

CHAPTER 4

SOME MAJOR OBSTACLES AND FLAWS IN EFFECTIVE PUBLIC HEALTH SERVICE DELIVERY AT S.S.R.N.H.

4.1 INTRODUCTION

This chapter discusses the research question, what are the obstacles and flaws to effective public health service delivery at S.S.R.N.H. ? Public health service delivery at S.S.R.N.H. is influenced by many factors, *inter-alia*, absenteeism, personnel turnover, stress, burnout and sexual harassment. In this section of the study, separate units deal with some of the causes and effects of these factors on public health service delivery.

For rendering efficient and effective public health services, the health personnel must have a high degree of discipline, obedience and loyalty. These traits are the cornerstones of an orderly structured public health service.

It is generally seen that a hospital is an extremely stressful environment to work in and health personnel project certain types of behaviour that may be tolerated within limits, but some behaviours such as lethargy, corruption and political interference cannot be tolerated at all. This chapter also addresses some of the abnormal behaviours and actions such as nepotism, neglect of duty, disobedience, dishonesty, bribery, alcohol and drug abuse that could have a bearing on effective public health service delivery at S.S.R.N.H. Attention has been devoted to the research survey using a self-administered questionnaire.

4.2 RESEARCH METHODOLOGY

The research survey was conducted independently by the author between January 2003 and June 2003 in order to gather baseline information on health personnel that have a bearing on public health service delivery at S.S.R.N.H. The data used in this research survey were collected during several visits to

different patients' wards, sections and units of S.S.R.N.H. The measuring instrument used in this regard was a self-administered questionnaire. This research method is qualitative in nature. The results obtained are presented in different tables.

The target staff for the study was the current health personnel of S.S.R.N.H. The total number for the research survey was 100 health personnel of S.S.R.N.H. The total number of health personnel employed at S.S.R.N.H. is 310. The study population comprised of 50 Doctors and 80 Nurses, 8 Health Managers and 12 Health Supervisors. In the management of S.S.R.N.H. Health Managers occupy a higher level in the institutional hierarchy compared to Health Supervisors.

One of the advantages of this chosen research method was that the questionnaire was easy to distribute to the study population. The information gathered by means of the questionnaire was kept confidential. Specific questions were framed by using this research method and the participants did not get any trouble to answer. However, this research method required a lot of time to frame questions. It was also time-consuming to analyse the collected data. Another disadvantage of this method was that several visits had to be effected to different patient wards, sections and units of S.S.R.N.H. in order to collect the questionnaire from the participants.

The health personnel play a vital role in the provision of health knowledge to patients particularly on health education, promotion, maintenance and restoration. Being the first point of contact in the public health service delivery, Doctors and Nurses play a vital role in patient teaching particularly on smoking, pregnancy and drug use. Furthermore, health education on the eradication of illness and prevention of communicable diseases like acquired immune deficiency syndrome (AIDS), tuberculosis, gastroenteritis and typhoid fever are mostly provided by Doctors, Nurses, Health Managers and Health Supervisors. In the public health care delivery, the health personnel emphasize the importance of changing life-style behaviours, for instance, not using alcohol, doing physical

exercise for 20 minutes three times per week, eating breakfast daily, reducing fats and getting 6 to 8 hours of sleep per night. Additionally, Doctors, Nurses, Health Managers and Health Supervisors play a key role in health maintenance that is health stabilization for people with chronic conditions, risk reduction and health protection for people without identified diseases. The importance of these health personnel in health restoration cannot be overlooked especially in the adaptation and crisis resolution for people experiencing some health threats or health deficits (Gardner 1996:23).

Another reason for selection of these participants is that the reputation of S.S.R.N.H. as an efficient and effective public health service provider depends on the Doctors, Nurses, Health Managers and Health Supervisors working in the institution. It is crucial to note that administrative health personnel particularly Health Managers and Health Supervisors were included in the research survey because these health personnel play a vital role in judicious use of health resources such as medical equipment, finance, manpower and drugs. Effective and efficient utilization of limited health resources is essential for rendering timely, prompt and quality patient care at S.S.R.N.H. The administrative health personnel have to keep pace with technological changes particularly with reference to the medical equipment.

New diseases will be identified and new groups of patients will have the opportunity of being diagnosed and treated. Three-dimensional holographic images of internal organs and tissues produced by combining information from Computerised Tomography (CT) and Magnetic Resonance Imaging (MRI) scans will reduce the need for laparotomy, laparoscopy and other invasive procedures. Minimally invasive surgery and fast acting anaesthetics will allow many more frail and elderly patients to be treated, ultrasound treatment of tumours, monitored by magnetic resonance imaging and nanotechnology, the science and technology of creating working machines or a molecular scale is likely to mature from its present infancy. Technologies have a profound effect on how public health care is managed by health professionals. Furthermore, administrative health

personnel also have to judiciously and frugally use public funds in the provision of effective public health services at S.S.R.N.H. Funds are always limited and should be efficiently and effectively utilized.

The Health Managers and Health Supervisors are responsible, among other duties, for the provision of medicine and drugs to the hospital. These health personnel ensure that patient cares are not hampered owing to lack or unavailability of drugs at S.S.R.N.H. For the administration of drugs to patients it is essential to observe all procedures. Therefore, administrative health personnel play a dominant role in enforcing rules and regulations pertaining to drugs administration.

Each potential respondent in the data collection process was given a questionnaire to read before deciding whether to participate in the survey or not. The questionnaire was delivered to different patient wards, sections and units of S.S.R.N.H. by the author. Participants belonged to a random probability sample chosen to represent distribution. That part of the study population who did not respond to the questions asked in the questionnaire was excluded from the analysis. 30 Doctors out of 50 agreed to participate representing 60% and 50 Nurses (62.5%) out of 80 Nurses responded. Concerning Health Supervisors, all 8 responded representing 100% and among Health Managers all 12 accepted to participate in the research survey. Therefore a total of 100 participants were involved in the entire research survey representing an overall response of 66.67%.

The participants were full of passion about improving the health environment at S.S.R.N.H. They returned the completed questionnaire on the deadline mentioned in the questionnaire. It was noticed by the author that there was effective cooperation between all the parties involved and this created a favorable climate for the conduction of the research survey at S.S.R.N.H. Despite being busy at S.S.R.N.H., the participants were enthusiastic and showed an interest in the research survey.

The conduction of such a research survey was important in order to gather data about health personnel's knowledge of and opinions about behavioural actions, *inter-alia*, absenteeism, stress, neglect of duty, sexual harassment, burnout and personnel turnover that influence public health service delivery at S.S.R.N.H. The significance of this research survey can be seen in the findings obtained about health personnel at S.S.R.N.H. For instance, a total number of 80 respondents overall agreed that morale of staff depends on a lack of favourable environmental conditions (Table 4.5(b)) as indicated on page 89.

Such a survey was also essential in order to gather data for future public health planning at S.S.R.N.H. There had been an emergence of both new and old diseases, for example AIDS, new variant Creutzfeldt-Jacob disease and tuberculosis. Resistance to antibiotic is growing. The rising prevalence of obesity amongst the young, of 'recreational' drug taking and other risky behaviours may have profound effects in the coming decades. Therefore, this research survey was important for collecting data from the environment prevailing at S.S.R.N.H. so that strategic health plans can be designed.

As pointed out earlier, the survey questionnaire's (Annexure 1) main purpose was to identify and collect data from Doctors, Nurses, Health Managers and Health Supervisors with reference to the public health service delivery at S.S.R.N.H. The questionnaire was administered in several parts, which include questions on:

Question number 1: Absenteeism at S.S.R.N.H. among Doctors, Nurses, Health Managers and Health Supervisors

This part of the questionnaire asked the respondents a question on the impact of absenteeism on public health service delivery at S.S.R.N.H. Thereafter the major causes of absenteeism, particularly the following were assessed, namely:

- the inability to attend to hospital work due to :
 - family responsibilities
 - illness
 - transportation problems;

- the motivation to attend to hospital work because of:
 - quality of supervision
 - adequate number of staff
 - decentralization of power and decision
 - boredom
 - poor intra-group and inter-group work relations; and

- health personnel policies regarding :
 - liberal sick-leaves
 - low pay
 - lack of effective health personnel selection, placement, orientation and training.

Question number 2: Personnel turnover among Doctors, Nurses, Health Managers and Health Supervisors

Participants were asked questions on the impact of personnel turnover on public health service delivery at S.S.R.N.H. Some of the major causes of personnel turnover were asked in this section, particularly on the following:

- Unavoidable personnel turnover such as pregnancy, illness and retirement with pension.
- Avoidable personnel turnover such as failure of job to keep health personnel in the institution's service.
- Low level of job satisfaction.
- Unfriendly work environment.

Question number 3: Stress among Doctors, Nurses, Health Managers and Health Supervisors

Section 3(a) of the questionnaire asked a question on the experience of stress at S.S.R.N.H. The second part of this section that is 3(b) was concerned with major factors influencing stress such as:

- intra-institutional stressors such as hospital decision making, inter-personnel relationship, nature of a task, lack of autonomy, hospital staff shortage and supervisors;
- extra-institutional stressors such as family commitment; and
- health personnel stress such as a mid-career crisis, start of a career and retirement.

Question number 4: Burnout among Doctors, Nurses, Health Managers and Health Supervisors

Participants were asked whether burnout exists at S.S.R.N.H., or not (section 4[a]). Section 4(a) was concerned with factors contributing to burnout such as:

- low pay;
- long working hours;
- lack of appreciation and understanding; and
- unresponsiveness to patient needs.

Moreover, section 4(c) asked questions on the physical symptoms of burnout, for instance, headache, backache, indigestion and lowered resistance to infection.

Question number 5: Morale among Doctors, Nurses, Health Managers and Health Supervisors

This part of the questionnaire asked the participants whether low morale is prevalent at S.S.R.N.H., or not (section 5(a)). The second part of the question,

that is 5(b), was concerned with the major causes of low morale at S.S.R.N.H. particularly the following:

- Incompetence and low level of integrity of health personnel.
- Lack of favourable environmental conditions.
- Lack of opportunities for promotion.
- Lack of recognition for good performance.
- Lack of supervision.

Question number 6: Sexual harassment among Doctors, Nurses, Health Managers and Health Supervisors

This section of the questionnaire asked question on the prevalence of sexual harassment at S.S.R.N.H (section 6(a)). Section 6(a) was concerned with the types of behaviours that are considered as sexual harassment, particularly the following:

- Body language.
- Surreptitious touching and groping.
- Use of power to deny or undermine the status.
- Verbal comments.

Furthermore, section 6(c) asked questions on the effects of sexual harassment at S.S.R.N.H. such as:

- depression;
- anxiety;
- helplessness;
- serious physical illness; and
- insomnia.

Question number 7 of the questionnaire asked respondents to record abnormal behaviours and actions that influence public health service delivery at S.S.R.N.H. particularly the following:

- Lethargy and disobedience.
- Nepotism.
- Shriking responsibility.
- Alcohol and drug abuse.
- Active political interference.
- Bribery and corruption.
- Dishonesty and retaliation.
- Neglect of duty.

Participants had to answer either yes or no in the questionnaire provided. Questions were recorded in English. The author eventually collected the questionnaire from patient's wards, sections and units. The results obtained were presented in different tables. The respondents' attitudes toward public health services delivery at S.S.R.N.H. were examined. The names of Doctors, Nurses, Health Managers and Health Supervisors who kindly agreed to participate in the study were kept confidential. The response rates of different questions listed in the questionnaire are analysed in the next section of this chapter.

4.3 SOME OF THE MAJOR OBSTACLES AND FLAWS IDENTIFIED AT S.S.R.N.H. IN PUBLIC HEALTH SERVICE DELIVERY.

The obstacles and flaws in effective public health service delivery identified at S.S.R.N.H. can have far-reaching consequences. It can bring about enormous institutional costs and negative spill-over effects on effective public health service delivery in the area. There are numerous obstacles and flaws in the public health service delivery identified at S.S.R.N.H. Some of these obstacles and flaws are highlighted hereunder.

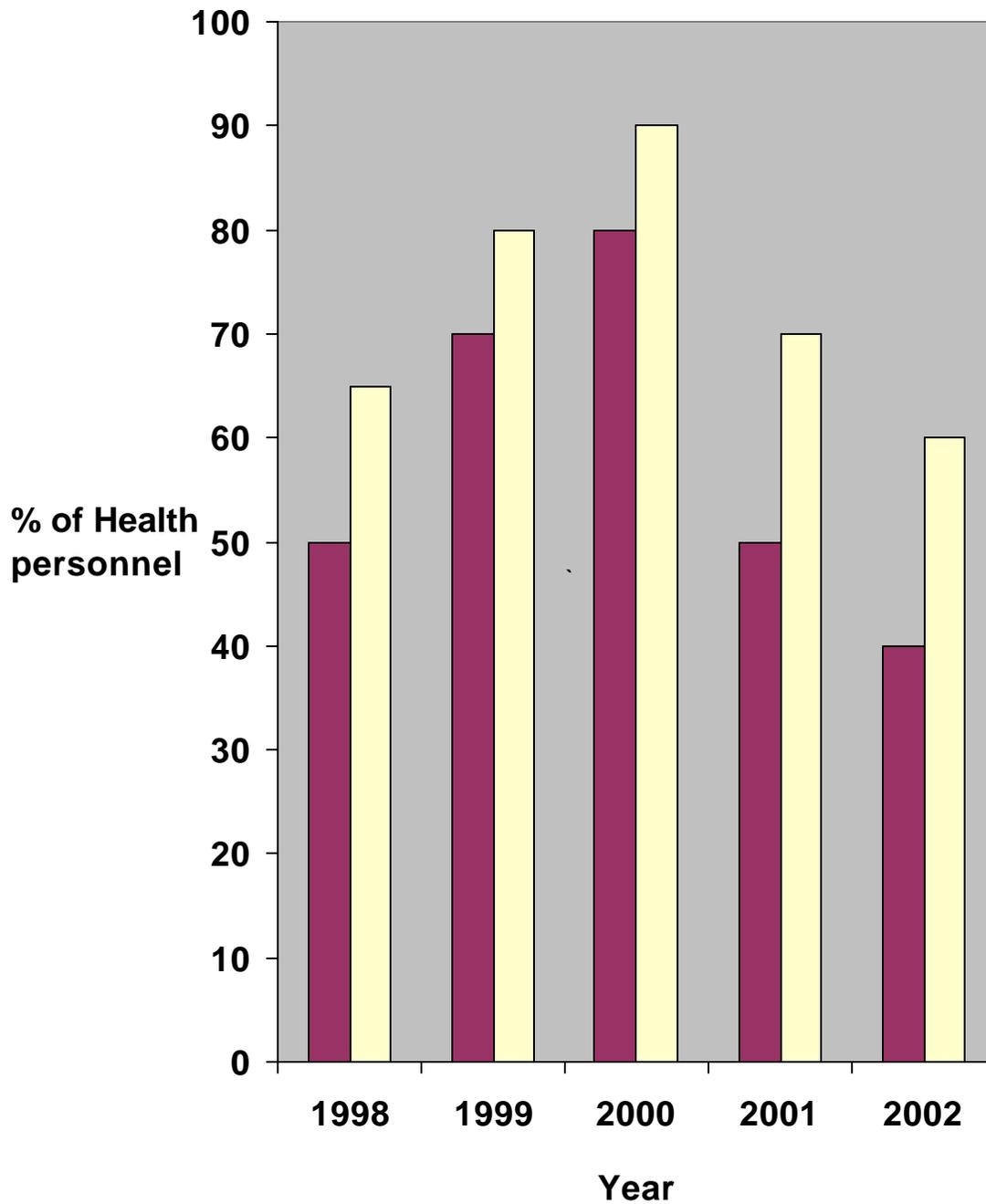
4.3.1 Absenteeism at S.S.R.N.H.

Absenteeism is generally defined as the use of time for activities that are not work related during times when a health worker is expected to be working (Gillies 1994:80). Absenteeism may often be attributed not only to physical conditions but also to negative factors in the work situation, such as stress, boredom and poor relationship with other health workers.

Figure 4.1 shows the percentages of attendances among Doctors, Nurses, Health Managers and Health Supervisors from 1998 to 2002 at S.S.R.N.H. This information was obtained from the Central Statistics Office, Ministry of Health and Quality of Life, Mauritius. A total of 100 Doctors and Nurses were evaluated for attendance. For Health Managers and Health Supervisors a total of 20 were evaluated. The results were plotted in a graph and eventually the figure 4.1 was obtained. On the vertical axis percentages of health personnel were plotted and on the horizontal axis the time frame in years (1998 - 2002). There was a continuous rise in attendances among Doctors, Nurses, Health Managers and Health Supervisors from the year 1998 until 2000. Initially, the attendances of Doctors and Nurses were 50% (50/100) and for Health Managers and Health Supervisors 65 % (13/20). Gradually the number of attendances increased to 70% (70/100) for Doctors and Nurses and 80% (16/20) for Health Managers and Health Supervisors in the year 1999. In 2000 the attendances reached 80% (80/100) for Doctors and Nurses, and 90% (18/20) for Health Managers and Health Supervisors.

Figure 4.1 furthermore shows that there was a gradual decline in attendances among the health personnel from the year 2000 until 2002. In the year 2001, the attendances among Doctors and Nurses were 50% (50/100) and Health Managers and Health Supervisors were 70% (14/20). The figure dropped to 40% (40/100) among Doctors and Nurses, and 60% (12/20) among Health Managers and Health Supervisors in the year 2002.

Figure 4.1: Trend in the percentage of attendances among Doctors, Nurses, Health Managers and Health Supervisors from 1998 to 2002.



Key:  = Doctors and Nurses

 = Health Managers and Health Supervisors

Source: Documentation Unit (2002:80).

Absenteeism is costly for S.S.R.N.H. It is a complex problem because attending to patient's needs cannot be postponed. The S.S.R.N.H. has to pay the absent health personnel. Also a replacement for the absentee may not be available or if available, may invariably need more supervision and orientation to the work situation. The continuity and efficiency of public health service delivery can be seriously affected (Damar 2002:23).

As a result of the negative effect of absenteeism on goal realisation at S.S.R.N.H., absenteeism as an indicator of possible serious health personnel problems should not be ignored. The section below outlines the impact of and factors causing absenteeism.

4.3.1.1 Impact of absenteeism on public health service delivery at S.S.R.N.H.

Section 1(a) of the questionnaire was concerned with the impact of absenteeism on public health service delivery at S.S.RN.H. The data collected from the questionnaire on this question is indicated in table 4.1(a).

Question	Number and (percentage)				Number and (percentage)				Total number and overall (percentage)	
	D		N		HS		HM		Yes	No
Do you believe that absenteeism has an impact on public health service delivery?	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
	27 (90)	3 (10)	49 (98)	1 (2)	7 (87.5)	1 (12.5)	11 (91.7)	1 (8.3)	94 (94)	6 (6)

Key : Doctors = D, Health Managers = HM, Nurses = N, Health Supervisors = HS

On question 1(a) overall, 94 participants (94%) said “yes” [(27 Doctors (90%), 49 Nurses (98%), 7 Health Supervisors and 11 (91.7%) Health Managers]. It is observed that in total 94% of the respondents said yes. Such a high response of participants shows that the respondents believed that absenteeism influence public health service delivery at S.S.R.N.H.

Additionally it is noted that overall, 6 participants (6%) answered “no” on question 1(a), for instance, among individual groups 3 of the 30 Doctors (10%), 1 of the 50 Nurses (2%), 1 of the 8 Health Supervisors (12.5%) and 1 of the 12 Health Manager (8.3%). Thus the highest number among individual groups was 3 Doctors (10%) compared to other groups which was 1. Hence, it can be deduced that more Health Supervisors (12.5%) compared to Doctors (10%), Nurses (2%) and Health Managers (8.3%) did not agree that absenteeism affect public health service delivery.

4.3.1.2 Major causes of absenteeism

Part 1(b) of the questionnaire asked the participants questions on the major causes of absenteeism. For instance, question 1(b)(i) was concerned with *the ability to attend to hospital work*, the parameters were family responsibilities, illness and transportation problems. Question 1(b) (ii) involved *motivation to attend to hospital work*. The variables were quality of supervision, adequate number of staff, decentralization of power and decision, boredom and poor intra-group and inter-group work relations. Ultimately question 1(b) (ii) was related to *health personnel policies* such as liberal sick leaves, low pay, lack of effective health personnel selection, placement, orientation, and training. The data collected on the above question is presented in table 4.1(b).

TABLE 4.1 (b) Views of health personnel on the major causes of absenteeism.										
Causes	Number and (percentage)				Number and (percentage)				Total number and overall (percentage)	
	D		N		HS		HM			
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
The ability to attend to hospital work										
• family responsibilities	20 (66.7)	10 (33.3)	40 (80)	10 (20)	7 (87.5)	1 (12.5)	9 (75)	3 (25)	76 (76)	24 (24)
• illness	25 (83.3)	5 (16.7)	32 (64)	18 (36)	6 (75)	2 (25)	10 (83.3)	2 (16.7)	73 (73)	27 (27)
• transportation problems	21 (70)	9 (30)	30 (60)	20 (40)	8 (100)	0 (0)	9 (75)	3 (25)	68 (68)	32 (32)
The motivation to attend to hospital work										
• quality of supervision	16 (53.3)	14 (46.7)	19 (38)	31 (62)	5 (62.5)	3 (37.5)	9 (75)	3 (25)	49 (49)	51 (51)
• adequate number of staff	23 (76.7)	7 (23.3)	21 (42)	29 (58)	6 (75)	2 (25)	8 (66.7)	4 (33.3)	58 (58)	42 (42)
• decentralisation of power and decision	29 (96.7)	1 (3.3)	30 (60)	20 (40)	5 (62.5)	3 (37.5)	11 (91.7)	1 (8.3)	75 (75)	25 (25)
• boredom	29 (96.7)	1 (3.3)	40 (80)	10 (20)	7 (87.5)	1 (12.5)	10 (83.3)	2 (16.7)	86 (89)	11 (11)
• poor intragroup and intergroupwork relations	27 (90)	3 (10)	30 (60)	20 (40)	6 (75)	2 (25)	9 (75)	3 (25)	72 (72)	28 (28)
Health personnel policies										
• liberal sick-leave	25 (83.3)	5 (16.7)	39 (78)	11 (22)	8 (100)	0 (0)	10 (83.3)	2 (16.7)	82 (82)	18 (18)
• low pay	28 (93.3)	2 (6.7)	48 (96)	2 (4)	7 (87.5)	1 (12.5)	11 (91.7)	1 (8.3)	94 (94)	6 (6)
• lack of effective health personnel selection, placement orientation and training	30 (100)	0 (0)	41 (82)	9 (18)	6 (75)	2 (25)	10 (83.3)	2 (16.7)	87 (87)	13 (13)

Key : Doctors = D, Health Managers = HM, Nurses = N, Health Supervisors = HS

On the variable, *the ability to attend to hospital work* it is observed from table 4.1(b) that, except transportation problems, the overall response on all other factors was at least 73%. The highest overall score obtained was on *family responsibilities* (76%). Among individual groups, the responses on family responsibilities varied, for instance, 20 of the 30 Doctors (66.7%), 40 of the 50 Nurses (80%), 7 of the 8 Health Supervisors (87.5) and 9 of the 12 Health Managers indicated “yes”. Hence, it can be deduced that 76 participants (76%) were of the opinion that *family responsibilities* lead to absenteeism.

Overall, 24 participants (24%) indicated “no” on the variable *family responsibilities*, for example, 10 of the 30 Doctors (33.3%), 10 of the 50 Nurses (20%), 1 of the 8 Health Supervisors (12.5%) and 3 of the 12 Health Managers (25%). Thus it can be concluded that 24% of participants were of the opinion that other causes of absenteeism probably exist at S.S.R.N.H. Also it is observed that 5 of the 30 Doctors (16.7%), 18 of the 50 Nurses (36%), 2 of the 8 Health Supervisors (25%) and 2 of the 12 Health Managers (16.7%) responded to “no” on the variable *illness*. It can be deduced that more Nurses (36%) compared to Doctors (16.7%) did not agree with *illness* as a factor contributing to absenteeism.

Section 1(b)(ii) of the questionnaire was concerned *with the motivation to attend to work*. The highest response to “yes” was on the variable *boredom*, overall, 86 participants (86%) for example, 29 of the 30 Doctors (96.7%), 40 of the 50 Nurses (80%), 7 of the Health Supervisors (87.5%) and 10 of the 12 Health Managers (83.3%) said “yes”. Hence, it can be concluded that participants were of the opinion that *boredom* is a major cause of absenteeism

Additionally, it is observed that overall, 11 participants (11%) responded “no” on this variable. The responses varied among the individual groups. For instance, 1 of the 30 Doctors (3.3%), 10 of the 50 Nurses (20%), 1 of the 8 Health Supervisors (12.5%) and 2 of the 12 Health Managers (16.7%) indicated “no”. The response was high among Nurses (20%) compared to Doctors (3.3%).

From this it can be deduced that more Nurses than Doctors did not agree that *boredom* causes absenteeism. Hence, the participants were of the opinion that other causes of absenteeism probably exist which lead to ineffective public service delivery.

Section 1(b)(iii) of the questionnaire asked the respondents a question on *health personnel policies*. Analysis of table 4.1(b) shows that the overall response rate to “yes” was above (82%) for all variables. The highest response was on the variable *low pay* 94%. For instance, 28 of the 30 Doctors (93.3%), 48 of the 50 Nurses (96%), 7 of the 8 Health Supervisors (87.5%) and 11 of the 12 Health Managers (91.7%) responded “yes” on the question concerning *low pay*. This percentage of 94 shows that the participants agreed that *low pay* is a major factor that causes absenteeism.

Furthermore, 6 participants (6%) overall responded “no” on the variable *low pay*. Among the individual groups the responses varied. For instance, 2 of the 30 Doctors (6.7%), 2 of the 50 Nurses (4%), 1 of the 8 Health Supervisors (12.5%) and 1 of the 12 health manager (8.3%) indicated “no” on this parameter. It is observed that the response to “no” among the number of Doctors and Nurses was not the same; the differences can be seen in the percentages obtained. More Doctors (6.7%) compared to Nurses (4%) responded “no” on the variable *low pay*. Also 1 health supervisor and 1 health manager responded “no” on the variable *low pay*. Hence, it can be deduced that these participants were of the opinion that there probably exist other major causes of absenteeism. Therefore, the figure 6% indicates that the 6 participants did not agree that low pay can cause absenteeism.

4.3.2 Personnel turnover at S.S.R.N.H.

Personnel turnover can be described as the process of change in the composition of the labour force. It refers to the movement of personnel in and out of the employment of an institution (Miller 2000:79). Personnel turnover is

another cause of ineffective public health service delivery at S.S.R.N.H. In the year 2002, 600 health personnel left S.S.R.N.H. compared to 200 in 2000 (Damar 2002:26). The annual personnel turnover is on the increase. Many Nurses have departed to England in order to get better pay. For instance, at S.S.R.N.H. a qualified general Nurse gets a monthly salary of Rs 7,000 and in England it is Rs 70,000 (Damar 2002:30). The constant heavy losses of recruited health personnel from the profession constitute one of the biggest problems of public health service delivery. It is a laborious and time consuming task to recruit enough health personnel, and the retention of staff is even more difficult. A high turnover of health personnel may cause low morale in the remaining staff.

Personnel turnover can lead to a decrease in the level of performance of health personnel, accompanied by impaired quality public health service delivery. Under these circumstances prospective patients select alternative institutions for hospitalization. The impact and major causes of personnel turnover are examined hereunder.

4.3.2.1 Impact of personnel turnover on public health service delivery at S.S.R.N.H.

Section 2 (a) of the questionnaire was concerned with the impact of the personnel turnover on public health service delivery at S.S.R.N.H. The data collected from the questionnaire on this question is shown in table 4.2 (a)

On question 2(a) overall, 86 participants (86%) indicated “yes” [29 Doctors (96.7%), 40 Nurses (80%), 6 Health Supervisors (75%) and 11 Health Managers (91.7%)]. Among the individual groups the response to “yes” on this variable was at least 75%, for instance, 29 of the 30 Doctors (96.7%), 40 of the 50 Nurses (80%), 6 of 8 Health Supervisors (75%) and 11 of 12 Health Managers (91.7%). Hence, such a high response of the participants indicates that the respondents

were of the opinion that personnel turnover has an impact on public health service delivery.

TABLE 4.2(a) Views of health personnel on whether personnel turnover has an impact on public health service delivery.										
Question	Number and (percentage)				Number and (percentage)				Total number and overall (percentage)	
	D		N		HS		HM			
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Do you believe that personnel turnover has an impact on public health service delivery?	29 (96.7)	1 (3.3)	40 (80)	10 (20)	6 (75)	2 (25)	11 (91.7)	1 (8.3)	86 (86)	14 (14)

Key : Doctors = D, Health Managers = HM, Nurses = N, Health Supervisors = HS

Moreover, it is observed that overall, 14 participants (14%) responded to “no” [1 doctor (3.3%), 10 Nurses (20%), 2 Health Supervisors (25%) and 1 health manager (8.3%)]. Compared to Doctors (3.3%), the response among the Health Supervisors was very high (25%). Thus it can be deduced that more Health Supervisors did not agree that this variable has an impact on public service delivery. It can also be concluded that 14 participants (14%) were of the opinion that other factors probably exist that have an impact on public service delivery at S.S.R.N.H.

4.3.2.2 Major causes of personnel turnover

Section 2(b) of the questionnaire asked the participants questions on the major causes of personnel turnover, for instance, *unavoidable personnel turnover* such as pregnancy, illness and retirement with pension, *avoidable personnel turnover* such as failure of job to keep health personnel in the institution’s service, *low*

level of job satisfaction and unfriendly work environment. Excessively high staff turnover is undesirable and costly because training and recruitment of staff takes time and money. The results obtained on this variable are presented in table 4.2(b).

TABLE 4.2(b) Views of health personnel on the major causes of personnel turnover.

Major causes	Number and (percentage)				Number and (percentage)				Total number and overall (percentage)	
	D		N		HS		HM			
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
• Unavoidable personnel turnover	29 (96.7)	1 (3.3)	40 (80)	10 (20)	6 (75)	2 (25)	11 (91.7)	1 (8.3)	86 (86)	14 (14)
• Avoidable personnel turnover	25 (83.3)	5 (16.7)	25 (50)	25 (50)	5 (62.5)	3 (37.5)	10 (83.3)	2 (16.7)	65 (65)	35 (35)
• Job satisfaction	29 (96.7)	1 (3.3)	30 (60)	20 (40)	5 (62.5)	3 (37.5)	11 (91.7)	1 (8.3)	75 (75)	25 (25)
• Work environment	21 (70)	9 (30)	41 (82)	9 (18)	8 (100)	0 (0)	10 (83.3)	2 (16.7)	80 (80)	20 (20)

Key: Doctors = D
Nurses = N

Health Managers = HM
Health Supervisors = HS

It is observed that at least 65% of the total group of respondents indicated “yes” on question 2(b). The highest response was 86 participants (86%) on the variable *unavoidable personnel turnover*.

Among the individual groups, 29 of the 30 Doctors (96.7%), 40 of the 50 Nurses (80%), 6 of the 8 Health Supervisors (75%) and 11 of the 12 Health Managers (91.7%) responded “yes” on *unavoidable personnel turnover* as one of the major

causes of personnel turnover. Therefore such a high percentage shows that the participants agreed that this variable causes personnel turnover.

Additionally, table 4.2 (b) shows that overall, 14 participants (14%) indicated “no” [1 doctor (3.3%), 10 of the 50 Nurses (80%), 2 of the 8 Health Supervisors (25%) and 1 health manager (8.3%)]. When analyzing table 4.2 (b), it is found that the response to “no” by the Health Supervisors was 25% and for Doctors was (3.3%). From these figures it can be deduced that more Health Supervisors did not believe that this variable causes personnel turnover. Moreover, it is observed that the highest response to “no” among all participants was on the variable *avoidable personnel turnover* (35%).

4.3.3 Stress at S.S.R.N.H.

Stress refers to a psychological and physiological condition that results from particular conditions in an individual's environment, including noise, pressure and monotony (Simon 2001:90). Public health service is a stressful occupation. Constant interaction with people who are sick can cause a situation such as spread of infection; in fact, a hospital environment is often seen as a stressful environment for rendering public health services (Miller 2000:24). Stress causes emotional misbalance thereby affecting the ability and potential of health personnel to perform health duties effectively. This, undoubtedly, can have disastrous consequences on quality patient's care.

Excessive pressure creates an area of perceived imbalance between demands and the ability to adapt to the hospital environment. In stressful situations, the health personnel become distressed, resentful and exhausted.

Stress is a result of change and conflict, and is an "energy-sapping, negative emotional experience that usually follows a stimulus that is consciously or unconsciously interpreted as a threat and that leads to a response aimed at ending the experience" (Simon 2001 : 80).

Stress is therefore not caused by the stressor, but by the way in which the health personnel perceives it. Stress experience and principal sources of stress in the public health service delivery at S.S.R.N.H. are discussed below.

4.3.3.1 Stress experience

The information obtained on the views of respondents regarding stress are shown in table 4.3 (a). On the question whether respondents experience stress at the hospital [question 3(a)], 95 of the total group of 100 participants responded “yes” [28 Doctors (93.3%), 48 Nurses (96.1%), 8 Health Supervisors (100%) and 11 Health Managers (91.2%)]. Hence, it can be deduced that (95%) of the participants agreed that the experience of stress is felt at S.S.R.N.H. 5 Out of 100 participants responded “no” [2 Doctors (6.7%), 2 Nurses (4%) and 1 health manager (8.3%)]. This is an indication that these respondents did not experience stress at S.S.R.N.H.

TABLE 4.3 (a) Views of health personnel on the experience of stress at S.S.R.N.H.										
Question	Number and (percentage)				Number and (percentage)				Total number and overall (percentage)	
	D		N		HS		HM			
Do you experience stress at the hospital?	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
		28 (93.3)	2 (6.7)	48 (96)	2 (4)	8 (100)	0	11 (91.2)	1 (8.3)	95 (95)

Key : Doctors = D, Health Managers = HM, Nurses = N, Health Supervisors = HS

4.3.3.2 Principal sources of stress

Section 3(b) of the questionnaire was concerned with the major factors influencing stress at S.S.R.N.H. These factors have been divided into the

following categories, namely intra-institutional stressors, extra-institutional stressors and health personnel stressors.

The views of respondents are shown in table 4.3(b)

TABLE 4.3 (b) Views of health personnel on the major factors influencing stress.										
Major factors	Number and (percentage)				Number and (percentage)				Total number and overall (percentage)	
	D		N		HS		HM			
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Intra-institutional stressors	23 (76.7)	7 (23.3)	30 (60)	20 (40)	6 (75)	2 (25)	10 (83.3)	2 (16.7)	69 (69)	31 (31)
Extra-institutional stressors	21 (70)	9 (30)	45 (90)	5 (10)	8 (100)	0	10 (83.3)	2 (16.7)	84 (84)	16 (16)
Health personnel stressors	21 (70)	9 (30)	48 (96)	2 (4)	6 (75)	2 (25)	10 (83.3)	2 (16.7)	85 (85)	15 (15)

Key : Doctors = D

Nurses = N

Health Managers = HM

Health Supervisors = HS

(a) Intra-institutional stressors. This includes aspects of the work milieu, such as hospital decision-making, interpersonal relationships, policy in respect of compensation, nature of a task, lack of autonomy and hospital staff shortages. The total score of the total group of participants obtained on the intra-institutional stressors is 69 to “yes” [23 Doctors (76.7%), 30 Nurses (60%), 6 Health Supervisors (75%) and 10 Health Managers (83.3 %)].

Among individual groups the response rate to “yes” was at least 60%. For instance, 23 of the 30 Doctors (76.7%), 30 of the 50 Nurses (60%), 6 of the 8 Health Supervisors (75%) and 10 of the 12 Health Managers (83.3%) indicated

“yes” on this question 3(b) (i) of the questionnaire. Hence, it can be deduced that participants were of the opinion that *intra-institutional stressors* is an important source of stress at S.S.R.N.H.

Additionally, 31 participants (31%) of the total group of participants said “no” on the variable *intra-institutional stressors*, for example, 7 of the 30 Doctors (23.3%), 20 of the 50 Nurses (40%), 2 of the 8 Health Supervisors (25%) and 2 of the 12 Health Managers (16.7%). Comparing the response of Nurses (40%) with that of Health Managers (16.7%), it can be concluded that more Nurses did not agree that *intra-institutional stressors* are major factors of influencing stress. Thus it can be stated that 31 participants (31%) were of the opinion that other factors may probably exist which influence stress at S.S.R.N.H.

(b) *Extra-institutional stressors*. This includes a variety of stressors such as family commitment, personal problems and social problems. Overall, 84 participants responded “yes” [21 Doctors (70%), 45 Nurses (90%), 8 Health Supervisors (100%) and 10 Health Managers (83.3%)] to this part of the question. Among the individual groups the response rate was very high on this variable. Thus it can be concluded that these participants believed that *extra-institutional stressors* influence stress.

It is observed from table 4.3 (b) that overall, 16 participants (16%) said “no” on this variable. The response of Doctors was (30%), Nurses (10%) and Health Managers (16.7%). From these responses it can be deduced that the participants did not accept that *extra-institutional stressors* are major factors influencing stress. Comparatively, more Doctors (30%) than Nurses (10%) agreed that *extra-institutional stressors* have no impact on stress.

(c) *Health personnel stressors*. This refers to the characteristics of the personnel that determine the way in which the work is interpreted and could include aspects such as mid-career crises, retirement and the start of a new career.

It is observed from table 4.3 (b) that the score was very high under the heading of health personnel stressors. On question 3(b) (iii) of the questionnaire, 85 participants (85%) overall indicated “yes” [21 Doctors (70%), 48 Nurses (26%), 6 Health Supervisors (75%) and 10 Health Managers (83.3%)]. It is observed that among individual groups the response rate was at least (70%). Thus it can be concluded that 85% of the participants agreed that *health personnel stressors* influence stress at S.S.R.N.H.

Overall, 15 participants (75%) responded “no” on this variable, for example 9 of the 30 Doctors (30%), 2 of the 50 Nurses (4%), 2 of the 8 Health Supervisors (25%) and 2 of the 12 Health Managers (16.7%). Hence, it can be stated that more Doctors (30%) compared to Nurses (4%) did not accept that *health personnel stressors* influence stress. Thus it can be deduced that overall, 15 participants (15%) were of the opinion that stress can probably be influenced by other factors.

It is often difficult to predict the level of stress, mainly because it may be specific to a certain individual and also to a specific culture. Stress can lead to burnout which undoubtedly is another obstacle to effective public health service delivery which has been researched at S.S.R.N.H. In stressful environments health personnel become resentful, exhausted and eventually experience burnout which will be examined in the next section of this chapter.

4.3.4 Burnout at S.S.R.N.H.

The syndrome known as burnout is closely related to stress. The term "burnout" refers to a state of emotional exhaustion, a depletion of energies, which may be an obstacle to effective public health service delivery (Simon 2001:41). It begins with frustration and disillusionment. Then it leads to the loss of ideals, purpose and energy. The burned-out health personnel may feel apathetic, alienated or exhausted. Burnout is often the end result of excessive pressure at hospital

work, especially where pressure is accompanied by the pursuit of unreachable hospital objectives (Bell 1999:53).

Burnout is harmful to the mental and physical health of the individual and causes work performance obstacles for the individual and institution. Burnout is the result of the negative interaction between the expectations and behaviour of personnel and the system within which they are working (Simon 2001:91).

Section 4(a) of the questionnaire was concerned with whether burnout of health personnel exists at S.S.R.N.H. The information collected on this question is indicated in table 4.4(a).

TABLE 4.4 (a) Views of health personnel on whether there is burnout of health personnel at S.S.R.N.H.										
Question	Number and (percentage)				Number and (percentage)				Total number and overall (percentage)	
	D		N		HS		HM			
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Do you think there is burnout of health personnel at S.S.R.N.H.?	25 (83.3)	5 (16.7)	37 (74)	13 (26)	8 (100)	0	10 (83.3)	2 (16.7)	80 (80)	20 (20)

Key : Doctors = D, Health Managers = HM, Nurses = N, Health Supervisors = HS

With reference to question 4(a) overall, 80 participants (80%) said “yes” [25 Doctors (83.3%), 37 Nurses (74%), 8 Health Supervisors (100%) and 10 Health Managers (83.3%)]. It is observed that among individual groups the response rate was at least 74%, for instance, 25 of the 30 Doctors (83.3%), 37 of the 50 Nurses (74%), all the 8 Health Supervisors (100%) and 10 of the 12 Health Managers (83.3%). Such a high response of the participants show that the

respondents were of the opinion that burnout of health personnel exists at the S.S.R.N.H. Hence, it can be deduced that a great majority of the participants (80%) accepted that burnout of health personnel influence public health service delivery.

Moreover, it is observed that overall, 20 participants (20%) answered “no” on question 4(a), for instance, 5 of the 30 Doctors (16.7%), 13 of the 50 Nurses (26%) and 2 of the 12 Health Managers (16.7%).

4.3.4.1 Factors contributing to burnout

Question 4(b) of the questionnaire was concerned with factors contributing to burnout. The question was based on variables such as *low pay, long working hours, lack of appreciation and understanding, and unresponsiveness to patient needs*. Analysis of the responses in table 4.4(b) shows that the lowest percentage of respondents which indicated “yes” on the above questions was 71%. This shows that at least 71% of participants agreed that the aforementioned variables contribute to burnout. Moreover, it is observed from table 4.4(b) that the lowest percentage of the respondents which answered “no” on the above factors was 10%. It can be concluded that at least 10% of the participants did not agree with the identified variables that can contribute to burnout.

The highest score obtained was on the variable factor *low pay*. Of the total group, 90 participants (90%) responded “yes” on this factor [29 Doctors (96.7%), 42 Nurses (84%), Health Supervisors (100%) and 11 Health Managers (91.7%)]. Among individual groups the response rate was at least (84%). Hence, it can be concluded that this variable can influence public health service delivery at S.S.R.N.H. in a negative sense.

Major factors	Number and (percentage)				Number and (percentage)				Total number and overall (percentage)	
	D		N		HS		HM			
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
• Low pay	29 (96.7)	1 (3.3)	42 (84)	8 (16)	8 (100)	0	11 (91.7)	1 (8.3)	90 (90)	10 (10)
• Long hours	25 (83.3)	5 (16.7)	37 (74)	13 (26)	8 (100)	0	10 (83.3)	2 (16.7)	80 (80)	20 (20)
• Lack of appreciation and understanding	13 (43.3)	17 (56.7)	40 (80)	10 (20)	7 (87.5)	1	11 (91.7)	1 (8.3)	71 (71)	29 (29)
• Unresponsiveness to patient needs	30 (100)	0	38 (76)	12 (24)	8 (100)	0	10 (83.3)	2 (16.7)	86 (86)	14 (14)

Key : Doctors = D, Health Managers = HM, Nurses = N, Health Supervisors = HS

Additionally, an analysis of table 4.4(b) shows that overall, 10 participants (10%) overall responded “no” on the factor, of *low pay*. [one of the 30 Doctors (3.3%), 8 of the 50 Nurses (16%) and 1 of the Health Managers (8.3%)]. Comparatively, more Nurses (16%) than Doctors (3.3%) did not agree with this factor. Hence, it can be deduced that 10% of the participants did not believe that this variable influence public health service delivery.

4.3.4.2 Physical symptoms of burnout

Part 4(c) of the questionnaire was concerned with physical symptoms of burnout. Analysis of the responses in table 4.4(c) shows that the lowest number of the respondents which indicated “yes” on the variables *headache, backache, indigestion and lowered resistance to infection*, was 54 (54%). Thus it can be

deduced that at least 54 participants (54%) agreed that the identified variables are physical symptoms of burnout.

The lowest response rate to “no” on these factors was 1%. It can be stated that at least 1% of the participants was of the opinion that burnout may probably be influenced by other factors.

Physical symptoms of burnout	Number and (percentage)				Number and (percentage)				Total number and overall (percentage)	
	D		N		HS		HM			
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
• Headache	30 (100)	0	49 (98)	1 (2)	8 (100)	0	12 (100)	0	99 (99)	1 (1)
• Backache	15 (50)	15 (50)	25 (50)	25 (50)	6 (75)	2 (25)	8 (66.7)	4 (33.3)	54 (54)	46 (46)
• Indigestion	19 (63.3)	11 (36.7)	20 (40)	30 (60)	7 (87.5)	1 (12.5)	9 (75)	3 (25)	55 (55)	45 (45)
• Lowered resistance to infection	28 (93.3)	2 (6.7)	37 (74)	13 (26)	8 (100)	0	11 (91.7)	1 (8.3)	84 (84)	16 (16)

Key : Doctors = D, Health Managers = HM, Nurses = N, Health Supervisors = HS

Table 4.4(c) shows that the response rate to “yes” on the variable *headache*, (99%), was 30 Doctors (100%), 49 Nurses (98%), 8 Health Supervisors (100%) and 12 Health Managers (100%). Thus it can be stated that the participants agreed that *headache* is a physical symptom of burnout.

Comparatively, the response rate to “yes” on the variable *backache* was 54 percent. 15 of the 30 Doctors (50%), 25 of the 50 Nurses (50%), 6 of the 8 Health Supervisors (75%) and 8 of the 12 Health Managers (66.7%) indicated “yes”.

Hence, it can be concluded that 99 participants (99%) agreed on *headache* and 54 participants (54%) on *backache* as being physical symptoms of burnout. The respondents considered headache as the main physical symptom of burnout as (99%) responded “yes” on this variable.

Analysis of the responses shows that 1 participant (1%) indicated “no” on the factor *headache* as compared with *backache* where the response was 46%. Therefore, a great difference in opinion regarding these variables is observed.

4.3.5 Morale of personnel at S.S.R.N.H.

Morale is the inner strength and energy which enable an official to cope with exacting demands and which counteracts indifference towards even the most menial task (Eriksen 2001:71). High morale implies perseverance. It is generally accepted that the efficiency of S.S.R.N.H. depends partly on the degree of cooperation among the health personnel and on the courage and perseverance of each health worker in rendering public health service to the community (Damar 2002:62).

4.3.5.1 Impact of low morale on public health service delivery at S.S.R.N.H.

Section 5(a) of the questionnaire asked the participants whether low moral at S.S.R.N.H. has an impact on public health service delivery. The results obtained in this question are presented in table 4.5(a).

On question 5(a), overall, 80 participants (80%) said “yes” [17 Doctors (56.7%), 45 Nurses (90%), all 8 Health Supervisors (100%) and 10 Health Managers (83.3%)]. It is observed that apart from the Doctors, the response to “yes” on this question was at least 83.3%. Such a high response of the participants shows that a low level of morale prevails at S.S.R.N.H.

TABLE 4.5(a) Views of health personnel on whether low morale at S.S.R.N.H. has an impact on public health service delivery										
Question	Number and (percentage)				Number and (percentage)				Total number and overall (percentage)	
	D		N		HS		HM			
Do you think that low morale has an impact on public health service delivery?	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
	17 (56.7)	13 (43.3)	45 (90)	5 (10)	8 (100)	0	10 (83.3)	2 (16.7)	80 (80)	20 (20)

Key : Doctors = D, Health Managers = HM, Nurses = N, Health Supervisors = HS

Additionally, 20 participants (20%) answered “no” [13 Doctors (43.3%), 5 Nurses (10%) and 2 Health Managers (16.7%)]. According to the percentage obtained, it is observed that more Doctors compared to Nurses and Health Managers did not believe that low morale has an impact on public health service delivery. Among individual groups the percentage of Health Supervisors was 0% compared to Doctors 43.3%. It can be concluded that overall, 20 participants (20%) were not agreeable on this question that low morale at S.S.R.N.H. has an impact on public health service delivery.

4.3.5.2 Major causes of low morale

Part 5(b) of the questionnaire was concerned with the major causes of low morale at S.S.R.N.H. The question was based on *incompetence and low level of integrity of health personnel, lack of favorable environmental conditions, lack of opportunities for promotion, lack of recognition of good performance* and ultimately *lack of effective supervision*. The outcome of the research survey is presented in table 4.5(b)

TABLE 4.5(b) Views of health personnel on the major causes of low morale at the hospital										
Major causes	Number and (percentage)				Number and (percentage)				Total number and overall (percentage)	
	D		N		HS		HM			
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Incompetence and low level of integrity of health personnel	18 (60)	12 (40)	38 (76)	12 (24)	8 (100)	0	11 (91.7)	1 (8.3)	75 (75)	25 (25)
Lack of favourable environmental conditions	17 (56.7)	13 (43.3)	45 (90)	5 (10)	8 (100)	0	10 (83.3)	2 (16.7)	80 (80)	20 (20)
Lack of opportunities for promotion	27 (90)	3 (10)	30 (60)	20 (40)	7 (87.5)	1 (12.5)	11 (91.7)	1 (8.3)	75 (75)	25 (25)
Lack of recognition of good performance	27 (90)	3 (10)	29 (58)	21 (42)	8 (100)	0	11 (91.7)	1 (8.3)	75 (75)	25 (25)
Lack of effective supervision	18 (60)	12 (40)	38 (76)	12 (24)	8 (100)	0	11 (91.7)	1 (8.3)	75 (75)	25 (25)

Key : Doctors = D, Health Managers = HM, Nurses = N, Health Supervisors = HS

The analysis of the responses presented in table 4.5(b), indicates that the lowest percentage of the respondents which responded “yes” on the identified major causes of low morale, was 75%. The highest response to “yes” was on the variable *lack of favorable environmental conditions* 80%. Among the individual groups it was observed that 17 of the Doctors (56.7%), 45 of the 50 Nurses (90%), Health Supervisors (100%) and 10 of the 12 Health Managers (83.3%) said “yes” on this particular variable. Except Doctors, the response rate on this variable was very high among Nurses (90%), Health Supervisors (100%) and

Health Managers (83.3%). It is observed that quite a significant percentage of Doctors, compared to Nurses, Health Supervisors and Health Managers did not believe that a *lack of favourable environmental conditions* can influence effective public health service delivery. The opinion of Doctors differs considerably from the other groups which all have more or less the same view in this regard. Therefore, Doctors need to be sensitive for the opinion of the other group in this regard.

Moreover, 20 participants (20%) responded “no” on the variable of *favourable environmental conditions*, [for example, 13 of the 30 Doctors (43.3%), 5 of the 50 Nurses (10%) and 2 of the 12 Health Managers (16.7%)]. Comparing results of Doctors (43.4%) with Nurses (10%) a great difference is found. Therefore, it can be deduced that more Doctors, (33.3%), (43.4 -10.1) than Nurses did not agree with this variable as one of the causes of low morale.

The mere fact that the existence of cases of low morale had been observed, can have disastrous consequences in and for an institution where health services are provided. Low morale among health personnel can have an impact on quality health care to patients.

4.3.6 Sexual harassment at S.S.R.N.H.

Sexual harassment is a phenomenon that is causing increasing concern at the hospital level (Eriksen 2001:60). This is another obstacle to effective public health service delivery identified at S.S.R.N.H. Sexual harassment is a manifestation of misconduct which is regarded as a prohibited personnel practice. It is deliberate or repeated unsolicited verbal comments, gestures or physical contacts of a sexual nature which are unwelcome (Gillies 1994: 76).

Sexual harassment at S.S.R.N.H. involves surreptitious touching and groping through which the offender is in reality sending a sexual signal to gauge the sexual potential of the victims. It also entails the use of body language, for

instance, signs, gestures, walking movement and the use of power to deny or undermine the status and role of a colleague. Sexual harassment can have a huge impact upon the safety of health personnel, meritocracy, patients and the hospital environment (Simon 2001:112).

Section 6(a) of the questionnaire was concerned with the question whether there is sexual harassment at S.S.R.N.H. The information obtained on the views of respondents regarding the existence of sexual harassment at S.S.R.N.H. are shown in table 4.6(a).

TABLE 4.6(a) Views of health personnel on whether there is sexual harassment at S.S.R.N.H.										
Question	Number and (percentage)				Number and (percentage)				Total number and overall (percentage)	
	D		N		HS		HM		Yes	No
Do you believe that there is sexual harassment at S.S.R.N.H?	Yes	No	Yes	No	Yes	No	Yes	No		
		30 (100)	0	46 (92)	4 (8)	8 (100)	0	11 (91.7)	1 8.3	95 (95)

Key : Doctors = D, Health Managers = HM, Nurses = N, Health Supervisors = HS

Overall, 95 participants (95%) responded “yes” on this question [30 Doctors (100%), 46 Nurses (92%), 8 Health Supervisors (100%) and 11 Health Managers (91.7%)]. Among the individual groups of participants the response rate was at least 91.7%. which indicates that there is sexual harassment at S.S.R.N.H.

Moreover, 5 participants (5 %) responded “no” [4 of the 50 Nurses (8%) and 1 of the 12 Health Managers (8.3%)]. Among these respondents, the percentage was more or less the same (8 and 8.3%). Thus, it can be deduced that 5% of the participants did not believe that sexual harassment exist at S.S.R.N.H

4.3.6.1 Types of behaviours that are considered as sexual harassment

Section 6 (b) of the questionnaire was concerned with the types of behaviour such as *body language, surreptitious touching and groping, use of power to deny or undermine status* and *verbal comments* that are considered as sexual harassment. Table 4.6(b) indicates the highest score obtained was on *body language* as one of the types of behaviour involving sexual harassment. 99 Participants responded “yes” [30 Doctors (100%), 49 Nurses (98%), 8 Health Supervisors (100%) and 12 Health Managers (100%)]. Hence, it can be stated that overall 99 participants agreed that *body language* involves sexual harassment. Overall, only 1 participant, (1%) responded “no” on this variable. Thus it can be concluded that only 1 respondent (Nurse) was of the opinion that *body language* cannot be considered as sexual harassment.

The lowest score obtained was on the factor *use of power to deny or undermine the status*. Overall, 64 participants (64%) responded “yes” [22 Doctors (73.3%), 23 Nurses (46%), 8 Health Supervisors (100%) and 11 Health Managers (91.7%)]. Among the individual groups, the responses varied significantly, for instance, 22 of the 30 Doctors (73.3%), 23 of the 50 Nurses (46%), Health Supervisors 100% and 11 of the 12 Health Managers (91.7%) responded on this variable. Apart from the Nurses, the responses by all the other individual groups were at least 73.3%. Hence, it can be concluded from this response that 64 participants agreed that *use of power to deny or undermine the status* is one of the types of behaviors that involves sexual harassment. The overall response rate on this variable however, is significantly lower than the other three variables which indicate that it is considered to be of lesser importance than the other three.

TABLE 4.6(b) Views of health personnel on the types of behaviours that are considered as sexual harassment.										
Types of behaviours that involve sexual harassment	Number and (percentage)				Number and (percentage)				Total number and overall (percentage)	
	D		N		HS		HM			
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
• Body language	30 (100)	0	49 (98)	1 (2)	8 (100)	0	12 (100)	0	99 (99)	1 (1)
• Surreptitious touching and groping	29 (96.7)	1 (3.3)	32 (64)	18 (36)	8 (100)	0	10 (83.3)	2 (16.7)	79 (79)	21 (21)
• Use of power to deny or undermine status	22 (73.3)	8 (26.7)	23 (46)	27 (54)	8 (100)	0	11 (91.7)	1 (8.3)	64 (64)	36 (36)
• Verbal comments	30 (100)	0	46 (92)	4 (8)	8 (100)	0	11 (91.7)	1 (8.3)	95 (92)	5 (5)

Key : Doctors = D
Nurses = N

Health Managers = HM
Health Supervisors = HS

Of the total group of participants, 36 participants (36%) responded to “no” on the variable *use of power to deny or undermine status* [8 Doctors (26.7%), 27 Nurses (54%) and 1 health manager (8.3%)]. Comparing, for instance, the results of the Nurses and Health Managers in this regard, it is found that 54% of Nurses indicated “no” whereas 8.3% of Health Managers did not believe that *use of power to deny or undermine status* involves sexual harassment. Therefore more Nurses than Health Managers, for instance, believe that this factor does not influence public health service delivery at the S.S.R.N.H.

4.3.6.2 Effects of sexual harassment

Section 6(c) of the questionnaire was concerned with the effects of sexual harassment, for instance, *depression, anxiety, helplessness, serious physical illness and insomnia*. Table 4.6(c) indicates that the response to “yes”, apart from *serious physical illness* for all other variables, was at least 70%. Such a high response shows that participants believed on the aforementioned effects of sexual harassment. It is also clear that suffering from *serious physical illness* is not considered to be as important as the other four variables.

TABLE 4.6(c) Views of health personnel on the effects of sexual harassment at the hospital.										
Effects of sexual Harassment	Number and (percentage)				Number and (percentage)				Total number and overall (percentage)	
	D		N		HS		HM		Yes	No
• Suffering from depression	28 (93.3)	2 (6.7)	48 (96)	2 (4)	8 (100)	0	10 (83.3)	2 (16.7)	94 (94)	6 (6)
• Suffering from anxiety	29 (96.7)	1 (3.3)	42 (84)	8 (16)	7 (87.5)	1 (12.5)	11 (91.7)	1 (8.3)	89 (89)	11 (11)
• Suffering from helplessness	20 (66.7)	11 (36.7)	32 (64)	18 (36)	8 (100)	0	11 (91.7)	1 (8.3)	70 (70)	30 (30)
• Suffering from serious physical illness	30 (100)	10 (33.3)	22 (44)	28 (56)	5 (62.5)	3 (37.5)	8 (66.7)	4 (33.3)	55 (55)	45 (45)
• Suffering from insomnia	28 (93.3)	2 (6.7)	49 (98)	1 (2)	8 (100)	0	11 (91.7)	1 (8.3)	96 (96)	4 (4)

Key : Doctors = D
Nurses = N

Health Managers = HM
Health Supervisors = HS

The highest overall score obtained was on the effect suffering from *insomnia*. 96 Participants responded “yes” [(28 Doctors (93.3%), 49 Nurses (98%), 8 Health Supervisors (100%) and 11 Health Managers (91.7%)]. Among the individual groups, the response was very high, for instance, 28 Doctors (93.3%), 49 of 50 Nurses (98%), all 8 Health Supervisors (100%) and 11 of 12 Health Managers (91.7%) indicated “yes” on the variable suffering from *insomnia*. From this figure it can be concluded that 96 participants were of the opinion that the victim of sexual harassment suffers from insomnia. Overall, 4 participants (4%) responded “no” [2 Doctors (6.7%), 1 Nurse (2%) and 1 Health Manager (8.3%)]. Therefore, it can be deduced that apart from Health Supervisors, all other individual groups did not totally agree on this after-effect of sexual harassment.

Additionally, the lowest overall score obtained was on suffering from *serious physical illness* as one of the after-effects of sexual harassment. 55 Participants responded “yes” [20 Doctors (66.7%), 22 Nurses (44%), 5 Health Supervisors (62.5%) and 8 Health Managers (66.7%)]. These results show that apart from the Nurses, the responses among all the other individual groups were at least 62.5%. Hence, 55 participants (55%) were of the opinion that the victim of sexual harassment suffers from *serious physical illness*. Overall, 45 participants (45%) responded “no” [10 Doctors (33.3%), 28 Nurses (56%), 3 Health Supervisors (37.5%) and 4 Health Managers (33.3%)]. From this, it can be deduced that more Nurses (56%) than the other groups did not believe that the victim of sexual harassment suffers from *serious physical illness*.

4.3.7 Abnormal behaviours and actions that could have a bearing on effective public health service delivery

Section 7(a) of the questionnaire was concerned with the types of abnormal behaviours and actions that could have a bearing on effective public health service delivery at S.S.R.N.H. Analysis of the responses in table 4.7 shows that apart from *shirking responsibility* (59%), for all other abnormal behaviours and actions the overall response rate to “yes” was at least 60%. Hence, it can be

deduced that at least 59% of respondents believed that *shirking responsibility* could influence public health service delivery at S.S.R.N.H. negatively. Furthermore, the overall response rate to “no” was at least 20%. Therefore, it can be stated that at least 20% of the participants did not believe that could affect public health service delivery at S.S.R.N.H. The section below discusses some of the responses on abnormal behaviours and actions of health personnel researched at S.S.R.N.H.

TABLE 4.7 Opinions of health personnel on the abnormal behaviours and actions that have a bearing on effective public health service delivery at S.S.R.N.H.

Abnormal behaviours and actions	Number and (percentage)				Number and (percentage)				Total number and overall (percentage)	
	D		N		HS		HM		Yes	No
	Yes	No	Yes	No	Yes	No	Yes	No		
• Lethargy and disobedience	20 (66.7)	10 (33.3)	28 (56)	22 (44)	7 (87.5)	1 (12.5)	10 (83.3)	2 (16.7)	65 (65)	35 (35)
• Nepotism	20 (66.7)	10 (33.3)	22 (44)	28 (56)	7 (87.5)	1 (12.5)	11 (91.7)	1 (8.3)	60 (60)	40 (40)
• Shirking responsibility	22 (73.3)	8 (26.7)	22 (44)	28 (56)	6 (75)	2 (25)	9 (75)	3 (25)	59 (59)	41 (41)
• Alcohol and drug abuse	27 (90)	3 (10)	24 (48)	21 (52)	8 (100)	0	11 (91.7)	1 (8.3)	75 (75)	25 (25)
• Active political interference	20 (66.7)	10 (33.3)	30 (60)	20 (40)	8 (100)	0	10 (83.3)	2 (16.7)	68 (68)	32 (32)
• Bribery and corruption	21 (70)	9 (30)	41 (82)	9 (18)	8 (100)	0	10 (83.3)	2 (16.7)	80 (80)	20 (20)
• Dishonesty and retaliation	22 (73.3)	8 (26.7)	20 (40)	30 (60)	8 (100)	0	10 (83.3)	2 (16.7)	60 (60)	40 (40)
• Neglect of duty	29 (96.7)	1 (3.3)	30 (60)	20 (40)	5 (62.5)	3 (37.5)	11 (91.7)	1 (8.3)	75 (75)	25 (25)

Key : Doctors = D
Nurses = N

Health Managers = HM
Health Supervisors = HS

4.3.7.1 Lethargy and disobedience

Lethargy and disobedience on the part of health personnel, can lead to ineffective public health service delivery. If an official willingly does not render public health services, such an official is guilty of a disciplinary offence (Simon 2001:90). A health supervisor has authority over subordinates. The subordinates can only take up a matter, with senior personnel in cases where the health supervisor's orders or assignments are unreasonable, unjustifiable or illegal (James 1995:16). The information obtained on the views of respondents concerning *lethargy and disobedience* at S.S.R.N.H. is shown in table 4.7. Overall, 65 participants (65%) responded to “yes” on the question *lethargy and disobedience* [20 Doctors (66.7%), 28 Nurses (56%), 7 Health Supervisors (87.5%) and 10 Health Managers (83.3%)]. Thus a huge difference in opinion can be observed among these individual groups. Hence, compared to the Nurses (56%) and Doctors (66.7%), the Health Supervisors (87.5%) and Health Managers (83.3%) strongly believed that *lethargy and disobedience* have a negative impact on public health service delivery at S.S.R.N.H.

Overall, 35 participants (35%) responded to “no” on the question *lethargy and disobedience* [10 Doctors (33.3%), 22 Nurses (44%), 1 health manager (12.5%) and 2 Health Supervisors (16.7%)]. Comparing the individual groups of Nurses and Health Supervisors it is observed that 22 of the 50 Nurses which represent 44% of the total group, said “no” while 1 out of the 8 Health Supervisors (12.5%) responded “no”. Hence, it can be stated that more Nurses (44%) did not agree that this variable affect public health service delivery compared to 1 health supervisor (12.5%).

4.3.7.2 Nepotism

One of the most serious malpractices that can occur in a public institution is that family members or friends of the hospital personnel benefit from certain contracts or activities (Simon 2001:92). It has happened that heads of sections have

entered into contracts with companies to render thousands of rupees worth of health services to the departments, only for it to be found at a later stage that the companies belong to the children of high-ranking officials or other family members (Gillies 1994:82). This reduces the efficiency of public health service delivery.

With reference to the research survey, 60 participants (60%) overall responded to “yes” on the question concerning *nepotism* [20 Doctors (66.7%), 22 Nurses (44%), 7 Health Supervisors (87.5%) and 11 Health Managers (91.7%)]. There were differences of responses among the individual groups, for instance, 11 of the 12 Health Managers which represent 91.7% answered “yes” whereas 22 of the 50 Nurses (44%) responded “yes”. Thus it can be concluded that 91.7% of the Health Managers were of the opinion that *nepotism* has a negative or positive bearing on effective public health service delivery at S.S.R.N.H whereas only 44% of the Nurses held this view.

Overall, 40 participants (40%) responded “no” on the question concerning *nepotism* [10 Doctors (33.3%), 28 Nurses (56%), 1 Health Supervisor (12.5%) and 1 health manager (8.3%)]. Additionally, it should be emphasized that 1 of the 8 Health Supervisors (12.5%) and 1 of the 11 Health Managers (8.3%) responded “no” on the question regarding *nepotism*. Among, the Doctors and Nurses the responses to “no” were 33.3% and 56% respectively. Therefore, compared to the Health Supervisors and Health Managers the responses to “no” were high among the Doctors and the Nurses. Thus overall, it can be said that 40% of the participants in the survey did not believe that *nepotism* affect public health service delivery in a negative sense.

4.3.7.3 Shirking responsibility

A health official may *shirk responsibility* by not doing assigned health duties. This type of behaviour involves assigning health duties to unqualified persons (Eriksen 2001:21). For instance, a Nurse may ask a Domestic Servant to

administer an injection to a patient. Such an action is totally non-admissible and subject to disciplinary measures. This is contradictory to administrative law and cannot be tolerated in the hospital.

Overall, 59 participants (59%) responded “yes” on the question *shirking responsibility* [22 Doctors (73.3%), 22 Nurses (44%), 6 Health Supervisors (75%) and 9 Health Managers (75%)]. Table 4.7 shows that except for the Nurses (44%), the responses to this variable were above 70% among the Doctors, Health Supervisors and Health Managers. For instance, 22 out of 50 Nurses (44%) and 22 of the 30 Doctors (73.3%) responded “yes”, whereas 6 out of the 8 Health Supervisors (75%) and 9 of the 12 Health Managers (75%) said “yes”. Hence, such a high percentage indicates that this variable definitely influences effective public service delivery at S.S.R.N.H. in a negative sense.

It is also observed that 41 participants (41%) overall responded “no” on the question regarding *shirking of responsibility* [8 Doctors (26.7%), 28 Nurses (56%), 2 Health Supervisors (25%) and 3 Health Managers (25%)]. Among the individual groups, the highest response on *shirking responsibility* was 28 out of 50 Nurses (56%) compared to 8 out of 30 Doctors representing 26.7%. Taking into consideration these figures it can be concluded that there was a difference of 29.3% (56 – 26.7) among the Nurses and Doctors as regarded to “no” on this variable which indicates that quite a significant number of Nurses compared to Doctors did not believe that *shirking responsibility* can influence effective public health service delivery at the S.S.R.N.H. The fact that the Nurses differ significantly from the other groups which all have more or less the same opinion in this regard, means that it is possible that the other groups may be aware of something that the Nurses are lacking information about. Therefore, the Nurses need to be sensitive for the view of other groups in this regard.

4.3.7.4 Alcohol and drug abuse

The quality of public health services can drop owing to alcoholism and drug abuse. Any health official, who drinks alcohol or uses habit forming drugs during official working hours or while on duty, is guilty of misconduct. The specific department can order an immediate medical examination of the health official (James 1993:20).

Table 4.7 indicates that overall 75 participants (75%) answered “yes” on the question regarding *alcohol and drug abuse* [27 Doctors (90%), 24 Nurses (48%), 8 Health Supervisors (100%) and 11 Health Managers (91.7%)]. It should be mentioned that apart from the Nurses (48%) the responses among all other individual groups were at least 90%. It can be said that the fact that the Nurses differ significantly from the other groups which all have more or less the same view in this regard, indicates that possibly the other groups may be aware of something that the Nurses are lacking information about. Thus the Nurses need to be sensitive for the opinion of the other groups in this regard.

Therefore, it can be argued that the participants agreed that alcohol and drug abuse during the office hours are subject to disciplinary action. Their opinions are indicative that effective public health services cannot be provided as long as this problem exists at S.S.R.N.H. Overall, 25 participants (25%) responded “no” on question *alcohol and drug abuse* [3 Doctors (10%), 21 Nurses (52%) and 1 health manager (8.3%)]. Comparing the responses of the Nurses and Health Managers, a huge difference of 43.7% is observed (52-8.3). Thus, it can be deduced that 43.7% more Nurses than Health Managers did not believe that this factor has an effect on public health service delivery at S.S.R.N.H.

4.3.7.5 Active political interference

When health personnel embark on any lobbying to achieve political favours it may result in the reduction of the quality of public health service delivery (Eriksen

2001:91). Health personnel who are actively or publicly involved in politics cannot be acceptable in a health institution like S.S.R.N.H.

Table 4.7 shows that overall, 68 participants (68%) answered “yes” on question *active political interference* [20 Doctors (66.7%), 30 Nurses (60%), 8 Health Supervisors (100%) and 10 Health Managers (18.3%)]. From these responses it can be mentioned that *active political interference* can lower the effectiveness of public health service delivery at S.S.R.N.H.

Additionally, 32 participants (32%) of the total group responded “no” on the question regarding *political interference* [10 Doctors (33.3%), 20 Nurses (40%) and 2 Health Managers (16.7%)]. Among the individual groups the highest response to “no” on this variable was 20 out of 50 Nurses (40%). Comparing the response percentages of the Nurses and Health Managers, a difference of 23.3% (40 – 16.7) is observed. Hence, it can be deduced from this figure that more Nurses than Health Managers did not believe that *active political interference* has an impact on public health service delivery at S.S.R.N.H.

4.3.7.6 Bribery and corruption

It has become common practice to "reward" someone who has rendered friendly or efficient public health service. In the public health service this type of "gift" is not acceptable which is considered as a form of "disguised subjective corruption". Accepting gifts, calendars or displaying the telephone numbers of contractors may be construed in the strictest sense as bribery. Health officials indulging in bribery and corruption are subject to disciplinary action (Miller 2000:2).

With reference to question 7(a) on *bribery and corruption* in the survey at S.S.R.N.H., 80 participants (80%) responded “yes” [21 Doctors (70%), 41 Nurses (82%), 8 Health Supervisors (100%) and 10 Health Managers (83.3%)]. Such a

high score indicates that *bribery and corruption* can affect the delivery of effective health services to patients at the hospital.

It is observed from table 4.7 that 20 participants (20%) responded “no” on the question *bribery and corruption* [9 Doctors (30%), 9 Nurses (18%) and 2 Health Managers (16.7%)]. Comparing the individual groups, it is observed that 9 of 30 Doctors (30%), 9 of the 50 Nurses (18%) and 2 of the 12 Health Managers (16.7%) did not agree that this variable has an effect on public health service delivery. Moreover, a huge difference is noted among Health Supervisors (0%) and Doctors 30% in this regard. Thus it can be concluded from this that Health Supervisors (100%) fully agreed that *bribery and corruption* can lead to ineffective public health service delivery whereas 30 % of the Doctors did not believe that this is the case.

4.3.7.7 Dishonesty and retaliation

Retaliation is based on the idea of getting even with an institution for actual or perceived inequalities (Miller 2000:90). One manifestation of retaliation is sabotage, which includes the intentional destruction of the property of the S.S.R.N.H. such as offices or equipment.

With reference to the survey carried out, table 4.7 shows that 60 participants (60%) of the total group of participants, responded to “yes” on the question regarding *dishonesty and retaliation* [22 Doctors (73.3%), 20 Nurses (40%), 8 Health Supervisors (100%) and 10 Health Managers (83.3%)]. This shows that a significant percentage of Doctors (73.3%), Health Supervisors (100%) and Health Managers (83.3%) compared (26.7%) did believe that *dishonesty and retaliation* can influence effective public health service delivery. The fact that Nurses differ considerably from other groups which all have more or less the same view in this regard means that it is possible that the other groups may be aware of something that Nurses are lacking information about. Thus Nurses need to be more sensitive as for as the opinions of other groups are concerned.

Overall, 40 participants (40%) responded “no” on question *dishonesty and retaliation* [8 Doctors (26.7%), 30 Nurses (60%) and 2 Health Managers (16.7%)]. Comparing the individual groups, it is observed that the highest response was 30 of the 50 Nurses (60%) whereas for the Doctors it was 8 out of 30 representing 26.7% and 2 Health Managers out of 12 indicating 16.7%. Hence, from this it can be deduced that more Nurses compared to the other individual groups in the research survey were not agreeable that *dishonesty and retaliation* have a negative or positive bearing on effective public health service delivery.

4.3.7.8 Neglect of duty

Neglect of duty in a hospital leads to ineffective public health service delivery (Gillies 1994:90). This occurs when health instructions are not obeyed by health personnel. Such behaviour is regarded in a serious light because it causes damage to the public institution and reduction in the quality of public health service delivery.

Table 4.7 shows that overall 75 participants (75%) responded to “yes” on the question *neglect of duty* [29 Doctors (96.7%), 30 Nurses (60%), 5 Health Supervisors (62.5%) and 11 Health Managers (91.7%)]. Among the individual groups the responses to “yes” on the question regarding *neglect of duty* was at least 60%, [for instance, 29 of the 30 Doctors (96.7%), 30 of the 50 Nurses (60%), 5 of the 8 Health Supervisors (62.5%) and 11 of the 12 Health Managers (91.7%)]. The response among Doctors is very high (96.7%) compared to the Nurses (60%); in other words, more Doctors than Nurses were of the opinion that neglect of duty has a bearing on effective public health service delivery at S.S.R.N.H. In a health institution like S.S.R.N.H. which provides health services to patients, *neglect of duty* can lead to death of patients. Therefore, an average response of (100%) on this variable, indicating “yes”, is much more preferable. The fact that only (60%) of the Nurses and (62.5%) of Health Supervisors

responded “yes” on the question *neglect of duty*, however, is something to be concerned about. A greater sense of responsibility especially from these two groups is preferable in this regard.

Overall, 25 participants (25%) responded “no” on the question *neglect of duty* [1 doctor (3.3%), 20 Nurses (40%), 3 Health Supervisors (37.5%) and 1 health manager (8.3%)]. Comparing the responses of the Doctors and Nurses it is found that the response among Nurses is very high (40%) whereas for Doctors it is only 3.3%. Therefore, it can be deduced that a significant higher percentage of Nurses than Doctors did not agree that this variable has an impact on public health service delivery at S.S.R.N.H.

4.4 SUMMARY

The purpose of this chapter was to explore and analyse the nature of public health service delivery at S.S.R.N.H. and to identify some major obstacles and flaws in effective public health service delivery at the hospital. The efficiency of public health service delivery is reduced owing to factors like absenteeism, personnel turnover, stress, burnout, morale and sexual harassment.

This chapter focussed on absenteeism as a costly variable that affects public health service delivery. Attention was devoted to the factors leading to absenteeism such as the ability to attend to hospital work and motivation to attend to hospital work. Personnel turnover has been examined in this chapter with particular attention to the major causes of personnel turnover. Public health service delivery becomes costly when there is an excessive high staff turnover. Additionally, hospitals are frequently seen as a stressful environment to work in. Constant interaction with sick people creates stress and this section of the study analysed some principal sources of stress at this hospital.

The syndrome known as burnout is linked with stress. Burnout is harmful to the mental and physical health of officials in a hospital. This chapter threw light on

the factors contributing to burnout, namely low pay, long hours, lack of appreciation and understanding and unresponsiveness to patient needs at S.S.R.N.H.

Furthermore, causes of low morale, such as a lack of supervision, lack of opportunities for promotion, lack of recognition of good performance, lack of favourable environmental conditions, incompetence and low level of integrity were analysed in this chapter. Also, the effects of sexual harassment on public health service delivery, among others, have been explained.

Ultimately, this chapter concluded with an overview of the various abnormal behaviours and actions that could have a bearing on effective public health service delivery *viz* lethargy and disobedience, nepotism, shirking responsibility, alcohol and drug abuse, active political interference, bribery and corruption, dishonesty and retaliation and neglect of duty. The next chapter highlights the current national health policy for improving public health service delivery in Mauritius.