voice, No Choice	
Directive	•Couldn't appeal •Manager's directive •Authoritative decision •Reasons for refusing to go not considered •Sent for counselling or suspension if refused •No voice •Possibility of being posted further away as punishment	-older ones in the Colonial area they have so much passion for nursing -20th Century nurses have changed their values. they have gone through their experience in community health join the workforce they have their values, their goals in their career development having clinical experience enough for them to take them to greener pastures don't see the importance of going back to community and	-should get a choice to select the place - might not perform that well -one of the contributing factors performance - I believe that all the nurses that are interviewed, most said yes nursing is something that they can serve anywhere at any time	Directive	**Authoritative Decision**

		experience Community Health appealing for their positions they have a good ground, good reason to do that they've gone past the experience further greener pastures better opportunities and that could be the reason why they are appealing against the decision to do their tour in their nursing journey.			
Option to appeal	•Initiation process •Victimised for objecting •Some success with exchange basis •Most not approved •Have to go if single •Appeals are restricted •Declined most of the time	I can see the difference between you know how you react towards your patients and sometimes I think you learn a lot being a Community Nurse hospital where they just mainly depend on what's there they can' mainly think outside the box compared to rural nursing	you take into consideration WHY they should move are appealing in the first place they agreed to be a nurse you know becoming a nurse you know within you to come and do nursing come and do nursing and to come and help the people with that I feel that they should be sent to wherever they have to go. Don't object. it's better that they go and experience it how it goes	Option to appeal Victimised and Punished for going against authority	
Recognition from MOH (qualification/extra duties)	•No recognition because pay is still the same •Maritime nurses only get a small allowance for looking	Intensive Care Unit we have keep having protocols that keeps getting reviewed any changes on the drugs	Public health more preventative and Hospital nurse more curative, public health nurse think outside the box- more work responsibilities.	Recognition from MOH (qualification/extra duties). Lack of recognition,	

	after cases 24/7 •Improve salary •Salary band is ineffective	protocol then we are informed Acute Ward we have that IV Drug Policy where we have to get checked by other nurse and they come sign apart from that we IV protocols (.....) drugs which is mostly prepared by doctors. ordered by Doctors and it's a call for the nurses to observe those administrations and documentation together with medications and the treatment chart counter signed and for the first dose will have to be given Policy in place and we have the list of medications we can give Documentation of the treatment chart is given by the Doctor sign the administration or if not pharmacists/doctors will order medications		insufficient pay, appeals are restricted.	
Renumeration	•Working condition •Salary has been stagnant for so long •Huge gap between the work		salary should go with the standardized practiced	Renumeration Salary stagnant, job test confusing, huge	**Devaluing of the nurses**

	that we do and the amount that we are being paid •Job test is confusing •After job test the junior midwives had an increase in salary while the senior midwife's salary remained the same		nurse at work how they refer us to because doctors are still treating us like we're their servants Nursing standard plus the establishment with regards to the Increase in population establishment goes with the working conditions Mental Leave I'm not worried about the ones that are misusing it Also, the working conditions in having the changing room/rest room on their own nursing work now is so heavy because in Fiji we are General nurses we are not specialized we do everything for Public relationship between them and the leaders for them to be great leaders	gap between workload and pay	
Salary Scale Band	•APA assessment is so unfair •Supervisors do not appreciate our work •The assessment is so biased •It depends on the supervisor and how they rate you •A nurse who just finished internship assessed to be in the same level as senior nurses	Unclear pathway on salary band Unclear pathway on promotion process	it's a just a process I don't think it's fair follow the structure in the My APA whatever the Manager say it's done they don't consider that they just look at the paper and they make decisions on it	Salary Scale Band APA determines salary scale, assessment biased, supervisors determine results, last increment 2 years ago	

	•It doesn't even come up to expectation •Pay us according to our roles •Workload •The last increment was 2 years ago •ICU, ED and other specialised areas have the same salary as the general registered nurses though work load is very different				
Is it Effective	•Its not effective •Does not match up •Recent graduate has more salary then senior nurses •Doing so much work but not acknowledged •I don't think its effective •2 years we have been assessed but everything is on hold •It is based on what the supervisor recommends •Bit unfair •I think its just bull crap •One developing competency and it spoils everything •Not effective, no output for it	Loopholes in the open merit system that does not take into consideration all other nursing factors such as area of work and experience.	National level yes depending on the Managers recommendations It's the managers as well they have given you the full competence then they will re-assess again communication is not there it depends on the mood too so when she was not happy with that (blabbering) but as soon as that assessment finished we were being allocated work which was not according to the salary new recruits are getting more than the nurses that we here before we want to move back to the old ways then increment has been done what about the 2nd 3rd one that's unfair to other people	Not effective, nurses not happy, No output	

	•Not happy, in the end-nothing to give us		to progress change in the difference		
Annual performance appraisal (APA) system	•Doing a lot but not recognised •Boss doesn't like you or has something against you •Its up to them whether your pay goes up or remains the same •You should be in the good books of your supervisor •You don't get anything out of the assessment	the service or meeting their needs especially the immediate needs that's quality quality patient care means equipment's, resources, staff personnel, delivery system but in this time there's a lot of challenges in defining this Quality Patient Care and for us nurses we need to be well equipped with skills and knowledge and last the facilities infrastructure system should be up to standard in order to deliver the quality patient care in a efficient delivery system. resources in terms of quality care we're improvising with whatever resources focusing on customer care mostly resources that we cannot be getting consumable beyond our authority	fear that has been implemented by our leader if you don't do this then its insubordination.	Annual performance appraisal (APA) system No results from the assessment, a lot of work is done but not reflected in the assessment	**Absence of Recognition (Devaluing of the nurses)**

Comparison to other health workers	•No difference in the pay •Doing 24hrs compared to hospital nurses doing only 8 hrs am doing more but paid the same •Doctors receive much better pay •4-5 times better than us •It depends on management •The doctors are well supported in their welfare •There is no difference between nurses that doing only clinical nursing compared to those that are doing both clinical and public health.	No rest area or security for safe keeping of the nurse's personal items		Comparison to other health workers Paid the same even though workload and hours are different between clinical and public and work roles.	
Recognition from the Ministry of Health	•Once in a blue moon then recognition is given •No just being transferred to one station and another •Not medal •Only from the community but not from the ministry	Lacking team building programmes to encourage team bonding and improvement of work performances	Authoritative leadership style in workplace	Recognition from the Ministry of Health Once in a blue moon, not from the Ministry	
Nursing Recruitment and Retention	•Give incentives to nurses •Overworked •Nursing staff shortage •Overtime available but discouraged by the long	Motivating factor for nurses to change work environment is mostly money	The salary. working condition currently cost of living is getting high	Nursing Recruitment and Retention No incentives, nurse's grievance ignored,	

	approval process to get paid overtime •Incentives is like boosting manpower •Better working conditions •Listen to our grievances •Take the ministries side instead of the nurse •Need improvement in the working situation •Salary band discussion	Compromised working conditions, increasing customer complains	work is not recognized not given the recognition that they deserve.	issues relating to salary band	
Motivational Factors	•Reward a nurse •A simple thank you •Give something a gift as an acknowledgement •Recognised for the hard work is enough •Pay like experience wise •No incentives •No insurance or protection for the nurses •Government doesn't even help if a colleague is sick •Pay according to IWP •Healthy working environment	before we were paid with night allowance so now even though they're still getting that night shift and they've reduced and when it comes to the 4th of 5th night, they start becoming sick overtime some are not getting paid and you know some nurses are cutting down on their overtime they are not paid well passion to work even though they are paid or not paid overtime as I've said that Nurses have changed the values and they have changed the ways if	Undervalued and invisible in the organisation. Leaves, establishment, salary not reviewed with specialised work areas. consolidative allowance and that is one thing claim their hours of overtime need to write down the time they have been working	Motivational factors Acknowledgement, Recognition, Reward, Insurance	**Incentives and Rewards (Devaluing of the nurses)**

		seeing things their taste and they are more concerned with wants than needs but they love to do overtime just to make money fair commitments so when overtime is limited some of them tend to be aggressive, get rebellious their respond is sick leave, refusing to do another overtime affects the teamwork its advantages and disadvantages at the end of today that question			
Incentives such as leaves	•Routine work •Salary wise yeah it will motivate •Motivational factors such as leave •You are lectured when you request for leave •Managers do not understand •Unutilised leaves can be paid as a motivational incentive •Sick leaves to be paid	Lacking resources to support management decisions	can't take leave or sick leave roster if you have been doing overtime overtime and the old roster they should never go sick leave you are sick so you can't overtime affect a nurse's performance definitely. given to them they play up Punctuality look for nurses to cover overtime was not being paid they mis-use it like even though they're not working they'll be just sitting there claiming hours being biased	Incentives such as leaves Salary, leave, Managers, incentives	

			nurses do overtime and when it's time to claim their hours it's not being processed depends on the supervisor bring everything and pile it on the desk everything is just delaying		
Professional Development	•Only the midwives •Same salary across the board •If lucky maybe just attend to two workshops •Expression of interest if you want to attend a workshop •CNE every Wednesday	Nursing Educator providers should work in correlation with the health organization in the development of speciality field	last minute and the repetition of the certificate by most of the new nurses we don't have the time, our nursing managers didn't send us was a lame excuse done 1 day prior to the arrival of the Council so 20 points not enough for the whole year. I think too 20 points is really less go back there's nothing done there. looking for points and ask any other training I also blame the supervisors fair of whatever field they are specialized in you don't throw any person into any training, CME 's are done that's just much better than in house training rather than sending the officer to attend a training	Limited professional development offered to nurses	

			sake of attending so it doesn't mean anything. I prefer more CME's. go back to 3 months to see that whatever they learnt carry the load.		
Has professional development contributed to more nursing opportunities	•It has remained the same •Nursing promotion and better pay •15 years and salary still the same •Go and study come back system still the same •Pay after studies is still the same •Ministry not sponsoring studies anymore •No pay rise after completely post nursing registration studies	we can't meet with qualifications low experience nurses graduating with bachelor's compared to some experience nurses who we have experienced with bachelor's even though they are not doing these basic nursing not really reflecting in the IWP. IWP's compared to the Junior ones like salary		Has professional development contributes to more nursing opportunities No nursing opportunities	

Appendix J: Tabulated Management Themes

Management	Summary – Code words from interview (Nurses Talanoa Interview)	Summary (coded words) (FG 1 Talanoa Leaders)	Summary (coded words) (FG 2 Talanoa Government officials)	Possible Themes	Major Themes
Pathway to Promotion	•Promotion and performance are based on who you know •Pathway to promotion is very long, months before receiving the results •Don't understand the pathway •Go for the interview but no results •Need both knowledge and experience wise and qualification •Favouritism •They don't go with experience •Not through following the proper channel	Unclear pathway between nursing experience and seniority and qualification Unclear pathway on salary band Unclear pathway on promotion process	Open Merit System does not reflect all the nurses working roles	Unclear pathway, long process, Favouritism, need to consider both knowledge and experience.	**Unclear Promotion Pathway**
Open Merit system	•Open merit is when the posts are advertised •Gives opportunity to everyone •Potential to share knowledge and skill	-The process of job test does not seem applicable to the nursing profession like the clerical offers.	Open Merit System lacking understanding of the nurse's work challenges and experiences not considered.	Advertised and open to anyone to apply, most nurses do not agree with it, considers only qualification, job test	

	•I don't agree with it because we do not recognise our senior nurses •Being demoted to go to the job test •Its just a merit. Look at qualification and not experience •I'm really not satisfied with open merit thing because supervisors do not come around to see and observe what we are really doing	-Cannot compare health workers to office workers -Open Merit system may be influenced by bias management decisions -Selection of an inexperience leader may be lead to low morale of the workers affecting work results and performance			
Professional Development (qualification and experience)	•Anyone can sit for the test •Young person may score higher points because they are strong mentally •Face to face it may be different •People have different ways to express themselves some verbally and some through writing •Senior nurses with so much experience is being demoted •They are not recognised for their years of services	-Nurses should be empowered to take ownership of their professional development -Continuous professional development should be relative to their area of work or area of interest in developing them	Nurses Lacking initiative to improve their professional development -last minute and the repetition of the certificate by most of the new nurses we don't have the time, our nursing managers didn't send us was a lame excuse -done 1 day prior to the arrival of the Council so 20 points not enough for the whole year.	Debatable as younger nurses' stronger points is a written job test compared to senior nurses	

Nursing Leadership Roles	•Need to be qualified in order to be successful •Some leaders did not go through the APA merit thing •If we were to have good leaders good nursing management, I would be willing to work for very less pay. •Greet me every morning with a smiley face that would take me through the day •Most leadership we have is ancient jaded leadership •They need to go for leadership training •Traditional leaders are just really bad, they are so biased •In terms of seniority and that plays a major role in influencing other nurses	Lacking resources to support management decisions	Authoritative leadership style in workplace Yes, fear that has been implemented by our leader if you don't do this then its insubordinate	Willing to work with less pay if the managers are good leaders, ancient, jaded leadership style, biased, culture and seniority plays a role.	
Does Qualification or Experience matter	•Work for 2-3 years before applying for bachelor's degree, apply for masters then get promoted by trade •Prefer more experience wise in the number of years you have worked.	Unclear pathway between nursing experience and seniority and qualification	Open Merit System lacking understanding of the nurse's work challenges and experiences not considered.	Experience is the preference for promotion with qualification, mentoring and leadership background	

	•Promotion through work •Qualification and experience are preferable •Mentoring •Upgrade knowledge in terms of leadership •Open merit system ned to get something out from leadership				
Recognition from Nursing Managers	•No nurse manager has come up to tell me that am doing good work •Never had a manager to come and pat me in the back •Some from previous supervisors •No one is recognising the skills that we have •Don't come down to our level and appreciate us • Not from the managers not from the ministry	Compromised working conditions, increasing customer complains Lacking team building programmes to encourage team bonding and improvement of work performances	-the system is such that you cannot fight against it -listen and take what they give cause if you fight, you'll take the foreign one meeting targets like there's no one to look after our concerns - Unfair working system for the nurse	No recognition from Nurse Managers	**Lacking Leadership**

Contribution to nurses' performances	•If I get a good pay your nursing leader is an 'asshole' then no way nurses would want to stay •Nurse managers attitude towards us •Management contribute to nurse's performance •Management qualification contribute to their attitude •Nurses performance reflects the supervisors also	Lacking resources and infrastructure for improvement of customer services	-they have removed consolidative allowance -only claim overtime see cases after hours -it has to be approved especially in the remote areas.	Nurse managers attitude, pay.	
Communication with Nurse Management	•Culturally we in Fiji we are not allowed to talk back to people in authority	Lacking counselling and social support to the nurses and management team unavailability of counselling and mental health support system	Threatened job security now they can terminate you on the spot Minister is not happy with you they can fire you on the spot a risk regardless of all the years you've been working but they are afraid. Very afraid nothing you know to back us up... your job is just not secure with this Government	Culture has a lot of influence on the way nurses and managers communicate	

Appendix K: Tabulated Work Environment Themes

Working Environment	Summary – Code words from interview (Nurses Talanoa Interview)	Summary (coded words) (FG 1 Talanoa Leaders)	Summary (coded words) (FG 2 Talanoa Government officials)	Possible Themes	Major Themes
Challenges in Meeting Individual Work Plan (IWP)	•Have to look for a boat for the vaccines •No refrigerator to store the vaccines •Damaged refrigerator replaced not supplied •Urban finish the shift forgets about the patient •Rural nursing takes their work home •Manpower, shortage of staff, nurses, shortage in everything •Medicine shortage •Have to walk for look for boat for shift clinics	Nil protocols for working conditions provided such as short-change shifts or call-back policies. Limited resources.	Unsafe working environment	Challenges in Meeting Individual Work Plan (IWP) No boats, no refrigerator in the maritime, late repair	
Challenges in the Maritime	•Nursing Ratio (1:425) in Maritime	Nurses get frustrated in terms of facility consumables that are not available	Devaluing of nurses	Challenges in the Maritime Staffing Ratio, Nurses risk life, no compensation, Risk of extreme events,	

	•Fork out own money to pay for transportation to an emergency •Not reimbursed for using own money •No life jackets when transporting patient across the sea to mainland •High risk to the patient and nurse's life •Not enough equipment's at maritime stations •Cannot take bloods •Solar powered station and only works when the sun is out •No sun (cloudy days) no power •Rough weather out at sea will cancel everything •Lack of drugs •Water problem •Work alone	beyond our control but the thing is when you work and it's almost 70% that during your 8 hours shift you go looking around for things and the turnovers is very fast. Nursing Manager that is quite challenging		isolation, lack of equipment.	

	•Lots of responsibilities in carrying out everything				
MOH Vision and Mission being achievable	•MOH vision and mission not that easy to achieve. •Otherwise No •Most objectives are achievable, but the coverage is not successful. •Cannot meet quality preventative if there are no resources. •Do not have the resource. •Out of stock •Community demands quality services. •General population being spoon feed by the ministry. •The nurses want to do more but have no resources to achieve quality health services. •Spoon feeding patients.	-sick patients nurse patient ratio would have to be considered -work be done but to give the quality patient care that'll be questionable won't be able to meet our targets, achieve the outcomes -not be many hands to do the work and it drains a lot of the energy on the nurses vulnerable to be sick, stressed out, burned out	Challenging working environment	MOH Vision and Mission being achievable Low-quality health care, Spoon Feed. No resources, No quality Service	**Unsafe Working Condition**

	•No medication available the public will complain to the higher levels. •No transport •No manpower to visit community cases				
Work Capacity	•Looks after one of the remote islands with her being alone in the station •Feels isolated •Don't have the luxuries like people in the urban areas •Stand-by for emergencies •See patients' odd hours of the morning. •Need to attend to them •40-45 patients to one nurse •Skip lunch when clinic is busy •Not being compensated •See more than 100 children in a day •Overworked with one manpower	battleground for Nursing Manager because in each unit we don't have the same number of beds and not all hospitals have speciality Lacking resources to support management decisions	Continuous burn out and stress	Work Capacity, Feels alone, isolated, 24/7 on-call, workload, overworked	

	•Don't take lunch or teatime because empathy for the children waiting •Clinic see more than 300-400 patients with maximum of 4-5 nurses.				
Challenges from the Public	Get swears for not providing services. •Stupid budgeting, they order, we are facing the brunt and get swears every day. •Limited resources out-of-stock •Trying to please the public with whatever they announce in the radio •Not providing what the community needs •Even though nurses don't do x-rays but they are the ones that gets the brunt when x-ray are unavailable	Compromised working conditions, increasing customer complains Lacking resources and infrastructure for improvement of customer services	Threatened job security	Challenges from the Public Verbal abuse, Nurse gets blamed for everything by the public	
Causes of Burnout and Stress	Overworked •Supervisors do not understand us.	Lacking team building programmes to encourage team	Challenging working environment	Causes of Burnout and Stress overworked, Management issues, no internet and	

	•They are moody they put everything on us •Overworked and underpaid •Cannot see 30-45 patients in a small amount of time •Stressful being away from home •Work colleague •Burn stress by drinking Kava •Don't have internet for phone connection •Manpower and the number of patients you see in a day •Workload like patient ration •Supervisors being biased •Too much working alone in the station •On call 24/7 •Staff shortage •Patients always complaining •Work environment	bonding and improvement of work performances	phone connection in the nursing stations, geographical environment	

	•Personal grudges •Staff not getting along				
Care of Mental Health	•Talanoa session •Viewed negatively in a cultural level •Grog especially with women of a certain age •Married with kids •Mentality what married women should not do (like having a glass of wine) •Take annual leave for mental health •Victimized if photo taken on destressing on a sick leave day •Family care leave available •Victimized if you voice that you are tired •Education •Pray •Watch a movie on a stressful day	Lacking counselling and social support to the nurses and management team	No mental health and work support	Care of Mental Health Victimised if you voice being tired, culturally inappropriate, Married women cannot have time to themselves	**Stress Burnout and Stigma**

Accessibility to counselling	•Available but not practiced. •Go to church •We don't have a counselling system •No one to talk to •Mental health is off because of stress •Worry about expecting cases that may come early hours of the morning (3am), then cooking dinner •Take own personal leave •Cannot tell a complete stranger over the phone how I am feeling •I don't know the person (counsellor) on the phone •When we grow up, we have someone to talk to like our mum •We are more reserved •We don't voice our grievances we always smile	unavailability of counselling and mental health support system	Stigma and Support	Accessibility to counselling Stigma of attending counselling, have to find own time, more reserved, culturally reluctant to seek help, no counsellors for nursing	

	•We do not show we are going through problems •Don not access counselling because of stigma •Do not utilise the service because of fear that your problems will be known to everyone •Think that counsellors are only for the sick •No special counsellors only for the nurses •Ashamed •More comfortable with family and friends •Choose other people to share problems with like church pastors				
Challenges in Delivering quality health care	•Lack of manpower •Resources •Transportation •Unable to meet quality services.	No rest area or security for safe keeping of the nurse's personal items	System is holding the nurse's performance back because of lack of resources (Failed health care system)	Challenges in Delivering quality health care Lack of resources and manpower that has led to staff frustration, Nurses welfare ignored	

	•Do not have enough resources •Folk out of our own pocket if we want to develop our own skills and knowledge •Staff are frustrated •Requests are not granted •Nurses welfares are ignored •Pantry or a place to rest is not provided	Managers are lacking Sometimes we're biased, discrimination or you might know and that's what affects the decision in recognizing Individuals. Colonial System only the Senior ones will take the cake			
Resources	•Have not been receiving out quarterly supply of medicine. •Salary •Work condition •Patient ratio •Resources out of stock/ shortage of trays	Policies to be reviewed.	Poor working conditions (NO resting place for nurses, no pantry and breast-feeding rooms)	Resources Manpower, work condition, space	**Nursing Work Conditions (Unsafe Working Condition)**

	•No space •No manpower and resources •Nurses from maritime when bring a case to mainland do not even have a shower area •Are not provided with accommodation •Many hours to travel by sea and are still expected to report to work at 8 in the morning •Wait with the patient at the hospital until admission with sometimes 4 hours of sleep •Not compensated for the long add hours •No proper tea room, no food, no fridge, no eating utensils •If we buy our own eating utensils…it gets stolen •No changing room •Nowhere to put our bags or hang our clothes when changing •Working condition		Current Work Conditions in delivering health care working hours does not take into account maritime nurses, accommodation for remote rural nurses when bringing cases across to divisional hospital not provided. No change in working conditions such as change room.	

	•No Privacy •Have placed request for facility cupboards •Still nothing has been done •No water for 2 months •No changing room or tea room •Bags are stolen because no place to keep bags •Sr said no other place •No locker •Breakfast not supplied anymore to morning nurses		Lack of facility maintenance, Lack of water supply in remote rural facilities, Managers ignorant to the improvements needed.	

Appendix L: Tabulated Job Satisfaction Themes

Job Satisfaction	Summary – Code words from interview (Nurses Talanoa Interview)	Summary (coded words) (FG 1 Talanoa Leaders)	Summary (coded words) (FG 2 Talanoa Government officials)	Possible Themes	Major Themes
Understanding of the nursing Roles	•Urban has hospitals/ Divisional Settings •Peri-Urban Sub divisional Hospitals •Health centres and nursing station are more remote areas. •Health centres rural •Nursing stations remote rural	Rural nursing works with far much lesser resources as compared to urban nurses and thus have developed the ability to think outside the box.	Public Health, it's like a big job for them more preventative rather than the curative is like a routine work A Public Health nurse does a lot she's alone hospital nurse is a curative measure Public Health Nurse is a preventive measure	Understanding of the nursing Roles Urban is Divisional and Sub divisional clinical Settings, Rural is remote community setting	**Roles and Responsibilities (Fiji Nursing)**
Responsibilities of the different nursing roles	•Hospital is more curative •Health centres is also part of the hospital •Rural and remote nursing is quiet far •Rural more on health promotion and home visits •They nearly do everything including roles like the maid and health inspectors	More clinical providing secondary health care	She is expected do both doctors work and nurse's work	Responsibilities of the different nursing roles Hospital Curative, Public Health Preventative	

	•Urban mostly deals with in-patients based on doctors' orders •Limited to 8 hours shift •Rural on-call 24hrs for emergency •Work beyond normal hours				
Most voiced working conditions with intent to stay	•Does not have internet connection •Carry water from the tank to the clinic, has been like this 4-5 month •Better to cater for family needs •Need good nursing leaders •Fiji is very poor and get less pay but certain incentives every now and then or a bonus is enough •Housing for shift nurses and maritime nurses •Give housing allowance • Once you look after manpower and human	-Well especially for resources in terms of quality care -Quality Care especially to our patients our customers and focusing on customer care you know we get all these negative comments but then you have to stick to your values - improvising with whatever resources available so that we can deliver high quality care to our patients	-to have push for more nurses -work according to the population increased -get the Nurses Establishment pushed up and get more nurses in.	Most Voiced Working Condition with intent to stay Improve working conditions such as water in remote facility, internet, good leadership, housing allowance, adequate resources to work with.	

	resource, they would obviously would like to stay rather than go abroad.				
Other mentioned factors	•No creche room •Doing much more then what we are being paid for •Expected to do more because of the demands from the ministry •We work with whatever resource we have now that's way above our pay grade •Recognised in what roles such as walking in the sun during the 8 hrs community shift work for those living in difficult geographical terrain and mostly being chased by dogs while surveying the community •If given the recognition they deserve 100% I guarantee less migration •Things that are not allowed can be included in the scope of practice (Like dispensing of	1-don't have the potential to be fully equipped to face the challenges because they are still new to the workforce, -2- the new ones they are going to be stressed out they won't be able to have the energy, stamina during low situations and it can be the source of stress and the source of conflict among the group because things like unfinished job incomplete job vulnerable to errors/mistakes that can happen.	Medical Insurance should be included as well for the welfare of the officers. organization looks after the staff as a family, the Family Care should be there in terms of medical support pay can't be deducted they can't afford it that's why the nurses said no because they were asked to pay when salary is already not enough	Other important factors No creche room, no recognition, improve scope of practice, measure pay according to workload, leadership training, provide counselling services.	**Nurses Voices**

	medication and IV cannulation). •Management being biased •No change rooms at all for the nurses from in clinical and public health nursing facilities •No privacy for the nurses •Remote area they need to be acknowledged for their hard work like walking for miles to conduct their clinics, riding on horse backs, crossing flooded rivers •Being on call 24/7 even on Saturday and Sunday • Good working condition and pay and nurses will be able to consider staying in Fiji.		