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Determinants of job dissatisfaction among nurses in two general hospitals in the Kongo Central Province of the DRC

Muzingu, K. A.[1,2], Ramazani, B. E. I.[3,4,5], Mukuna, B.[6], Ngbolua, K. N.[7,8], & Mabakutuvangilanga, N. S.-D.[1,3,4,9]

[1]*Doctoral School, Higher Institute of Medical Techniques of Kinshasa, Kinshasa, Democratic Republic of the Congo* [2]*Department of General Care, Nursing Sciences Section, Higher Institute of Medical Techniques of Kisantu, Kongo Central, Democratic Republic of the Congo* [3]*Research Center in Nursing Sciences, Higher Institute of Medical Techniques of Kindu, Kindu, Maniema Province, Democratic Republic of the Congo* [4]*University Research School in Nursing Sciences, Education and Health Practices Laboratory (LEPS), (EA 3412), UFR SMBH, Sorbonne Paris Nord University, Bobigny, France* [5]*Nursing Sciences Section, Higher Institute of Medical Techniques of Kindu, Kongo Central, Democratic Republic of the Congo* [6]*Department of Health Sciences, National Pedagogical University, Kinshasa, Democratic Republic of the Congo* [7]*Department of Biology, Faculty of Science and Technology, University of Kinshasa, Kinshasa, Democratic Republic of the Congo* [8]*Research Center in Pharmacopoeia and Traditional Medicine, Higher Institute of Medical Techniques of Kinshasa, Kinshasa, Democratic Republic of the Congo* [9]*Department of Nursing Sciences, Higher Institute of Medical Techniques of Kinshasa, Kinshasa, Democratic Republic of the Congo*

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Correspondence to:
Dr. Mabakutuvangilanga N. Simon-Décap
decapntela@gmail.com

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ABSTRACT

Introduction
Professional satisfaction among nurses is a critical factor in ensuring the highest quality of clinical care. In the Democratic Republic of Congo (DRC), operational and working conditions for nursing personnel remain structurally deficient. However, there is a pronounced lack of analytical studies identifying the exact organizational and clinical determinants of nurses' job dissatisfaction in this territory, presenting an important gap in health services literature.

Purpose
This study aimed to identify the micro-level and macro-level organizational determinants influencing job dissatisfaction among nurses in the Kongo Central province of the DRC.

Methods
A multi-center, cross-sectional analytical quantitative design was deployed in two referral hospitals within the Kongo Central province. Utilizing an exhaustive census sampling methodology, 90 registered nurses were enrolled. Data collection was performed via a secure, structured digital questionnaire utilizing KoboCollect. Statistical analyses comprised descriptive metrics, bivariate analysis ($p < 0.05$), and a multivariate logistic regression model to isolate independent predictors of professional dissatisfaction.

Results
The descriptive analysis revealed an overall job dissatisfaction rate of 64.4% (yielding a satisfaction rate of only 35.6%). Bivariate analyses identified several operational factors significantly associated with professional dissatisfaction: lack of open communication ($p = .020$), unmanageable workload ($p < .001$), insufficient rest periods ($p < .001$), low workplace autonomy ($p < .001$), weak institutional leadership ($p = .014$), disregard for nurses' opinions ($p = .001$), inadequate nursing staff numbers ($p < .001$), workplace safety deficits ($p < .001$), and poor physical environmental conditions ($p < .001$). The multivariate logistic regression model isolated four primary independent determinants of job dissatisfaction: insufficient rest periods (OR = 21.99; 95% { CI } [3.45, 140.12]; $p = .001$), unmanageable patient volume (OR = 20.35; 95% { CI } [3.11, 133.05]; $p = .002$), excessive physical/mental workload (OR = 6.16; 95% { CI } [1.41, 26.90]; $p = .015$), and lack of management consideration for nurses' professional opinions (OR = 14.03; 95%{ CI } [1.46, 134.84]; $p = .022$).

Conclusion
The primary determinants of job dissatisfaction among nurses are fundamentally rooted in remediable organizational and structural factors. These findings highlight an urgent need for strategic healthcare policy modifications in the DRC, including the formal regulation of shift schedules, mandatory minimum rest allocations, workload balancing, and the integration of participatory governance systems.

INTRODUCTION

Nurses' job satisfaction is a structural prerequisite for achieving optimal quality of care, sustaining patient safety profiles, and maintaining institutional stability. Working conditions in clinical environments encompass not only material provisions and physical infrastructure but also broader structural, organizational, relational, and psychosocial climates (Fallahnezhad et al., 2023). Globally, frontline nursing personnel frequently encounter heavy workloads that cause systematic stress, psychological distress, and systemic burnout, which can compromise essential clinical duties such as maintaining direct patient hygiene and therapeutic surveillance (Gustafsson & Hemberg, 2022; Lasater et al., 2025).

Maintaining an equitable, evidence-based workload is essential; excessive acute care demands significantly degrade professional satisfaction while exponentially escalating the risk of adverse clinical outcomes (Kutney-Lee et al., 2021). Furthermore, the integration of flexible scheduling paradigms functions as an operational mechanism that enables nurses to balance professional obligations with domestic demands, thereby mitigating workplace stress and improving organizational retention (Turnbach et al., 2024). Conversely, poorly designed shift rotations, uncompensated overtime, and frequent nocturnal shifts severely disrupt biological circadian rhythms, causing chronic fatigue, cognitive lapses, and deep-seated career dissatisfaction (Chen et al., 2022). Environmental conditions—including workplace hygiene, structural safety protocols, and the availability of functional clinical equipment—are vital to nursing well-being and clinical efficacy (Lasater et al., 2025). A supportive, collaborative, and professional work environment, where nursing staff feel validated by peers and direct supervisors, contributes significantly to mitigating turnover intent (Nsimba et al., 2025). Furthermore, involving nurses in institutional decision-making processes enhances their professional autonomy, role clarity, and sense of recognition, which directly improves institutional engagement (Côté, 2022).

Despite global insights into healthcare human resource dynamics, a significant contextual gap remains in the scientific literature. While the structural predictors of professional dissatisfaction are well-documented within high-income Western healthcare models, the specific operational determinants driving dissatisfaction within the sub-Saharan African context—particularly within the Kongo Central province of the Democratic Republic of Congo (DRC)—remain critically underexplored (Nsimba et al., 2025). These regional structural challenges directly impact the daily operational realities of frontline healthcare providers. This necessitates context-specific, localized research to inform regional public health directors, healthcare managers, and policymakers on strategies to optimize low-resource healthcare delivery systems. Although general descriptive reports have highlighted broader systemic deficits in the DRC, no dedicated analytical research has isolated the explicit organizational and psychosocial determinants of job dissatisfaction within the general referral hospitals of Kongo Central (Nzuanda et al., 2025).

To establish an analytical baseline, this study is grounded in Herzberg's Two-Factor Theory of Job Motivation and Satisfaction (Alrawahi et al., 2020). This theoretical framework is highly effective for examining health human resource challenges because it distinguishes between extrinsic "hygiene" factors (the working environment, administrative policies, interpersonal relationships, and compensation, which prevent dissatisfaction when optimized) and intrinsic "motivator" factors (recognition, professional autonomy, and advancement, which actively cultivate job satisfaction). This model is highly relevant to the contemporary DRC healthcare context, where extreme organizational and resource constraints severely degrade basic hygiene factors, while top-down, non-participatory management systems simultaneously suppress essential intrinsic motivators.

Accordingly, this study operationalizes Herzberg's framework by mapping specific institutional attributes: the hygiene dimension comprises shift flexibility, physical workload, structural working conditions, institutional safety, and supervisor recognition; the motivator dimension targets clinical autonomy, peer collaboration, and participation in institutional feedback loops. The objective of this study was to identify the independent organizational, structural, and psychosocial determinants of job dissatisfaction among nurses working within two

general referral hospitals in the Kongo Central province of the DRC.

METHODS

Study Design

This study utilized a multi-center, analytical cross-sectional quantitative design. This epidemiological approach allows for data collection at a singular point across multiple clinical institutions, providing an analytical framework to evaluate the strength of association between specific independent organizational exposures and the dependent binary health workforce outcome (job dissatisfaction) (Muamba, 2024).

Research Setting

The investigation was conducted across two distinct healthcare facilities located within the Kongo Central province of the Democratic Republic of Congo:

1. **Saint Luc General Referral Hospital** (located in Kisantu, serving an urban/peri-urban demographic catchment).
2. **Sainte Julie-Billiart General Referral Hospital** (located in Ngidinga, serving a predominantly rural demographic profile).

The selection of these specific institutions provided a diverse sample across different geographic and resource settings within the regional health zone.

Population and Sampling Technique

The target population comprised all actively practicing registered nurses deployed within the clinical sub-departments (including Internal Medicine, Pediatrics, Surgery, Obstetrics/Gynecology, and Emergency Care) of both selected hospitals. Given the finite size of the eligible institutional workforce, an **exhaustive sampling methodology (census)** was implemented to eliminate selection bias and capture all eligible personnel (Schwalbe-Koda et al., 2025). To fulfill the inclusion criteria, participants were required to:

- Provide written informed consent.
- Hold a minimum of six months of continuous professional experience within their respective facility.
- Be actively rostered and present during the designated data collection window.

Out of the total baseline workforce pool across both institutions, 90 nurses met all criteria and were included in the final analytical cohort.

Data Collection Technique and Tool

The primary research instrument was a multi-component structured questionnaire adapted from validated instruments measuring health workforce environments, customized to map directly to the hygiene and motivator constructs of Herzberg's Two-Factor framework (Alrawahi et al., 2020). The instrument was organized into two primary blocks:

i. **Sociodemographic Profiles:** Mapping age, sex, marital status, professional grade, operational facility, and years of experience.

ii. **Operational and Workplace Attributes:** Sectioned into **Hygiene Factors** (comprising 14 clear items evaluating shift patterns, weekly service hours, perceived physical/mental workload, rest area infrastructure, career advancement, and safety indicators) and Motivator Factors (comprising 11 clear items evaluating clinical autonomy, participation in organizational decisions, management recognition, and peer collaboration).

Responses were evaluated using structured scales to evaluate workplace adequacy and agreement.

Validity and Reliability of the Instrument

To ensure linguistic clarity and face validity, a formal pre-test was executed with five registered nurses practicing at Nsonankulu Hospital in Mbanza-Ngungu; these personnel were excluded from the final study sample. The pre-test identified minor ambiguities in item phrasing, which were revised to optimize comprehension (Chen et al., 2022). Internal reliability was assessed using Cronbach's alpha (alpha), which yielded an overall instrument coefficient of .91, demonstrating excellent internal consistency and scale reliability (Bourque et al., 2019).

Bias Mitigation Strategies

Cross-sectional institutional research is vulnerable to selection bias, recall bias, and social desirability bias. To minimize these limitations:

- Participation was strictly voluntary, and zero institutional penalties were associated with non-participation.
- Total identity masking and anonymity were maintained throughout the dataset.
- The digital questionnaires were entirely self-administered on handheld mobile devices without the presence of senior nursing supervisors or hospital administrators, minimizing social desirability and institutional coercion (Kawabata et al., 2024).

Data Collection Process

Field data collection was executed electronically using KoboCollect software installed on encrypted mobile devices (Marc et al., 2023). Completed question modules were synchronized daily to a secure, password-protected cloud server, which eliminated data loss and optimized data cleaning protocols (Genet et al., 2025). Restrictive access controls ensured that only the principal investigator and the study coordinator could access the primary database.

Statistical Analysis

Cleaned datasets were exported to IBM SPSS Statistics Version 26.0 for window environments for formal statistical analysis. Categorical and demographic variables were processed using descriptive frequencies and percentage proportions. In the bivariate analysis stage, Pearson's Chi-square (χ^2) tests and Fisher's exact tests were calculated to evaluate associations between independent workplace variables and the binary outcome of job dissatisfaction.

To isolate independent predictors while controlling for confounding variables, all significant factors identified during bivariate testing were entered into a multivariate logistic regression model using a backward stepwise selection process. Adjusted Odds Ratios (ORs) and their corresponding 95% Confidence Intervals (CIs) were calculated. The threshold for statistical significance was established a priori at $p < .05$.

Ethical Considerations

Ethical clearance and formal protocol approval were granted by the Institutional Ethics Committee of ISTM Kinshasa (Approval No. 165/ESU/CBE/ISTM/KIN/RDC/PBBL/2025).

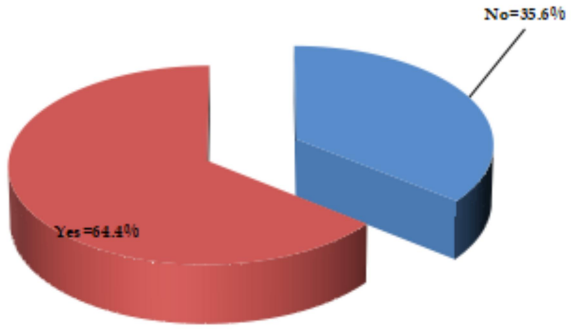
Administrative authorization was obtained from the medical directors of both referral hospitals. Absolute confidentiality was maintained for all participants. The data were secured on encrypted storage media, utilized exclusively for this academic investigation, and handled in strict accordance with the ethical tenets of the Declaration of Helsinki (World Medical Association, 2025).

RESULTS

Prevalence of Job Dissatisfaction

Descriptive processing of the primary outcome variable indicated that the overall prevalence of job dissatisfaction among the surveyed nursing cohort was 64.4% (n = 58), leaving a professional satisfaction rate of only 35.6% (n = 32) **(Figure 1)**.

Figure 1:
Job Dissatisfaction Status Among Surveyed Nurses



Sociodemographic Factors and Job Dissatisfaction

Bivariate evaluation crossed job dissatisfaction across core sociodemographic characteristics **(Table 1)**. No statistically significant associations were found for age, sex, marital status, or professional tenure ($p > .05$). Sociodemographic profiles did not significantly influence job dissatisfaction within this cohort.

Table 1:
Study of job satisfaction according to sociodemographic characteristics

Sociodemographic characteristics	Job Dissatisfaction: No (n=58)	Job Dissatisfaction: Yes (n=32)	Total	χ2	OR (95% CI)	p
Age Groups				3.08		.543
Under 25 years	3	1	4		0.03 (0.03–3.58)	
25 to 34 years	22	15	37		0.29 (0.03–2.74)	
35 to 44 years	17	9	26		0.38 (0.04–3.77)	
45 to 54 years	11	7	18		0.31 (0.03–3.24)	
55 years and above	5	1	6		1.00 (Reference)	
Gender				2.91		.088
Male	25	8	33		0.44 (0.16–1.14)	
Female	33	24	57		1.00 (Reference)	
Marital Status				3.99		.262
Single	24	17	41		1.99 (0.83–4.79)	
Married	34	15	49		1.00 (Reference)	
Contract Type				1.88		.870
Under Contract	39	21	60		0.81 (0.33–2.00)	
Under Status	19	11	30		1.00 (Reference)	
Departments				5.86		.555
Surgery	13	4	17		0.41 (0.08–2.09)	
Gynecology & Obstetrics	6	5	11		1.34 (0.39–4.65)	
Physiotherapy	2	0	2		0.63 (0.54–0.74)	
Internal Medicine	10	8	18		1.60 (0.55–4.57)	
Orthopedics	3	3	6		1.89 (0.36–9.99)	
Pediatrics	21	12	33		1.05 (0.43–2.58)	
Emergency / Intensive Care	4	2	6		1.00 (Reference)	

Analysis of Hygiene Factors

Bivariate cross-tabulations focusing on structural hygiene components revealed strong associations with job dissatisfaction **(Table 2)**. Specifically, excessive weekly service hours (OR = 11.50, p = .002), unmanageable workloads (OR = 9.07, p = .001), and unmanageable patient volume (OR = 5.06, p = .006) were strongly associated with dissatisfaction. Deficits in workplace rest areas (OR = 5.77, p = .002), limited professional development opportunities (OR = 4.40, p = .002), and poor physical safety conditions (OR = 4.01, p = .029) were also significantly associated with higher dissatisfaction rates. Conversely, a favorable work-life balance functioned as a significant protective factor against job dissatisfaction (OR = 0.24, p = .002).

Table 2:
Relationship Between Working Conditions, Work-Life Balance, and Job Dissatisfaction

Variables	Job Dissatisfaction: No (n=58)	Job Dissatisfaction: Yes (n=32)	Total	χ2	OR (95% CI)	p
Work-Life Balance Factors						
Flexible Schedule				3.44		.063
No	26	8	34		2.43 (0.15–1.06)	
Yes	32	24	56		1.00 (Reference)	
Organizational Change Communication				4.31		.038
No	35	12	47		2.54 (1.04–6.17)	
Yes	23	20	43		1.00 (Reference)	
Open Communication with Management				5.43		.020
No	33	10	43		2.90 (1.17–7.21)	
Yes	25	22	47		1.00 (Reference)	
Manageable Number of Patients				12.29		.006
No	45	13	58		5.06 (1.98–12.92)	

Variables	Job Dissatisfaction: No (n=58)	Job Dissatisfaction: Yes (n=32)	Total	χ2	OR (95% CI)	p
Yes	13	19	32		1.00 (Reference)	
Acceptable Weekly Service Hours				25.34		.002
No	46	8	54		11.50 (4.14–31.95)	
Yes	12	24	36		1.00 (Reference)	
Reasonable Workload				20.84		.001
No	49	12	61		9.07 (3.31–24.87)	
Yes	9	20	29		1.00 (Reference)	
Working Conditions Factors						
Workplace Safety				4.74		.029
No	17	3	20		4.01 (1.08–14.96)	
Yes	41	29	70		1.00 (Reference)	
Adequate Break Rest Conditions				14.27		.002
No	45	12	57		5.77 (2.24–14.85)	
Yes	13	20	33		1.00 (Reference)	
Work-Life Balance Challenges				6.33		.012
No	22	21	43		0.32 (0.13–0.79)	
Yes	36	11	47		1.00 (Reference)	
Work Impact on Personal/Family Health				9.72		.002
No	20	22	42		3.52 (1.42–8.70)	
Yes	38	10	48		1.00 (Reference)	
Career Development Opportunities				9.31		.002
No	32	7	39		4.40 (1.64–11.78)	
Yes	26	25	51			

Bivariate analysis of physical/mental stress indicators and supervisor support roles confirmed that high psychophysical stress profiles significantly increased job dissatisfaction (OR = 19.15, p < .001; Table 3). Conversely, low emotional exhaustion functioned as a clear protective factor (OR = 0.27, p < .001). A lack of professional recognition from administrative supervisors (OR = 4.35, p = .020) and an absence of formal leadership training for nurse managers (OR = 3.21, p = .014) were also significantly associated with job dissatisfaction.

Table 3:
Analysis of Professional Dissatisfaction Concerning Workload and Autonomy in Work Organization

Variables	Job Dissatisfaction: No (n=58)	Job Dissatisfaction: Yes (n=32)	Total	χ2	OR (95% CI)	p
Workload Factors						
Emotional and Mental Burden				15.96		< .001
No	2	11	13		0.27 (0.19–0.39)	
Yes	56	21	77		1.00 (Reference)	
Manageable Complexity / Urgency				18.14		< .001
No	27	1	28		0.49 (3.45–211.23)	
Yes	31	31	62		1.00 (Reference)	
Sufficient Time for Quality Care				16.06		.002
No	22	0	22		0.53 (0.22–1.30)	
Yes	36	32	68		1.00 (Reference)	
Workload Stress				6.73		.009
No	12	15	27		0.30 (0.12–0.77)	
Yes	46	17	63		1.00 (Reference)	
Workload Adjustability				4.56		.090
No	1	4	5		0.12 (0.01–1.12)	
Yes	57	28	85		1.00 (Reference)	
Workload Negatively Impacts Health				19.73		< .001
No	5	16	21		19.15 (3.95–92.73)	
Yes	53	16	69		1.00 (Reference)	

Staff Recognition Factors						
Acknowledged by Management				5.40		.020
No	18	3	21		4.35 (1.17–16.16)	
Yes	40	29	69		1.00 (Reference)	
Alignment with Institutional Values				3.20		.149
No	9	1	10		5.69 (0.69–47.14)	
Yes	49	31	80		1.00 (Reference)	
Leadership / Management Training				6.03		.014
No	30	8	38		3.21 (1.24–8.31)	
Yes	28	24	52		1.00 (Reference)	
Continuous Professional Development				1.56		.212
No	24	9	33		1.80 (0.71–4.57)	
Yes	34	23	57		1.00 (Reference)	

Analysis of Motivator Factors

Evaluating intrinsic motivators confirmed that non-participatory management environments significantly increased job dissatisfaction **(Table 4)**. Excluding nurses' opinions from operational governance increased the risk of dissatisfaction by more than eightfold (OR = 8.33, p = .002). Similarly, the absence of active feedback loops (OR = 7.32, p = .005) and poor institutional conflict management (OR = 10.81, p = .015) were strongly associated with higher dissatisfaction rates.

Table 4:
Analysis of Job Dissatisfaction Based on Professional Relationships, Workplace Collaboration, and Autonomy

Variables	Job Dissatisfaction: No (n=58)	Job Dissatisfaction: Yes (n=32)	Total	χ2	OR (95% CI)	p
Professional Relationships						
Support from Management				3.83		.050
No	18	4	22		1.78 (0.73–4.35)	
Yes	40	28	68		1.00 (Reference)	
Good Relations with Colleagues				1.31		.252
No	1	2	3		0.26 (0.02–2.99)	
Yes	57	30	87		1.00 (Reference)	
Good Relations with Management				4.48		.070
No	11	1	12		7.26 (0.89–59.10)	
Yes	47	31	78		1.00 (Reference)	
Workplace Social Support				4.11		.078
No	16	3	19		3.68 (0.98–13.79)	
Yes	42	29	71		1.00 (Reference)	
Effective Conflict Management				7.29		.015
No	15	1	16		10.81 (1.36–86.21)	
Yes	43	31	74		1.00 (Reference)	
Work Collaboration						
Positive Work Atmosphere				2.37		.129
No	4	1	5		2.37 (0.25–22.14)	
Yes	54	32	86		1.00 (Reference)	
Transparent Peer Communication				3.27		.132
No	12	2	14		3.91 (0.82–18.72)	
Yes	46	30	76		1.00 (Reference)	
Mutual Respect Among Peers				1.49		.410
No	6	1	7		3.54 (0.39–169.62)	
Yes	52	31	83		1.00 (Reference)	
Cohesive Care Team Function				0.72		.390
No	11	2	13		0.28 (0.05–1.37)	
Yes	47	30	77		1.00 (Reference)	
Environmental Conditions Satisfaction				13.92		.001
No	21	1	22		24.11 (3.04–191.34)	
Yes	27	31	58		1.00 (Reference)	
Workplace Exposure to Violence				6.03		.014
No	28	24	52		2.80 (1.08–7.25)	
Yes	30	8	38		1.00 (Reference)	

Daily Work Autonomy						
Structural Autonomy in Routines				16.39		.001
No	28	2	30		0.41 (0.17–1.01)	
Yes	30	30	60		1.00 (Reference)	
Inspiring Leadership from Supervisors				6.49		.021
No	22	4	26		4.28 (1.32–13.85)	
Yes	36	28	64		1.00 (Reference)	
Opinions Weighed in Decisions				11.35		.002
No	55	22	77		8.33 (2.09–33.17)	
Yes	3	10	13		1.00 (Reference)	
Clear Information Delivery				4.67		.031
No	26	7	33		2.90 (1.08–9.77)	
Yes	32	25	57		1.00 (Reference)	
Active Participation in Feedback				17.93		.005
No	46	11	57		7.32 (2.78–19.26)	
Yes	12	21	33		1.00 (Reference)	
Institutional Staffing Suitability				19.22		.006
No	35	4	39		10.65 (3.30–34.39)	
Yes	23	28	51		1.00 (Reference)	

Multivariate Logistic Regression Analysis

The multivariate logistic regression model isolated the independent predictors of job dissatisfaction **(Table 5)**. When controlling for confounding variables, four core institutional attributes remained significantly associated with job dissatisfaction: insufficient physical rest periods (OR = 21.99, p = .001), unmanageable patient volume per shift (OR = 20.35, p = .002), exclusion of nurses' opinions from institutional decisions (OR = 14.03, p = .022), and an excessive physical/mental workload (OR = 6.16, p = .015).

Table 5:
Multivariate Logistic Regression Analysis of Predictive Factors for Job Dissatisfaction

Predictor variables	B	SE	Wald	df	p	Exp(B)	95% CI for Exp(B)
Gender (Male)	0.241	0.152	2.51	1	.113	1.272	[0.945, 1.712]
Lack of flexible schedule	0.582	0.184	9.99	1	.002	1.789	[1.248, 2.566]
Lack of change communication	0.412	0.141	8.54	1	.030	1.510	[1.145, 1.991]
Lack of open management dialogues	0.634	0.195	10.60	1	.001	1.885	[1.286, 2.763]
Unmanageable patient volume	0.712	0.210	11.50	1	.110	2.038	[1.351, 3.074]
Unacceptable service hours	0.325	0.165	3.88	1	.049	1.384	[1.002, 1.911]
Unreasonable overall workload	0.854	0.223	14.70	1	< .001	2.349	[1.517, 3.636]
Unmanageable care urgency/complexity	0.445	0.178	6.25	1	.120	1.560	[0.101, 2.212]
Insufficient quality care time	0.698	0.201	12.10	1	.110	2.010	[0.356, 2.978]
Lack of organizational autonomy	0.512	0.167	9.39	1	.220	1.669	[0.202, 2.317]
Lack of inspiring leadership	0.741	0.192	14.90	1	.060	2.098	[0.439, 3.058]
Opinions ignored by management	0.489	0.156	9.82	1	.220	1.631	[0.201, 2.214]
No active feedback meetings	0.311	0.148	4.41	1	.036	1.365	[0.021, 1.825]
Inadequate institutional staffing	0.654	0.215	9.25	1	.120	1.923	[0.262, 2.931]
Negative regular work environment	0.812	0.245	11.00	1	.210	2.252	[0.394, 3.640]
Deficient workplace safety	0.556	0.188	8.75	1	.310	1.744	[0.205, 2.524]
Poor work-life balance reconciliation	-0.610	0.194	9.95	1	.002	0.542	[0.371, 0.793]
Lack of recognition by hierarchy	0.788	0.212	13.80	1	.410	2.199	[0.451, 3.332]
Institutional value friction	0.423	0.159	7.08	1	.010	1.527	[0.118, 2.084]
Constant	-1.250	0.452	7.59	1	.006	0.288	–

DISCUSSION

Sociodemographic Characteristics

This study found an overall job dissatisfaction rate of 64.4% among the nursing workforce across the two surveyed referral hospitals in Kongo Central. This finding is consistent with recent findings in similar regional healthcare systems, which reported that 97.7% of regional nurses experienced a deficient professional quality of life, with job dissatisfaction serving as an independent predictor of low retention (Nsimba et al., 2025). The high prevalence of professional dissatisfaction highlights an imbalance in nurses' work environments, which can directly undermine the safety and quality of clinical care.

Regarding demographic characteristics, this study found no statistically significant correlation between age, gender, marital status, or facility location and job dissatisfaction ($p > .05$). This finding contrasts with studies that identified marital status as a significant predictor of career burnout (Alzoubi et al., 2021). These differences may stem from specific localized coping mechanisms, community structures, or informal peer networks within the sub-Saharan context that help cushion demographic-specific pressures (Turnbach et al., 2024).

However, operational challenges such as excessive working hours significantly increased dissatisfaction within this cohort ($p = .002$). When shifts systematically exceed standard baseline hours, the risk of career dissatisfaction increases significantly (Valdes et al., 2022). Within Herzberg's Two-Factor framework, excessive shift duration and unmanaged workloads represent fundamental failures in extrinsic hygiene factors, which can lead directly to persistent professional dissatisfaction (Alrawahi et al., 2020).

Hygiene Factors

Working Conditions, Patient Loads, and Work-Life Interference

The analysis indicates that organizational deficits significantly increase the risk of job dissatisfaction. Nurses managing unmanageable patient volumes had a 5.06-fold increased risk of job dissatisfaction ($p = .006$), which was further compounded by irregular weekly schedules (OR = 11.50, $p = .002$) and high acute workloads (OR = 9.07, $p = .001$). These findings are consistent with established health workforce research confirming that high nurse-to-patient ratios are strong predictors of career burnout and professional attrition (Carthon et al., 2021; Cho & Kim, 2019). In low-resource clinical settings, high odds ratios suggest that excessive shift demands serve as primary structural barriers to stable workforce retention.

Institutional Communication and Organizational Support

The relational climate with hospital management emerged as an important operational factor. Inadequate communication from leadership increased the risk of job dissatisfaction by 2.90 times ($p = .020$), while ambiguous organizational change management increased it by 2.54 times ($p = .038$). This is consistent with recent research showing that transparent communication channels and supportive leadership serve as psychological buffers against high workplace demands (Nikpour & Brooks Carthon, 2023). In evolving healthcare systems, clear communication by management is a cost-effective strategy for preserving staff engagement.

Work-Life Balance and Well-Being Profiles

This study identified a strong association between a nurse's personal well-being and their work environment. A poor work-life balance was significantly associated with career dissatisfaction (OR = 0.24, $p = .002$), and work-induced family stress increased dissatisfaction by 3.52 times ($p = .002$). These dynamics align with established research on work-family conflict and role strain among healthcare workers (Lee et al., 2022). Notably, access to clear career development paths remained an important source of professional satisfaction (OR = 4.40, $p = .002$), indicating that opportunities for professional growth can serve as key motivators even in high-pressure clinical environments.

Physical Safety and Rest Infrastructure

The results highlight the importance of physical safety and rest infrastructure within medical facilities. Inadequate rest areas during shifts (OR = 5.77, $p = .002$) and poor workplace safety measures (OR = 4.01, $p = .029$) were associated with higher job dissatisfaction. This is consistent with international research emphasizing the importance of safe, well-equipped working environments for healthcare workers (Weiser et al., 2024). These findings suggest that administrative interventions should prioritize regulating workloads and improving basic break infrastructure alongside financial or other incentive programs (Hudays et al., 2023). While flexible scheduling did not reach the threshold for statistical significance in this sample ($p = .063$), rigid shift structures remain a barrier to overall workforce satisfaction.

Workload and Psychophysical Exhaustion

The data confirm that high physical and mental workloads are strong predictors of job dissatisfaction. High physical and mental health strain was associated with a significant increase in dissatisfaction (OR = 19.15, $p < .001$), consistent with research on high psychological demand in clinical environments (Cortés Borra et al., 2025). Prolonged exposure to high workloads without sufficient organizational resources can lead to professional burnout

and systemic fatigue (Chen & Jamiat, 2023; Huang et al., 2024).

Managerial Support and Leadership

The study highlights the protective role of effective leadership. A lack of recognition from management increased dissatisfaction (OR = 4.35, p = .020), and the absence of leadership training for supervisors was a significant factor (OR = 3.21, p = .014). This supports previous research establishing a link between supportive leadership styles and improved nurse retention (Nantsupawat et al., 2017). Conversely, organizational value alignment (p = .149) and continuing education (p = .212) were not statistically significant in this context, suggesting that fundamental needs like safety, rest, and recognition take precedence over self-actualization goals in resource-constrained environments.

Motivator Factors

Participatory Governance and Clinical Autonomy

A key finding from this study is the impact of involving nursing staff in decision-making processes. Excluding nurses' opinions from operational management decisions increased dissatisfaction by 8.33 times (p = .002), which was compounded by a lack of active feedback loops (OR = 7.32, p = .005). This supports the understanding that professional autonomy and institutional voice are important psychological needs for healthcare workers (Li et al., 2025; Taylor-Clark et al., 2022). Top-down management structures that lack feedback mechanisms can significantly reduce professional engagement.

Professional Relationships and Conflict Management

While informal social connections among peers were not statistically significant in this sample (p = .252), functional collaboration was essential. The absence of effective institutional conflict management was strongly associated with dissatisfaction (OR = 10.81, p = .015), and a lack of clear information from leadership increased the risk of discontent (OR = 2.90, p = .031). This reinforces the role of authentic leadership in fostering a supportive work environment (Cortés Borra et al., 2025; Turnbach et al., 2024). The finding that conflict resolution has a stronger statistical association with satisfaction than peer socialization suggests that while staff can adapt to varied social environments, unresolved professional tensions are difficult to sustain.

Integration of Herzberg's Two-Factor Model

Applying Herzberg's model provides a framework for interpreting these findings by separating extrinsic hygiene factors from intrinsic motivators (Alrawahi et al., 2020). The high level of dissatisfaction observed in this cohort is primarily linked to deficiencies in hygiene factors, such as heavy workloads, insufficient rest periods, and safety concerns. According to the theory, addressing these hygiene deficits is necessary to eliminate baseline dissatisfaction, though further intrinsic motivators are required to build long-term engagement.

At the same time, a lack of intrinsic motivators—such as professional recognition and involvement in operational decisions—limits engagement by reducing opportunities for professional growth. In this specific context, hygiene factors appear to be prominent, as basic operational needs must be addressed before intrinsic motivators can be fully effective. Improving workforce retention requires a combined approach that addresses both environmental hygiene factors and participatory governance structures (Bohm, 2012).

Limitations of the Study

This study has several limitations that should be considered. First, the cross-sectional design captures data at a single point in time, which prevents the establishment of direct causal relationships between organizational factors and job dissatisfaction. Second, reliance on self-reported data may introduce reporting or social desirability biases, though anonymous data collection was used to mitigate this. Finally, the study was conducted within two general referral hospitals in the Kongo Central province, which may limit the generalizability of the findings to urban centers or other regions with different healthcare infrastructure and resource allocations within the DRC.

CONCLUSION

This study aimed to identify the primary organizational, structural, and psychosocial determinants of job dissatisfaction among nurses working in two general referral hospitals within the Kongo Central province of the Democratic Republic of Congo. The analysis revealed

a high overall job dissatisfaction rate of 64.4%, highlighting a significant challenge that can impact both nursing well-being and the quality of patient care.

The findings indicate that this dissatisfaction is primarily driven by structural and organizational factors rather than individual demographic characteristics. Grounded in Herzberg's Two-Factor Theory, the multivariate analysis isolated four primary independent determinants of dissatisfaction: excessive workload, insufficient physical rest, unmanageable patient volumes, and a lack of management consideration for nurses' opinions. These factors combine to create a demanding work environment that can lead to physical and mental fatigue.

While these results provide useful insights, their interpretation should account for methodological limitations, including the cross-sectional nature of the data and the focus on a specific geographic region, which may affect generalizability across the entire country.

Addressing these challenges requires a coordinated approach. Health authorities and hospital administrators should consider measures to optimize nurse-to-patient ratios, improve basic hospital rest infrastructure, and adopt collaborative leadership styles that encourage transparent communication and professional recognition. Further longitudinal research adapted to resource-constrained settings could help track these organizational dynamics over time and support the development of sustainable workforce strategies.

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Data Availability Statement: The quantitative survey data from 90 nurses at Saint Luc de Kisantu and Sainte Julie-Billiart de Ngidinga hospitals were collected via KoboCollect and processed using Excel (v10) and SPSS (v26). To maintain participant confidentiality and comply with ethical agreements, raw datasets are stored securely and not publicly available. All aggregated data and statistical analyses (chi-square tests, prevalence ratios, and multivariate logistic regression) are included within the manuscript. De-identified data requests may be directed to the corresponding author (simondecapntela@gmail.com).

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Ethical Approval: This study was conducted in accordance with the Declaration of Helsinki. Ethical approval was granted by the Ethics Committee of the Institut Supérieur des Techniques Médicales (ISTM) in Kinshasa (Decision No. 165/ESU/CBE/ISTM/KIN/RDC/PBBL/2025). Site access authorizations were secured from the hospital administrations. All participants provided written informed consent prior to inclusion. Data collection and processing strictly complied with confidentiality and professional secrecy requirements.

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ORCID iDs:
Muzingu, K. A.[1,2]: Nil identified.
Ramazani, B. E. I.[3,4,5]: Nil identified.
Mukuna, B.[6]: https://orcid.org/0009-0009-3597-574X
Ngbolua, K. N.[7,8]: Nil identified.
Mabakutuvangilanga, N. S.-D.[1,3,4,9]: https://orcid.org/0000-0002-2357-7211

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