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Editorial

Nigerian doctors' willingness to work at COVID-19 treatment center: How does Abraham Maslow's motivation theory explain this finding?

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Between April and June, 2020, Adeniyi *et al*. surveyed a group of 112 doctors (specialists, medical officers, and resident doctors) working at a tertiary hospital in a Nigerian city during a pandemic sensitization and preparedness meeting.[1] According to the authors, only 35% of the surveyed doctors were willing to work in the COVID-19 treatment centers as they perceived themselves not having adequate training, equipment, and compensation. Maslow's theory of human needs embedded with professional growth, skill acquisition, and motivations argue that as human needs are satisfied, they remain intrinsically and extrinsically motivated, explore their latent and inner core, develop their professional capacities, capabilities, and practices, and ultimately attain the state of self-actualization.[2] According to Abraham Maslow, there are five levels of humans needs and human action is grounded in the satisfaction of these unmet needs. At the base of the hierarchy are basic physiological needs, followed in order by safety, social, esteem, and self-actualization needs. The physiological needs include food, shelter, clothing, and water, which to large extent motivate individuals to find a job and use available earnings to provide for self, families, and friends. Having met those basic needs, individuals progress to the second level in Maslow's hierarchy which is safety needs. To stay on the job, health workforce needs security, safety, and protection from work hazards and stress.[2]

PANDEMIC REALITIES, MIGRATION, AND PHYSICIAN WELFARE SYSTEM IN NIGERIA

Frontline medical workers in Nigeria unfortunately struggle to overcome fundamental needs at Maslow level one hierarchy ladder. Poor remuneration and deplorable working conditions have led to massive exodus of doctors. It has been reported that of the 75,000 registered doctors in Nigeria, over 33,000 have migrated to higher income countries to seek better living and working conditions, leaving an underserved health systems with a doctor patient ratio of 1:10,000 as against the recommended 1:600 by the World Health Organization.[3,4] Nigeria has witnessed more than three periods of national doctors' strike over the past 1 year. Major asks from the government include improved working conditions, adequate budgetary allocation for health, and improved pandemic packages for effective response. The findings of Adeniyi *et al*., therefore, may not be shocking in the current system.

ANALYZING GOVERNMENT PANDEMIC PACKAGES FOR THE HEALTH WORKFORCE THROUGH GLOBAL LENS

In August 2020, France recognized the contributions of frontline health workers by announcing monthly raise of USD 208 for nurses and care workers.[5] In African countries such as Ghana and Sierra Leone, pandemic packages for COVID-19 and previous pandemic responses have motivated health care workers (HCWs). In Ghana for instance, the government paid USD 4322 insurance cover for illness or death related to COVID-19 duties, daily allowance of USD 25.6 for contact tracers and tax exemption on monthly salaries for a specific period for frontline workers.[3,4] During the Ebola response in Sierra Leone, team members responsible for interment of Ebola victims earned USD 100 weekly.[4] In contrast, doctors in Nigeria historically receive less than USD 20 monthly as hazard allowance with no upward review in view of the pandemic.[4] Doctors have embarked on industrial strikes to seek implementation of an upward review of the hazard allowance and life/health insurance covers, but, this is yet to be fully actualized.[6] It is obvious that a better remuneration package for doctors and HCW in Nigeria is needed, considering the risks they encounter.[7] At the peak of the 2009 H1N1 influenza pandemic that spread to 26 countries, Imai *et al*. in their survey of HCWs reported that being protected (disease prevention and compensation) by national and local governments and hospital leadership was associated with higher motivation and lower hesitation to work in pandemic treatment centers.[8] Therefore, a whole-system approach that recognizes and compensates the value and contribution of the health workforce to pandemic response is needed at all levels.

PHYSICIANS' STRUGGLE WITH MEETING FUNDAMENTAL NEEDS AND WILLINGNESS TO WORK IN PANDEMIC RESPONSE

Maslow further emphasized social needs as the third step in the hierarchy of needs. Many doctors who work on the frontline have limited contact with families and friends during pandemics bringing to the fore another consequence of being a frontline worker. Although not addressed by Adeniyi *et al*., there is a need for an organizational culture that promotes staff bonding to reduce social isolation and adverse mental health consequences. Maslow also described esteem needs and, in this context, includes trainings, scholarships, and recognition. Adeniyi *et al*. reported that doctors felt ill-equipped to manage infectious disease like COVID-19 and required trainings on Infection Prevention and Control (IPC). This was noteworthy considering that the institution for this study had experience in the management of Lassa fever as one of the designated treatment centers in the country. Adeniyi *et al*. reported that 62.3% of surveyed doctors reported the need for additional training to influence their willingness to work in COVID-19 treatment centers. Challenges in accessing training funds have been reported in Nigeria.[9] However, the Nigerian Center for Disease Control escalated its IPC training program across Nigeria during this pandemic and the current situation regarding IPC training needs is likely to have changed. Australia which is globally acknowledged to have mounted one of the most effective pandemic responses prioritized IPC training for health workers to improve their confidence in the pandemic response.[10]

To improve the esteem of health workers during this pandemic, some countries have introduced a variety of measures to support and recognize health workers and encourage them in their service. Such measures include well-being and mental health initiatives, salary increases and bonuses, childcare services, free transportation, and continuous professional development credits and free lodging.

CONCLUSION

Several lessons could be learnt from the findings of Adeniyi *et al*., with far-reaching implications for pandemic policy and practices in Nigeria and possibly other African countries. The extent to which the government provides fundamental and higher order needs including mental well-being and esteem needs for HCWs will shape the future of pandemics in Nigeria with long-term effect on sustainability of the health workforce. We, therefore, call on the Nigerian government to embrace Maslow's ideas and review existing processes and policies around health worker training and welfare. This is the time to begin preparations for the next pandemic by laying the foundation of a well-motivated workforce.

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