A COMMUNICATION PERSPECTIVE ON CHALLENGES FACED BY KEY GOVERNMENT SECTORS IN THE ADOPTION AND APPLICATION OF BATHO PELE PRINCIPLES:

A Case Study of Addington and R. K. Khan hospitals

By

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DECLARATION

I, Padhma Moodley, declare that this dissertation: "A communication perspective on the challenges faced by key government sectors in the application and adoption of Batho Pele principles: A case study of Addington and R.K.Khan hospitals" is my original work. All sources contained herein, have been indicated and acknowledged by means of complete references. No person has been quoted without their permission. Respondents' privacy has been respected. Proper acknowledgement is given to authors for the use of their work.

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Padhma Moodley Date

Writing Conventions

The following conventions are used in this study:

- Hall (2002:165). This means Hall, 2002: page165.
- Illustrative graphics and table of figures are given in chronological order.
- Footnotes are not used in this study in order to allow an uninterrupted reading of the dissertation.
- Appendix is not used in this study in order to allow continuous interpretation of the dissertation.
- This thesis is written using South African English.
- The writer uses the ampersand logogram to denote 'and' in names of authors.

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DEDICATION

The efforts of this study are dedicated to:

- My mother who lost her battle to cancer during the compilation of this thesis.
- For my daughters, Maxine, T.J and Sarah.
- To those who have to utilise the public health facilities in South Africa.
- To every working mother who I know have infinite reserves of energy for their families.

This is for you.

ABSTRACT

A Communication Perspective on Challenges Faced by Key Government Sectors in the Adoption and Application of Batho Pele Principles:

A Case Study of Addington and R.K.Khan Hospitals.

The under-resourced and overused public health sector of South Africa has been the subject of national policy reform initiatives and frequent government led investigations. Subsequently, in October 1997, the government introduced eight Batho Pele principles to serve as acceptable policy and legislative framework regarding service delivery in the public service. However the media has constantly criticised the public health system for their pathetic service delivery. Hospitals and clinics have been portrayed as being overburdened and under-productive. Multiple efforts by the government to remedy (and rescue) the situation have not decreased nor diminished the problems.

The primary goal of this study is to examine the *current* quality of service offered by the public health system in South Africa especially in terms of service delivery proposed by the Batho Pele principles. More importantly, how the Batho Pele principles are communicated to the external publics will be evaluated to ascertain the challenges key government sectors face in the adoption and application of these principles. The participation of patients and staff members of two public health facilities in KwaZulu-Natal provided this study with valuable information on which this study is based. The data was collected through the use of structured interviews of in-patients and questionnaires for both outpatients and staff members. A total of 255 patients and 92 staff members participated in this study. Further, the study exposes provocative and controversial issues in the public health system and hopes to stir awareness amongst its respective leaders and its publics. This study demonstrates how challenges faced by the public health organisations through poor ineffective communication techniques caused it to fail to meets its intended purpose. This study also exposes provocative and controversial challenges which place our health care system at risk of total annihilation if left unattended. The study speaks to issues of accountability such as: planning, budgeting and decision making and the plight of the people of our nation.

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Acronyms

ANC	African National Congress
DA	Democratic Alliance
DOH	Department of Health
GCIS	Government Communication and Information Systems
GDP	Gross Domestic Product
HIV/AIDS	Human Immunodeficiency Virus/ Acquired Immuno Deficiency Syndrome
HSRC	Health Science and Research Council
HST	Health Systems Trust
ICU	Intensive Care Unit
JLI	Joint Learning Institute
LIC	Low Income Countries
NDOH	National Department of Health
NGO	Non-Governmental Organisation
OECD	Organisation for Economic Co-operation and Development
PHC	Public Health Care
PRISA	Public Relations Institute of South Africa
RDP	Reconstruction and Development Programme
SPSS	Statistical Programming for Social Sciences
TB	Tuberculosis
WHO	World Health Organisation
WPTPSD	White Paper on Transforming Public Service Delivery

CHAPTER ONE

ORIENTATION TO THE STUDY

INTRODUCTION

This study seeks to determine the challenges faced by key government sectors in the adoption and application of the Batho Pele principles at provincial hospitals in KwaZulu–Natal. The hospitals address the public health sector where the need for service delivery is dire. The selection of the hospitals in representing a key government sector is important to this study as it is in these hospitals that larger numbers of people are attended to on a daily basis also, it where the success or failure of service delivery can be evaluated. This study will trace the initial creation of the Batho Pele Principles then proceed to determine how these principles were adopted by the public health personnel. Further the application of these principles to the services rendered will be evaluated. Key to this study will be the comparative analysis of the on-going Batho Pele assessments that are carried out systematically. The findings of these assessments will be an important component to this study as it will be used to guide this study towards highlighting the primary challenges faced by the public health sector in the implementation of the Batho Pele Principles.

BACKGROUND OF THE STUDY

Most developing and third world countries face major challenges when it comes to service delivery of basic medical care. This is according to Peters (2009:2) who further recommends that strengthening health care is a priority for countries to be able to meet the basic health needs of their people especially for poor and vulnerable populations. South Africa is no exception to this as the spotlight is continually being shed on the poor service delivery which is encountered on a daily basis.

To remedy the situation which has drawn immense public attention since the early 90's, the government initiated a proposed solution which is called "Batho Pele" which means 'People First'. According to the Batho Pele handbook (1995), the principles of Batho Pele were conceived with the intention of improving service delivery within government sectors by supporting the transformation of the public service into a citizen orientated organisation. The Batho Pele handbook further elaborates that this was extended to the White Paper on transforming the public service also known as the Batho Pele White Paper. The principles include the following:

- Consultation
- Service Standards
- Access
- Courtesy
- Information
- Openness and Transparency
- Redress / Dealing with complaints
- Best Value

In KwaZulu-Natal there are three additional principles. These are:

- Encouraging Innovation and Rewarding Excellence
- Service Delivery Impact
- Leadership and Strategic Direction

STATEMENT OF THE PROBLEM

It has been more than fourteen years since the implementation of the Batho Pele policy. However many major government sectors especially hospitals are still plagued by poor service delivery, which the government had intended would be remedied by the application of the Batho Pele principles. This study aims to investigate the challenges faced in the adoption and application of Batho Pele principles at provincial hospitals in KwaZulu-Natal that could be remedied through improved communication strategies.

MOTIVATION FOR THE STUDY

Although the Batho Pele Principles were implemented over fourteen years ago, the provision of services especially in the public health sector has not been addressed at a feasible pace. Chelechele (2010:44) states that even though South African public service in national, provincial and municipal spheres, has committed itself to addressing the problems and disparities of service provision, many provinces are still confronted with extensive service backlog. Chelechele attributes this to poor policy implementation and the lack of monitoring of the service in the provincial government.

The White Paper (1997) requires of departments to regularly and systematically inform the public on current and new service provision. This ultimately means that there has to be consultation between government and the users of services through customer surveys, interviews and with individual users. According to a report compiled by Job Mokgoro

consulting c.c. (2003), on the Batho Pele Policy Review final report and recommendations, consultation should be seen as a two way process, when deliberations take place between the government and the public. This study is, therefore, motivated by the lack of consultation between the government and the public in the area of service delivery. An essential aspect of Batho Pele is the ability to transform the manner in which civil servants communicates with the public.

The government has invested in the Batho Pele Principles which were conceived to improve service delivery. However, the rate of adoption and application of these principles have not been considered in the evaluation of the influence of Batho Pele Principles on service delivery. The challenges that these key sectors have experienced in the adoption and application of the Batho Pele Principles will be investigated. The public health sector is one of the government sectors that is the focus of this study.

Significance of study

Poor service delivery at key government sectors have constantly come under the spotlight of society in South Africa. This research aims to highlight the challenges faced by these sectors in the adoption and application of the Batho Pele Principles to remedy the current situation. The research would be valuable as this study would provide the stakeholders with an independent view on the challenges faced at key government sectors.

The Research Question

This study addresses the following main problem:

What are the communication challenges faced by key government sectors in the application and adoption of Batho Pele Principles?

Objectives of the Study

The main problem has been sub-divided into the following objectives:

1. To analyse the application and adoption of the Batho Pele Principles towards the improvement of service delivery in key government sectors.
2. To evaluate the effects of the communication challenges faced by key government sectors in the application and adoption of Batho Pele Principles.
3. To determine the effectiveness of the communication strategies implemented in the adoption and application of the Batho Pele Principles.

4. To ascertain the effectiveness of the application of Batho Pele Principles in key government sectors.

RESEARCH METHODOLOGY

Research methodology refers to the methods, techniques and procedures that are utilised in the process of implementing the research design (Babbie and Mouton, 2001:647). The methodology planned for this study will now be briefly explained and described.

The nature of the study deemed it necessary to employ both quantitative and qualitative research approaches. This study seeks to evaluate the success of the Batho Pele principles which are aimed at improving the level of service delivery in hospitals within the Durban south basin. A quantitative research approach involves the analysis of numerical data. Thomas (2003:1) provides an appropriate explanation of the use of quantitative research approach which he says focus attention of measurements and amounts of the characteristics displayed by the people and the events the researcher studies. Patton (2002:4) states that qualitative data usually comes out of three kinds of data collection. He cites these to be: in depth open ended interviews; direct observation and written documents. He further elaborates that qualitative data can be presented together with quantitative data. An important observation in his book is that he states that the quality of qualitative data depends to a large extent on the methodological skill, sensitivity and integrity of the researcher. Another important observation is that he identifies that in order to generate useful and credible findings; it requires discipline, knowledge, training, practice, creativity and hard work.

RESEARCH DESIGN

The research design employed in this study will be a survey. The empirical research will be conducted by means of questionnaires that will be designed for the internal publics of the hospitals which will include staff members and for the external publics of the hospitals which will include both in and out patients. Semi- structured interviews will also be used to collect data. The responses on all completed questionnaires will be encoded into the statistical programme called SPSS 18.0 for processing and analysis.

SAMPLING

The sample size required for this research study will be 400 participants inclusive of the external and internal publics of the two hospitals involved in this research. Convenience sampling will be used for this study. Convenience sampling selects cases that are based on their availability

(Terre Blanche and Durrheim, 1999:279). The patients at the hospital will be approached by the researcher according to their availability as well as available staff members.

Ethical considerations

Bless et al. (2007) state that "most researchers may be well-intentioned and honest people; however, there is always a potential for the rights of research participants to be violated, either knowingly or unknowingly. Participants have basic rights when they elect to participate in a research study, chiefly right to privacy and protection from physical and psychological harm." Hayes (2000) emphasizes that it is our responsibility as researchers to make sure that we do not put ourselves in situations that are outside our professional competencies, in other words, the researcher will only focus on the participants' views relating to the aim of the study. This study involves patients at hospitals which will require ethical clearances from the University of Zululand, permission from the hospitals as well as ethical clearance from the Provincial Department of Health. Informed consent will be obtained from the participants.

Conclusion

The orientation provided an overview of the path that this study will take to achieve its objectives. The background of this study highlighted the importance of the basis for this research whilst the motivation provided the impetus for this study. The significance of addressing the state of the level of service delivery at key government sectors, very especially the public health sector is the valuable contributions this research will make towards the improvement of service delivery in South Africa. The objectives were outlined which will guide the direction of the research methodology and design of this study. The next chapter introduces communication within the organisation and looks into valuable components that contribute towards effective organisational communication.

CHAPTER TWO

COMMUNICATION FOR ORGANISATIONAL HARMONY

INTRODUCTION

This chapter provides a comprehensive detailing of communication within an organisation, in order to illustrate the nature of communication within the government and its various publics. The discipline of communication cannot be excluded from government's aims to improve service delivery within South Africa. The absence of proper communication strategies could see the failure of the mission of the GCIS which is to lead the strategic communication of government, ensure coherence of message and open and extend channels of communication between government and the people towards a shared vision (GCIS, 2010).

According to the Batho Pele Handbook (1995) the transformation of service delivery in South Africa relies on the communication strategies utilized by the government to propagate the Batho Pele Principles. In so doing, the government has realised that customer satisfaction cannot solely be achieved without good internal and external communications. These sub fields of communication lend itself to a context of communication which is organisational communication.

ORGANISATIONAL COMMUNICATION

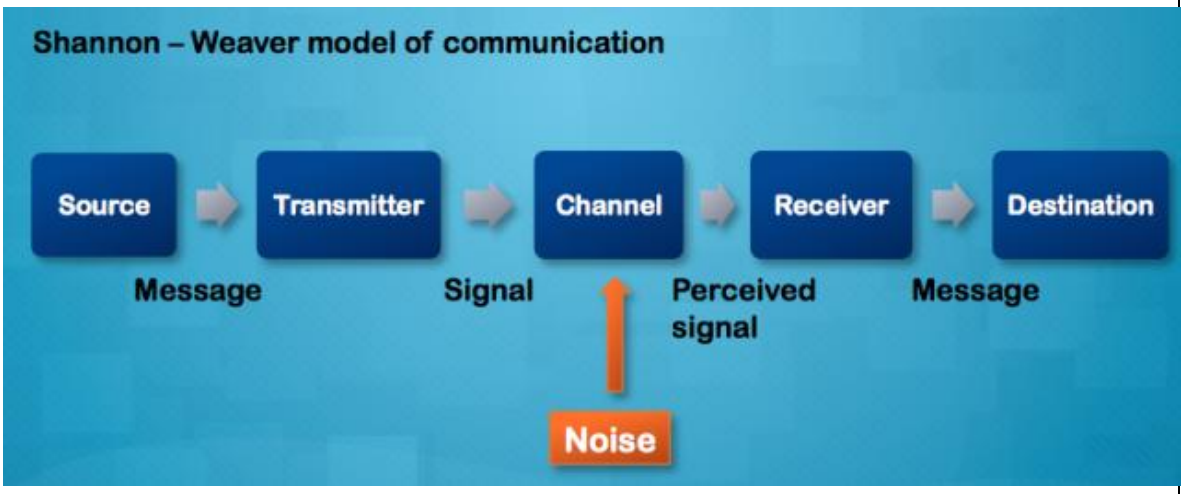
According to Conrad and Poole (2004) the word 'organisation' refers to structure. Wood (2009) describes this structure as a set of procedures, relationships, and practices that provides predictability for members so that they understand roles, procedures, and expectations and so that work gets done.

Neher (1997:31) views organisations in general as on-going patterns of interactions among people; these patterns are usually planned, sequential and systematic. According to Baker (2002), organisational communication spans "communication at the micro, meso, and macro levels; formal and informal communications; and internal organisational communication practices (newsletters, presentations, strategic communications, work direction, performance reviews and meetings) as well as externally directed communications (public, media, inter-organisational)". Goldhaber (1990) identifies a number of "common characteristics in the diversity of definitions of organisational communication which 1) occurs within a complex open system which is influenced by, and influences its internal and external environments, 2) involves messages and their flow, purpose, direction, and media, 3) involves people and their attitudes,

feelings, relationships, and skills". These views contribute towards the understanding that organisations are held together by communication (Steinberg 2011:291).

A Model of Communication

According to Andretta (2010), a communication model that best describes organisational communication is that of Shannon and Weaver (1949) as cited by Fiske (1990:6) which is concerned with the efficiency of message transmission and the element of what Shannon and Weaver termed as 'noise' described the interference or unwanted information that affects the transmission of the intended message. Andretta further states that noise may include different meanings people associate with words, tone, gestures, and other body language.



Source: Sandu, O (2010)

FIGURE 1: The Shannon and Weaver Model

This communication model was originally developed to evaluate the efficiency of telephone cables and radio waves. However the design of the model has been utilised to explicate more complex issues on communication by various other the theorists whose focus rests on the multitude of factors that affect the transmitter - receiver relationship. Hall (2002:163) further states that the individual and organisational factors contribute to communication problems, such as omission, distortion and overload. Andretta (2010) explains that individual human factors affecting the flow of information may include motive, knowledge, experience, attitudes,

values and beliefs while organisational factors may include technological sophistication, size, structure and complexity.

Effective Organisational Communication

According to Andretta (2010), the assumption that effective internal communication is essential to the effective functioning of any organization is supported by a large body of theoretical and empirical literature. Hall (2002:165) suggests that effective communication should consist of accurate information with the appropriate emotional overtones to all members who need the communication content. This assumes neither too much nor too little information is in the system and that it is clear from the outset who can utilise what is available.

Neher (1997) formulated five basic propositions which may be used as a premise for his view on communication. In brief the five basic propositions are:

- Communication is the fundamental process of organising.

This means that the requirement for organizing is bringing people together in order to achieve a specific goal. Good governance relies very heavily on the organisational skills of its departments to ensure its own effectiveness.

- Understanding organisational communication provides insight into the working of organisations in our lives.

This means that having a good understanding of organisational communication will enable the staff members to participate more effectively in government as well as to interact more effectively with each other.

- Communication skills are the basis for effective leadership in organisations.

This proposition places emphasis on the importance of leadership skills in the effective functioning of organisations such as government departments. Key to the leadership skills are essentially communication skills.

- Communication is the key to sound decision making within organisations.

Decisions are often made by groups within the organisation, although there are individual roles within organisations where the final responsibility for decision making is assumed. Effective organisations are often characterised by good leadership and sound decision making.

- Diversity characterises modern organisations.

This identifies with the diversity within the South African work environment. The heterogeneous organisations lend itself to the many opportunities for a multicultural and non-sexist work environment, even at management levels. The major implication here is that the communication processes that take place in the organization could involve cultural differences.

Perspectives of Organisational Communication

According to Du Plessis et al. (2001) the communication activities in an organization can be looked at from various perspectives. Ultimately these perspectives provide a number of ways in which one can view organisational communication. These perspectives include the functionalist perspective, interpretivist perspective and the critical perspective. Du Plessis et al. (2001) provide a brief explanation for each of the perspectives:

Functionalist Perspectives

In this perspective the messages and/or behaviour are interpreted in terms of functions they perform, such as maintenance functions. Du Plessis et al. (2001) continues to explain that this approach entails adoption of a model which explains communication in terms of scientific laws that can predict behaviour and the effect of messages. It is usually aimed at determining how to improve things. For example, communication audits are carried out to determine the effectiveness of communication in an organization.

Interpretivist Perspective

This perspective, according to Du Plessis et al. (2001), is primarily directed at understanding and explaining human behaviour. It concentrates on understanding people's experiences rather than on improved productivity. Typical investigations would focus on establishing how many of the social needs of people are satisfied by their interaction with those with whom they work. According to anthropologist Havilland (1993), culture consists of the abstract values, beliefs, and perceptions that lie behind people's behaviour. This idea captures the important difference between the interpretivist and the traditionalist perspective of organisational communication. The traditionalist understands the world of social action by studying and relating observable and tangible actions and conditions. The interpretivist tries to uncover the culture that, as Haviland

puts it, lies behind these actions and conditions. Social action is possible only to the extent that people can share subjective meanings. According to Putnam (1982), the culture of an organization is a network of such meanings. Therefore it can be said that an organization exists in the shared experiences of the people who constitute it. This means, that organisational reality is socially constructed through communication.

Critical Perspective

The concern in this perspective according to Du Plessis et al. (2001) is with issues relating to power and control within organisations. Usually it is strong ideological researchers which attempt to establish whether employees are being exploited by management or owners.

Further, Tompkins and Redding (1988) explain that "critical scholars regard organisations as instruments of privilege or even outright oppression. They focus their attention on the relationship between privileged classes (or privileged conditions) and disadvantaged or oppressed organisational groups. They are concerned with the way in which that relationship is created and sustained through symbols and discourse. The privileged usually include owners, executives, the political elite, and even dominant ways of thinking and acting (e.g., masculine rationality)". The disadvantaged or oppressed usually include workers, women, minorities, and others who are denied privilege or otherwise discounted in organisational life.

Theories of Organisational Communication

In order to best understand the ways in which organisations have progressively changed and developed their approach over the years, a brief explanation of organisational theories that played an integral role will be discussed.

The Classical and Scientific Management Approach

Du Plessis et al. (2001) state that systematic research and theorizing about management emerged in the 19th century with the advent of the Industrial Revolution. This development gave rise to the possibility of reproducing products on a mass basis. The challenge this posed to the owners of the factories was how to organize work effectively in order to ensure quality and increase efficiency. People such as Charles Babbage and Frederick Taylor and others attempted to solve this problem. This gave rise to the scientific management theory.

The scientific management approach emphasized the importance of the thorough analysis of work and work flow. This in turn highlighted the function of organization as a key management function. Du Plessis et al. (2001) further state that the philosophy underlying this approach was that workers were lazy and not very intelligent, or that they deliberately withheld

their cooperation. Consequently there was a belief that all that was needed was to motivate workers economically. This underlying philosophy in its turn led to a leadership style of strict control, little delegation of authority and the powerful and speedy administration of punishment in order to maintain discipline. According to Ivo (2006), the classical management approach placed much emphasis on industrialisation. The well-being of the employees was not considered at any level.

Human Relations and Human Resource Development Theories

According to Harrison (1997), the Human Relations System was seen as a progress from the rigidity of the classical and scientific approach. Du Plessis et al.(2001) place the theory into perspective by stating that the focus of the Human Relations and Human Resource Development theories shifted to aspects such as motivation, group dynamics and other interpersonal processes whose goal was to change and to explain human behaviour in respect of productivity and to improve physical and psychological welfare. This meant the key management function became the handling of staff. No longer were workers seen as mere tools, but as valuable resources in enterprises, who merited investment in order to ensure economic survival. As a result of this, managers were prepared to balance their own needs such as productivity and profit against those of their employees- job satisfaction and self-actualisation.

System and Contingency Theories of Organisations

According to Waldron et al. (1997) modern management is characterized by two approaches, the systems and the contingency approach. The systems approach views the organization as a total system comprised of interacting subsystems, all of which are in complex interaction with the relevant external environment. Du Plessis et al. (2001) state that whereas the systems approach emphasises the environment in which the organisation functions, the contingency theory sees the environment in which the organisation functions as decisive to what happens to the organisation. Du Plessis et al. further state that the system and contingency approaches heralded a move away from the earlier mechanistic views on organisations. Organisations were now seen as dynamic and living organisms which were in interaction with the environment in which the organisation existed. The systems theory emphasised the interdependence of the part which constitute the system, as well as the systems interaction with the environment. Within the different systems approaches, communication is seen as a key activity.

Functions of Communication in Organisations

According to McCroskey and McCroskey (2005) and Baker (2002) communication serves many functions in organisations. It is the culmination of the various functions that facilitate effective communication within the organisation. Each of the following function of communication is not mutually exclusive to one another. The following functions are a collaboration of different theorists based on the nature of the organisation.

Informative Function

McCroskey and McCroskey (2005) state that the informative function of communication is

> "fairly self-explanatory. It is the function of providing needed information to personnel so they can do their jobs in an effective and efficient manner. People need to be informed about any changes of procedure or policy that are related to their work. Sometimes this function is accomplished by people at higher levels sending information to people at lower levels and the reverse".

At other times, people needing information must contact people who have the needed information to acquire it. Much of the informative communication in organizations is conducted in a written format. This way, a whole group of employees can be informed with one message and at one time. On the other hand, managers may decide to call a meeting once each week (or month) which is primarily of an informative nature. McCroskey and McCroskey further state that most employees understand that such meetings are for the purpose of disseminating information and can be prepared to inquire about matters which they feel they need additional information.

Regulative Function

McCroskey and McCroskey explain that the regulative function of communication is "involved with the communication that is directed toward regulatory policies within the organization or messages about maintenance of the organization." According to Baker (2002) communication as a means of coordination and regulation becomes more important, complex, and difficult. For example, an employee might be informed by the manager that he or she has broken some rule or regulation and is not to break it again. Communication that involves the regulative function is often not pleasant, but it is essential to the smooth operation of the organization.

Integrative Function

McCroskey and McCroskey (2005) see the integrative function of communication as "being focused on coordination of tasks, work assignments, group coordination, or the fusing of work units toward a common goal." In other words, it is communication directed at getting people

to work together and have tasks coordinated so that the "left hand knows what the right hand is doing." It is an attempt to get people to work together and make things run more smoothly. For example, consultants often will find employees duplicating each other's work, whereas if there were more integrative communication, one could do one task and another do a related task.

Management Function

McCroskey and McCroskey (2005) explains the management function is "communication focused on getting personnel to do what is needed, learning information about personnel to know them better, and establishing relationships with personnel. If one can meet the interpersonal relationship goal and the understanding goal, he or she might have a better chance at knowing "how to manage" the employees".

Altinoz (2009) explains that improving management begins with communication. Managers utilise communication in many organisational activities such as decision-making, problem solving, explaining organisational decisions, using discretion, giving authority, motivating, organization development, making suggestions, reconciling, managing conflicts, training, informing, planning, and setting goals and objectives. Planned communication by management contributes to the improvement of the linear, vertical, and inter-departmental relations among employees, causing positive change in their expectations, morale, and behaviours. This change in behaviour increases staff productivity and energy in their functions.

Persuasive Function

Champoux (1996), maintain the persuasive function of communication is an outgrowth of the management function. Here the supervisor tries to influence the employee to perform a particular task. Whereas simply issuing an order might accomplish the same function, this approach makes for much better relations between supervisors and subordinates.

Socialisation and Organisational Function

Neher (1997) and Rogers and Rogers (1976) emphasize the social and organisational functions of organisational communication as "a whole rather than focusing on the functions of specific communication exchanges". Thus they combine the functions of informing, directing, and regulating into the broader category of behavioural compliance. They also give greater emphasis on the role of communication in managing threats to organisational order and control, identifying problem solving and conflict management, negotiation, and bargaining as key functions of organisational communication.

Myers and Myers (1982) and McCroskey and McCroskey (2005) see the socialisation function as being integrated into the communication networks in the organisation. Baker (2002) states that the socialisation function of communication is "stressed in the human relations perspective of organisations which asserts that capturing the hearts and minds of organisational members is necessary to effectively coordinate organisational action in the pursuit of collective organisational goals". Communication directed at socializing organisational members focuses on articulating and reinforcing organisational values and aligning individual goals with organisational goals. According to Baker (2002) it is directed at establishing an appropriate organisational culture and climate. This form of communication cannot be one-way or top-down. It must occur reciprocally between organisational leaders and organisational members.

The Formal Organisational Structure

Du Plessis et al. (2001) state that the formal organisational structure represents links or relationships prescribed by the organisation through rules, lines of reporting and chains of command. Functionally the organisational structure, and the formal pattern of communication within this structure, reflects the organisation's need to gather process and disseminate information that is important for its operation and survival.

The Informal Organisational Structure

According to Du Plessis et al. (2001), an informal structure exists alongside the formal structure. It is associated with social and open, more informal, communication links between members of the organisation. In comparison with the formal structure, the informal structure changes more rapidly because it reflects links and relationships between people, which will change from time to time as employees resign and move away.

Channels of Communication

Communication flows through a channel. A channel is the means through which a message is carried across from the communicator to the recipient. Du Plessis et al. (2001) confirms not all channels are equally suitable for all messages. They differ in channel capacity and noise. Noise is any random interference that distorts the communicated signal passing through a channel. Most channels of communication are subject to some kind of noise interference. Because people are aware that their messages are often distorted, they tend to increase the redundancy of their messages.

Du Plessis et al. (2001) further explain the flow of communication can be up, down and across a chain of command. In organisational communication there are two distinct types of

communication flow: vertical communication which refer to the upward and downward flow of communication and horizontal communication which refer to the lateral flow of communication.

Downward Communication

According to Andretta (2010), downward communication refers to information that flows from positions of higher authority to those of lower authority and may include information about organisational policies and practices, job instructions, organisational goals, and performance feedback. Du Plessis et al. (2001) explain that bureaucratic organisations depend on downward communication. This is ultimately characteristic of the classical management approach where the focus is very task-oriented, and not employee-oriented. The need for downward channels springs from the need for control, especially financial or budgetary control. Du Plessis et al. (2001) further explain the following purposes for downward communication:

- Giving instructions and providing training
- Imparting information (company policies, trends and plans)
- Providing a rationale for directions and policies
- Evaluating work performance

Du Plessis et al. (2001) state that upper management tends to rely heavily on print or mediated channels for downward messages. This reliance on formal, especially written, channels is probably one of the main reasons for reported dissatisfaction among employees. Many employees would prefer to receive information about company policies and plans through face-to-face channels such as meetings.

Andretta (2010) concurs with Herzberg that an open and supportive communication climate is also central to Herzberg's (1968) motivation-hygiene theory which suggests that a democratic management style promoting growth, empowerment and job enrichment is necessary to motivate its workforce. Herzberg states that motivating factors such as recognition, responsibility and advancement lead to job satisfaction while hygiene factors such as relationships with superiors, work conditions and salary are essential to prevent dissatisfaction although do not, in themselves, create higher levels of motivation.

Upward Communication Channels

Du Plessis et al. (2001) explain that upward communication in the classical approach focussed on the feedback, regarding employee production rate and performance. In the human resource

development theory, upward communication functions in a way that includes messages concerning employee morale, commitment, participation and decision making.

Andretta (2010) provide a more clear understanding by her explanation which states that upward information refers to information that flows from sub subordinates to supervisors and managers and may include suggestions for organisational improvement, employee concerns, and information about operational issues. Hall (2002:170) argue that people are unlikely to pass information up if it will be harmful to themselves or their peers. Downs and Adrian (2004:55) suggest a filtering out of 'upward communication out of a need for self-preservation related to their mobility aspirations and their desire to gain their managers' trust'.

Tourish and Hargie (2004:189-190) state that it is widely acknowledged that upward feedback, upward communication and open door policies deliver significant organisational benefits such as enhanced participation, better decision making and an enhancement of organisational learning.

Du Plessis et al. (2002) however maintain that some channels used for downward communication such as mentoring, interviews and conferences, may also be used for upward communication. Upward communication is still at risk, as employees may not communicate openly as they may fear discrimination or rejection of some sort.

Horizontal Communication Channels

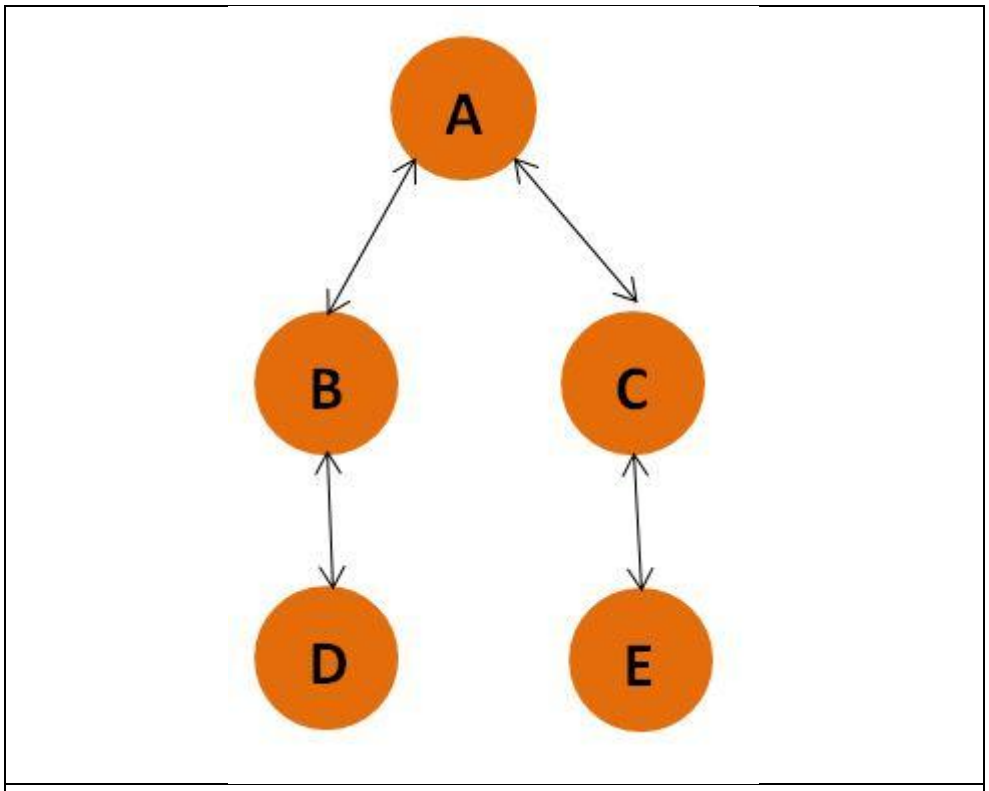
According to Lunenburg (2010), upward and downward communication flows generally follow the formal hierarchy within the school organization. However, greater size and complexity of organisations increase the need for communication laterally or diagonally across the lines of the formal chain of command. This is referred to as horizontal communication. Du Plessis et al. (2001) identify other terms usually associated with horizontal communication: interdepartmental communication, peer communication, bridge or gangplank. It refers to communicating with someone on the same hierarchical level and is preferable to upward or downward communication channels.

Communication Networks in Organisations

Barker and Angelopulo (2006), explains that networks are linked communication channels or lines that the organisation uses to convey information from one person to another. Communication networks therefore signify the existence of specific patterns by which messages are communicated between three or more individuals. According to Neher (1997), networks in an organisation are the stable patterns of relationships by which communication flows through

several contacts linking one point to others. These links are clustered together in groups which are connected to one another by individuals. Barker and Angelopulo (2006) further state that networks can be centralised or decentralised. The following networks are distinguished in organisations: chain networks; Y networks; wheel networks; circle networks and all-channel networks.

A CHAIN NETWORK PATTERN



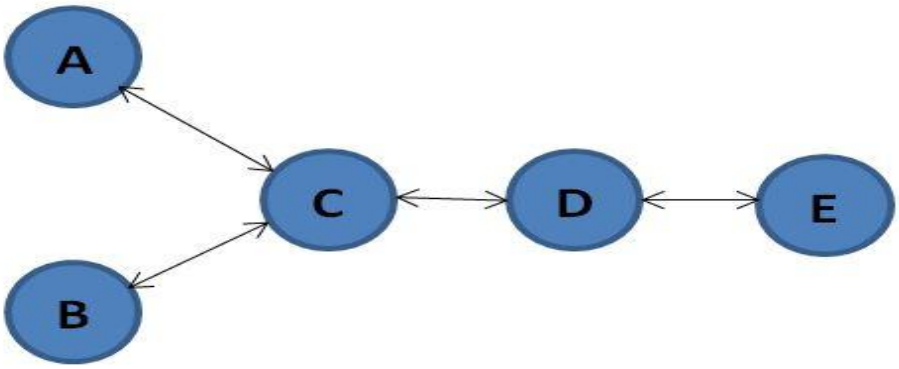
Source: Barker and Angelopulo (2010:77)

FIGURE 2: A Chain Network Pattern

According to Du Plessis et al. (2001), the chain network pattern occurs particularly within the formal communication system. Next to the wheel network it ranks highest in centrality. In this network, two people serve as end persons (D and E), having only one person with whom they can communicate directly (D only communicates with B and E only communicates with C) . They typically send information to the other individual (B and C) who serves as a relay, each relays sending their own messages, along with those of their end person, on to the fifth person who collects the information. The central person (A) then formulates an answer and sends it back to the relay persons (B and C) who then send it onto their respective end persons (D and E). Communication is thus downward, one-way and moves through various organisational levels to the respective receivers of the message. According to Barker and Angelopulo (2006)

information is task-oriented and extremely accurate because the channels are clear and the commands are direct. This network consists of members; therefore the employees are mere senders and receivers of the communication message. Network roles in the chain network include members and gatekeepers.

A Y-Network Pattern

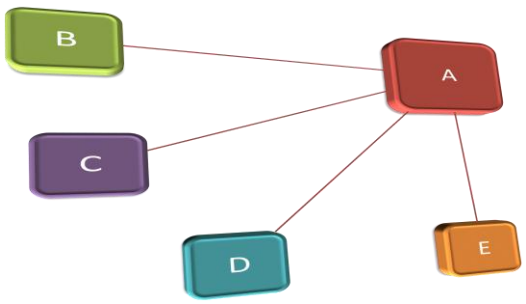


Source: Barker and Angelopulo 2010:78

FIGURE 3: Y Network Pattern

According to Barker and Angelopulo (2006), the Y-network functions within the formal communication system. In this pattern, persons A and B send messages to C but they can receive messages from no one else. C and D exchange messages, E can receive messages from D but cannot send any messages to anyone but D. Du Plessis et al.(2001) further explain the central person C serves as a bridge between members, thus connecting two groups in the network by being a member of both. The communication style is formal and communication takes place via C. Information is once again task oriented and because it consists of clear commands and direct information pertaining to specific tasks, the information is usually very accurate.

A WHEEL NETWORK PATTERN

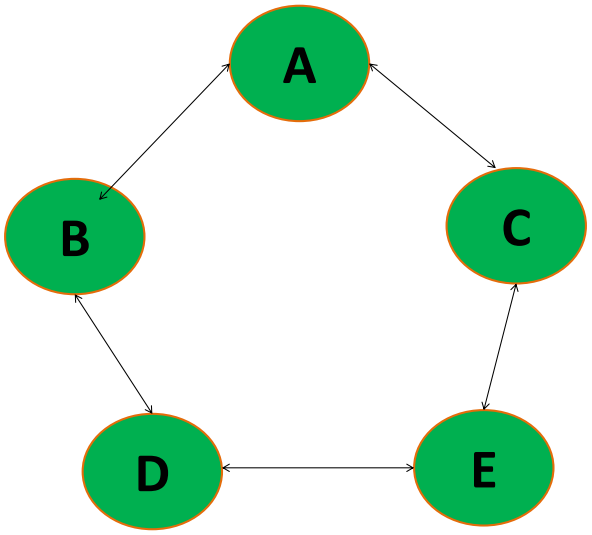


Source: Barker and Angelopulo 2010:79

FIGURE 4: Wheel Network Pattern

According to Du Plessis et al.(2001) the wheel network pattern also occurs within the formal communication system. In this pattern no individual (B, C, D or E) can exchange messages except through the central figure A. It thus makes coordination of thought or action virtually impossible. It is considered the most structured and centralised of all the patterns. Problems are solved by the members (B, C, D or E) sending messages to the top or central member A who makes decisions and sends the information back to (B, C, D or E). Barker and Angelopulo (2006) further explain that messages do not have to go through many levels. Although only one person receives all the information and has to send back information the content of the message can still be distorted.

A CIRCLE NETWORK PATTERN



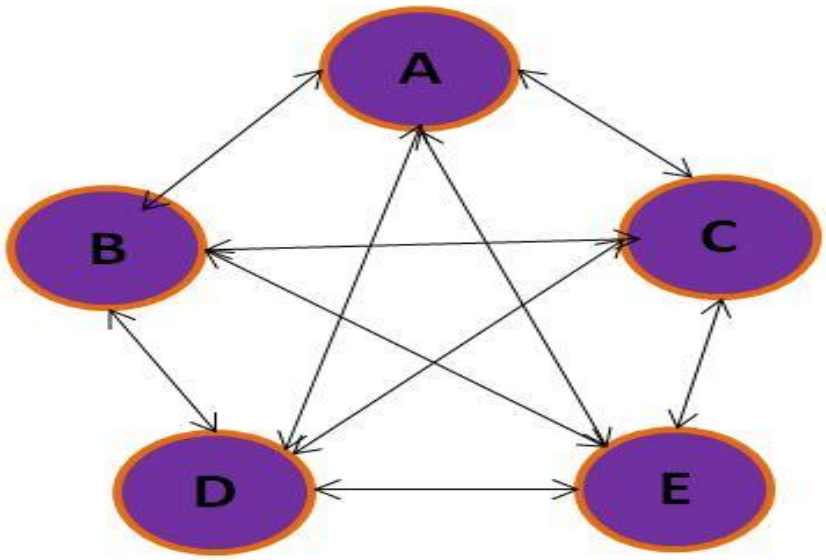
Source: Barker and Angelopulo 2010:79

FIGURE 5: Circle Network Pattern

Du Plessis et al. (2001), clarifies that the circle network occurs within the informal communication system. This pattern contrasts sharply with the wheel, Y and the chain networks. In this system every member (A, B, C, D, E) has equal communication opportunities. Everyone can communicate with the person to the right and the left (A communicates with B and C; B communicates with A and D; C communicates with A and E; D communicates with B and E; E communicates with C and D). To solve problems in the circle network, members typically pass information around to all members who act as their own decision making centres.

Barker and Angelopulo (2006), maintains that "groups involved in the circle network can be frustrated as communication is slow and it is not always easy to move messages from one part of the line to another. Communication is more employee-oriented than task-oriented. There is also participation in the decision making process and problem-solving. Only members can be identified in this network; there are no isolates, liaisons, bridges, cosmopolites, gatekeepers or opinion leaders."

ALL CHANNEL NETWORK PATTERN



Source: Barker and Angelopulo (2010:80)

FIGURE 6: All Channel Network Pattern

According to Barker and Angelopulo (2006), the all channel network which is also referred to as the star network can be described as being part of the informal communication system. It is the result of all the lines drawn with the circle network to connect all the people. There are no communication restrictions on any member, and each person communicates information to all others directly. All members formulate their own answers in a problem-solving format. The channel maximises opportunities for feedback and results in greater accuracy of messages.

INTERNAL COMMUNICATION

Mersham and Skinner (2005:68) define internal communication as all kinds of interaction that occurs between members of an organisation. This type of communication may be looked at from various perspectives. According to Roehler (2007), the objective of the internal communication strategy is to foster a strong communication culture within the business by creating a two-way flow of information that moves information from the top to the bottom and then moves feedback back up to the top. The goal is to filter the message coming from upper management down to all employees to provide them with a better understanding of the purpose, goals, and directions of the business or organisation.

PRINCIPLES OF EMPLOYEE COMMUNICATION

Mersham and Skinner (2005) also explain the following principles of employee communication:

- **Communication is a fundamental component of management.** It should be viewed as a contributing partner with other key staff functions in influencing employee understanding of both business goals and public relations issues.
- **Commitment by top management.** This is necessary as well as their participation and support of the communication process at all levels of the organisation. An overall policy on organisational communication and succinct guidelines for managers and supervisors are also absolutely essential. It is essential that top management be committed to open, honest communication.
- **A communication strategy is essential.** Communication must be a planned process involving both communication professionals and key management people. Development of a strategic plan, including short and long term goals are essential to guide the management communication professionally.
- **Managers are the key to success**. Managers are the key conduits and catalysts for effective communication and the system must recognise their need for information, training and rewards for good communication performance. Managers must ensure that ideas and criticism are acted upon or transmitted to the right persons for appropriate action.
- **Priority issues should form the content**. There should be the core content of the management communication programme and should be discussed in an open and understandable manner through various channels of communication.
- **Regular evaluation will ensure effectiveness.** The communication process should undergo regular evaluation to prove its worth in terms of employee/management relations as well as employee performance and awareness of key public issues. It is essential that the communication function be tested periodically to determine its efficacy and to provide directions on areas for improvement.

External Accountability of Organisations

According to Mersham and Skinner (2005) external accountability is the degree to which an organisation is dependent on, or responsible to, its environment. Familiar forms of dependence through exchange transactions with its environment typically include an organisations need to:

- Earn income;

- Provide goods and services to its clients;
- Carry out social investment;
- Attract external investment;
- Provide profit for shareholders and
- Operate within the country's laws and the regulations that apply to it.

In its accountability towards the public, the Government Communication and Information System have outlined the following objectives in its corporate strategy for 2009-2012 (GCIS, 2010):

- Provide strategic leadership in government communication.
- Strengthen the government-wide communication system for effectiveness and proper alignment.
- Continuously communicate and inform the public on the policies and programmes of government to improve their lives.
- Learn and explore communication methods and practices to enhance communication.
- Lead and guide the domestic and international marketing of South Africa.
- Build partnerships with strategic stakeholders in pursuit of GCIS's vision.
- Ensure the optimal functioning of GCIS through integrating and aligning organisational processes and systems.

Communication Strategies to Implement Change

According to Barker and Angelopulo (2009), the term strategy is derived from the Greek word *strategia*, meaning the art of war. The term was first used in the context of war and was applied to business management since the 1960s. Chandler (1962:13) defines strategy as the determination of the basic goals and the objectives of an enterprise and the adoption of courses of action and the allocation of resources necessary for carrying out these goals. Chandler's definition encompasses three main points namely:

- Determination of goals and objectives
- Adoption of certain courses of action
- Allocation of resources.

THE RELATIONSHIP BETWEEN STRATEGY AND COMMUNICATION

Moss and Warnaby (1998) explain, the relationship between strategy and communication is distinguishable between the two concepts – strategy communication and communication strategy. Strategy communication refers to the role of communication in facilitating the strategy making process (development and implementation), while communication strategy is a functional level strategy. Barker and Angelopulo defines functional strategy as strategies that are developed for each functional area in an organisation, for example, marketing, public relations, human resources and finance. The purpose of functional strategies is to indicate what each functional area must to do to support the business and corporate strategies. Steyn and Puth (2000), point out the emphasis is on optimal utilisation of resources and coordination between functional areas. Their model for developing a corporate communication strategy is cited hereunder as it provides comprehensive steps involved in devising an effective communication strategy.

Source: Steyn and Puth (2000:63)

FIGURE 7: Model For Developing Corporate Communication Strategy

ANALYSE THE INTERNAL ENVIRONMENT

The first step in this model refers to an analysis of the internal environment. Steyn and Puth (2000) advise to make communication relevant in the organisations strategy formulation

process; the communications manager should be familiar with the organisations internal environment before developing the corporate communication strategy.

Identify Strategic Stakeholders and Publics

According to Grunig and Repper (1992), strategic stakeholders are those that are 'critical, crucial, essential, important or vital for an organisation in the accomplishment of its mission'. Steyn and Puth (2000:66) describe stakeholders as people who are affected by decisions of an organisation or if their decisions affect the organisation. Communication programmes should only be planned with the most important: the most strategic stakeholders. The most important stakeholder for the government in disseminating news, information and or policy change will be the society it serves.

Steyn and Puth (2000:67) state that the key components that the communication function should be anchored around are the organisations stakeholders.

Identify and Prioritise Key Strategic Issues

Steyn and Puth (2000:68) explains that strategic issues are developments, events and trends that are considered consequential by an organisations management because of the potential to impact the organisations strategy.

Identify Implications of Strategic Issues for Stakeholders

According to Steyn and Puth (2000:69), an important step in developing the communication strategy is to identify the implications that the key strategic issues will have for strategic stakeholders.

Decide On the Corporate Communication Strategy

A corporate communication strategy indicates the direction that an organisation needs to take with regard to its communication with stakeholders. Steyn and Puth (2000:70) calls it a grand or a long term strategy determining in broad terms what needs to be done to create a competitive position with regard to stakeholders that is compatible with overall enterprise or corporate strategy.

Set Communication Goals

A goal can be identified as a mini-vision which is the destination an organisation wants to reach. According to Steyn and Puth (2000: 70), it is neither specific nor measurable which the attributes of the objectives of an organisation are. A communication goal is therefore the destination to be reached by means of the organisations communication.

Develop a Communication Policy

Trainor (1990) explains that a communication policy could deal with:

- Functional communication areas (internal or external communication) and specified communication programmes.
- Functional relationships between corporate communication and other departments.
- The structure of the corporate communication department, hierarchical orientation and lines of command
- Corporate communication goals and objectives.

According to Steyn and Puth (2000:72) an example of a communication policy might be a commitment to honesty and openness, transparency, access to top management, credibility, compassion, trust, integrity and sensitivity for the diverse nature of stakeholders and publics. It is further stated that the communication policy must be enforceable, precise and clear. Messages must be consistent in all departments or divisions must have the same standards when communicating internally or externally.

Submit Communication Strategy (Draft) to Top Management

Steyn and Puth (2000:72) maintain that top management should be kept informed on the different steps during the development of the corporate communication strategy. They should be informed of the logic that guided the formulation of the strategy, and in which way communication will provide a solution to critical organisational problems.

Conduct a Media Analysis

The purpose of the overall media analysis according to Steyn and Puth (2000) is to investigate the different communication media that might be suitable for the specific organisation and its stakeholders.

Develop a Strategic Communication Plan

Steyn and Puth (2000:73) see the communication plan as the framework within which communication programmes, communication campaigns and communication plans are developed.

This model provides the basis for a communication strategy for any size of organisation. Accommodations are made for a number of deviations that organisations might want to take.

Steyn and Puth (2000:76) maintain that the development of a communication strategy takes place continuously and is not a once off exercise.

Communication Between Nurses And Patients

This multi case study also examines how effective communication takes place between nursing staff and patients. According to Chapman (2009) as health care providers try to accomplish more in less time, the relationships between patients and providers-and among providers-naturally suffer. Stress and pressure from time constraints often cause miscommunication, flawed assumptions, decreased staff and patient satisfaction, and poor or non-existent care coordination.

According to Smith and Pressman (2010) although effective communication with patients is increasingly understood as a key to effective, patient-centred care in all health care settings, the quantity and quality of training that nurses get in ways to promote and enhance effective nurse: patient communication is sadly lacking.

Shafer (2007) recommends, the use of various programs that train physicians, nurses, and social workers to relay difficult messages to patients, enhancing their necessary communication skills. She advocates the importance of provider-patient communication throughout the diagnosis, treatment, and recovery processes in order for health care professionals to provide quality care.

The use of symmetrical communication is encouraged when nurses display active listening skills to the patients they are treating instead of adopting asymmetrical communication skills which can lead to misdiagnosis of the patient (Shafer 2007).

Public Relations

According to Anand and Chakravati (1981), "almost every enterprise is actively concerned with securing the satisfaction from its constituency and in case of hospitals, the constituency is the community it serves". Hospitals cannot serve in isolation and hence they need to assist the society and to gear themselves to meet the expectations of the society to give them fullest satisfaction. Good services coupled with sound working practices and fair treatment of employees and medical staff is not enough unless a sound programme of public relations is developed and practiced. Public relations is an important function to build up corporate image of the hospitals in the minds of the public and the patients.

Defining Public Relations

Du Plessis (2010) provides a simple approach to defining public relations through the analysis of the concept. He states that any organisation (and individual) functions in an environment where it is in contact with and, most of the time, also dependent on other people and organisations. From this he postulates public relations is therefore concerned with the relationships between different entities. According to Skinner and Von Essen (1993:8) public relations is the deliberate, planned and sustained effort to establish and maintain mutual understanding between the organisation and its publics, both internally and externally. However over a short period of time this definition has evolved into becoming more definitive and specific. PRISA (www.prisa.co.za) has changed it to suit the changing nature of and views on public relations. Their definition is: *Public Relations is the management, through communication, of perceptions and strategic relationships between an organisation and its internal and external stakeholders.*

Du Plessis (2010:196) further explains this definition by pointing out that the emphasis is on public relations as a management function with communication as a means to manage perceptions and strategic relationships.

Understanding of Public Relations

The theoretical starting points of public relations provide a way forward in understanding how it is practised and what public relations entails. Mc Coy and Hargie (2003) argue that a thorough understanding of theory may lead to the setting of realistic objectives for public relations and thus enable practitioners to evaluate their successes according to relevant and appropriate criteria.

Grunig and Hunt's Model of Public Relations

Grunig and Hunt (1984) developed an understanding of public relations by distinguishing between four models. Du Plessis (2010), suggest that whilst these models were developed historically, all of them continue to be used in one form or another:

- **Publicity Model:** This model is characterised by one way communication that emphasises the importance of persuasion and a philosophy of publishing at all costs to defeat the opposition. According to Du Plessis (2010), this model is distorted and only partially true and the primary objective here is to tell rather than to listen. Many public relations practitioners today still see their role as one of generating publicity, which is done within a more ethical framework.

- **Public Information Model:** The primary objective of this model is to disseminate information; still this is from a one way perspective of communication. The emphasis is less on a persuasive approach to public relations, but there is a belief that providing as much information as possible will serve as the organisations best interest.
- **Two-way Asymmetrical Model:** This model sees persuasion as the purpose of communication. Formative research is done to establish the current situation of the public(s) and their attitudes, views and behaviour, and a programme of communication is developed to either maintain or change the situation. Communication is driven by the formulation of objectives, which provide the criteria for regular evaluation of progress to establish whether these objectives have been reached. Feedback exists in the form of understanding the 'receivers' in order to maintain or change their attitudes, perceptions and behaviour, and to enable the communicator to target them. The organisations best interests are often still the most important objective of public relations efforts.
- **Two-way Symmetrical Model:** The purpose of this model is to gain mutual understanding between an organisation and its publics. Communication is two-way, with balanced effects. According to this model, public relations practitioners serve as how the public perceives an organisation and to determine the impact of organisations actions on the relevant public(s). Evaluative measurement is also applied to determine to what extent a public relations intervention has impacted on the understanding that an audience has of the organisation, and what managements understanding is of the publics.

A Process Approach

Du Plessis (2010:200) states that a process approach assumes that public relations involves a series of routine or accepted procedures in an on-going and systematic process that is not limited to a specific time frame. Du Plessis further recommends the following four step approach which was initially devised by Cutlip and Center (1952):

- **Defining the problem (or opportunity):** In this step, the attitudes, opinions, behaviours and knowledge of those concerned with and affected by the acts and policies of an organisation are probed and monitored. Research and fact finding provides the foundation for all the other steps by determining the relevant facts.

- **Planning and programming:** Information gathered in the first step is used to make decisions about the publics, objectives and procedures, to identify relevant publics and to plan the strategies that need to be used in the campaign or programme
- **Taking action and communicating:** This step involves implementing the programme of action and communication, which will achieve the specific objectives that will enable each of the publics to accomplish the goal.
- **Evaluating:** In this step, the preparation, implementation and results of the programme are assessed. Programmes are continued or terminated in light of whether or not objectives have been achieved.

A Systems Approach

According to Theaker (2001:55), applying a systems theory perspective, organisations can be classified into two main categories. The way that public relations is conducted is critically influenced by the type of organisation within which it is practised. Systems can be categorised by the level and nature of interaction they have with their environments. Organisations can be seen to be relatively closed or relatively open- social systems can never be entirely closed or open. The relatively closed organisations do not take much account of the environment, they do not adapt to changing circumstances and usually they eventually cease to exist. Relatively open organisations are very responsive to the environment. They are acutely aware of change, and adjust and adapt to either counteract or accommodate it. A key concept is that the organisation both affects and is affected by the environment in which it operates. Public relations is often seen as being 'reactive' or 'proactive'.

Du Plessis (2010: 201), state that the systems approach is widely used and is multidisciplinary. In its most elementary form, the approach emphasizes the importance of maintaining the equilibrium and interdependence of the various systems and sub-systems in society. In an organisational context, specifically with regard to the public relations of an organization, the system can be seen as involving mutually dependent relationships that are established and maintained between organisations and their stakeholders.

A Values-Driven Approach

According to Guth and Marsh (2000), a value driven approach is based on the organisations core values that should govern the public relations process from inception to conclusion. Further Guth and Marsh state that Public Relations is the values-driven management of relationships between an organisation and the publics that can affect its success. The values-

driven approach is the process of uncovering not where an organisation wants to go but also the principles they will observe in getting there. According to Du Plessis (2010:204) the task of public relations practitioners is to ensure that these values are the driving forces of an organisation and its communication practices.

Functions of Public Relations

Du Plessis (2010:205) maintains the ultimate aim of public relations is to manage perceptions and relationships between an organisation and its stakeholders. Lubbe (2000) suggests three functions that public relations must fulfil in order for this to be done:

- Interpretation of the needs, attitudes and opinions of people, groups or organisations.
- Communication of these to relevant stakeholders.
- Management of this process of communication to change or maintain needs, attitudes and opinions.

Lubbe (2000) states that since public relations has grown from serving mainly a publicity function to a discipline which focuses on building and maintaining relationships within society, three separate but related functions can be distinguished within public relations: an interpretative function, a management function and a communication function.

Interpretative Function

Public Relations as an interpretative function lies in how organisations understand and meet the needs of various publics and those of society as a whole. Dozier (1995) suggests that "public relations managers are in a good position to provide an interpretive function as they have wide contact with the external and internal environment, and access to research and research findings".

According to Du Plessis (2010:206), "organisations that practice public relations as an interpretive function are able to do so proactively, anticipating changes within the environment, adjusting their policies and procedures, and actively influencing the environment as well as allowing the environment to influence their actions and decisions". Further, the key objective of public relations is to inform the public, resulting in the publicity model of public relations. However according to Steinberg (2011) communication is more than simply providing information, it is seen as a transaction between participants during which relationships develop. Du Plessis (2010: 207) surmises then that the communication function of public relations is

managed well when transactional communication occurs between an organization and its stakeholders.

According to Du Plessis (2000), organisations that practise public relations as an interpretative function are able to act proactively, anticipating changes within the environment, adjusting their policies and procedures and so actively influencing the environment.

The Management Function

Skinner *et al.* (2010:6) explain that the management function of public relations is practised at an advanced level by experienced practitioners. The authors further explain the beneficial results of public relations as a management function: a management position affords the public relations practitioner the opportunity of being sensitive to and coming into contact with both internal and external publics, whose collective views constitute public opinion. This enables the public relations practitioner to evaluate internal and external opinions, attitudes and needs on an on-going basis, to advise management regarding their possible effect, and to act as an instrument in bringing about policy changes and directing new courses of action. All of these actions are performed to maintain a harmonious and balanced relationship between the organisation and its various target publics.

Conclusion

In this chapter, the discipline of communication was examined in respect of organisational communication. A model of communication that represented Shannon and Weavers view of communication was briefly explained to introduce the variable of 'noise' within their communication model. The different perspectives of organisational communication were explored to provide a more comprehensive outlook on organisational communication. Theories of organisational communication were unpacked to demonstrate the development of organisational communication through the years. The functions of communication were examined understand the relevance of communication within an organisation. The flow of communication within an organisation was explored to understand the significance of formal and informal communication. The different communication networks present within various organisations were discussed to elucidate the flow of information.

Further, the internal communications as well as external communication were analysed. One of the key objectives of this study is to determine the effectiveness of the communication strategies implemented in the adoption and application of the Batho Pele Principles. In order to properly gauge the process of the way in which communication strategies are devised, a

model of a communication strategy is provided. The researcher examined public relations as being an important variable in this research as the relationship between the hospital and the public is relative to public relations. Public Relations have been defined and the various approaches of public relations are provided. Further the researcher discussed two functions of public relations relative to this research. In the next chapter the discipline of public administration will be discussed.

CHAPTER THREE

PUBLIC ADMINISTRATION

INTRODUCTION

In this chapter, the issue of service delivery will be examined within the ambit of public administration. The public sector has an enormous responsibility to ensure citizen's needs are adequately satisfied. Mabala (2006) state that the activities of the state that are performed in the delivery of essential services are usually identified as forming part of public administration.

According to Mabala (2006), public administration is said to have originated through the realisation by a group of people that they had to work together in an orderly manner for a common cause. It can also be said to be a system used by government to render services in terms of an agreement between themselves and the community. Cloete (1991:56) support this view by saying that the administration of public affairs results from political activities, and forms part of political life and does not only take place in a political environment, but concerns all areas of social life. The administration of public affairs provides the government with the mechanism to ensure that effective service delivery takes place.

Fry (1989:78) is of the view that public administration refers to two activities. On the one hand, it refers to administration or management of matters which principally have to do with society, politics, and its subparts which are not private, commercial or individualistic. On the other hand, it refers to the disciplined study of such matters. This definition provides a simple but comprehensive meaning to public administration which encapsulates the vast majority of activities and concerns of contemporary public administration.

Cayer (2003:1) compares the office of public administration to life in a swamp where footing is uncertain, the path unclear and the terrain keeps shifting. Public administrators are affected by politics, changing political power relationships, economic swings, and volatile social issues. They are accountable to numerous authorities including politically elected officials and the general public. Their accountability includes requirements to utilize financial resources responsibly and also to be responsive to the democratic values of the governmental system.

A more profound view of public administration and its responsibility towards society is explained by Bresser-Pereira (2005) whereby "in each country, the strength or capability of the state organization depends, first, on its democratic political institutions, that make the rule of

law effective, human rights assured, and the government or administration, legitimate and second, on the quality of its public policies, particularly of their economic and social policies, which lead to the achievement of such objectives at a more operational, decision-making level. It depends, thirdly, on the quality of public administration, which implements these laws and policies – a public administration which, in the past, was provided by the state, is also required to be efficient. The strategic core of the government must count with professional senior civil services of the highest quality working together with elected politicians in taking government decisions. On the other hand, each government must design a decentralized state structure, and make agencies accountable for results rather than for procedures, in order to provide with efficiency the social and scientific services that characterize modern democracies".

The Principles of Public Administration

In accordance with the constitution of the South African government under Section 195, the basic values and principles that govern public administration is listed hereunder:

- Public administration must be governed by the democratic values and principles enshrined in the Constitution, including the following principles:
- A high standard of professional ethics must be promoted and maintained.
- Efficient, economic and effective use of resources must be promoted.
- Public administration must be development-oriented.
- Services must be provided impartially, fairly, equitably and without bias.
- People's needs must be responded to, and the public must be encouraged to participate in policy-making.
- Public administration must be accountable.
- Transparency must be fostered by providing the public with timely, accessible and accurate information.
- Good human-resource management and career-development practices, to maximise human potential, must be cultivated.
- Public administration must be broadly representative of the South African people, with employment and personnel management practices based on ability, objectivity, fairness, and the need to redress the imbalances of the past to achieve broad representation.

The above principles apply to administration in every sphere of government; Organs of state; and Public enterprises. The functions of public administration are guided by the principles of public administration.

THE FUNCTIONS OF PUBLIC ADMINISTRATION

Van der Waldt and Du Toit (2008:180) state that public institutions exist to achieve certain objectives aimed primarily at providing services and/or products to improve the general welfare of the public. As organisational structures these institutions do not achieve these objectives of their own accord. A trained and experienced management corps is needed to convert objectives into activities.

Van der Waldt and Du Toit (2008:180) further state that management's task is therefore to combine, allocate, coordinate and use the institutions resources or inputs productively so that the institutions objectives are achieved as economically as possible.

The basic management functions, the resources and objectives of an institution are not separate elements, but together they form an integrated whole. The most important elements of this integrated whole or system are planning the objectives and the resources needed to achieve the objectives, organising the resources, taking the lead to facilitate and start the process and keep it going and finally controlling the resources to establish whether the objectives were achieved as effectively and productively as possible. According to Cloete (1991:2) and Van Der Waldt and Du Toit (2008:181) an effective public administration is performed through a number of functions which are the following: policy making, planning, organising, financing, personnel provision, and control. These functions are performed by different individuals and groups of people with the purpose of ensuring successful implementation of the aims of the state in its quest to deal with the needs of the communities:

POLICY MAKING

Thornhill and Hanekom (1995:54) defines policy as a desired course of action and interaction which is to serve as a guideline in the allocation of resources. According to Malan (2001:35), there are many characteristics, which define a policy, some of these characteristics that describe a policy are that it defines organisational principles, policy sets out the way that things are done, policy creates a framework for the way work is performed and it sets the standards for the organisation and it generally is formed from best practice.

Wissink (1990:41) distinguishes between fundamental and incremental policy-making roles of public managers. The fundamental role refers to the important role public manager's play in

providing optimal information and advice on policy issues to the policy-makers. The level of complexity of the policy issue concerned determines the amount of information needed. With regards to the incremental role, Wissink (1990:43) states that the degree of specialisation and professionalism of public managers causes policy to be adjusted constantly in the implementation phase. Van Der Waldt and Du Toit (2008:276) state that, as policies are executed; public managers make recommendations on their relevance and practical effectiveness. Policies therefore undergo incremental adjustments until they are suitable for a particular policy issue. An important point to note according to Waldt and Du Toit (2008:276) is that with regards to management applications, public managers play mainly an incremental role in constantly evaluating existing policies for efficiency and effectiveness. Because they can analyse the influence of policies and evaluate problems experienced in the implementation and application of policies at community level, they are in a favourable position to analyse policies.

Policy Analysis

Hanekom (1991:66) explains that the reasons for analysing policies are scientific, professional or political. The author further explains that the scientific reason is based on the need to make sure that government activities can keep up with the complexity of society. This entails, among other things, determining the impact of a specific policy on society, public institutions and the political system. The professional reasons are for the need to constantly identify alternatives and evaluate and adjust existing policy. The political reasons emerge because the policy analysis determines whether objectives have been achieved through the policy.

Implementation of Policy

According to Adamolekun (1983) in Makinde (2005), policy implementation refers to the activities that are carried out in the light of established policies. Egonmwan (1991) further explains that it the process of converting financial, material, technical and human inputs into outputs – goods and services.

Hood (1976:6) suggests a model of implementation that as he explains would produce perfect policy implementation. Such a model would include a

> "unitary administrative system with a single line of authority, enforcement of uniform rules or objectives, a set of clear and authoritative objectives implementable on the basis of perfect obedience or perfect administrative control, perfect coordination and perfect information within and between administrative units, absence of time pressure,

> unlimited material resources for tackling the problem and unambiguous overall objectives and perfect political acceptability of the policies pursued".

He further states the model of perfect administration is an ideal-type construct to discover the sources of implementation failure. Lane (1998:94) argues that the model approaches implementation from the narrow focus of the characteristics of pure authority relations- hierarchy, obedience, control and perfect coordination- viewed as the mechanism for accomplishment of successful implementation.

Edwards (1980) further identifies critical factors that are crucial to successful policy implementation. These critical factors are communication, resources, dispositions or attitudes, and bureaucratic structure. Makinde (2005) explains, "these four factors operate simultaneously and they interact with each other to aid or hinder policy implementation". According to Makinde, communication is "an essential ingredient for effective implementation of public policy. Through communication, orders to implement policies are expected to be transmitted to the appropriate personnel in a clear manner while such orders must be accurate and consistent". He further states that

> "…inadequate information can lead to a misunderstanding on the part of the implementers who may be confused as to what exactly are required of them. In effect, implementation instructions that are not transmitted, that are distorted in transmission, that are vague, or that are inconsistent may cause serious obstacles to policy implementation. Conversely, directives that are too precise may hinder implementation by stifling creativity and adaptability", (Edward III, 1980).

Where implementation orders are clear, consistent and accurately transmitted, the absence of adequate resources will result in implementation problems. Resources include both the human and material such as adequate number of staff who are well equipped to carry out the implementation, relevant and adequate information on implementation process, the authority to ensure that policies are carried out as they are intended, and facilities such as land, equipment, buildings, etc. as may be deemed necessary for the successful implementation of the policy. Makinde (2005), further states that "without sufficient resources it means that laws will not be enforced, services will not be provided and reasonable regulations will not be developed. In addition to communication and resources, disposition or attitude is another key factor that affects policy implementation. Most implementers can exercise considerable discretion in the implementation of policies because of either their independence from their nominal superiors

who formulate the policies or as a result of the complexity of the policy itself". The way the implementers exercise their discretion depends, to a large extent, on their disposition toward the policy. Therefore the level of success will depend on how the implementers see the policies as affecting their organisational and personal interests.

Lane (1998), explains implementation in a "democratic system of government rests upon the public power entrusted to politicians and public officials, whether administrators or professionals". Politicians and officials are expected to deliver on policies; this is the basic restriction on the degrees of freedom on decision-makers and implementers in relation to their principals, the citizens (1993:103).

According to Lane (1998:103), trust is basic to the implementation process. The concept of implementation is suitable for the detection of goal changes, programme redefinition, discrepancies between innovation objectives and consolidation goals, short term goals and long term objectives- phenomena that, interpreted according to a conception of implementation as equivalent to evolution, learning, perspective or coalition, make accountability in implementation virtually impracticable.

Policy	Strategy	Planning
Specific principles adopted by organisations and teams often based as much on politics as information. Heavily influenced by objective information, politics, public opinion, and the media (but not necessarily in that order	The key steps that need to be taken (that wouldn't happen anyway) that are critical to achieving the changes needed over 5 years. Needs to be supported by good intelligence. However, such input should not unduly restrain creative thinking	All the steps that need to be taken to achieve the key steps of the strategy. Progression takes place in small. Incremental and predictable steps. It is a logistic exercise
Example: It is the policy of the ambulance service to take severely injured people to trauma centres not necessarily the nearest emergency department	*Example: the strategic intent of the local health department is to ensure that within 5 years nowhere in the area is more than 30 minutes ambulance travel time from a trauma centre*	*Example: the detailed day-to-day project plan of how the local trauma service will be developed over the next year*
Source: Puncheon *et al.* 2008:378		
Table 1 :The relationships between policy, strategy, and planning with examples		

According to Markwell (2009), understanding the links between 'policy and strategy' and the concepts of '*culture and change'*, within organization environments, are important in terms of, 'doing things right' and 'doing the right things'. The principles and values identified within policy directs both the context and content of strategic development and where these are not aligned, the development and outcomes of strategic operations can become unsustainable.

Policy-making in South Africa

Mabala (2006) describes the process of policy- making in South Africa whereby the Cabinet *Lekgotla*, which is a gathering of the President and Cabinet ministers together with the directors-general of government departments, is held during February and July. During this gathering, issues are discussed to guide the government to meet its objectives for that particular year. The

decisions made at the *Lekgotla* tend to guide future government actions and processes and as such, become government policy when implemented. After the Cabinet *Lekgotla*, every government department is expected to identify issues raised at the *Lekgotla* affecting its activities and then work out strategies and mechanisms of addressing them (GCIS: 2005).

PLANNING

Waldt and Du Toit (2008:181) see planning as a basic management function which helps institutions keep up with change and which management can use to determine in advance what the institution should achieve. The authors further explain that plans are usually prepared to offer guidelines to managers for what they are going to do in the department. According to Sheoraj (2007), planning is the means by which purpose is translated into programs and involves the identification of key controllable items that are to be manipulated to achieve organisational objectives.

According to Lerner (1992:56), the organizing, staff, leading and controlling functions stem from the planning function. The manager is ready to organize only after goals and plans to reach the goals are in place. In their definition of planning, Waldt and Du Toit (2008:182) add that planning is a process that involves every manager to some extent. The higher the post in the hierarchy the more significant the extent of planning and the greater its impact.

Smith and Cronje (1992:88) add that the purpose of a plan is to facilitate the achievement of an institutions purpose, mission and objectives. The outcome of this definition means that planning is aimed at determining future circumstances and identifying the measures needed to realize them.

Planning Hierarchy

According to Waldt and Du Toit (2008:182) the main responsibility of top management is to draw up corporate strategic plans. Planning enables top management to see the institution as a whole system in which the objectives of the different functions are reconcilable with one another and with the main goals and objectives of the entire institution.

Components of planning hierarchy	Level of management
Purpose or mission	Top
Objectives	Top
Strategies	Top
Policy aspects	Top
Procedures and standards	Top/Middle
Programmes	Top/Middle
Budgets	Middle/Line
Daily/weekly planning	Line
Source: Adapted from Koontz *et al.* 1984:105	

Table 2: The Planning Hierarchy

The above is a summary of the planning hierarchy. Waldt and Du Toit (2008:182) state that middle management focuses on the tactical or operational plans to achieve the strategic objectives. Middle management is also responsible to provide guidelines to the line managers which are the tactics to be implemented to achieve functional objectives. Hence Waldt and Du Toit (2008) refer to it as tactical planning.

Barriers to Planning

Waldt and Du Toit (2008) identify typical problems or barriers to planning:

- Internal and external circumstances affecting the initial preparation and implementation of a plan
- Human factors can cause plans to fail
- Ineffective organisational system
- Management's attitude towards planning.

ORGANISING

Mabala (2006), explains that organising normally includes the scientific structuring of an organisation to implement the plans. The organising process should take into consideration the differing needs, available resources as well as human resource capacities, in organising. Cloete (1991:112) defines organising as classifying and grouping functions and allocating groups of

functions to institutions and workers in an orderly pattern so that workers aim at achieving the objectives. Van Der Waldt and Du Toit (2008:188) distinguish between macro- and micro-organising. Macro organising refers to the division of government activities into significant working spheres with the aim of achieving the political objectives of the government. Micro organising entails, organising within a public institution and refers to the division and allocation of functions to employees. Cloete (1991:121-128) identifies the following as micro- organising:

- Horizontal division of work
- Assignment and delegation of authority
- Coordination
- Setting channels of communication
- Control.

Michelle (1996:13) further explains, work division is the foundation of an organisation and planning form the heart of any institutional structure. It is for this purpose that organising can be seen as all the activities that is grouped or allocated into functional divisions.

Financing

According to Van Der Waldt and Du Toit (2008:301), almost every decision in an institution has financial implications. The increasing size and complexity of public institutions and the scarcity of resources have emphasised the importance of financial management. The authors further state, that the optimal use of financial resources is vital in an environment characterised by constant change and increasing needs and requirements of the community. Mabala (2006) states that the financing of government operations is normally the responsibility of the Minister of Finance, acting in conjunction with Cabinet. This entails, amongst others, raising funds through taxes, the raising of loans nationally or internationally, the selling of government stock as well as by attracting donor funds. In South Africa, part of the financing function of the National Treasury, of which the Minister of Finance is a member, is to ensure through its monitoring process that the funds provided are utilised effectively and are accounted for.

The Personnel Function

According to Andrews (1998: 2), the normative criteria inherent in public administration must mutatis mutandis be applied to personnel administration in public institutions. She further states that because public officials render a service to the community and are remunerated from public funds, it is self-evident that specific ethical norms must be used as a standard by which the actions of public officials may be judged. According to Strauss and Sayles (1980), the

personnel function is especially concerned with the development of highly motivated, smoothly functioning work force.

Andrews (1998:10) state that financing is an essential enabling function which must be undertaken to make funds available so that the personnel function may be carried out. It is quite impossible to supply personnel and to train, utilise, remunerate and retain them if the necessary funds are not available. The execution of the personnel function is therefore dependent on the availability of the necessary funds by means of an annual budget which must be approved by Parliament. The effective execution of the personnel function is therefore dependent on exceptional planning and realistic budgeting.

Personnel Motivation and Guidance

According to Andrews (1998:15) guidance is in fact a management function in which motivation can be included. The function of guiding subordinates means that external motivation will be provided to stimulate the internal motivational component to become active and in so doing fully utilize the employee. Provision of personnel is made possible by executing the processes of human resource planning, position determination and job classification, recruitment, selection and placement.

Personnel Evaluation

Personnel evaluation refers to the evaluation of an employee's behaviour, actions, competence and performance in his work. The purpose of personnel evaluation is to recognize and reward the personal abilities that the individual brings to his job, measured by the extent to which his output or the quality of his work exceeds the minimum that can reasonably be expected for his basic rate of pay. Andrews (1998:15) further state that the system used in the South African Public Service to evaluate personnel is known as the merit system. According to this system, the work performance of senior personnel is assessed in respect of responsibility, insight and the ability to guide and direct.

CONTROL

Salman (2000:75) states that control means that members of the organisation have their actions, determined or influenced by membership of that organization. Van Der Waldt and Du Toit (2008:201) maintain that once planning has been done and the employees know what to do and how to do it and they have the necessary support and motivation, a system is needed that will enable management to determine whether the work is progressing as planned. This system is known as control.

According to Andrews (1998:15), the control function can be viewed as an umbrella function because it includes the function of control, evaluation and public accountability. Control is undertaken to determine if a task is conforming to predetermined standards. According to Robbins in Andrews (1998:15), the control function consists of the following three components:

- Actual measurement of work
- Comparison of work with a predetermined standard;
- Correction of any deviations which may exercise an essential influence on the anticipated goal.

The characteristics of work which can be controlled are:

- **Quantity** which can be easily measured
- **Quality** which is often difficult to measure because reliable norms and standards by which judgments may be made do not exist;
- **Costs**, which imply that the input to and results of the work can be judged in monetary terms and;
- **Time**, which can be evaluated according to fixed standard times.

Andrews (1998) argues that evaluation refers to the reconsideration of activities to determine if they are still aimed at the realization of the goal. Accountability is a management function which cannot be delegated. That is the head of a department can delegate tasks, but he will always remain accountable for their effective performance. Control therefore is an important management function because it is carried out to evaluate whether a task is performed in such a manner that the head of the institution involved can account in public for its effective performance.

Importance of Control

Van Der Waldt and Du Toit (2008:201) state that there are a number of reasons for the implementation of effective control systems:

- Effective control systems lead to standardised actions to increase efficiency
- Effective control systems evaluate top management's efficiency in planning
- Effective control systems help to prevent malpractices and waste

- Effective control systems encourage delegation, as subordinates to whom authority is delegated can be monitored better
- Effective control systems lead to performance appraisal of all employees.

The authors explain that control should not be seen as a negative measure but rather as an uninterrupted monitoring process for comparing planned results with actual results. Collier (2008:54) states that a significant responsibility of governance is to ensure that system of management control are adequate. These management controls comprise budgets, non-financial performance measures, personnel and other administrative controls as well as cultural norms. The relative importance of these controls in the overall control package constitutes the control mix. Collier (2008) further explains that a control mix is a function of an organisations institutional environment, with pressure being exerted through government funding, together with mimicking by public sector managers of private sector practices and professional norms.

The Challenges of Public Administration

Van Der Waldt and Du Toit (2008:377) explain that the primary task of public managers is to satisfy the numerous needs and desires of the community. The challenge facing managers is to address these multiple needs and desires with limited resources. Figure 8 is a diagrammatic representation of public environmental issues and challenges.

Source: Van Der Waldt and Du Toit (2008:376)

FIGURE 8: Public Management Issues, Challenges and Remedies

Van Der Waldt and Du Toit (2008:376) suggest that preparation for change within an organization can be applied functionally in various ways. The authors mention some of the most important ways are strategic management, visionary and transforming leadership, services marketing and effective environmental scanning. It is imperative that managers should be adaptable and have the required abilities to manage the institution during periods of change. However, the authors do recognize that there are variables in the macro environment which can impact on the institution so unexpectedly and suddenly that management may be caught off guard. Contingency measures therefore become high priority for the survival of any institution.

As indicated in Figure 8, the current and future challenges from the environment can be divided into macro-issues and micro- challenges. Macro- issues refer to the external environment of public institutions while micro-challenges refer to the demands made on present and future public managers in the organisational context. In this regard, Van Der Waldt and Du Toit (2008:377) provide a distinction between issues and challenges. The authors explain that issues refer to general macro-environmental trends that bring about issues for authorities at all levels and in all hierarchies and challenges are derived from these issues since public institution is influenced directly or indirectly by issues. An issue therefore becomes a management challenge which it has to be addressed tactically and operationally within the organisational context.

Macro-Environmental Issues

Van Der Waldt and Du Toit (2008:378) explain briefly the issues confronting public managers within the macro-environment. They identify them to be political issues, economic issues, technological issues and social issues and legal issues.

Political Issues

The authors contend that public administration functions within a political milieu which means that public managers have to direct their activities in accordance with the requirements of the political supreme authority. Public management is not detached from political events in southern Africa and the world. Globalisation has seen the world shrink and become much 'smaller' the so called 'global village'. Because a country cannot satisfy all its needs independently, international cooperation is needed. The dilemma facing public managers is that when a new party comes into power, public institutions sometimes have to undergo adjustments in order to accommodate the policy directions of the new party.

Social Issues

Van Der Waldt and Du Toit (208:379) explain the importance of the social environment in government activities and administrative processes as any government action has a direct or a potentially direct impact on people. The ethnic and cultural diversity of South Africa means the needs and desires differ from community to community. Public managers must find out about the community's culture, needs, preferences, faith, language, traditions and so on to prevent government action from prejudicing the interests and values of certain communities.

Economic Issues

According to Ernst and Young and Games (1996:21-24), economic trends in South Africa which may present unique challenges for the public manager are:

- **Increasing Poverty:** 17 million South African citizens are living below the minimum acceptable standard of living; 12 million do not have direct access to clean water; 21 million do not have toilets or refuse removal services and more than 7million are unemployed. Only 26 per cent of black people have running water in their homes and only 28.9 per cent have electricity.
- **High Unemployment:** In 1994, the official unemployment rate was 29 per cent of the total population. More recent estimates in the formal sector point to as much as 46 per cent and in areas such as Queenstown in the Eastern Cape Province, as much as 72 per cent. According to calculations by the Reserve Bank, approximately 300 000

new job seekers enter the labour market annually, of which only 6 per cent find work. However a positive trend is that the number of people who create work for themselves has increased by 100 per cent among blacks, 72 per cent among whites and 97 per cent among Asians.

- **Growing informal sector:** The number of entrepreneurs in the informal sector is displaying an upward trend. The informal sector is currently contributing approximately 10 per cent of the gross domestic product.
- **Growth in small business:** Of the more 800 000 formal businesses in South Africa, 80 per cent are small or medium enterprises. These enterprises provide approximately 85 per cent of the total number of private job opportunities.
- **Focus of Government on reconstruction and development:** the governments Reconstruction and Development Programme is a long term strategy whereby almost R 37.5 billion will be invested primarily in the upliftment of people. Some of the primary objectives of the programme are:
    - Free compulsory education for 10 years
    - Job creation through public programmes
    - A national youth service programme
    - Community development funding
    - Water supply
    - Electricity supply
    - Free health care for children under the age of five
    - An extensive affirmative action programme in the public service
- **Increasing Social Responsibility**: According to the Weekly Mail and Guardian (October 1993), the increasing social responsibilities of both the private and public sectors are based particularly on the following criteria:
    - Job creation
    - Sound labour relations and favourable working conditions
    - Training opportunities
    - Equal opportunities for women and the disabled
    - Affirmative action
    - Employee participation and transparency
    - Economical use of resources
- **Increasing government spending:** In 1996 the Government of National Unity was spending approximately R 3 700 per person per annum. The nation debt amounts to

> approximately R 280 000 million and is increasing by approximately R 3000 million monthly. This amount includes the R 14 000 million debt by the former self-governing states. State expenditure is increasing by 32,1 per cent per year, whereas the economy is only growing at approximately 3,5 per cent. The public service currently employs approximately 1,5 million people, representing R 57 000 million in salaries (Pretorius, 2006).

A further financial challenge for the public manager lies in the management of the considerable amount of money (approximately R 12 billion) that has poured into the country from foreign investors and donors since 1994 for reconstruction and development programmes. The determination of development priorities in conjunction with all role players and the control of funds present unique challenges. Van Der Waldt and Du Toit (2008:382) explain that the public manager plays an important role in the preparation of budgets and consequently has to be well informed about economic realities in the country.

Technological Issues

The development of information technology is seen as management aid according to Van Der Waldt and Du Toit (2008:383). The authors further explain that rapid technological development in the last few decades has created the need for special coordination and research institutions to test new inventions. Technology poses a challenge to the public manager who has to put into operation the new technological aids. These technological aids refer mainly to management aids which can facilitate the work processes of public administration and result in efficiency and savings.

Legal Issues

Van Der Waldt and Du Toit (2008:384) explain that legal issues include factors such as the constitutional system, the nature of the legal system, legislation and directives concerning the formation and control of institutions within the state. The authors provide a brief discussion on the most general and important legislation and directives with reference to the challenge they present for the public manager.

Constitutional Act 108 of 1996

The requirements set for the public service in terms of section 195 and 197 of the Constitution of the Republic of South Africa Act 108 of 1996 and which must be carried out into effect by public managers include the following:

- A non- partisan, career institution that functions according to equitable and fair principles
- Efficient public administration broadly representative of the South African community
- All member of the public must be served in an unbiased and impartial manner
- The policies of the government of the day must be loyally executed in the performance of administrative functions.
- The public service must be organised into departments and other organisational components with heads that are responsible for their efficient management and administration.

The Public Service Act 103 of 1994

According to Van Der Waldt and Du Toit (2008:384), the Public Service Act 103 of 1994 places obligations on public managers for the effective management and administration of public institutions. In terms of Section 7 (3)(b) of the Act, heads of departments are responsible for the efficient management and administration of their departments, the maintenance of discipline, the promotion of sound labour relations and the proper use and care of state property, and they have to perform the functions that may be prescribed.

The Reconstruction and Development Programme

Van Der Waldt and Du Toit (2008:385) summarises the requirements of public managers as set out in section 1.4 of the White Paper on the Reconstruction and Development Programme 16085 of 1994:

- Meeting the basic needs of society
- Developing human resources
- Creating economic growth and prosperity
- Democratising the state and society
- Implementing the Reconstruction and Development Programme.

White Paper on Service Delivery (Batho Pele)

According to Van Der Waldt and Du Toit (2008: 385), the White Paper on Service Delivery (October 1997) aims to redress the need for a specific policy and criteria for the transformation of public service delivery. It also provides the principles, known as the Batho Pele Principles, meaning 'people first', which would enable national and provincial administrations to develop

the strategies to promote continuous improvement in the quantity, quality and equity of service provision. The principles for public service delivery outlined in the White Paper will be discussed in greater detail in the subsequent chapter but will only briefly be mentioned here:

- Consultation with the public as the client
- Service standards
- Access to services
- Courtesy
- Information
- Openness and transparency
- Redress or responsiveness
- Value for money

The White Paper on the Transformation of the Public Service

This lays down the following guidelines for public managers of the future:

- Service orientation and the delivery of high quality services
- Responsiveness to the needs of the public
- Representative of all sectors and levels of society
- Reasonable labour practices for all employees
- Directed at socio - economic development and the reduction of poverty
- Objective: oriented-ness and productivity
- Holistic, integrated and well – coordinated service delivery
- Participative management in terms of consultation with the community
- Accessibility and informative-ness
- Honesty, transparency and accountability
- Respect for the Constitution and loyalty to the government of the day.

National Crises, Disasters and Security

Van Der Waldt and Du Toit (2008:388) explain that in South Africa crises and disasters often influence public administration. Examples include oil spill, floods and instances of violence. From sheer necessity new organisational arrangements have had to be made, such as the

establishment of Civil Defence which coordinates the consequences of disasters in cooperation with state departments.

Micro-environmental Challenges

Cook and Russel (1981:651) identify the following internal environmental challenges confronting public managers:

Administrative and managerial challenges

Political, social, economic and technological challenges are a continuous process resulting in unique challenges for public management. Within the micro- or internal environment of public institutions, issues are operationalised, strategically planned and addressed by means of services and/or products. Aspects which have to be managed and administered within the South African context include:

- Rationalised state departments
- New or amended directives or prescriptions
- New legislation of the Government of National Unity
- New Organisational units and structures
- New political leaders with different political viewpoints and convictions the appointment of new colleagues and other officials – particularly after the national elevations of June 1999
- The adherence to the recommendations of the Presidential Review Commission.

Thornhill and Hanekom (1995:257) explain that these challenges are associated with a considerable degree of uncertainty. All new administrative and managerial systems will be subject to continuous adaptations to meet the needs of the new non-racist, non-sexist and fully democratic South African society. Thornhill and Hanekom (1995:248) further state that it is important for public managers to determine the rate at which change takes place. Public managers therefore not only manage change but they must also act as leaders and initiate change within the institution.

According to Dr Ncholo (1996:5-6), Director General of the Office of the Minster of the Public Service and Administration, in Van Der Waldt and Du Toit (2008:391), public managers face specific challenges some of which are listed below:

- A clear and realistic vision for the department

- Creativity in managing change and solving problems
- Consultation with and participation of all role players
- Making the department people-oriented and not bureaucratic
- Management development and training
- The ability to determine priorities
- To be the initiators of change
- To achieve the stated objectives of the department
- Service delivery and social equality
- Sound labour relations
- A professional ethos and the recognition of values, norms and standards of all communities within South African society

Cloete and Mokgoro in Van Der Waldt and Du Toit (2008:391) list the following challenges facing public managers:

- The incorporation of new values
- The rationalisation of administrative structures and processes
- The phasing in of new management and administrative approaches and strategies which will lead to the effective functioning of the public sector.

Van Der Waldt and Du Toit (2008:392) cite other factors within the institution which result in increasing changes in public management specifically and public administration in general include continuous evaluation of existing processes and methods.

Personal Intellectual Challenges

According to Van Der Waldt and Du Toit (2008:392) personal intellectual challenges refer, to the educational and academic qualifications of managers, their personal skills and traits, as well as their experience and creativity. According to McCurdy (in Thornhill and Hanekom 1995:259) public managers should fulfil the following roles in order to cope with these intellectual challenges:

- Organisers to incorporate the knowledge and principles of public administration in an organisational structure
- Leaders who understand the behavioural principles of management and administration
- Politicians in order to muster support for public programmes

- Policy analysts to determine the results and sacrifices of a policy
- Experts on how authority and power can be used to the advantage of a community
- Scientists able to make rational decisions and manage change
- Agents for change who can apply organisational development to utilise the potential of human resources to the maximum
- Internationalists able to judge the effects of local circumstances on administration.
- Reformers able to predict future discontinuity and prepare the institution for it
- Diagnosticians able to identify weak points, strong points, opportunities and threats in respect of the institution and to act accordingly.

These roles indicate the unique intellectual challenges facing public managers as well as the diversity and holistic nature of the training they should undergo in this regard.

Goldman (1996:47-50) defines 'emotional intelligence' as the ability of managers to reconcile their personalities, behaviour and perceptions with specific circumstances and he identifies the following as emotional intelligence of managers as being particularly decisive:

- Analysing and evaluating their own behaviour consciously through self-knowledge
- Managing their tempers and holding their own
- Self-motivation
- Avoiding acting impulsively and assessing the situation and the desirable response
- Maintaining sound interpersonal relations.

Insufficient relevant management information

According to Van Der Walt and Du Toit (2008:393) managers are dependent on reliable and relevant information to be able to make decisions. Stone and Wankel (1986:640) state that information should be evaluated on the basis of its utility which apart from its accuracy will facilitate or delay its use.

Conclusion

The researcher explained the principles of public administration within the constitution of the South African Government. The functions of public administration were identified and

explained in detail. The importance of each element that operates in unison to form an integrated whole was discussed. The researcher highlighted the concepts of planning and the resources needed to achieve the objectives at length given the importance of these variables. Policy making within South Africa and the degree to which it impacts on service delivery was explained. Further, implementation was discussed as this lends itself to the implementation of the Batho Pele Principles on which this study is based.

Organising was explained within the domain of public administration. Financing, another important function of public administration was discussed. The researcher explicated the ways in which funds were raised to meet up with the financing of government operations. The personnel function was discussed to highlight the importance of the role of public servants in South Africa. The issue of control was discussed within the realm of public accountability. Further, the various challenges that public administration undertake concluded chapter three. In the next chapter, the researcher will examine the agenda of service delivery as the conceptual framework for this study.

CHAPTER FOUR

THE AGENDA OF SERVICE DELIVERY

INTRODUCTION

This chapter seeks to analyse service delivery in its broadest form and from various perspectives. This will provide this study with a comprehensive and detailed outlook of service delivery as this forms one of the key variables of this study.

The government has a responsibility towards its citizens to offer services that are of an acceptable standard and that which meets the needs and requirements of its citizens. Humphreys (1998) defines public services "as those services which are mainly, or completely, funded by taxation. As such, they can differ markedly from commercial private-sector services in a number of ways." Lennan (2009:21) explains, service delivery is commonly understood to mean the provision of goods or services by a government or other organisations to those who need or demand them. However, in South Africa, given the previous political dispensation, the provision of services by the government is linked to the larger task of redistribution, social justice, poverty alleviation and economic growth. In this way the delivery process is strongly associated with and influenced by development and the developmental state is associated with the capacity to provide social justice.

According to Hartley and Skelcher (2008:8), the fact that services are funded primarily through the public purse means that there is the potential for a high level of debate, accountability and scrutiny which may affect the management of public organisations.

Humphreys (1998) further explains,

> "in the public services, different guiding principles, such as equitable treatment and the allocation of resources according to need, pervade the processes of decision making, management and provision. As a result, financial subventions may be given to the service providers (e.g. in transport) to ensure that such services are maintained, albeit at a reduced level, outside peak times and in less densely populated rural areas".

THE PUBLIC AS CUSTOMER

In this study, the public is viewed as a customer that receives service from a service provider. The service provider in this instance refers to the government responsible for the necessary services. The reciprocal view of a private enterprise, involves the expansion of the

organisations market share, however in public enterprises, the fewer the customers, the easier it would be to appease with regards to providing good quality services. This anomaly sets the public enterprise apart from the private enterprise.

Further the White Paper on Transforming Public Service Delivery which is discussed in detail in this chapter provides a comprehensive understanding of how citizens receiving public services ought to be treated. The White Paper on the Transformation of Public Service Delivery (1997:13) states that in a genuinely competitive commercial market, private companies cannot afford to ignore the needs and wishes of their customers if they want to stay in business, as this will lead to unsatisfied customers taking their business elsewhere. It emphasises that knowing what the customer wants and providing it quicker, better and cheaper than your competitors, is essential to business success. As competitive companies worldwide soon discover, 'the customer comes first' is not an empty slogan but a fundamental business principle.
However within the context of government being the exclusive provider of some services, citizens have no option but to subscribe to the services offered by the government. The WPTPSD clarifies that many public services, such as revenue collection or the imposition of law are not 'services' but are regulatory in function. Further it is stated that the concept of citizen as a 'customer' may therefore seem inappropriate within this realm, nevertheless the term 'customer' is a useful term in the context of improving service delivery as it embraces certain principles which are as fundamental to public service delivery as they are to the provision of services for commercial gain.
According to the WPTPSD (1997:13) to treat citizens as 'customers' implies:

- Listening to their views and taking account of them in making decisions about
- Determining what services should be provided;
- Treating them with consideration and respect;
- Making sure that the promised level and quality of service is always of the
- Highest standard; and
- Responding swiftly and sympathetically when standards of service fall below
- The promised standard.

The imperative to utilize the word 'customer' will therefore be useful in taking forward the Batho Pele initiative.

Pretorius (2006) states that, in ensuring relevant and successful service delivery, it is vital that consumers of public service are consulted as far as possible in order to determine their needs and priorities. Research conducted by Zeithaml, et al. (1993:1-12) shows that as customers evaluate the levels of performance of a service, customers typically compare that performance to what they had expected. Naidoo (2004) explains, expectations provide a base line for the assessment of a customer's level of satisfaction.

Van Der Waldt and Du Toit (2008:119) offer a simple approach to understanding the public as clients of public institutions. The authors view clients as the individuals or institutions that use the services and or products of public institutions. Because these services are paid for by way of taxes and levies, the public expects the services and or products to meet its requirements.

Naumann (1995:23) contends that customer's perception is an episode in which a customer comes into contact with any aspect of that company, however remote, and thereby has an opportunity to form an image about the services provided by that company. Therefore organisations should be customer-orientated, with customer friendly systems and a work environment that reinforces the notion of quality service delivery.

Mc Lennan (2009:40) suggests defining recipients of services as clients does pressurize government to operate more effectively, but it also redefines the rights of citizenship, limiting access to those savvy enough to work the system.

Blem (1995:69) argues that in South Africa, many customers are used to mediocre services. Some customers have not experienced good quality service. The customer who has to put up with poor services such as; who is ignored while employees are chit-chatting or while employees are conducting personal conversations may draw conclusions about the quality of service being offered in terms of efficiency and integrity.

THE GOVERNMENT- CITIZEN PARADIGM

According to Gore (1993) in Kalianan (2008:89), "the conceptualisation (and relegation) of the citizen to a customer is often portrayed as beneficial development within the Producer-Customer Paradigm". The need to serve the sovereign customer coheres well with the democratic political ideology where the citizen is the ultimate repository of power (Self, 2000). "Customer satisfaction is the main mantra of this paradigm. It defines the role and challenge of the producer i.e. agencies or authorities as seeking to satisfy their customers", (Pierre, 1998). This paradigm redefines the role of the authorities to one of production and that of the local citizens as one of consumption. Kalianan (2008) further explain that, in the Government-

citizen model, the citizens have an obligation to provide inputs into the policy making, for example determining what, how, what level, and who is entitled to receive benefits. There is a clear reciprocal relationship marked by mutual obligations. The role of the citizens is not just to consume and provide feedback on their satisfaction. They are to participate and determine, in a collective manner, what will be produced, how and for whom. This mutuality of obligation is absent in the private parallel. It is not the satisfaction of the consumer *per se* that marks the quality of governmental service but the satisfaction of the community at large.

According to Farnham et al. (2005) in almost all OECD countries there has been a decrease in trust in government during the 1980's and 1990's. Due to increased individualism, higher educational achievements and growing expectations, citizens have become more critical of governments and demand higher standards of public services.

THE ROLE OF GOVERNMENT IN SERVICE DELIVERY

Mabala (2006) maintains that the effectiveness of the public service to deliver essential services to a country's citizens is dependent, to some extent, on the political guidance provided by members of Parliament to the executive function of the state, as well as the success with which the administrative officials are able to implement government projects.

McLennan (2009:19) explains that public service delivery is highly politicised in South Africa because it represents some of the contradictions of the transition from apartheid to democracy. On the one hand, it is a continuing crisis as the damaging effects of apartheid disrupt the government's ability to grow the economy, compete globally and meet local demands. On the other hand, it is a redistributive route to development for those previously denied the rights of citizenship, education and employment. Mc Lennan (2009:20) warns, failure to pay attention to the politics of delivery can compromise the achievement of the developmental vision set out by the government.

According to Attkinson and Marais (2006), the main mechanism for service delivery is municipal government. It has been tasked with implementing the construction and maintenance of basic infrastructure including water supplies, electrification, housing, and sanitation and refuse collection.

The OECD (2008) maintains that the state (or more precisely, the governing regime) plays a political "game" when it struggles to secure power; its success in doing so depends on, among other things, legitimacy. The source of legitimacy might be the leaders' ability to deliver economic growth, national prestige, or public services.

Alternatively (a more partial) legitimacy might derive from signals of special allegiance to certain traditions or ethnic groups. Thus, legitimacy may or may not relate to equitable service delivery. Even well-established states can fail to provide services capably and equitably.

The Responsibility of the Local Municipality

The Municipal Systems Act explains the significance of a municipality within a community. According to the Constitution of South Africa

> "A municipality is a local government system, which can provide democratic and accountable government for local communities; ensure the provision of services to communities in a sustainable manner; promote social and economic development; promote a safe and healthy living environment; and encourage the involvement of communities and community organisations in the matters of local government".

The Municipal Structures Act defines a municipality as the structures, political office bearers and administration of the municipality; a geographic area; and the community of the municipality. In other words, a municipality consists of a municipal institution (political and administrative structures), and the people who live in the local area.

Accountability of Government

The OECD (2008) states that governments everywhere deliver services effectively when there is accountability between citizens and their leaders. Accountability emerges as a complex chain of relationships linking users, policy makers and service providers. Services reach the public in a two-step process: policy makers allocate and providers produce the services. But in fragile states this broad service compact often breaks down and service users must take an active role in imposing accountability by engaging directly with service providers.

In terms of Section 133(3) (b) of the South African Constitution, members of the executive council of provinces as well as ministers at national sphere are required to provide the legislatures with full and regular reports concerning matters under control. This is done in full recognition of the role that is to be played by the legislatures.

The OECD further explains service delivery is not only a technical task but also a governance process. Adequate service delivery rests on a four-part relationship of accountability between the citizens and their leaders:

1. Citizens elect political leaders, who are evaluated based (in part) on their policies regarding services.
2. The policymaker chooses a package of services and allocates them to beneficiary groups.
3. The policy maker selects agents to implement (produce) the services in the package. (These agents may be units of the public administration or, alternatively, non-state providers.)
4. The policy maker sets standards for the expected level and quality of performance, monitors the outputs and rewards or sanctions the implementer as appropriate.

Services reach the public in a two-step process: allocation (by policymakers) and production (by service providers/implementers). Accountability between the policy maker and the implementer is defined by a compact, which includes service delivery standards, monitoring methods, rewards and sanctions. This service compact cannot fully specify outcomes, especially for services that are inherently transaction-intensive and hard to monitor (such as classroom education). Moreover, the user of the services – the client – is not a party to the service compact.

Latib (1995:7) states that traditionally accountability means one being answerable for ones behaviour or actions, however the classical approach which is the dominant approach in the South African public service requires only that rules, regulations, orders and instructions be adhered to. He further emphasises that public servants have therefore been considered accountable only to the extent to which they are legally required to answer for their actions. Latib (1995:17) also explains the general characteristics of the present system of accountability in South Africa:

- A concentration and centralisation of accountability, mainly in the office of the Auditor-General.
- A lack of balance amongst the various accountability mechanisms in favour of financial accountability, with other forms of accountability only playing a secondary role.
- Inadequate and unclear relationships between directly complementary institutions, for example, between the Auditor-General and the Parliamentary Committee on Public Accounts.
- A predominance of procedural accountability, which is inevitably characterised by an internal bias and control bias in respect of bureaucratic output norms.

- Aspects involving internal outputs in the public service receive more attention than broader aspects such as environmental impact, social responsiveness, etc.
- Accountability mechanisms are slanted in favour of corrective aspects of accountability

  (that is: departures from procedural standards), with a weak impact on other processes (eg decentralised decision-making units, substantive policy).

He further explains the appropriate mechanisms and strategies for maximising the democratic accountability of a future public service will largely depend on the constitutional framework that emerges from current transitional processes.

According to The World Bank Report (2011) the following recurring issues associated with the incomplete implementation of the Batho Pele principles (the short route to accountability) emerge:

- Participation is often diluted to mere community consultations and treated as something to check off on the official's checklist of "his" project.
- Little or no choice of providers by users, combined with low or absent user fees and co-payments.
- Underdeveloped or absent user supervisory committees and power over service providers.
- No systematic and institutionalized use of client feedback mechanisms such as citizen report cards.
- No systematic and institutionalized reporting by service providers and local governments to the citizens about coverage and quality of services and use of resources.
- Insufficient use of local languages in information provision and feedback mechanisms.
- Ineffective complaints, redress, and sanctioning/reward mechanisms.

The report further states that despite President Zuma's considerable efforts to strengthen the long route to accountability, the underdevelopment of the short route is further aggravated by the following problems in the long route:

- Compacts focused on inputs and outputs, rather than on outcomes.
- Services organized as centrally driven sector silos, which are difficult to coordinate, as demonstrated internationally and in South Africa.

- Complex procedures, some still stemming from apartheid, developed in central offices rather than in the field through participatory methods, and after field testing, prior to adoption.
- Lack of practical and comprehensive operation manuals for implementation.
- Inadequate monitoring, evaluation, feedback, and learning processes, which treat monitoring and evaluation as ancillary rather than integral to service delivery.
- Financial management and information systems not integrated with the data on inputs and outputs, resulting in dispersed, inaccessible, poor, and untimely basic data on services.
- Underdeveloped feedback mechanisms with no systematic approach for correcting errors quickly.
- Lack of follow-up and sanctioning—both exacerbated by poor data—when manager performance is unsatisfactory, including in financial management.
- Incomplete decentralization due to a lack of consistent application of the subsidiarity principle.
- Overlapping mandates and responsibilities among the centre, provinces, districts, municipalities, and service providers, and a lack of coproduction agreements that define the functions and responsibilities of the actors.
- Excessively complex Integrated Development Plan process, interpreted differently by politicians/policymakers than by citizen-users.
- Municipalities preferring to deliver services themselves rather than through public-private or other partnerships, due to the onerous requirements for contracting service provision.

THE IMPLEMENTATION OF POLICY

Pillay (2009:148) explains that the role of the provinces relates largely to the implementation of policy while national governments role revolves around the development of policy in particular the formulation of norms and standards in a range of areas, such as education and health, the two largest sectors in terms of funding and the employment of human resources. Pillay (2009), further states that while national government ministries and departments formulate national policy in education, health, agriculture and so on, they have little influence over whether appropriate resources are directed towards the attainment of national objectives. This is because funding flows from the centre to the provinces in the form of unconditional block

grants. Provincial governments have the autonomy to distribute these funds between various functions as they see fit. This distribution may not necessarily coincide with the objectives of the national government.

This blurred line or disconnection between policy formulation and implementation poses the greatest challenge to serve delivery at the provincial level.

Hanekom et al. (1996:38), explains the fact that policies are sanctioned by legislators and promulgated in legislation of one or other kind, does not necessarily lead to their implementation. According to Edwards and Sharkansky (1978:295-321) various factors exert an influence on implementation such as:

- Communication: transmission, clarity and consistency;
- Resources: Staff, information and authority;
- Disposition of implementers: bureaucratic politics, incentives and bypassing channels;
- Standard Operations Procedures;
- Follow up.

Communication of Policy

Edwards and Sharkansky (1978:295) state that the first requirement for effective implementation is that those responsible for carrying out a decision must know what is required of them. They further states that orders to implement a policy must be consistent, clear and accurate in specifying the aims of the decision makers. Cloete (1982:8) shares the same view in that laws, regulations, official guidelines and official documents should be so carefully worded that political office- bearers, public officials and lay members of the public can see at a glance what actions are expected or under way. This ultimately means that official documents should be worded in such a precise manner that the carriers of this information will be able to quantify and qualify information to the extent that decisions made and actions taken are to be accountable in accordance with the prescriptions or the factual data.

The reference to communication as a factor which influences public policy implementation can be analysed from a three-pronged view namely:

- Transmission: the absence of a sound communications system and the blockage of information somewhere in the system result in ignorance of decisions and orders.

- Clarity by which is meant that orders or instructions should not be vague or ambiguous about when or how implementation is to be carried out. Vagueness according to Cloete (1982) can make changes in policy difficult and can also result in changes far greater than those anticipated.
- Consistency: because there is seldom just one order, implementation orders may be inconsistent as well as vague.

Jones (2008) states that when people are communicating strategy, people are actually inculcating change. The key for communicating strategy is to be able to align the extent and scope of the change and the approaches of implementation with the values and principles outlined in the related policy document.

Markwell (2009) advises, "the environment for communicating about health has changed considerably. These changes include dramatic increases in the number of communication channels and the number of health issues vying for public attention". There are a number of ways of communicating messages and some of these can also be used to communicate health messages. These can be divided into five categories:

Communication Category	Example of Communication Medium
Intrapersonal	Internal communication (e.g. what we think, when we listen to an inner voice)
Interpersonal	One to one, small group, emails, telephone calls and other activities that allow personal listening and response
Organisational	Lectures, seminars, debates, meetings, memos, intranets, newsletter, workshops, displays
Community	Local radio, talks, seminars, debates, local newspapers, bill boards, bus tickets, health fairs
Public/Media	Newspapers, television, radio, internet, CD-ROMs, mobile phones

Source: Markwell (2009)

Table 3: Categories of Communication to develop a communication strategy.

Further, according to the Implementation of Programme and Policy Initiatives Report (2006), communication about a policy or programme initiative needs commitment and support from all those involved with implementation. This involves being 'outward-looking', that is, a view not only from the agency perspective but also from the perspective of stakeholders, and in particular on how the target audience will react and the best means of communication. The report further recommends, the objective of communication should be clear (and in line with the initial policy objective). This is assisted by the development of a communication strategy which also provides a means of assessing success or otherwise.

Communication is a central component of any change process. The greater the impact or change, the greater the need for clear communication of the reasons and rationale behind it, the benefits expected, the plans for its implementation and its proposed effects. The report importantly points out that without effective communication, stakeholders may miss out on

vital information and may not understand why change is needed, or the benefits to them of the change. The objectives of communication are to:

- keep awareness and commitment high
- maintain consistent messages
- ensure that expectations do not drift out of line with what will be delivered.

Resources

Hanekom et al (1996:41) argue that the lack of resources not only hinders policy-making, it also limits the effective implementation of a policy. Edwards and Sharkansky (1978) put this into perspective by offering that no matter how clear the implementation orders are, if the personnel responsible for carrying out policies lack the resources to do an effective job, policy makers will be disappointed with the outcomes.

Service Delivery in South Africa

Moller and Radloff (2011: 295) explains in the democratic era, South Africans consider decent living conditions as their right. The new constitution adopted in 1996 guarantees the right to have access to adequate services and places the onus on the state to progressively realise this right.

Since 1994, under democratic rule, considerable progress has been made in service delivery, especially to the formerly disadvantaged in South African society in terms of access to housing, and infrastructure. However seventeen years on and the government continually comes under fierce criticism for the lack of basic services at previously disadvantaged areas. The development of infrastructure, has given rise to the hope that services will be rendered, yet there still remains a question of having adequately trained public servants to man these centers. As a developing country, South Africa has indeed made tremendous progress in ensuring the injustices of the past are dealt with. Whilst the previous government handed over the reins of a stable economic environment, there were tremendous ill balances socially which the ANC had inherited. According to a speech given by the then Minister of Public Works Minister Skweyiya (1997), he stated that many of the Public Service's systems and procedures were outdated, bureaucratic, over-prescriptive, time-consuming and wasteful, and unresponsive to citizens' real needs. Citizens were not systematically consulted about their views on how public service should be provided. The public service is largely characterised by a lack of transparency and there are few mechanism which enable ordinary citizens to hold public servants to account.

The new democratic government had to immediately start a process of repair and restoration. The Reconstruction and Development Program (RDP) was one such means government adopted to repair the breaches of the past.

Reconstruction and Development Programme

According to Chikulo (2003), the governments development strategy was first articulated in the original 1994 RDP document (ANC 1994:1) in which the ANC sought "to mobilise all our people and our country's resources towards the final eradication of apartheid and the building of a democratic, non-racial and non-sexist future". The programme sought to attain socio economic growth and basic needs delivery, while at the same time addressing the legacy of injustice. The Programme (ANC 1994) put emphasis on 'people-centred development', 'integrated development' and 'sustainable development' that is democratic and participatory. The RDP proposed several dimensions that should be addressed to achieve socio-economic transformation of the South African society. The RDP further set out various socio-economic commitments and targets for delivery as follows:

- The creation of 2.5 million jobs over a ten-year period;
- The building of one million houses by the year 2000;
- The connection to the national electricity grid of 2.5 million homes by 2000;
- The provision of running water and sewerage to one million households;
- The distribution of 30% of agricultural land to emerging black farmers;
- The development of a new focus on primary health care;
- The provision of ten years of compulsory free education for all children;
- The encouragement of massive infrastructural improvements through public works; and
- The restructuring of state institutions by 1997 to reflect the broader race, class and gender composition of society.

Chikulo (2003) further adds that "the RDP was expected to engineer growth, through increased public expenditures on social service provision. The RDP put emphasis on programmes to meet basic needs and enhance human resource development, placed a major emphasis on social infrastructure and development programmes that address poverty and inequality".

Thus, during the 1994-1996 period, the RDP was viewed as the cornerstone of government development policy – a yardstick against which the success of the government development

policy could be assessed. However, as a development policy document, the RDP had a number of shortcomings. First, it looked more like a 'wish list' than a strategy document focusing on opportunities and constraints. Second, it made no attempt to set priorities; or to assign responsibility for the implementation of each programme component. Third, it lacked mechanisms for inter-departmental coordination. Finally, local government, which has been assigned constitutional responsibility for promoting socio-economic development, did not have adequate planning and implementation capacity.

Further to the Reconstruction and Development Programme, the Government of National Unity pre-empted to address the imbalances of the past through the transformation of administration of public service delivery. According to the White Paper on the Transformation of the Public Service (WPTPS, 1995), published on 24 November 1995 there are eight transformation priorities, amongst which Transforming Service Delivery is the key. This is because a transformed South African public service will be judged by one criterion above all: its effectiveness in delivering services which meet the basic needs of all South African citizens. Improving service delivery is therefore the ultimate goal of the public service transformation programme.

The South African White Paper on Transforming Public Service (1995) states its vision as:

> *The Government of National Unity is committed to continually improve the lives of the people of South Africa through a transformed public service which is representative, coherent, transparent, efficient, effective, accountable and responsive to the needs of all.*

According to the White Paper (1995) the government envisages a public service which is:

- Guided by an ethos of service and committed to the provision of services of an excellent quality to all South Africans in an unbiased and impartial manner;
- Geared towards development and the reduction of poverty;
- Based upon the maintenance of fair labour practices for all public service workers irrespective of race, gender, disability or class;
- Committed to the effective training and career development of all staff;
- Goal and performance orientated efficient and cost effective;
- Integrated, coordinated and decentralised;
- Consultative and democratic in its internal procedures and in its relations with the public;

- Open to popular participation, transparent, honest and accountable;
- Respectful of the Rule of Law, faithful to the Constitution and loyal to the Government of the day.

In pursuit of this vision, the Government of National Unity sees its mission as:

> *The creation of a people centred and people driven public service which is characterised by equity, quality, timeousness and strong code of ethics.*

The above provided the Public Administration with direction and the public with the reassurance that the public service within South Africa was going to be transformed. However a more significant approach in the form of the White Paper on the Transformation of Public Service Delivery provided a spotlight on the issue of public service delivery within South Africa which was in need of dire attention.

THE IMPETUS FOR BATHO PELE

The South African White Paper on Transforming Public Service Delivery (1995) stipulates its purpose which is 'to provide a policy framework and a practical implementation strategy for the transformation of public service delivery. This White Paper is primarily about how public services are provided, and specifically about improving the efficiency and effectiveness of the way in which services are delivered. The focus is not about what services are to be provided, instead what should be delivered which will be improved as a result of the Batho Pele approach.

Further it can be stated according to the WPTPSD (South Africa 1997:9), it urgently seeks to introduce a fresh approach to service delivery: an approach which puts pressure on systems, procedures, attitudes and behaviour within the Public Service and reorients them in the customer's favour, an approach which puts the people first. This does not mean introducing more rules and centralised processes or micro-managing service delivery activities. Rather, it involves creating a framework for the delivery of public services which treats citizens more like customers and enables the citizens to hold public servants to account for the service they receive.

DEFINING BATHO PELE

According to Khoza (2007) Batho Pele is a Sesotho expression which means "people first". The WPTPSD (South Africa 1997) further explains, "Batho Pele has the potential to bring about a major change in the way that public services are delivered". This White Paper marks the

start of a continuous process of improvement which will lead to public services that the public have a right to expect and that public servants are proud to provide. The WPTPSD further states that during the period of transformation and reform, public servants will face constant changes and sometimes confusing challenges, Batho Pele served to remind the public servants, that their main goal, their prime motivation, their most important task is service to their customers. Further, the Batho Pele message is that the customer comes first, last and all the time.

THE PURPOSE OF BATHO PELE

According to the WPTSD (1997), the Batho Pele White Paper is primarily about how public services are provided, and specifically about improving the efficiency and effectiveness of the way in which services are delivered.

The Batho Pele white paper aimed to introduce a fresh approach to service delivery: an approach which put pressure on systems, procedures, attitudes and behaviour within the public service and reoriented them in the customer's favour, an approach which put the people first.

UNDERSTANDING THE BATHO PELE PRINCIPLES

In terms of the WPTPSD (Batho Pele White Paper), every government department is required to implement eight service delivery principles, known as the Batho Pele Principles. Each of these principles have been carefully constructed to enhance the quality and accessibility of government services by improving efficiency and effectiveness and accountability to the citizens of South Africa. In treating the citizen as a customer, the Batho Pele White Paper exhibits this intention of the government to adopt a customer- orientated approach to service delivery which are informed by the the eight service delivery principles of: consultation; service standards; access courtesy information; openness and transparency; redress and value for money (1997:15)

Consultation

'Citizens should be consulted about the level and quality of public services they receive and wherever possible should be given a choice about the services that are offered' (South Africa 1997:15).

Naidoo (2004) explains that "consultation will give customers the opportunity of influencing decisions about public services by providing objective evidence which will determine service delivery priorities. Further she states that, consultation can also help to create a more participative and co-operative relationship between the public sector and prospective recipients of services". Monyakane (2007) explains that "the public must be consulted regularly and

systematically and must where the need arises be engaged in review of past, present and potential essential services". The public service must also use methods that are suitable to the 'characteristics of the users, consumers concerned and purpose of consultation'. The WPTPSD (1997:16) states that, to ensure comprehensiveness and representativeness, which includes coverage of the views of the entire range of existing and potential customers, including those who have been previously been denied access to public services, those who have been previously disadvantaged, and those who have previously found it hard to make their voices heard because of geography, language barriers, fear of authority or any other reason, more than one method will be needed. Such methods could include interviews with individual citizens; customer surveys; meetings with relevant representative bodies about providing more effective forms of service delivery. The Batho Pele White Paper also advises the consultation process should be undertaken sensitively whereby people should not be asked to reveal unnecessary personal information and they should be able to give their views anonymously if they so wish.

Setting Service Standards

> *Citizens should be told what level and quality of public services they will receive so that they are aware of what to expect* (South Africa 1997:15).

According to the WPTPSD (South Africa 1997: 16-17), the standards for the quality of services should be published at national, provincial and departmental levels. These standards must be relevant and meaningful to the individual user and be specific and measurable. Users should be able to judge whether the promised services were received or not. Standards should be published and displayed and performance of health care providers must be measured at least once a year. The WPTPSD proposes that individual provinces may set their own standards provided these meet or exceed the national baseline. Service Standards must be relevant and meaningful to the individual user. This means that they must, cover the aspects of service which matter most to users, as, revealed by the consultation process, and they must be expressed in terms which are relevant and easily understood. Standards must also be precise and measurable, so, that users can judge for themselves whether or not they are receiving what was promised. The WPTPSD clearly stipulates that "some standards will cover process, such as the length of time taken to authorise a housing claim, or to issue a passport or identity document or to answer letters". Other standards will be about outcomes. In the health care for example, standards might be set for the maximum time a patient should have to wait at a primary health care clinic, or for a non- urgent operation; or for the information they are entitled to receive about their treatment, and about who is responsible for their case. The WPTPSD emphasises

that the standards must be set at a level which is demanding but realistic. Ultimately this means that they should reflect a level of service which is higher than that which is currently offered, but at the same time which can be achieved with dedicated effort and by adopting more efficient and customer focussed working practices. To achieve the goal of making South Africa globally competitive, standards should be benchmarked against international standards, taking into account South Africa's current level of development.

According to Khoza (2007), within a public hospital, certain service standards pertaining to the functioning of the ward are to be displayed on the wall in the units so that they can be visible to patients and their families. These include:

- A shift roster for the nursing staff
- Ward rounds
- Schedule for serving of meals to patients
- Schedule for nurses' tea breaks and lunch times
- Schedule for visiting times

The response by the government in respect of setting service standards in the health sector can be seen in the Policy on quality in Health Care for South Africa which was released by the National Department of Health in 2007. The tenets of this policy are discussed in the subsequent chapter of this research study.

Increasing Access

> *All citizens should have equal access to the services to which they are entitled.* (South Africa, 1997:15).

Monyakane (2007) explains to curb the inequality in service delivery, more especially to close the gap between the first world and third world conditions in South Africa and redress the disadvantages of existing barriers to access, Batho Pele suggests that access to services be increased through specific programmes.

This principle includes access of health services to patients who were previously disadvantaged as a result of poor infrastructure and barriers to access such as social, cultural, physical, communication and attitudinal factors (South Africa 1997:18).

The WPTPSD (1997) further emphasises, one significant factor affecting access is geography. Many people who live in remote areas have to travel long distances to avail themselves to public

services. Further, another significant factor is the lack of infrastructure, which exacerbates the difficulties of communication with and travel to remote areas. In drawing up their service delivery programmes, national and provincial departments must therefore develop strategies to eliminate the disadvantages caused by these factors, for example, by setting up mobile units and redeploying facilities and resources closer to those in greatest need.

The move to make services more accessible to those previously disadvantaged, does bridge the gap created by the previous political dispensation.

Courtesy

> *Citizens should be treated with courtesy and consideration.* (South Africa 1997:15).

According to the WPTPSD, the Code of Conduct for Public Servants issued by the Public Service Commission, makes it clear that courtesy and regard for the public is one of the fundamental duties of public servants, by specifying that public servants treat members of the public "as customers who are entitled to receive the highest standards of service". Many public servants do this instinctively; they joined the public service precisely because they have a genuine desire to serve the public.

It is highly recommended in the WPTPSD (1995) that National and provincial departments must specify the standards for the way in which customers should be treated. These are to be included in their departmental Codes of Conduct. These standards should cover, among other things:

- greeting and addressing customers;
- the identification of staff by name when dealing with customers, whether in
- person, on the telephone or in writing;
- the style and tone of written communications;
- simplification and 'customer-friendliness' of forms;
- the maximum length of time within which responses must be made to enquiries;
- the conduct of interviews;
- how complaints should be dealt with;
- dealing with people who have special needs, such as the elderly or infirm;
- gender and
- language.

Within the ambit of this study, patients are to be treated as individuals, with fairness, in an unhurried manner, with empathy and understanding as well as with consideration and respect. An important aspect of encouraging customer-focused behaviour is to provide staff with opportunities to suggest ways of improving service and for senior managers to take these suggestions seriously. This applies particularly to staff who come into regular contact with the public because they usually have an accurate appreciation of their needs and concerns. All managers should ensure they receive first-hand feedback from front-line staff and should personally visit front-line staff at regular intervals to see for themselves what is happening (South Africa 1997:19).

Monyakane (2007) adds, because a culture of courtesy facilitates all other processes, it is vital in public service delivery. It encourages interaction between public and public offices so that consultation may occur, communication can improve and access to services and information may be facilitated.

Further, these improvements promote fairness and reasonableness in that health worker will also consider the public interest in every decision they take.

Providing more and better Information

> *Citizens should be given full, accurate information about the public services they are entitled to receive* (South Africa, 1997:15).

According to the WPTPSD (1995), "information is one of the most powerful tools at the customer's disposal in exercising his or her right to good service. It is mandatory for National and provincial departments to provide full, accurate and up-to-date information about the services they provide, and who is entitled to them. This must be done actively, in order to ensure that information is received by all those who need it, especially those who have previously been excluded from the provision of public services". The consultation process should also be used to find out what customers and potential customers need to know, and then to work out how, where and when the information can best be provided.

Implementing Batho Pele will require a complete transformation of communication with the public. Information must be provided in a variety of media and languages to meet the differing needs of different customers. This is essential to ensure the inclusion of those who are, or have previously been disadvantaged by physical disability, language, race, gender, geographical distance or in any other way. Written information should be plain and free of jargon, and supported by graphical material where this will make it easier to understand. There should

always be a name and contact number for obtaining further information and advice. All written information should be tested on the target audience for readability and comprehensiveness. However, it should not be assumed that written information alone will suffice: many people prefer to receive information verbally, so that they can ask questions and check their understanding.

Khoza (2007) adds that the principle on the provision of information aims to empower patients to understand the health services they are entitled to receive.

Openness and Transparency

> *Citizens should be told how national and provincial departments are run, how much they cost and who is in charge.* (South Africa, 1997:15).

Fundamental to the public service transformation process Openness and transparency are the hallmarks of a democratic government. In terms of public service delivery, their importance lies in the need to build confidence and. trust between the public sector and the public they, serve. A key, aspect of this is that the public should know more about the way national and provincial departments are run, how well they perform, the resources they consume, and who is in charge.

Redress

> *If the promised standard of service is not delivered, citizens should be offered an apology, a full explanation and a speedy and effective remedy; and when complaints are made, citizens should receive a sympathetic, positive response.* (South Africa, 1997:15).

Monyakane (2007) surmises the key to the Batho Pele principles lies in the ability to identify quickly and accurately when services are falling below the minimum promised standard and having procedures in place to remedy the situation.

The WPTPSD (1995), further explains that the Batho Pele principle of Redress requires a completely new approach to handling complaints. Complaints are seen by many public servants as a time-consuming, irritation. Where complaints procedures, exist, they are often lengthy and bureaucratic, aimed at defending the department's actions rather than solving the user's problem. Many departments have no procedures for regularly reviewing complaints in order to identify systemic problems. Indeed many organisations do not collect any statistics about the number and type of complaints they receive. Often, 'complaints' are counted as such only when they are submitted in writing through the formal channels. Yet many members of the public do

not bother using these channels because they have no confidence in their effectiveness, and because they find the process time-consuming and sometimes daunting. As a result, public sector organisations frequently underestimate the level of dissatisfaction which exists. The WPTPSD proposed that each department should regularly review complaints and how they have been dealt with.

National and provincial departments are required to review and improve their complaints systems, in line with the following principles:

Accessibility

Complaints systems should be well-publicised and easy to use. Excessive formality should be avoided. Systems which require complaints are to be made only in writing may be convenient for the organisation but can be off-putting to many customers. Complaints made in other ways, such as face-to-face, or by telephone, should therefore also be welcomed.

Speed.

The longer it takes to respond to a complaint, the more dissatisfied customers will become. An immediate and genuine apology together with a full explanation will often be all that they want. Where delay is unavoidable, the complainant should be kept informed of progress and told when an outcome can be expected.

Fairness.

Complaints should be fully and impartially investigated. Many people will be nervous of complaining to a senior official about a member of their staff, or about some aspect of the system for which the official is responsible. Wherever possible, therefore, an independent avenue should be offered if the complainant is dissatisfied with the response they receive the first time round.

Confidentiality.

The complainant's confidentiality should be protected, so that they are not deterred from making complaints by feeling that they will be treated less sympathetically in future.

Responsiveness.

The response to a complaint, however trivial, should take full account of the individual's concerns and feelings. Where a mistake has been made, or the service has fallen below the promised standard, the response should be immediate, starting with an apology and a full explanation; an assurance that the occurrence will not be repeated; and then whatever remedial

action is necessary, Wherever possible, staff who deal with the public directly should be empowered to take action themselves to put things right.

Review.

Complaints systems should incorporate mechanisms for review and for feedback suggestions for change to those who are responsible for providing the service, so that mistakes and failures do not recur.

Training.

Complaints handling procedures should be publicised throughout the organisation and training given to all staff so that they know what action to take when a complaint is received.

Getting the best possible value for money

Public services should be provided economically and efficiently in order to give citizens the best possible value for money. (South Africa, 1997:15)

The WPTPSD states that to get the best possible value for money, improving service delivery and extending access to public services to all South Africans must be achieved alongside the governments GEAR strategy for reducing public expenditure and creating a more cost-effective public service. The paper calls for procedures which must be simplified and waste and inefficiency must be eliminated. Khoza (2007), notes that this is an important principle especially for unit managers to plan, organise and control all resources in such a way that cost effective patient care can be rendered. Further nursing units must control their resources in order to prevent unnecessary shortages, for example, shortage of linen.

CONCLUSION

This chapter detailed service delivery in South Africa and immediately introduced the public as a customer – a view which the government hoped to achieve with the introduction of the Batho Pele Principles. Various other important factors pertaining to policy implementation was explored providing impetus for the subsequent chapters. The White Paper Towards Public Service Delivery Transformation was discussed briefly highlighting its importance to this study. The purpose of Batho Pele was explained as well as the eight Batho Pele Principles which are further explored in this research. The next chapter addresses service delivery in the public health sector of South Africa.

CHAPTER FIVE

SERVICE DELIVERY IN THE PUBLIC HEALTH SECTOR IN SOUTH AFRICA

INTRODUCTION

According to Cloete (1986:10), hospitals are undoubtedly the dominant institutions in the provision of health services. Whittaker et al. (1998:263) explain that "the country is the most heavily industrialized country in Africa with a total population of approximately 40.3 million people. The adult population comprises 25.6 million people of whom 14.3 million (56%) are 'economically active'. The health services are provided by both the public and the private sectors". The public sector caters for approximately 70—80% of the country's population, many of whom were disadvantaged during the apartheid era. South African health services are undergoing profound changes as a result of political and social imperatives. Until relatively recently, the public sector provided mainly hospital based care. In an attempt to address the inequalities of apartheid there has been a move towards a primary health care approach.

Kautzky (2008) explain that "an assessment by the WHO in 2003 found that more than 60% of health care institutions in South Africa struggled to fill existing posts, with more than four thousand vacancies for general practitioners and more thirty two thousand vacancies for nurses throughout all provinces". In the Public Sector, 31% of posts were unfilled nationally and an estimated 40% of posts in the Free State and 67% of posts in Mpumalanga remained vacant. The critical shortage of trained health personnel and the inability to fill essential posts, constitutes a key barrier to achieving the implementation and provision of district-based health services in South Africa today. Kautzky (2008) further explains, "rooted in distributional inequities in the national health system, as well as the significant loss of health workers through international emigration, the problem is severe and fundamentally systemic. The trend today has worsened with an estimated 63% of general practitioners now working in the private sector, nearly twice as many as in the public sector. Similarly the private sector now absorbs an estimated 62% of national health expenditure providing medical care to approximately seven million people, while the public sector absorbs only 38% and provides for an estimated 35 million people".

Further to an investigation by the *Sunday Times* Newspaper in 2012, South Africa's 452 government hospitals are on the brink of collapse. They have a serious shortage of medical

professionals, many of whom are underpaid and overworked, lifesaving equipment, food for patients, and funds to renovate dilapidated buildings and infrastructure (Naidoo et al*.,* 2012).

The doctor to patient ratio in Limpopo is just 17 doctors per 100 000, whereas the national average is 55 doctors to 100 000. According to Naidoo et al.(2012), this falls short of the norms in middle-income countries such as Brazil, where the national average is 185 to 100 000. In developed countries the average is 280 per 100 000.

THE PERSISTENCE OF POOR SERVICE DELIVERY

Mathoho (undated), maintain that the new government came to power and adopted a form of governance that was not suitable to deliver effective and efficient services in the country and immediately embarked on public service reform. All the three spheres of government (national, provincial and local) went through the reform process. Ultimately it is the municipal government that is held responsible for poor service delivery. A noteworthy statement made by President Zuma in his address to Mayors and Managers forum in 2009 says,

> "The municipalities are the first door that our people knock on when they need assistance from government. When people are frustrated with the slow movement of the wheel of government they engage municipalities before other spheres. Citizens also blame municipalities for functions that they have no direct control over… we should be mindful of the fact that we are discussing service delivery against a background of a global economic crisis, which means we really do not have the type of resources we need to fulfil our goals".

Local government Bulletin (2009), show that there are other external factors that municipal governments have to contend with in the effective delivery of services.

The current state of service delivery is relatively poor when one considers the resources that have been made available to the various departments. In spite of having reform and development plans and policies to address the inaccuracies of the past, it has not been adequate to ensure that the preamble in the constitution is carried out or even adhered to.

Moller and Radloff (2011) explain that, the country has experienced problems in meeting the increased energy needs of an expanding economy. In 2006, South Africans experienced regular electricity outages to conserve energy. As of 2010, consumers paid 30% more for electricity than previous years, to support plans to improve future supplies. South Africa is also reaching

its limits of its fresh water resources and water conservation is urgently needed to provide a growing population with access to piped water and water-borne sanitation.

Moller and Radloff (2011) further states the country has always prided itself that its tap water is safe to drink, however in recent years there have been reports of sewerage leaks into dams and rivers. Poor water quality is also linked to poor maintenance of treatment works. According to Roodt and Eddy (2010), up to 50% of municipalities did not have a qualified engineer on their staff in 2008. Moller and Radloff further explains, in 2008, the media broke news of the deaths of 78 Eastern Cape babies from diarrhea. The deaths were initially attributed to exposure to contaminated water but further inquiries linked them to poor and negligent health services.

According to Khoza (2007) a report by Nthite (2006:1) claimed that various patients complained that they were not attended to when they presented themselves at a certain academic and district hospital, although they were injured and were bleeding. They had to queue for longer than six hours and were ignored by the nurses who were either on tea or lunch breaks. Further according to the *Daily Sun* (2007:5), a mother took her baby to the hospital because her seven month old baby girl was suffering from diarrhoea. During her hospital stay the baby lost four fingers when nurses forgot to unstrap a band around her arm after inserting a drip. She said when the mistake was discovered the baby was transferred to another hospital for an emergency operation. As a result the baby had to undergo four more operations and was discharged from the hospital three months later. Another case of poor standard of service was reported by Premdev in the *Sunday Tribune* (2006:3) when a woman who was referred to a hospital to deliver her baby who later died of complications. She was left by herself to deliver the baby and her screams for help fell on deaf ears.

In 2005, the Democratic Alliance investigated a number of hospitals and listed the 'five worst hospitals' in the country. However their research does not confirm that all 388 public hospitals were visited before this conclusion was reached. The findings of their research are still relevant to this study and will therefore be discussed.

One of the hospitals listed under the 'five worst hospitals' was the Rob Ferreira hospital which is based in the capital of Mpumalanga and serves about 500 000 people (Arentstein, 2001). Based on previous media reports and a visit to the hospital, the findings accordingly are that:

- there was a 67% vacancy rate
- The hospital has fewer than 50% of the nurses it needs (356 out of 694).

- The hospital needs 12 pharmacists - it only has one.
- It only has four of the 20 specialists it needs.
- It only has four of the ten dentists it needs.
- Doctors reported in 2002 that they had been forced to operate by torchlight, and that basics such as sterile gloves, swabs, intravenous drips were unavailable. Nurses stated that at one stage they had been expected to keep intensive care patients alive by manually pumping air into their lungs during the many power black-outs.
- In 2003 it was reported that doctors at the hospital had to refer between 30 and 40 patients to Pretoria hospitals every month because the hospital had no money to fix a urology theatre table or C-Arm equipment used during hip or femur operations.
- Further it was reported in 2001 that the hospital had one ambulance which did not have a spare tyre to service 500 000 people (Arenstein, 2001).
- In 2001 staff at the hospital were charged with gross mismanagement for complaining about working conditions and in May 2004 the deputy director-general of health in Mpumalanga warned staff that they would have to improve service delivery or face being asked to leave.

The hospital rated the second worst according to the Democratic Alliance was the Umtata General Hospital based in the Eastern Cape. According to Fernandez-Mena et al. (2002), Umtata General Hospital is the referral centers for 25 rural hospitals in the Eastern Cape Province of South Africa, the nearest San Barnabas Hospital (30 Km away) the farthest Reitvlei Hospital (225 Km away). With a total of 1149 beds Umtata General Hospital serves a population of 2, 4 million approximately. The findings are as follows:

- In 2001, upon a visit by a journalist, it was found that there were cockroaches crawling over babies; an unbearable stench; floors covered with dirt; and patients forced to share beds in overfilled wards. Babies were kept in a ward which had not been fumigated since 1998.
- The hospital's budget was reportedly barely enough to pay for salaries and maintenance, leaving virtually no money for medication, and
- nurses were obliged to pay for stationary out of their own pockets
- The hospital needed about 37 specialist doctors and 39 medical officers. Another 30 nurses and 32 nursing assistants were needed.
- On another visit by journalists to the hospital in 2002, it was found that it had

run out of disinfectant, antiseptic cream, anti-tetanus injections, gauze and the re-agent needed to process HIV tests. It also suffered periodic shortages of essential drugs such as antibiotics and patients were sharing beds.

- Ninety-one mothers were sharing 48 beds in the maternity ward, some lying top-to-toe. In the outpatients ward, urine and blood were splattered in the corridor. Bins were overflowing and used needles were scattered on the floor.

In 2003 the Human Rights Commission visited several hospitals in the province, including Umtata. Among other revelations about circumstances at the hospital, it found that:

- Switchboard staff spent too much time on personal calls, so phones rang

  "Forever".

- There were no ambulances stationed in the hospital, and it relied on scarce

  Metro ambulances.

- There was no mammogram and no ultra-sound machines.
- Only one theatre was working. It could not be established why the other two were not used.
- Maternity ward beds were shared, although some patients were in an advanced stage of pregnancy.
- There was a serious shortage of medicine. The main problem was internal, "where people just take medicine and drugs for their own use".
- There were major staff shortages; for example, there are three qualified pharmacists instead of the regulatory 19.
- Some beds had no linen, and linen was never adequate. The laundry was not functioning well and at times linen stayed dirty for days.
- Management was "only concerned about outsourcing everything. Some had shares in the companies to which they wanted to outsource".

Since then, Njamela (2006) reported on Health-e, News Service that a massive 348 nurses and 68 doctors have resigned from Mthatha in the past three years. This is evidence of an exacerbating problem that has spiralled out of control. Further when Health-e visited Umtata

General Hospital in 2006, AIDS patients were dying while waiting for antiretroviral drugs as only 10 new patients a week were accepted to the treatment programme. At the time of Health-e's visit, patients were sprawled all over the reception area, some emergency cases on stretchers or sitting on benches with drips on their arms waiting to be admitted.

The third hospital under the spotlight of the Democratic Alliance was the Cecilia Makiwane hospital, based in the Eastern Cape. This hospital serves a community of about three million people and has 1 724 beds (Njamela, 2006). Further it was reported that:

- Fifty six doctors resigned in 2005, which is a clear indication of among others dysfunctional management (Njamela, 2006).
- Almost two-fifths of the medical specialists' posts are also vacant, and over one in five nurses posts are vacant, (Njamela, 2006).
- Four mothers lost their babies; due to a power failure at the hospital as a result the hospital is expecting to face a massive lawsuit. The hospital volunteered to assist with the burial expenses.
- Nurses at Cecilia Makiwane Hospital refused to speak on the record even though Health-e had provincial permission to interview them for fear of victimisation.
- Morale amongst the nurses was low. They were particularly bitter about their poor salaries, saying they had to work extremely hard because of staff shortages.
- One nurse was in the ward to care for the 30 patients. Burn victims need specialised attention as they are highly susceptible to infection.

The Democratic Alliance reported that:

- In 2002, the Health Professions Council of South Africa announced that it would withdraw doctors from the hospital because "outdated equipment, unacceptable accommodation and poor training facilities", which meant that the hospital did not comply with the Medical and Dental Professions Board's criteria for accreditation.
- There is insufficient linen and most patients had blankets from home. They rely on food being brought in by relatives, and the nurses said the quality of the food ranged from average to poor.
- The toilets are filthy, with running sewage on the floors; no seats; no toilet paper; and no soap. The grounds are in a terrible condition, infested with dozens of cats, and covered in garbage, rubble and a chaotic mess.

- In the burns unit, the staff are enormously overworked. There were just two nurses on duty caring for 40 patients during the DA visit – and the ward stank of rotting flesh. Newly operated-on patients are not isolated, but laced immediately into the overcrowded ward where infection is apparently rife.

Further to this was the hospital rated by the D.A. as the fourth worst hospital in South Africa. The Natalspruit hospital located in Gauteng services the areas such as Katlehong, Thokoza, Germiston, Vosloorus, Standerton and Heidelberg (D.A., 2006). Further the hospital is built on unstable dolomite which is at a severe risk of sinking (Madlala 2006). The hospital conditions have deteriorated over the years due to neglect and mismanagement of priorities. The following problems were identified upon the DA's investigation:

- Following a newspaper report in 2001, it was found that that the roof was leaking; wards were infected with cockroaches; there were burst water and sewage pipes; the floors needed new tiles and lighting was hopelessly inadequate. Overcrowding was also reported to be a severe problem. Admission in the paediatric ward was around 110%, and sometimes went up to 140%. It was reported that the hospital had recently had to add 70 more beds without waiting for government approval, because approval had taken so long and levels of overcrowding were unsustainable.
- In August 2004, after a staff revolt against conditions of work, it emerged that not much had changed since the investigation in 2001. Staff claimed that the hospital was near collapse, and about 1 270 employees out of a staff complement of 1 336 had signed a petition demanding the removal of the CEO, Dr Daisy Pekana.

Further, it emerged that the hospital should have had a staff complement of 1 838, but there were 569 vacancies. The hospital had neither anaesthetists nor urologists, and remaining doctors were reported to have had to work more than 100 hours of overtime a month because of the shortage. Over the previous two years, 290 doctors, specialists, and nurses had reportedly left. The provincial department of health stated that although the money was available to employ staff, they simply could not find people willing to work there.

- In September 2004 it was reported that 76 children out of the 363 who had been admitted had died at the hospital in one three month period, many of them from easily preventable infections. An investigation into the problems revealed that there was a severe staff shortage, particularly in the children's ward, leading to negligence of key

health aspects. For example, procedures such as wearing sterile gloves and washing hands between patients were not followed. Provincial officials stated that although there was money available to employ more staff, they simply could not find people willing to work there.

- In November 2004, after a meeting with the Gauteng Portfolio Committee on health, it was revealed that six babies had died in Natalspruit as a result of an outbreak of Klebsiella. Unhygienic conditions and severe nursing staff shortages were blamed. According to the MEC, there were only two or three registered nurses at a time in the unit to look after 70 babies.
- The DA's visit in 2006 revealed the medicines were dispensed efficiently, but that there were many complaints about file mismanagement. Two women had been waiting for over six hours for their files. There were insufficient beds in the general wards and in the neo-natal ward. In the latter there were 78 babies, yet they were only designed for 43. There were four ICU beds for the babies, and five babies, so two shared a bed. The Matron said they only had the five respirators and that if another newborn needed one, it was up to her to decide which baby lived and which baby died. There was only one other available incubator close by, and it was occupied. This was the same ward which seven months ago had babies sharing three to a bed, and in which six died of Klebsiella infection.

The final hospital on the list of the five worst hospitals in South Africa was the Mahatma Ghandi Memorial Hospital situated in Kwa-Zulu Natal. This was a rather newly established hospital in comparison to the others mentioned in the DA's report; the hospital was built in 1997. The hospital has a large maternity section; further ten per cent of the babies born in South Africa are born at the Mahatma Ghandi Hospital. Despite being a modern and sophisticated hospital compared to other public hospitals in South Africa, the Mahatma Ghandi Hospital gained notoriety for the spate of newborn deaths which could have been easily preventable. Between May and June 2005, twenty two babies died from Klebsiella infection. After these deaths were exposed in the media, a report was leaked showing more than 40 babies had also died from hospital acquired infections in 2003. Many parents were not informed of the reason for their babies' deaths. The hospital tried to cover up the tragedy by informing parents their babies died from natural causes. The health minister's response to the public exposure was to conduct a quick investigation and provide answers to a community seething

with anger. This investigation found that poor hygiene, overcrowded units, understaffed and under-equipped neonatal units, and sharing of incubators contributed to the outbreak.

Aside from the DA's report on the five worst hospitals, the *Sunday Times* carried out a special investigation into 25 healthcare facilities over a period of one month, in South Africa (2012) the report reveals that the state of the health care in South Africa is in dire need of an immediate government intervention.

Naidoo and Mthethwa (2012) investigated hospitals in the Eastern Cape region and found that, whilst the Eastern Cape health department spent more than R 1- billion rebuilding and renovating some of its 82 state hospitals, the province is still plagued by service delivery issues. Spokesman for the Eastern Cape health department, Mr S. Kupelo confirmed that the bulk of the monies was allocated to 62 rural hospitals built by missionaries more than 80 years ago. He stated that some of the hospitals had to be demolished and rebuilt. Kupelo confirmed that there were further plans which were being finalised to rebuild Madwaleni Hospital in Elliotdale at a cost of R 500 million. Further, a report by the *Sunday Times* in February 2012 stated that the hospital which serves 260 000 people, was in a terrible condition and that patients often queued for more than eight hours to see a doctor. The hospital has just four doctors. Naidoo and Mthethwa (2012) further state that the shortage of doctors has crippled the provinces rural hospitals where there are no doctors at all at some rural hospitals.

According to Kupelo, the challenges faced by rural hospitals are compounded by poor leadership and management, shortage of much needed staff as well as a lack of facilities. Kupelo stated that the department is currently addressing these problems. Naidoo and Mthethwa further state that Mjanyana Hospital in Engcobo, which is situated about 70km from Mthatha has just one doctor in attendance, whereas Greenville Hospital in rural Bizana has been operating without any doctor for more than a year. The report by the *Sunday Times* also revealed that Eastern Cape has 1800 doctors and specialists on its payroll to deliver healthcare to nearly seven million people.

Further, nurses at the Nelson Mandela Academic Hospital in Mthatha were guaranteed at the end of March 2012 that R5.5million would be paid out for night duty allowances dating back to 2007. This came after nurses went on a 'wildcat' strike and held two hospital managers hostage for several hours over the non-payment (Naidoo and Mthethwa, 2012).

Bailey et al. (2012) investigated the hospitals in the Gauteng province and found that the hospitals in Gauteng are under siege as doctors, nurses and patients battle with broken equipment, shortages of linen, medicine and food, flooded theatres and no telephone lines. The conditions at the Chris Hani Bharagwanath hospital in Soweto were described as 'disgusting'. The hospital has been plagued by power cuts and was short of 25 basic medicines. Further, a urologist had to utilise the light from his cell phone to complete a surgical procedure when the backup generator failed to function after a power outage. At the same hospital, a neurologist removing a brain tumour had to use the light of a torch to stitch up a patient.

Steve Biko Academic Hospital in Pretoria recently turned away cancer patients due to non-functional radiation equipment necessary to treat cancer patients. Bailey et al. (2012) reported that a patient, who underwent surgery at the hospital to remove nine lymph glands, was discharged three days later because of the shortage of beds in the surgical ward. Five days after his discharge, he had to be readmitted due to severe haemorrhaging. The investigation of the hospital by the *Sunday Times* further revealed that two of the ten lifts were out of order.

The Charlotte Maxeke Johannesburg Academic Hospital experienced similar challenges; a radiation machine was not repaired due to a payment dispute with the service provider. There was a shortage of equipment and medicines and for the past two months the hospital had been hit by a shortage of dairy products, tea and sugar. Patients rely on their families and staff members to provide such supplies.

The ill-fated Natalspruit Hospital in Alberton did not have a functional telephone system for more than a month. Doctors and nurses had to utilise their cell phones to make necessary calls. Linen shortages at the Thembisa Hospital meant that there were not enough blankets or even sheets for patients. Bailey et al. (2012) further state that staff at this hospital are not provided with the necessary aprons, gloves and goggles when they deal with patients with infectious diseases. One patient at the hospital claimed, he was admitted 12 hours after arriving at the casualty ward.

The Gauteng Department of Health spokesman Simon Zwane stated that the hospitals are overburdened because of HIV/Aids trauma and the migration of patients from other provinces.

Govender (2012) investigated the Mpumalanga province and found that at some clinics nurses are forced to dispense medication. Govender mentions an in-depth report on service delivery at

the Mkhondo municipality which includes the town of Peit Retief which paints a shocking picture of the state of health services in the area. Upon further investigation by the *Sunday Times* it was found that locals are unhappy with the poor service being meted out. Alleged poor treatment of a seventy three year old man resulted in his untimely death. Nurses at the hospital neglected to maintain his hygiene due to a stroke he suffered. Further, his wife was expected to clean him whenever he soiled his underwear. Nurses left his food by his bedside, knowing full well that he was unable to eat by himself.

The report compiled by the Mpumalanga legislature's research policy and knowledge management unit follows an investigation into among other things services offered by Piet Retief hospital as well as six of the eleven health centres and clinics. Govender (2012) states that "one of the biggest problems identified was the dire shortage of doctors and nurses. There are 315 vacancies at the hospital for medical and non- medical staff". According to the report, some health care facilities were forced to hire retired nurses. Other findings in the report include:

- There is no full-time doctor in the Amsterdam Clinic and staff members have had to use their own money to buy stationery and cleaning materials.
- The generator at Amsterdam clinic has not been functional since 2006.
- The blood pressure machine at Amsterdam clinic reflected wrong readings
- Waste at Driefontein Community Health Centre is attracting maggots as a result of non-collection of medical waste.
- The dire shortage of much needed equipment at the Iswepe Community Health Centre which includes a heart machine, blood pressure monitor and machines that measures the foetal heartbeat during pregnancy.
- A staff member at Piet Retief hospital stated that patients had not been served vegetables, beef and mutton for months. This is cause for concern especially for diabetic and hypertensive patients who require vegetables and meat in their diet.
- Staffs were forced to borrow sugar from the Carolina Hospital after the kitchen at Piet Retief ran out of supplies.

According to Mpumalanga Health Department spokesman Dumisani Mlangeni, the legislatures report 'correctly captures the gaps in the health service delivery, meaning acute

shortage of medical staff, inconsistent distribution of drugs, and ageing infrastructure and equipment (Govender, 2012).

CHALLENGES FACED BY THE PUBLIC HEALTH SECTOR

According to www.southafrica.info, South Africa consists of a large public sector and a smaller but fast growing private sector. Further, The public sector is under-resourced and over-used, while the mushrooming private sector, caters to middle- and high-income earners who tend to be members of medical schemes (18% of the population), and to foreigners looking for top-quality surgical procedures at relatively affordable prices.

According to Schaay et al. (2011), the challenges faced by the health sector have been highlighted in public reviews and studies and have been the subject of a series of national policy reform initiatives and government-led investigations. Schaay et al. refer to a series of six papers on health in South Africa published by *The Lancet* in 2009 which presents an overview of the unique features of South Africa's history that have contributed to the systemic problems existing today. Further in the WHO (2000) league table of health system performance, South Africa was ranked 175th out of 191 member states. This is as a result of the poor state of public health care in South Africa. The challenges described below are cumulative problems that have contributed towards the poor state of the service delivery within the public health sector in South Africa.

- Leadership and management failures

The persistence of poor service delivery can be partly attributed to poor management as the numerous reports show. Rust and De Jager (2010) explain that, there is a lack of leadership and management capacity within the public health sector in South Africa. e.g. head office officials at provincial level have very little understanding of the operational complexities of running bigger hospitals. These offices micromanage the hospitals and handcuff the hospital managers with endless regulations and tedious procedures. Further, hospital managers have little control over budgets, procurement, discipline, staffing levels and staff structures. They are disempowered and frustrated by the centralized control that departmental officials exert over their everyday activities. The result is that hospital managers cannot be regarded as accountable for health-care failures in the hospitals, as they lack the necessary powers to change things.

According to Arenstein (2001), the delivery of 996 vital medicines was halted at hospitals in the Mpumalanga province due to an outstanding bill of R 23 million. The outstanding payment to 13 of South Africa's largest pharmaceuticals dated back to October 2000. One of the hospitals severely affected by this situation was the Rob Ferreira Hospital in Nelspruit which is recognised as one of the largest provincial hospitals in the Mpumalanga province. As a result of financial mismanagement by the Mpumalanga province, the Rob Ferreira hospital which serves roughly 500 000 people were left without supplies which had to be bartered from neighbouring hospitals. Further, Arentstein (2001) states that senior hospital staff, which could not be named for fear of victimisation said stocks of sterile gloves, ran out after staff were forced to use them when supplies of less expensive general purpose latex gloves were depleted. This is just one example of the effects that financial mismanagement has on the public health sector.

- Poor hygiene

Cullinan (2006) provides the following challenges documented at various hospitals throughout South Africa. She highlights poor hygiene and poor infection control which during the course of 2005 led to the deaths of 26 babies as a result of Klebsiella at the Mahatma Gandhi Hospital in Durban. She further explains that the source of the bacteria was the intravenous formula fed to the babies through drips. One batch of infected IV formula was being used to feed a number of babies in an attempt to cut costs. Sadly no one was held responsible for these deaths. Presumably because there was a chain of negligence. This ranged from the ward staff to the province, which had been told by the hospital that its neonatal intensive care unit was overcrowded and understaffed. Cullinan addresses another case of poor hygiene and poor infection control which the Mandela/HSRC "South African National HIV Prevalence, HIV Incidence, Behaviour and Communication Survey, 2005" found that 3.3% of new HIV infections in 2005 were of children aged 5 to 9. These infections could not be linked directly to mother-to-child transmission, and the authors suggest potential sources of their infection to be "child abuse and infection through the health system".

According to Cullinan (2006), "the authors based their claim on a previous study, HIV risk exposure in children aged 2-9 years served by Public Health Facilities in the Free State, South Africa", (HSRC, MRC, University of Stellenbosch, Cadre). The study found "Poor infection control practices were found in some labour and maternity areas and in dental facilities, in particular through poor cleaning techniques and traces of visible and invisible blood found in these areas and on dental instruments."

The study found that 24.6% of dental instruments ready to be used on patient's mouths and gums and 24% of instruments destined to be used for maternity and paediatric patients were contaminated with invisible blood and 17.5% had visible blood.

The Free State is considered to have a relatively strong and well-functioning health service, which means that infection control in weaker provinces is likely to be even worse. Cullinan (2006) further addresses the issue of *abuse and neglect of patients*: In February 2005, there were press reports of psychiatric patients at Townhill Psychiatric Hospital in Pietermaritzburg being abused, including raped, by staff. An official investigation that followed made a number of shocking findings, including:

• "overwhelming evidence" of neglect of patients by staff,

• evidence of physical, sexual, verbal and emotional abuse of patients by staff,

• Ample evidence of staff stealing patient's food and belongings.

The AFP (Agence France-Presse) reported on the link between the deaths of six babies and poor hygiene at a hospital in Johannesburg. In its report, provincial health boss, Mahalangu stated "the outcome of the investigation was that that the cause of death for all six babies was related to an intestinal virus which is spread by contaminated hands". Mahalangu came to the defence of the nurses by stating that there was not enough wash basins, sanitisers and paper towels. The department report further identified overcrowding and staff shortages as a major contributor to poor hygiene at the hospital. HIV exposure was ruled out as the cause of infection.

- Shortage of Skilled Staff

According to Rust and De Jager (2010), trained medical professionals have left for the more lucrative private sector where conditions and pay are better, thus staff shortages and management failures compromise patient care. This has led to a cycle of young professionals choosing to move to the private sector where conditions and pay were better. Public hospitals are highly stressed institutions due to understaffing; public health service is basically running on the commitment of nurses and doctors to serve their communities, despite pathetic pay packages, enormous workloads and horrible working conditions. Further Rust and De Jager points out that patients are dying unnecessarily because South Africa's public hospitals are over-burdened, understaffed and poorly managed.

According to Media Club South Africa, in 2007 the government entered into an agreement to recruit 2 000 Tunisian doctors to combat the long-standing shortage of doctors in rural areas. In

addition, 450 doctors from Cuba and Iran have also been employed by the Department of Health. Johannesburg Hospital has entered into an agreement with Maputo Central Hospital which will lead to patient referral and exchange of health professionals between the two hospitals. The government has even made it easier for other foreign doctors to register here. Newly graduating South African doctors and pharmacists now complete a year of compulsory community service in understaffed hospitals and clinics. Still this initiative or attempt by government has not aided the serious problem of staff shortages.

In 2004 the government launched the Community Health Worker Programme to develop community-based generalist health workers. Their training combines competencies in health promotion, disease prevention, primary healthcare and health-resource networking, as well as coordination. It is estimated that there are 40 000 such workers in the country.

Dieleman and Harnmeijer (2006) state that "since the start of the Joint Learning Initiative (JLI), in 2003, the human resources crisis in low-income countries (LICs) has received global attention, particularly the crisis in sub-Saharan Africa". In some countries less than 50% of the required staff is available to serve rural populations; while at times care is provided by non-qualified staff" (WHO, 2006; Hongoro and Normand, 2006). This situation seriously compromises the health status of the communities, particularly the poor. Dieleman and Harnmeijer (2006) further state that retention of health workers, particularly in rural areas of LICs, is high on the agenda, due to the severe staff shortages that hamper the attainment of the MDGs. As there are fewer health workers in rural areas, loss of health workers in these areas will severely contribute to accessibility problems (Salafsky et al., 2005). Studies have shown that at hospital level, lower nurse-to-patient ratios lead to more complications and poorer patient outcomes (Aiken in Duffield and O'Brien-Pallas, 2003). In addition, staff shortages negatively affect the motivation of the remaining staff as they create increased workload, causing extra stress and the risk of more staff leaving or being absent from work.

A report by the *Sunday Times* after a month long investigation in 2012 revealed that there are 106 518 vacancies within the health sector that needs to be filled. However the Department of Health has stated that it could not afford to fill all of the vacancies. Naidoo (2012) states that based on the Department of Health's response, the government needs an additional R38 billion a year to fill all the vacancies in the public hospitals and clinics countrywide. Further according to the Health Departments report, the total of 106 518 vacancies include 44 780 nurses which would cost the state R 17, 6 billion; 10 860 doctors which would cost a total of R 8,6 billion; 3 491 specialists would set the state back by R 3, 6 billion. A further R496 million would be

needed for the 921 posts available for dental pratcitioners, R 204 million for radiographers and R 305 million for physiotherapists (Nadioo, 2012).

- Overcrowding of Patients

Another major challenge faced by the health sector is the overcrowding of patients. Rust and De Jager (2010) suggests two reasons for this which are: the AIDS epidemic and rapid urbanisation, where a large number of people are now living in unhealthy conditions in informal settlements. Research conducted by the HSRC has found that non-AIDS patients, particularly the elderly and children, are being "crowded out" of hospitals by people with AIDS related infections, whose sickness are more critical and need more care.

Waiting times for the elderly with chronic illnesses (eg diabetes, hypertension) to see doctors and to get their medication from the pharmacy at Out Patients Departments are indicators of the levels of service they face. Further insufficient beds at public hospitals are unable to cope with the large communities they serve.

- Poor Working Conditions

The massive staff shortages within the public sector means that public servants are required to do more and more work. The poor working conditions are a precursor for the high rate of absenteeism and demoralised staff. Cullinan (2006) proposes a good indicator of a healthy, disciplined working environment is the absentee rate among staff. She further highlights serious short comings hospital staff has to deal with daily. She mentions that there is often very little support for health staff. Further she mentions the problems doctors experience when attending to patients. The drastic shortage of skilled staff which are categorised according to specialist doctors, ordinary doctors, professional nurses and pharmacists leads to unfortunate delays in patients being treated.

According to Palitza (2006), "South Africa already suffers a shortage of health workers, due in large part to unattractive working conditions. Many posts for health workers remain vacant, notes a study by a national research organisation, the Durban-based Health Systems Trust (HST). This will inadvertently compromise the quality of care patients receive".

De Villers (2010) states from a medical perspective, it has been stated that poorly equipped and managed hospitals, inappropriate training and an excessive workload are significant contributors to the problem.

- Non Functional Equipment

Bodenheimer, (2005) and Raab (2001), as cited in Dasanayaka (2008), state that technology management is strategically important to technology driven organisations such as public sector hospitals because the major part of the health budget spend on health equipment and devices. Especially a well prepared technology management policy as a part of good governance framework help to maximize the gains from available expensive technology equipment in public sector hospitals to improve overall health of any nation (Grimes and Jahnke, 2004; Halbwachs and Korte, 1990).

Dasanayaka (2008) further states, with limited financial resources on one hand and increased expectations of the public for a better health care service on the other hand, developing countries have many challenges to face in making the right medical equipment available in proper working order at all times in hundreds of public hospitals in their countries. The problems of non-functional equipment have exacerbated the state of service delivery at public hospitals in South Africa.

According to Cullinan (2006), it has been found that resuscitation trollies are often not properly equipped, staff members are not trained to use these and there is sometimes a shortage of oxygen. In [persistence of poor service delivery] it was very evident that a number of hospitals throughout South Africa are besieged with non-functional equipment.

- Poor Performance

According to WHO (2006) "poor performance results from too few staff, or from staff not providing care according to standards and not being responsive to the needs of the community and patients". As Hughes et al.(2002) state, most performance problems can be attributed to unclear expectations, skills deficit, resource or equipment shortages or a lack of motivation (Hughes et al., 2002). These causes are rooted in a failing health system, low salaries, difficult working and living conditions and inappropriate training. Zurn et al (2004:3) identifies three factors that are believed to play a role in performance of health workers:

    - capability of staff to attend to their jobs (knowledge, skills and experience).
    - motivation of staff to put effort into their work.
    - organisational support and opportunities including a physical and social environment conducive to work.

- Theft

Although many hospitals have tightened up on stock control, theft is still a serious problem. According to a report in *Business Day* (2006) the Public Service Accountability Monitors head, Adrienne Carlisle stated that two of the Eastern Cape provincial pharmaceutical depots had failed to submit proper records for the past nine years, making it easy for drugs to be "misallocated", Carlisle further added that neither the provincial health department nor depot managers can account for transactions involving purchase of medicines in the province for the (past nine years).

- Policy Implementation

Policy implementation is one of the biggest challenges the government face in the light of improving service delivery. According to Makinde (2005), it is to be noted that the fact that communication, resources, and positive disposition are put in place does not guarantee implementation success. If there is no efficient bureaucratic structure, the problem of implementation can still arise especially when dealing with complex policies.

Gunn (1978 in Hunter, 2003) has identified ten common barriers to effective health policy implementation:

1. The circumstances external to the implementing agency impose crippling constraints.
2. Lack of adequate time and sufficient resources.
3. The required combination of resources is not available.
4. The policy to be implemented is not based on a valid theory of cause and effect.
5. The relationship between cause and effect is indirect and there are multiple intervening links.
6. Dependency relationships are multiple.
7. There is a poor understanding of, and disagreement on, objectives.
8. Tasks are not fully specified in correct sequence.
9. There is imperfect communication and coordination.
10. Those in authority are unable to demand or obtain perfect compliance.

Anderson and Hussy (2006) state that whether policies are implemented from the top-down, bottom-up or according to the principal agent theory, policy implementation involves three activities:

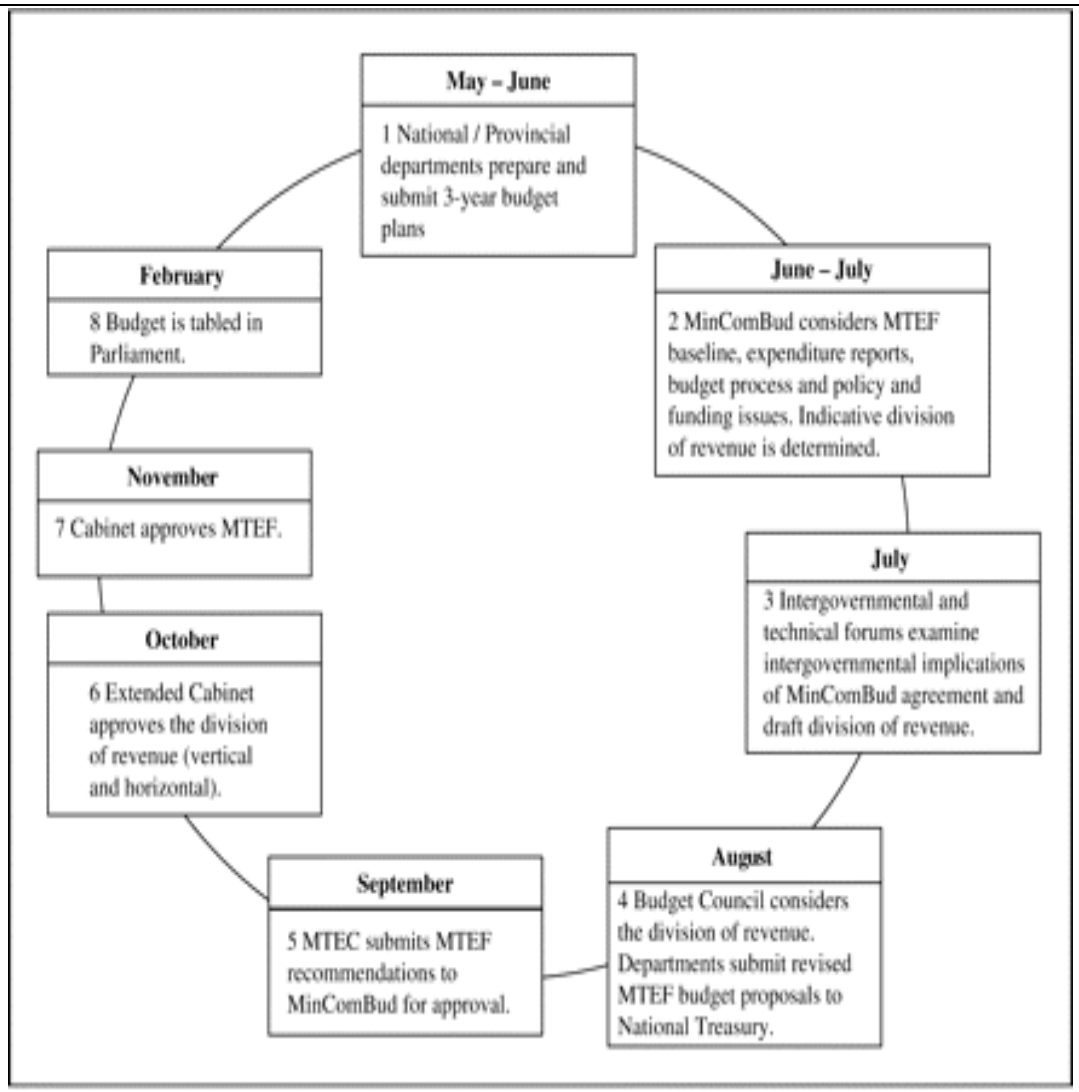
- Interpretation: translation of the policy into administrative directives.

- Organization: establishment of administrative units and methods necessary to put a programme into effect.
- Application: routine administering of the service.

Jenkins et al. (2006) explain that, interpretation of policy directives requires the translation of knowledge on interventions into the particular local context. Factors to take into account when interpreting health policy include:

- Local resources, including human resources and infrastructure.
- Specific characteristics of the population.
- Baseline incidence of the health problem.
- The latency period before an effect of the intervention will be observed.
- A balance between achieving targets that reflect process change and those that reflect risk factor change.
- Local variations in the likely effectiveness of particular interventions.
- Lack of Financial Resources

According to Botha and Hendriks (2008), approximately R135 billion (or 8%) of South Africa's GDP is spent on healthcare through various financial intermediaries and government, with this cost projected to grow (National Treasury, personal communication). A portion of this, 5%, is spent in the private sector through medical schemes. Further it is stated that an already overburdened public sector and provider of last resort caters for approximately 85% of the population on a health budget of less than 44% of the total health expenditure. Health services are resource dependent and, given the mounting challenges of both financial and human resource concentration in the private sector, low staff morale in the public sector, with queuing and poor service quality at point of service at public health facilities a common occurrence; there is a need for an alternative Gilson and Mills (1995) state that, a key concern for the health sector is that decentralization of spending and decision making can increase inequities in the financing and hence provision of health services (like Public Health Care) across geographic areas. Okorafor and Thomas (2007) maintain that PHC budgets are largely decided by the Provincial Department of Health, with little or no interference from the NDOH. Each province conducts its negotiations independent of others.



MinComBud = Ministers Committee on the Budget; MTEF = Medium Term Expenditure Framework; MTEC = Medium Term Expenditure Committee.

Source: National Treasury (2006)

FIGURE 8: Annual budget cycle: South Africa

The above figure sets out the annual budget cycle. Initial budget plans are prepared by all spending agencies at provincial and national levels (Step 1). These are reviewed by the Minister's committee on the budget (MinComBud) and intergovernmental technical forums to determine an indicative division of revenue (Steps 2 and 3). Departments then submit their revised budget plans. These are considered to ensure that the figures fall within the guideline allocations determined through the vertical and horizontal divisions (step 4). The estimates developed then go on to form part of the final national budget presented to parliament (Step 8) (National Treasury 2006). This process has effectively undermined the NDOH, leaving it unable to determine health resource allocations across provinces, with health allocations subject to

competition from other sectors at the provincial level (Gilson et al. 1999; Thomas and Muirhead 2000) in Okorafor and Thomas (2007). According to information collected through the interviews of government officials and NGO informants on resource allocation practices, Okorafor and Thomas found that most officials at the district level commented that PHC activities were under-funded, and that this was in part due to the limited involvement of district-level officials in the budgeting process. Resource allocation to PHC in South Africa is dependent on budgetary negotiations within the Provincial Departments of Health. Evidence shows that huge inequities in resource allocation across districts within provinces still exist (Thomas et al. 2003).

- Lack of Accountability

Cloete and Mokgoro (1995) explain that basic human dignity and individual rights are habitually abused without redress as public complaints are not taken seriously and complainers are seen as merely trouble makers. Here public accountability fails not so much because the political ethos does not recognize the authority of the public. In a situation where an anti-democratic attitude has developed over a long period of time, the spirit that pervades may be quite undemocratic and unaccountable. Cloete and Mokgoro further explain that by changing the ethos or attitude of public servants is a vital step in the direction of a democratic and accountable system of governance.

In 1994, the government launched the Batho Pele initiative in a move to address the inequalities in service delivery and thereby improve access to public services through increased transparency, accountability, and citizen involvement in public service planning and operations. The Batho Pele message resonates strongly with that of the 2004 World Development Report: services can improve by empowering poor people to monitor and discipline service providers by raising their voices in policymaking and strengthening incentives for service providers to serve the poor (World Bank, 2011)

The World Bank Report (2011) identifies further issues with regards to accountability since the implementation of the Batho Pele principles:

• Participation is often diluted to mere community consultations and treated as something to check off on the official's checklist of "his" project.

• Little or no choice of providers by users, combined with low or absent user fees and co-payments.

• Underdeveloped or absent user supervisory committees and power over service providers.
• No systematic and institutionalized use of client feedback mechanisms such as citizen report cards.
• No systematic and institutionalized reporting by service providers and local governments to the citizens about coverage and quality of services and use of resources.
• Insufficient use of local languages in information provision and feedback mechanisms.
• Ineffective complaints, redress, and sanctioning/ reward mechanisms.

The continued lack of accountability by the government and its subservient departments to its citizens is a precursor to a general lack of confidence in the government itself.

- Lack of Basic Supplies

According to Arenstein (2011), at the Rob Ferreira hospital, doctors reported in 2002 that they had been forced to operate by torchlight, and that basics such as sterile gloves, swabs, intravenous drips were unavailable. Nurses stated that at one stage they had been expected to keep intensive care patients alive by manually pumping air into their lungs during the many power black-outs.

Further according to Fernandez-Mena et al. (2002), Umtata General Hospital is the referral centers for 25 rural hospitals in the Eastern Cape Province of South Africa, it was found that it had run out of disinfectant, antiseptic cream, anti-tetanus injections, gauze and the reagent needed to process HIV tests. It also suffered periodic shortages of essential drugs such as antibiotics and patients were sharing beds. Ninety-one mothers were sharing 48 beds in the maternity ward, some lying top-to-toe.

Upon a visit to various public hospitals by the Human Rights Commission in 2003 it was found that there was there was a serious shortage of medicine. The main problem was internal, 'where people just take medicine and drugs for their own use'.

Bailey et al. (2012) investigated the hospitals in the Gauteng province and found that the hospitals in Gauteng are under siege as doctors, nurses and patients battle with broken equipment, shortages of linen, medicine and food, flooded theatres and no telephone lines. Linen shortages at the Thembisa Hospital meant that there were not enough blankets or even sheets for patients. Bailey et al. (2012) further state that staff at the hospital are not provided with the necessary aprons, gloves and goggles when they deal with patients with infectious diseases.

Govender (2012) visited the Piet Retief hospital during an investigation for the Sunday Times Newspaper and found that patients had not been served vegetables, beef and mutton for

months. This is cause for concern especially for diabetic and hypertensive patients who require vegetables and meat in their diet. Also staff members were forced to borrow sugar from the Carolina Hospital after the kitchen at Piet Retief ran out of supplies.

- Lack of Communication

Coeira (2006) points out that the care of patients now almost inevitably seem to involve many different individuals, all needing to share patient information and discuss their management. As a consequence there is increasing interest in, and use of, information and communication technologies to support health services.

According to Hunter (2005), nearly half of hospital patients are given no details about the side effects of the medicines they are given, and less than half of the healthcare staff they encountered washed their hands before carrying out an examination. This severe lack in communication can lead to disastrous consequences for the hospitals concerned.

Ramduny (1997) explain that poor communication has been a major cause of frustration and a major cause of the isolation experienced by health workers in the rural areas. Therefore, the successful implementation of a district health system would to a great extent depend on providing an effective and efficient means of communication for health workers, health managers and consumers of district health care.

Okorafor and Thomas (2007) state that further problems related to a lack of communication between different levels of government and the availability of appropriate financial lead to a poor budgetary process.

- Lack of equipment

According to the Democratic Alliance in 2003 it was reported that doctors at the Rob Ferreira hospital had to refer between 30 and 40 patients to Pretoria hospitals every month because the hospital had no money to fix a urology theatre table or C-Arm equipment used during hip or femur operations. Arenstein (2001) reported that the hospital had one ambulance which did not have a spare tyre to service 500 000 people.

A visit by the Human Rights Commission in 2003 to the Umtata General Hospital revealed that there were no ambulances stationed in the hospital, and it relied on scarce metro ambulances. Further they discovered there were no mammogram and no ultra-sound machines. Only one

theatre was working. It could not be established why the other two were not used. It also reported that maternity ward beds were shared, although some patients were in an advanced stage of pregnancy.

In 2006 the D.A. visited the Natalspruit hospital and found that they only had the five respirators and that if another newborn needed one, it was up to the Matron to decide which baby lived and which baby died. There was only one other available incubator close by, and it was occupied. This was the same ward which seven months ago had babies sharing three to a bed, and in which six died of Klebsiella infection.

Bailey et al. (2012) visited the Chris Hani Bharagwanath Hospital where it was revealed that a urologist had to utilise the light from his cell phone to complete a surgical procedure when the backup generator failed to function after a power outage. At the same hospital, a neurologist removing a brain tumour had to use the light of a torch to stitch up a patient.

Steve Biko Academic Hospital in Pretoria recently turned away cancer patients due to non-functional radiation equipment necessary to treat cancer patients. Bailey et al. (2012) reported that a patient, who underwent surgery at the hospital to remove nine lymph glands, was discharged three days later because of the shortage of beds in the surgical ward. Five days after his discharge, he had to be readmitted due to severe haemorrhaging.

POLICY ON QUALITY IN HEALTH CARE FOR SOUTH AFRICA.

In identifying a dire need for a relook at the decaying public health care system in South Africa, the National Health Department decided to refocus its collective efforts towards improving the quality of care provided in public health facilities and communities.

According to Mseleku, (2007), The Policy on Quality in Health Care for South Africa is to be used as a guide by health care personnel to help focus their intentions and guide their efforts. A precise of the policy will now be discussed.

- The key aims of the policy;

The National Policy on Quality in Health Care provides a way to improve the quality of care in both the public and private sectors. Achieving the goal of a quality health care system requires a national commitment to measure, improve and maintain high-quality health care for all its citizens. This involves measuring the gap between standards and actual practice, and working out ways to close the gap. The national aims also reflect the needs of specific vulnerable populations and geographical areas. Within each of these broad aims, health care providers

should establish specific measurable objectives so that they can track progress in achieving these aims. National aims for improvement include, but are not limited to:

- Addressing access to health care;
- Increasing patients' participation and the dignity afforded to them;
- Reducing underlying causes of illness, injury, and disability through preventive
- and health promotion activities;
- Expanding research on evidence of effectiveness;
- Ensuring the appropriate use of health care services; and
- Reducing health care errors (adverse events).

Within each of these broad aims, health care providers should establish specific measurable objectives so that they can track progress in achieving these aims. The Policy identifies problems with quality in health care in both the public and private sector. These include:

- Under-use and overuse of services;
- Avoidable errors;
- Variation in services;
- Lack of resources;
- Inadequate diagnosis and treatment;
- Inefficient use of resources;
- Poor information;
- An inadequate referral system;
- Disregard for human dignity;
- Drug shortages;
- Records not well kept; and
- Poor delivery systems.

These shortcomings endanger the health and lives of all patients, add costs to the health care system, and reduce productivity an in retrospect impact on service delivery. To achieve necessary improvements, a national policy on quality in health care is needed, together with commitment from all stakeholders, beginning with leadership from the highest levels of government, the national health system, labour, and the health care professions.

- Issues addressed in developing the policy.

The decision to engage the public and private health sector in improving the quality of health care was driven by the following:

- Improve access to quality health care Reduce excess capacity, plan packages of care at each level of care and allocate resources equitably to improve access to appropriate health care.
- Increase patients' participation and the dignity afforded to them Community participation and the adoption of the Batho Pele principles are key to empowering users of services to take control of their own health care and that of their families.
- Reduce underlying causes of illness, injury, and disability Prevention is a good way to reduce the burden of disease and improve the quality of life.
- Expand research on treatments specific to South African needs and on evidence of effectiveness. Research and its application will help us to understand what treatments work best in South Africa.
- Ensure appropriate use of services, the appropriate selection of treatments and use of services require the practice of evidence-based health care.
- Reduce errors in health care; health care can be improved by increasing patient safety.
- Targeting quality assurance interventions.

The policy identifies four main targets of intervention which are:

- Interventions aimed at health professionals.

There is a need to develop expertise to help clinicians modernise their practice. One of the greatest challenges facing health professionals is the rate of change and technical innovation in the health sector.

- Interventions aimed at patients.

Understanding patient's perceptions and concerns is key to improving quality. There is a growing emphasis in health care on partnerships between the patient and the provider. It is clear that improved communication between the health professional and the patient and providing patients with understandable information about their condition and treatment options has a positive effect on health outcomes.

- Interventions aimed at the community

The active involvement of communities improves the overall health status of the population.

- Interventions aimed at systems

Managers can help to improve quality through modernising health care delivery systems. The policy mentions that by identifying weaknesses in systems that cause errors in processes or outcomes, the systems can be redesigned to avoid such errors and improve the quality of health care delivery.

- The Policy

This policy is based on a two-pronged approach to quality improvement:

- Creating the environment in which quality health care will flourish

This will be done by strengthening the hand of the user; focussing on equity of health care and vulnerable populations; promoting public/private partnerships and the accountability of both sectors for quality improvements and reducing errors and increasing safety in health care. Each of these points will be discussed very briefly.

- Strengthening the hand of the user: this requires information that they can use to make informed decisions. The needs of the users of health care services are of utmost importance. Empowered users have the ability to influence the quality of the care they receive.
- Focussing on equity of health care and vulnerable populations: equity can be used as the driving force to improve quality care to underserved populations. Equity means ensuring that the whole population has access to quality health care.
- Promoting public/private partnerships and the accountability of both sectors for quality improvement: All participants in the health care system must be accountable for improving the quality of health care in South Africa.
- Reducing errors and increasing safety in health care: An "adverse events" reporting system will help to reduce errors and increase safety.
- Building the capacity to improve quality: this will be done by fostering evidence-based practice and innovation; adapting organisations for change; engaging the health care

workforce; providing appropriate training and investing in information systems that measure quality improvements.

Each of these points will be discussed very briefly.

- Fostering evidence-based practice and innovation: Fostering evidence-based practice requires building up expertise in research on effectiveness issues, technology assessments and dissemination processes.
- Adapting organisations for change: being able to adapt organisations for change requires skilled managers with a commitment to creating learning organisations seeking excellence, focussed on users and working with clinicians.
- Engaging the health care workforce: health professionals need to be closely involved in working out ways to improve the way they work.
- Training and professional development: providing quality care to patients requires training skilled health workers and establishing a culture that values lifelong learning and recognises its important role in improving quality.
- Investing in information systems that measure quality improvements: National standards for private and public information systems are required to measure quality improvements across the National Health System.

Conclusion

This chapter comprehensively examined the state of service delivery within the public health sector in South Africa. The public health sector of South Africa continues to be plagued by service delivery issues. The researcher explored serious management challenges that will impede the success of policy implementation and further addressed operational challenges that are frequently faced by the public health sector. The policy on quality in health care for South Africa was briefly explained to provide a complete picture of the current state of what measures the government has taken in its quest to improve the quality of health care in South Africa. The next chapter will provide the conceptual framework on which this research is based.

CHAPTER SIX

CONCEPTUAL FRAMEWORK

INTRODUCTION

The conceptual framework is a system of concepts, assumptions, expectations, beliefs and theories that supports and informs the research (Miles and Huberman, 1994). Miles and Huberman further define a conceptual framework to be a visual or written product, one that explains graphically or as a narrative the main concepts, key factors or variables and the presumed relationship among them to be studied. Reichel and Ramey (1987) put it more simply by saying that it is a model which the researcher presents by making use of other models within the field of study. The models and theories which relate to this study are: Shannon and Weavers Communication model; the service quality model as well as the uses and gratifications theory.

The theory has several purposes, and several accompanying ways of assessing whether it is productive. The main purpose or goal of the theory is to pose questions that provide explanations about phenomena, but there are other more specific uses for it as well. According to Roseberry (2009:9) logical consistency of the theory is based on the assumptions behind it and what it is theorising about. For example, one could theorise that people with advanced college education tend to live in elite suburbs. But the theory would have little appropriateness, since there is nothing that logically connects a person's street address with their educational achievement.

The second factor is the shift concerning the nature of the entities that are being studied and their mode of action and relating with marketing strategies in rural areas. According to Roseberry (2009:21) it is wise to consider conceiving of human beings as people and their mode of action as social beings.

This chapter conceptualises a model to enhance the standard of service delivery through the elimination or reduction of challenges faced by the public sector.

THE USE OF MODELS

Models probe one to ask questions. Therefore, a model is useful when it provides a general perspective as well as a point of reference to interpret raw data and to ask questions. Although models are flexible, they generate calculated pathways to obscure destinations.

Models also assist to clarify complex events (or issues). They do this, as Chapanis (1961) noted, by reducing complexity to simpler, more familiar terms. Thus, the aim of a model is not to ignore complexity or to explain it away, but rather to give it order and coherence. It is important to note that, especially in third world countries, conceptual frameworks should be as simple as possible to ensure successful implementation.

Background to Shannon and Weaver

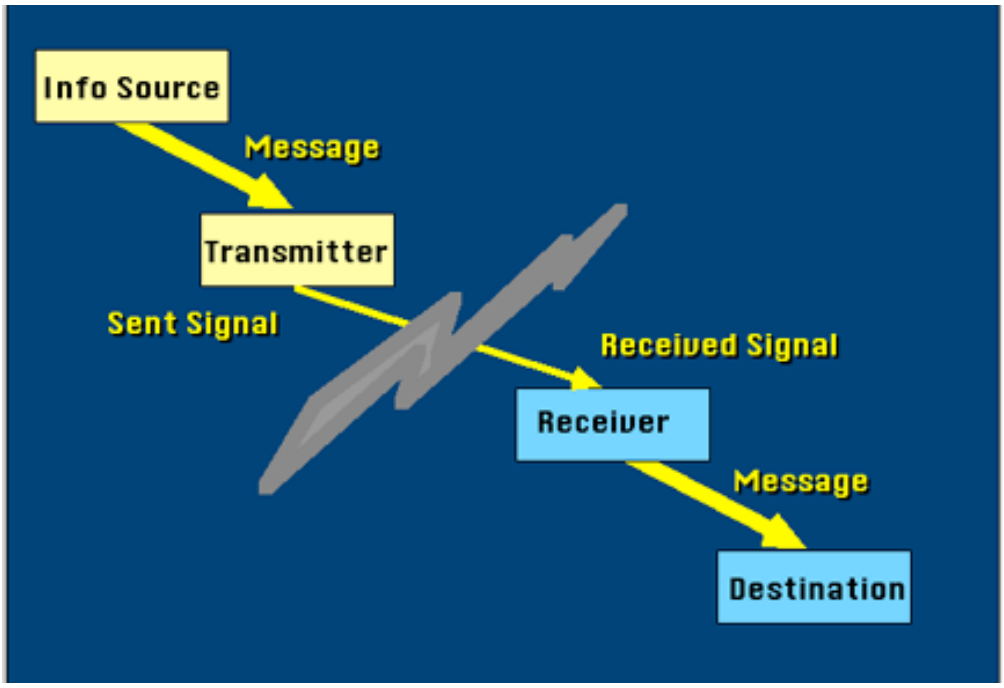
According to Chandler (1994) Claude Shannon and Warren Weaver were not social scientists but engineers working for Bell Telephone Laboratory in the United States. Their goal was to ensure the maximum efficiency of telephone cables and radio waves. Steinberg (2011) explains that they were primarily interested in finding engineering solutions to problems of signal transmission. They developed a model of communication which was primarily intended to assist in developing a mathematical theory of communication. Chandler further states that, Shannon and Weaver's work proved valuable for communication engineers in dealing with such issues as the capacity of various communication channels in 'bits per second' which refers to bandwidth.

Shannon and Weaver model

The Shannon and Weaver Model has contributed significantly to communication theory, however this model has had a number of shortcomings. For example nowhere in the model is there room for feedback. Some proponents suggest that Claude Shannon developed the original theory without the component of feedback which was added by Weaver which gave the model more clout and effectiveness. This model arose from the study on how to send maximum amount of information through a channel. This model formed the technical view of information transmission. However more recently it has been applied to interpersonal communication.

The Shannon-Weaver model for communication is primarily intended to model communication from an engineering perspective, but it can be applied to human communication as well. The model, as depicted in Figure 1, is composed of seven components: the source, destination, message, transmitter, receiver, signal, and noise (Shannon, 1974). However in spite of all the critiques offered about this model, it still stands out as being considerably effective in this research.

The Communication Model by Shannon and Weaver.



Source: Croft, (2004)

FIGURE 9: Shannon and Weaver Communication Model.

Figure 9 represents a communication model developed by Shannon and Weaver with the following components: Information Source, Message, Transmitter, Signal, Receiver, Destination and Noise which is depicted as the lightning bolt in this representation of Shannon and Weavers Model. Each of these components will be unpacked to reveal its relation to this study:

Information source or encoder: Carson (n. d) explains the source of communication is the initiator, or origin, that puts the model into action. It is an individual or group that has a specific reason to begin the communication process, which means that there is a message they want another individual to receive. Once the purpose of the source has been decided, there must be a specified format for the message to take. This is what the communication encoder does; it takes the concept that the source wants sent out, and puts it into a suitable format for later interpretation. Within this study the information source represents the public servants such as hospital staff members. They include doctors, nurses, administration staff members as well as other members of staff that may be employed by the hospital.

Message: According to Carson, the information, idea, or concept that is being communicated from one end of the model to the other is the message. Most of the time, in human communication, the message contains a distinct meaning. When the model was created, Shannon and Weaver were not concerned whether the message had substance, but rather that it was being transmitted. The message that is to be encoded by the hospital staff is the Batho Pele Principles which must be implemented in every area of their jobs.

Transmitter: The transmitter is described by Steinberg (2011) as a telephone or one that carries the signal or message. In the case of interpersonal communication it is the voice of the person who speaks the message that has been encoded.

Channel: Carson (n. d) explains that it is essential for meaningful communication that a suitable means to transmit the message be selected. He further explains the channel is the route that the message travels on be it verbal or nonverbal. According to Shannon and Weaver (1949:7), the communication channel is described as the physical or technical medium of transmission. The Batho Pele principles will be communicated to the external public by means of communication either through actions that the nurses perform or through instructions staff members meter out to the external public.

Signals: Noth (1995) explains the signals are the sound waves of the voice when this model is applied to communication. In order for the communication encounter to take place, staff members must be audible to the external publics they deal with.

Noise: Chandler (1995) sees noise as a dysfunctional factor, any interference with the message travelling along the channel (such as 'static' on the telephone or radio) which may lead to the signal received being different from that sent. This element or component of the communication process cannot be excluded as it carries with it intrinsic effects in a communication encounter. Carson (n. d) explains that it is inevitable that noise may come into play during the communication process. Noise could be seen as an interference or distortion that affects or changes the initial message. He describes noise as being physical or it can be semantic. In order for communication to be effective, noise must be reduced. In this study noise represents the challenges that the staff members face in implementing the Batho Pele Principles. Chapter 5 addresses these challenges in detail which hinders policy implementation, such as the Batho Pele Principles. The removal of noise from the communication encounter will ensure that the message is transmitted clearly. However given the challenges the public sector experiences in policy implementation, this is hardly possible.

Receiver: Carson (n. d) explains that before the message reaches the intended recipient or communicator, it must be decoded or interpreted from the original form into one that the receiver understands. South Africa has eleven official languages and it is therefore important for the government to take cognisance of members of the external publics who fall under the various language groups. This is so that the message that has been encoded by hospital staff will be correctly decoded by the external publics.

Destination: This explained by Carson (n. d) as the second party at the end of the channel, the source or initiator has used. Schramm (Steinberg, 2011) in his model of communication highlighted the importance of meaningful messages that are exchanged between two active participants. This was another short coming of Shannon and Weavers Model. The external publics represent the destination in Shannon and Weavers Model of communication.

Feedback: What Shannon and Weaver did not consider at this point was feedback which was added later to the model. Feedback in any communication encounter is very important as it is means of evaluating the communication encounter. Was the message received what was originally intended? The feedback that the hospital receives from the external public acts as an evaluation tool in the communication encounter. Here either a positive or negative response can be expected from the external public. Based on the responses, the policy can be adapted to ensure future success

Steinberg (2011) explains that the process of communication involving the components of Shannon and Weavers model as indicated in section 6.3.2. She explains the process by using the metaphor of a telephone call. An information source (communicator) encodes a message which is relayed by the transmitter (telephone) into a signal which is sent through a channel (telephone line) to the receiver. The signal is received at the other end (telephone) and converted back into a message which is heard by the recipient (destination). Noise does not form part of the communication process but becomes a part of it through the external and internal factors experienced by both the sender and receiver.

The Application of Shannon and Weavers Model

What was originally intended for an engineering firm became one of the most frequently used models applied in communication research. Although a severe shortcoming of the model was that it represented communication as a linear process, the impact of noise depicted within the process set it apart from other communication theories. Fougler (2004) explains that part of its

success is due to its structuralist reduction of communication to a set of basic constituents that not only explain how communication happens, but why communication sometimes fails.

The primary aim of this study was to determine the challenges faced by key government sectors in the adoption and application of the Batho Pele Principles. In Chapter Four the importance of communication in policy implementation is explained in detail. The researcher draws specific attention to the following as explained in Chapter Four. The reference to communication as a factor which influences public policy implementation can be analysed from a three-pronged view namely:

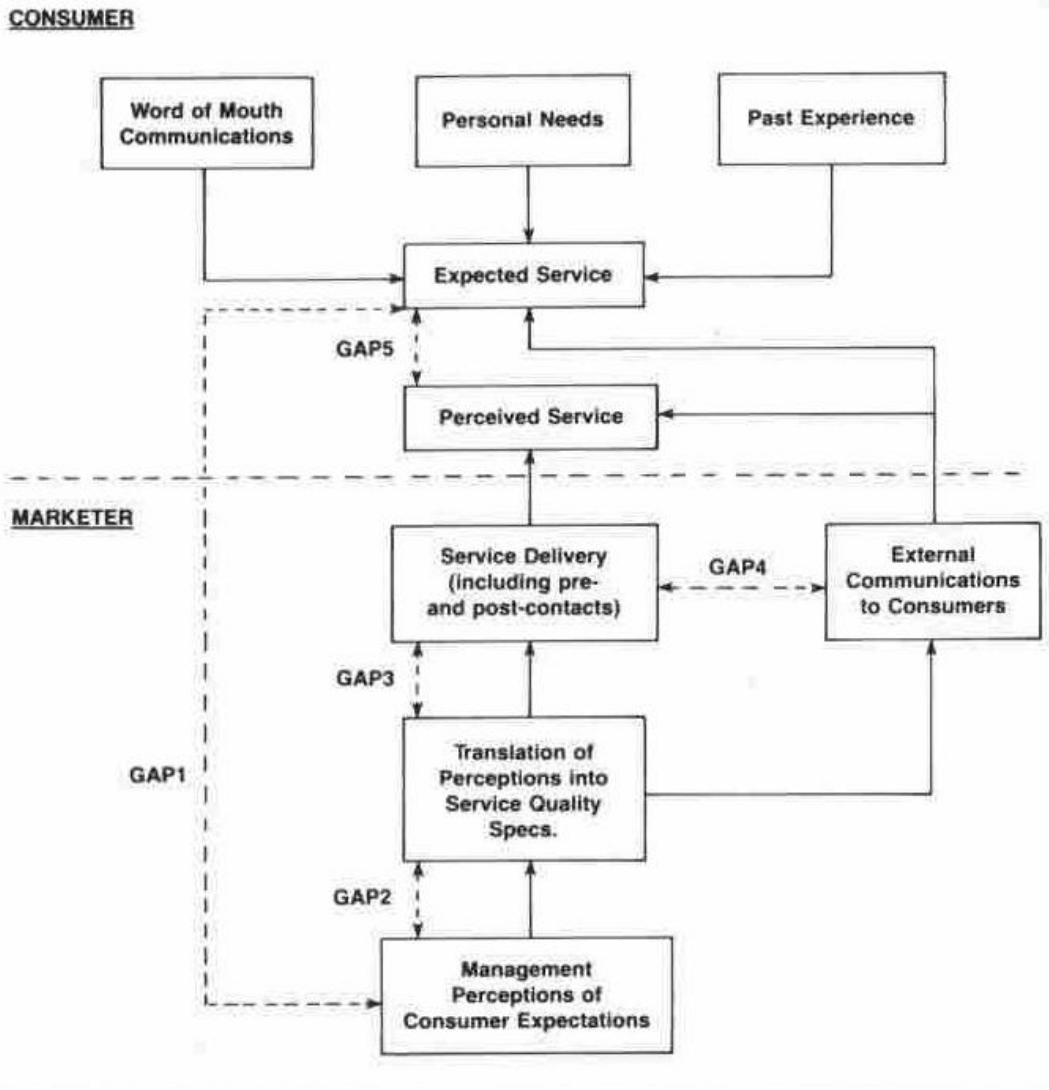
- Transmission: the absence of a sound communications system and the blockage of information somewhere in the system result in ignorance of decisions and orders.
- Clarity by which is meant that orders or instructions should not be vague or ambiguous about when or how implementation is to be carried out. Vagueness according to Cloete (1982) can make changes in policy difficult and can also result in changes far greater than those anticipated.
- Consistency: because there is seldom just one order, implementation orders may be inconsistent as well as vague.

Public servants have an enormous task on their hands when it comes to communicating with the various publics they engage in. Hospital staff members are no exception to the pressure of dealing with the challenges that the job presents as well as ensuring that policy is implemented to the best of their ability on every level. In order for the policy to be communicated to the external publics, it is important that the staff members are adequately equipped to facilitate policy implementation.

THE SERVICE QUALITY MODEL

The components of service delivery include: the service provider, the service and the receiver. Pue (1996) suggests the instantaneous nature of the provision of service and its consumption results in an interaction between the server and the consumer enabling either party to influence the quality of the service. The fact that the output of the service delivery interaction is not tangible creates the possibility for customers to rely on other indicators to evaluate the quality of the interaction. Quality is not evaluated by the customers solely in terms of the outcome of the service; they also consider the process of the service delivery.

Gronoos (1984) suggests a customer's assessment of the service quality results from the comparison to the customer's expectation to the perception of the actual service delivered. The model on service quality proposed by Parasuraman, Ziethaml and Berry (1985) argues that the difference between the customers' expectations and actual service provided cannot be managed directly but through other 'gaps' and through discrepancies between expectations and performance that occur in organisations. Figure 10 is the service quality model which provides a graphical representation of these gaps.



Source: Parasuraman, Zeithaml and Berry (1985)

FIGURE 10: Service Quality Model

The gaps are summarised as follows:

Gap 1: The gap between consumer expectations and management perceptions of those expectations.

Gap 2: The gap between management perceptions of consumer expectations and the firms service quality specifications

Gap 3: The gap between service quality and actual service delivery

Gap 4: The gap between actual service delivery and what is communicated to customers

Gap 5: The gap between customers perception and expectations of a service.

The authors of this model have identified a set of theoretical constructs and variables to assess each of these gaps and thereby developed a set of communication and control to reduce the size of noise generated within each of these gaps (Ziethaml, Berry and Parasuraman, 1987).

The identification of 'noise' generated within each of these gaps shows a distortion of the intended 'message' (service quality) from reaching its destination (customer). Further this model also identifies 'personal needs' which motivates the customer to utilize a service. The gratification or satisfaction the customer receives will prompt a repeat action in the future.

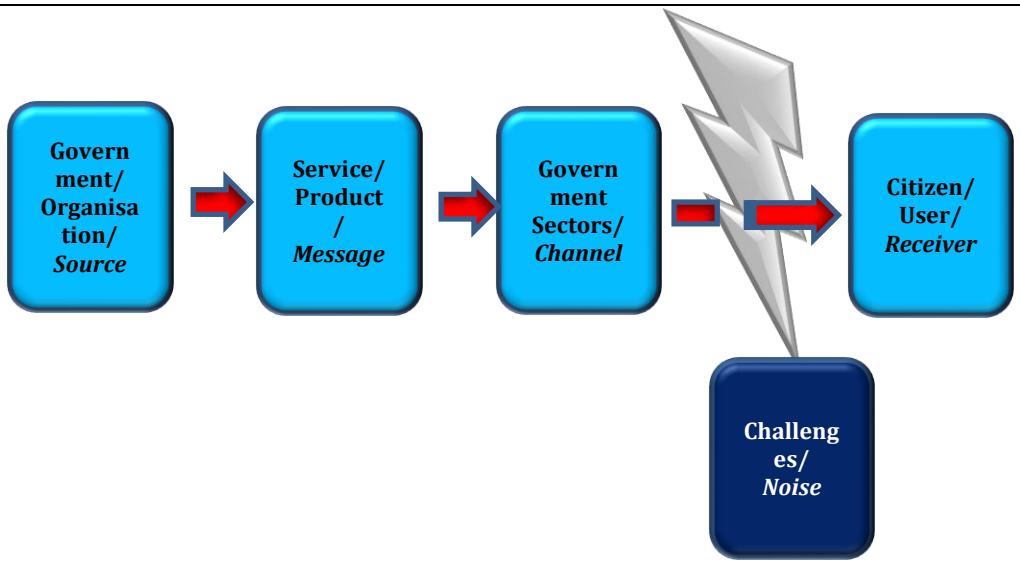
Uses and Gratifications

According to Hobson and Dorothy (1982:34) one of the influential tradition in the media research is referred to as uses and gratifications (occasionally needs and gratifications). This approach focuses on why people use particular media. Uses and Gratifications can be seen as part of a broader trend amongst media researchers which is more concerned with what people do with media, allowing for a variety of responses and interpretations. Gratifications could also be seen as effects: e.g. thrillers are likely to generate very similar responses amongst most viewers. According to Blumler and Katz (1974:40-50) Uses and Gratifications theory arose originally in the 1940s and underwent a revival in the 1970s and 1980s. The approach springs from a functionalist paradigm in the social sciences. It presents the use of media in terms of the gratification of social or psychological needs of the individual. The mass media compete with other sources of gratification, but gratifications can be obtained from a medium's content (e.g. watching a specific programme), from familiarity with a genre within the medium (e.g. watching soap operas), from general exposure to the medium (e.g. watching TV), and from the social context in which it is used (example: watching TV with the family). McQuail (1987: 236) argue

that Uses and Gratifications explain how people's needs influence how they use and respond to a medium. It also has explains the influence of mood on media choice: boredom encourages the choice of exciting content and stress encourages a choice of relaxing content. The same TV programme may gratify different needs for different individuals. Different needs are associated with individual personalities, stages of maturation, backgrounds and social roles.

CONCEPTUALIZING A MODEL FOR SERVICE DELIVERY IN THE PUBLIC HEALTH SECTOR

Shannon and Weavers communication model stresses that the distortion or noise must be identified and eliminated in the communication process; in this case issues which create problems within the service delivery structure must be identified and addressed to provide services that the public needs satisfied. The noise has been identified as the challenges faced within the public health sector also that which prevents an acceptable standard of service that is meted out to the public. In other words, anything that hinders service quality can also be deemed as noise. Further, according to the uses and gratification theory, people will continue to utilize a service if it satisfies the need that motivated it in the first place.



Adaptation of Shannon and Weavers Model to Service Delivery

FIGURE 11: Service Delivery Challenges

Figure 11 depicts an adaptation of the Shannon and Weavers model of communication to demonstrate how challenges or noise impede the delivery of the service or message. The model shows that the government provides a service through its various sectors which is intended to reach the citizen or user, however as a result of the many challenges discussed in this study the

services are distorted or are of a poor standard when it reaches the citizen. This is as a result of the 'noise' or challenges which prevents or weakens the government's intention towards its citizens.

In view of Shannon andWeaver, the model of service quality as well as the uses and gratifications theory, the following criteria is suggested to enhance service delivery within the public sector:

- Universities must offer professional courses in public service delivery. This will ensure that obstacles to understanding policies are eliminated and a structured pattern to manage the public services is sustained.
- The 'noise' that represents the lack of management and leadership skills and constraints experienced by management must be worked at to ensure the challenge or 'noise' is eliminated or reduced. Further, an evaluation of the structure and management of the public health facility be carried out to correctly assess inefficiencies and inadequacies.
- To correctly evaluate the standard of services within the public health sector, there should be an assessment of the performance of the hospital which will address key challenges experienced within the management structures and thereby expose inefficient management within key departments of the public health facility. This will inadvertently impact the level at which the needs of the public are satisfied.
- A complete reformation of the technological capacity of the public health facility be done to ensure the enhancement of medical equipment and the maintenance of such thereby eliminating the 'noise' or distortion of the service delivery caused through a lack of equipment or non-functional equipment.
- Government should consider a payment reform that is designed to create financial incentives which will promote efficiency, quality and improved working conditions. This will enable government to reduce the number of vacancies within the health sector and promote a way to address the work overload that is being experienced within the public health sector.
- To overcome the lack of financial resources within the public health sector, there should be estimates of the sum total of government resources each hospital consumes, both in absolute numbers as well as a percentage of total government expenditure in the health sector should be done.

Conclusion

The conceptual framework guides the tenet on which this study is based on. The aspect of noise in Shannon and Weavers model of communication plays an important role in the effective transmission of a message. The analogy drawn from this summarises the impact the challenges will have on service delivery, which are faced by the government in successfully implementing a policy. In the next chapter the methodology of this research is explained.

CHAPTER SEVEN

METHODOLOGY

INTRODUCTION

This chapter provides a detailed examination of the concepts that influenced the data collection and the data analysis process. The discussion of such is vital as it will assist in guiding the readers understanding of the path the researcher undertook to provide the findings for this study. The research design used for this study will be discussed to demonstrate how the researcher acquired data relevant to the research problem. Leedy and Ormrod (2001) defines research methodology as an operational framework, within which pertinent facts are placed so as to extract a clearer meaning. Also they mention that research methodology is the approach followed in obtaining, process and analysing data which must be compatible and aligned with the goals and objectives of the research. To facilitate this process the objectives of the study will be explicated once again.

RESEARCH OBJECTIVES

The literature review in this study provides adequate support to understand each of the objectives listed hereunder. The objectives of the study were:

- To analyse the application and adoption of the Batho Pele Principles towards the improvement of service delivery in key government sectors.
- To evaluate the effects of the communication challenges faced by key government sectors in the application and adoption of Batho Pele Principles.
- To determine the effectiveness of the communication strategies implemented in the adoption and application of the Batho Pele Principles.
- To ascertain the effectiveness of the application of Batho Pele Principles in key government sectors.

The main research question guides the research in this study was:

What are the communication challenges faced by key government sectors in the application and adoption of Batho Pele Principles?

The primary aim of this study is to determine the challenges faced by key government sectors in the application and adoption of Batho Pele Principles. The key government sector that this

study is focussed on is the public health sector. The public health sector was selected as it represents one of the two largest social services (Stack and Hlela, 2002).

The Rationale for the Case Studies

The multi case study was conducted to examine the challenges faced by the public health sector as one of the government sectors in the adoption and application of Batho Pele Principles. The hospitals selected for this study were the R.K.Khan and Addington hospitals. Both hospitals are based in Durban and service the greater Durban or Ethekwini area which is located in the province of KwaZulu Natal. In total, there are eleven provincial hospitals that service a population of 3.48 million people (Brinkoff, 2009).

According to Cullinan (2006), there are three categories of hospitals in South Africa. The most common names used to refer to these categories are District, Regional and Tertiary (provincial tertiary and national central) hospitals although government is now replacing these with the names level 1, 2 and 3 hospitals. As their names imply, they offer different levels of service.

Of the 388 public hospitals found nationally, 64% are district hospitals. Secondary and specialised hospitals making up 16% each of the total number. Together provincial and national hospitals comprise less than 4% of all hospitals in the public sector.

According to the Department of Health (2012) the R.K. Khan and Addington hospitals qualify as both a regional and a district hospital.

- The R. K. Khan Hospital

According to the records held by the Department of Health (2001), the R.K. Khan Hospital in Chatsworth, Durban bears the name of the renowned Indian philanthropist and humanitarian, the late Advocate Rahim Karim Khan who founded the R.K. Khan Hospital Dispensary Trust. The Trust donated 50 percent of the initial capital cost of building the core block of the hospital. The site on which the hospital stands is 44.9459 acres in extent; originally prime farming area, earmarked for housing purposes.

The first outpatient was treated on 3 March 1969 and the first inpatient was admitted in July 1969. R K. Khan has grown from being a community hospital to one of the four major hospitals in the Durban region. It functions as a Regional Hospital and has 543 beds. R.K. Khan Hospital is a referral hospital for St. Mary's Hospital and KwaDabeka Clinic.

According to Subban the manager of the hospital (2009), the hospital performs a significant amount of work that may be classified as tertiary as they experience major problems in transferring patients who require a higher level of care. It is fortunate that the hospital has the medical staff with the necessary expertise and experience who can manage these patients. The hospital budget does not cover this cost.

Further, Subban (2009) explains, the hospital has a catchment population of over 1 500 000 who are amongst the poorest in Ethekwini. St Mary's Hospital, a subsidised institution, is the only hospital between R. K. Khan and Edendale Hospital in Pietermaritzburg. Furthermore, the Primary Health Care facilities including Community Health Clinics in their drainage area are inadequate. Therefore, the workload at the hospital is huge and an enormous challenge to manage adequately. There are over 400 000 patients that attend annually and over 36 000 patients admitted. The huge numbers of patients seen to throughout the year places a great amount of stress on its staff as well as challenges that occur as a result of the overwhelming numbers of patients seen to regularly.

The hospital performs almost 10 000 surgical procedures annually including an average of 180 caesarean sections a month (more than 6 500 babies are born at this hospital in a year). During his visit at the R.K.Khan hospital in 2010, the MEC for health, S. Dhlomo, was quoted as saying that "While there is good work, in general, there are shortages such as the shortage of doctors, nurses and pharmacists" (D.O.H. 2010). The admission by the MEC is evident that government is aware of the many problems public health facilities face as a result of dire shortages which ultimately will have a negative impact on the level of service delivery.

- Addington Hospital

According to the Department of Health (2001), Addington Hospital was named after Rt. Hon. Henry Addington who held the post of Prime Minister of Great Britain in 1801. The hospital which is situated in Durban South Beach was officially opened on 10 November 1967. The vision of Addington Hospital to achieve an optimal health care status for all patients, families, and communities through innovative and dynamic health care leadership (D.O.H., 2001). Addington is both a district and regional hospital with 571 beds. The hospital caters for a broad populous and offers a variety of services to the public. According to Khoza (2012), the hospital sees on average 567 932 outpatients a month whilst 33 710 in patients are treated at the hospital.

The Gateway Clinic serves as the adult primary health care of Addington. The clinic comprises of two components:

1. A Primary Health Care Clinic where patients with minor ailments are seen by trained primary health care sisters free of charge

2. At Poly clinic, Doctors attended to patients with more complicated cases and a fee is levied according to the patient's income.

The Casualty Department of Addington Hospital caters to patients in need of emergency treatment, while the Poly Clinic attends to patients with non-emergency or routine problems. At the Gateway Clinic, patients are assessed, investigated and treated either by Primary Health Care sisters or if necessary by doctors, who may refer them for specialist treatment if needed. Once patients are stabilised they are referred back to their local clinic or MOPD for chronic care. Critically ill patients are given priority and "fast tracked" through the system, as are certain other classes of patients.

- Addington Hospital under scrutiny

The South African Broadcasting Corporation reported in June 2012 on issues of maladministration at the hospital (Mgobozi and Lee, 2012) in which Dr Zungu revealed that, more than 15 people including senior managers have been suspended in the hospital after allegations of fraud and corruption. Whilst the hospital has to contend with a high turnover of patients, it has become apparent that blatant mismanagement has occurred which has drawn deep concerns over the management of the hospital.

According to Bolani (2012), a new senior matron was employed at the hospital as a result of a backlog of 400 scheduled surgeries which had yet to be performed and a further 1000 surgeries which had not been logged into the system. The Head of Department of Health for KZN, S. Zungu stated that the new appointment is to ensure that there is adequate planning at ward and theatre level to ensure equipment and stock is always readily available to perform all elective surgeries. The problems faced at Addington Hospital recently made it a prime candidate for this research study.

RESEARCH DESIGN

According to Churchill et al. (2010) the research design ensures that the study will be relevant to the problem and will ensure the use of economical procedures. Further research designs can be

broken into three basic types: exploratory, descriptive or causal. The design used in this study involves the use of both exploratory and descriptive research. The researcher utilised both quantitative and qualitative research methods to gather data for the study.

- Quantitative Research Methods

Burns and Grove (2005) describe quantitative research methods as being formal, objective and systematic in which data is used to gather information about the world. The impetus to use quantitative research methods was to gauge the opinions of the patients and hospital staff members in respect of the adoption and application of Batho Pele Principles. This was ultimately determined by counting the responses using statistical software.

The benefits of quantitative research methods to this research were as Burns and Grove (2005) highlight that it focuses on specific concepts. This study closely examined how the public responded to each of the Batho Pele Principles during their treatment at the hospitals. Further, the internal staff members were monitored on how each of these principles were applied. Specific questions were asked for each of the Batho Pele Principles.

Burns and Grove also mention that quantitative research uses structured questions, interviews and observations. The primary data gathered for this research were based on the structured questions which were in the form of a questionnaire. Du Plooy (2001) mentions that the objectives of a quantitative design are to predict, describe and explain quantities, degrees and relationships, and to generalise from a sample by collecting numerical data. In order to understand the challenges faced by key government sectors in the application and adoption of the Batho Pele principles, the researcher had to quantify responses from the respondents. This also assisted in predicting, describing and explaining the outcomes for each of the questions asked in the questionnaire.

- Qualitative Research Methods

Cohen et al. (2000:.282) state that in qualitative data the data analysis is almost inevitably interpretive. The questionnaires aimed at the internal publics of the hospital were made up of quantitative and qualitative questions. The benefit of the qualitative approach used in this study was to extract meaningful responses from a particular group of people. As Welman et al. (2005:193) explain that the primary task of qualitative research is to uncover explicate the ways in which people in particular settings come to understand, account for, take action and manage

their situations as well as the problems and difficulties they encounter. Utilising just quantitative research methods would have seriously disadvantaged the findings of this survey.
Creswell (2003) suggests that integration of two types of data might occur at several stages in the research process. It could occur during data collection, analysis, interpretation, or in some combination of these stages. The integration process of the quantitative data as well as the qualitative data occurred during data analysis and the interpretation of the data in this research.

THE DATA COLLECTION INSTRUMENT

As mentioned earlier, the data collection instruments used in this research were two questionnaires targeted at different publics of the hospital. Welman et al. (2005:174) explain when the researcher poses the questions contained in a structured questionnaire to a respondent in a personal or telephonic interview, such a previously compiled questionnaire is also known as an interview schedule. Due to the nature of part of the respondents [External publics] involved in this research, the questionnaires were also used as an interview schedule. The internal publics were handed the questionnaires which were collected at a later stage. The use of the Likert Scale was employed in both questionnaires to project outcomes in this research as it is the most popular type of scale used in the social sciences. The reason for this is mainly because it is easier to complete and it is used for multidimensional attitudes (Welman et al. 2005).

- Internal Publics Questionnaire

The questionnaire targeted at the in and out patients of Addington and R.K. Khan hospitals was made up of closed ended questions which had a numeric value assigned to each answer. All forty four questions were quantitative in nature. Section A addressed demographics of the respondent whilst Section B addressed the service delivery drivers which were the Batho Pele Principles. Each of the Batho Pele principles were explained and had sub questions assigned to it in order to facilitate the understanding of the principle as well as to ensure the authenticity of the respondents answers.

- External Publics Questionnaire

The questionnaire targeted at the internal public of the hospitals was similarly constructed with the inclusion of a section for management. Section A addressed the demographics of the staff member, Section B targeted questions on training and development in respect of the implementation of the Batho Pele Principles. Section C addressed the service delivery drivers for public servants. Here again each Batho Pele Principle was explained before questions were

assigned. Section D pertained to the anticipated challenges faced in the implementation of the Batho Pele Principles. Section E was designed exclusively for hospital management to answer. This section addressed the monitoring and evaluation of the Batho Pele Principles. This questionnaire was also constructed with the use of qualitative research methods. This gave the hospital staff an opportunity to voice their concerns and views on the goings on at the hospitals.

Ethical Considerations

According to Welman et al. (2005:181), ethical behaviour is important in research, as in any other field of human activity. Polit and Beck (2004:141) also reminds researchers that when humans are used as study participants, care must be exercised to ensure that the rights of those humans are protected. The ethical principles applied to this study were:

- Ethical approval from the University of Zululand
- Permission from the Management of Addington and R.K. Khan hospitals
- Authorisation from the KZN Provincial Administration of the Department of Health
- Informed Consent
- Anonymity and Confidentiality

In order to begin the process of conducting this research, ethical approval had to be obtained from the Research Ethics Committee of the University of Zululand. At the time of the application for ethical clearance, the University's Research Ethics Committee was without proper accreditation. The researcher's initial application for ethical clearance was in November 2011. After a considerable amount of time, during which the University's Research Ethics Committee was legitimately registered to the proper authorities, the researcher finally received ethical clearance to conduct the study in June 2012. The next step was to obtain written permission from the management of Addington and R.K. Khan hospitals.

- Permission from the management of Addington and R.K. Khan Hospitals

In order to secure permission from the management of Addington and R.K. Khan Hospitals, the researcher had to provide a motivation for the research. Further to this the questionnaires that were to be used in the study had to be forwarded to support the motivation for the research. The efficiency and enthusiasm that was greeted by the management of both hospitals in granting the researcher permission was evident of a level of transparency to the general

public. Both hospitals management granted permission for the study without any delays whatsoever. The next step was to secure authorisation from the KZN Department of Health.

- Authorisation from the KZN Provincial Administration of the Department of Health

The researcher could not gain access to the hospitals unless the KZN Provincial Administration of the Department of Health granted the authorisation. The researcher was requested to forward documentation to support the reason for the study as well as approval granted by the University of Zululand and permission granted by both hospitals management. The Department of Health's response was without any delays whatsoever. The authorisation that was received from the Department of Health was then forwarded to both hospitals to confirm final permission had been granted.

- Informed consent

During the application of the questionnaires, the respondents were clearly informed what the objectives of the study were; what they were required to do in order to participate in this survey and what they agreed to. Polit and Beck (2004) explains that respondents have received adequate information regarding the research and are capable of understanding the information. Leedy and Ormrod (2001) state that researchers have the ethical obligation to inform research participants of the following while conducting research:

- The nature of the research in which the research participant is required to participate in,
- The participation of the research participant is strictly voluntary,
- The research participant has the right to withdraw at any time during the research.

The respondents were required to complete an informed consent form which formed part of the questionnaire which were retained by the researcher for record purposes. Each and every respondent who participated in this study gave their written consent.

- Anonymity and Confidentiality

All respondents were assured of their identities being protected and not being disclosed by any means during or after this study had taken place to any other source. This was done to protect the respondents in this study where an initial or tick was requested to authenticate the

participants response. The internal publics of the hospitals were satisfied with this as their anonymity gave them the freedom to express and reveal certain opinions and views of the hospital.

SAMPLING

The population for this study was made up of a set of individuals that according to LoBionodo-Wood and Haber (2006) state that as having certain specified properties which in the case of this study, represented the patients and staff members at the R. K. Khan and Addington Hospitals in Ethekwini, Durban.

Churchill et al. (2010) explain that the importance of drawing a sample which is to determine what is likely to be true for a population based on data obtained from only a subset of that population. Further non-probability sampling was used in this study as not every element of the population had an opportunity to be included in the sample. Not every patient could be requested to fill out a questionnaire due to the severity of their illnesses. Not every staff member especially nurses and doctors could complete a questionnaire due to the high levels of workload and the demands on their time during their shift.

RELIABILITY

According to Welman et al. (2005:145), reliability is concerned with the findings of the research and relates to the credibility of the findings. LoBiondo-Wood and Haber (2006) suggest that the reliability of a research instrument is defined as the extent to which the instrument yields the same results on repeated measures. The researcher ensured that each of the Principles of Batho Pele was explained to provide the respondent with an understanding of its meaning and by using simple language. Each of these principles was further broken down by a number of questions in order to authenticate the responses of the respondents as well as to contribute towards the reliability of this study. The researcher is confident that if the same respondents were addressed on the Batho Pele Principles *ceteris paribus,* the responses generated will be the same.

VALIDITY

Welman et al. (2005:142) states that validity is the extent to which the research findings accurately represent what is really happening in the situation. Welman et al. further explains when we measure something with an instrument, the instrument we use to measure the variable

must measure that which it is supposed to measure. The validity of this study is projected through the objectives of this study which guided the formulation of the questionnaires. The purpose of the external publics [patients] being questioned on the Batho Pele Principles was to test the success of the application of the Batho Pele Principles. The purpose of the internal publics [staff of the hospitals] being questioned on the Batho Pele Principles was to test the success of the adoption of the Batho Pele Principles and the challenges faced in the application of same.

DATA COLLECTION

The respondents in this study involved patients and staff members of Addington and R.K.Khan hospitals. The patients at the hospitals were further made up of in and out patients. Both hospitals concerned provided the researcher with brief introductions with various management personnel in each department to explain her presence there. The researcher handed out questionnaires to the outpatients that were awaiting treatment at the various clinics at the hospitals. The researcher explained to each patient, the various constructs of the questionnaire and the importance of their honest response before they engaged in providing their responses.

In order to access the in-patients at the hospital, the researcher addressed each ward within the hospitals. The sister in charge had to be notified of the researchers visit in order for the researcher to address the patients. Patients that were healthy enough to participate were approached by the researcher. During the application of the questionnaires to the in-patients, the researcher had to adapt the questionnaire to an interview schedule as many patients wanted to participate but were unable to write as a result of their medical condition. This process was time consuming but highly rewarding as the researcher could keep a track of the number of respondents. The researcher managed to obtain 255 responses from the external publics of both the hospitals. This was made up of 152 in patients and 103 outpatients.

The internal staff members of Addington and R.K. Khan Hospital] publics were made up of nurses, doctors, administrative staff as well as any member of staff employed by the hospitals that engaged with the public one way or another. One of the biggest challenges faced in this study was to address the staff of the hospitals. Due to the staff shortages as well as huge workloads, the nursing staff as well as doctors found it difficult to participate in this study. However due to repeated applications of the questionnaires to the internal publics of the hospital, the researcher extracted responses from 105 staff members of the hospital. This was made up of seven administrative staff, six doctors, seventy five nurses and two radiographers.

Conclusion

This chapter explains the route the researcher undertook in order to compile data for this research. The motivation for the case studies was presented to provide clarity as to the selection of Addington and R.K. Khan hospitals in this study. The researcher further elaborated on the quantitative research methods used that was the primary means to quantify the data. The importance and relevance of the ethical considerations was explained especially as this study involved patients whose rights had to be protected. The researcher then explained various other processes involved in this study with respect to data collection. In the next chapter, the data will be analysed and explicated.

CHAPTER EIGHT

Data Summaries and Interpretations

Introduction

This chapter presents and discusses the data collected through the questionnaires. The process undertaken to capture and analyse the data collected will be discussed at length. The data will be summarised and presented in graphical and tabular form using the appropriate statistical methods after which it will be analysed according to each of the objectives that directed this study. Krueger and Casey (2000) suggest that the purpose should drive the study. Further they believe that analysis begins by returning to the intention of the study.

Data Processing

Questionnaires were used to collect data for both Internal Publics and the External Publics of both public health facilities. The questionnaires design comprised both open - ended and closed - ended questions for which the Likert scale was used to codify the data. The statistical program used for this study was SPSS [Statistical Programing for Social Sciences] version 20.

It was not compulsory for the respondents to answer each and every question on the questionnaire. The respondents were allowed to omit questions which placed them in a situation of discomfort. As a result of this, there is a slight discrepancy between the number of questionnaires used to investigate the different objectives. Questionnaires which contained unanswered questions relating to a specific objective were omitted when the objective was investigated.

The questionnaire that represented the Internal Publics of the public health facilities consisted of 128 questions. This questionnaire consisted of five sections:

- Section A- Demographics of the respondents
- Section B- Training and Development of the Respondents
- Section C- Batho Pele Principles
- Section D- Challenges faced by the internal staff of the public health facilities
- Section E- Managements Monitoring of the Batho Pele Principles.

Sections A, B and C are interdependent. The information in each of the aforementioned section directly impacts the other sections of the questionnaire. The response to these sections

will be analysed according the objectives of the study. However Section D and E relate to the challenges faced by staff members of the public health facilities.

The questionnaire used for the External Publics of the public health facilities were consisted of 50 questions and divided into two sections:

- Section A- Demographics.
- Section B- Relevant Aspects of Batho Pele Principles.

Data Analysis

It is critical to this study that the analysis of both questionnaires is done simultaneously to provide a view of the adoption (Internal Publics) and the application (External Publics) of the Batho Pele Principles. The analysis and interpretation of the data will be done in relation to the objectives of the study. The challenges faced by staff members, i.e., Section D and E of the Internal Questionnaire, will be analysed and interpreted thereafter. It is important to understand the relevance of the demographics of the respondents in this research as it will provide an insight to this study in respect of being adequately trained and having a sense of maturity in meeting with the needs of the external publics.

Demographics of the Internal Publics

The demographics comprise of the following variables: Gender, Age, Population group, Education Level and Profession. The relevance of each of these variables will be discussed.

Gender: Table 4 shows that of the overall respondents 19.6 % were male and 80.4% were female. Observation at the public health facilities revealed that there is a generally higher presence of female staff than male staff.

	Frequency	Percent
Male	18	19.6
Female	74	80.4
Total	92	100.0

Table 4. Gender of the respondent

The gender analysis of the respondents is important to this study as it highlights an imbalance in gender equity in the public health facilities selected as the case study for this research. In the latter part of Chapter Seven it is revealed that 75 nurses undertook to participate in this study.

A breakdown of the gender (nurses) reveals that 88 % are female whilst 12% are male. According to Marks (2000), it is commonplace to assert that nursing is a profoundly gendered profession. The term itself derives from women's role as mothers and nurturers. However there is a serious need for more male nurses in the public health sector as the average age of the female nurses makes it very challenging to cope with patients that are borderline psychotic.

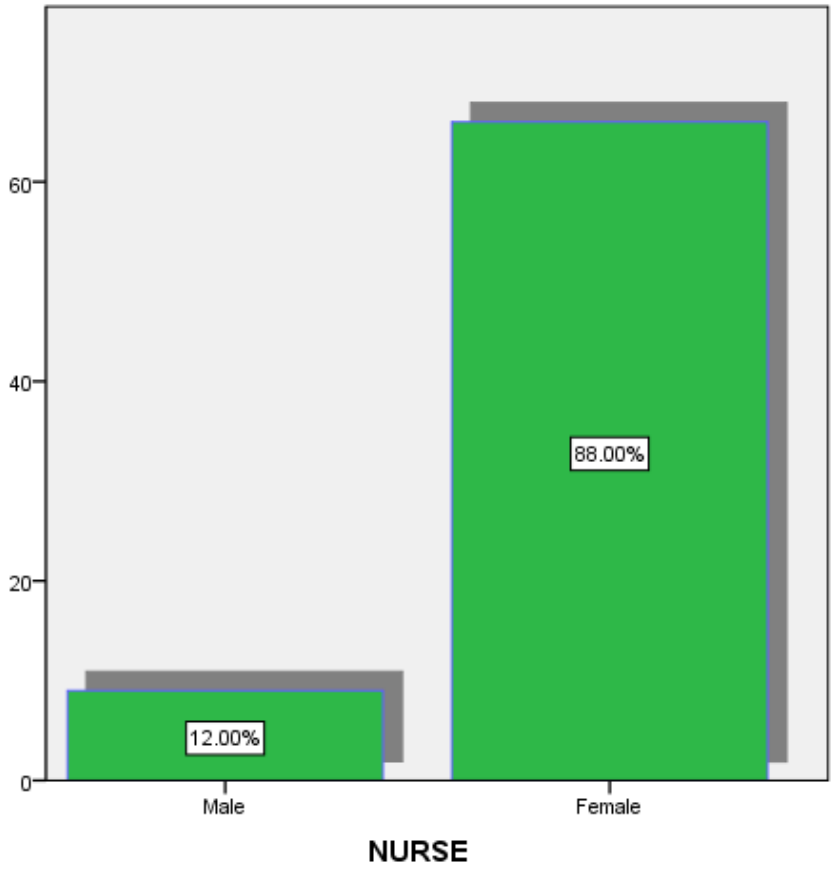


FIGURE 12: Gender (Nurses)

Age of respondents (internal publics – staff)

The age of the respondents is relevant to this study since it could be used to determine the maturity level and experience of the staff members in performing their duties. Figure 13 shows a broad distribution of the age of the respondents which means that the public health facilities has the potential to offer the external publics mature staff to understand their need for assistance.

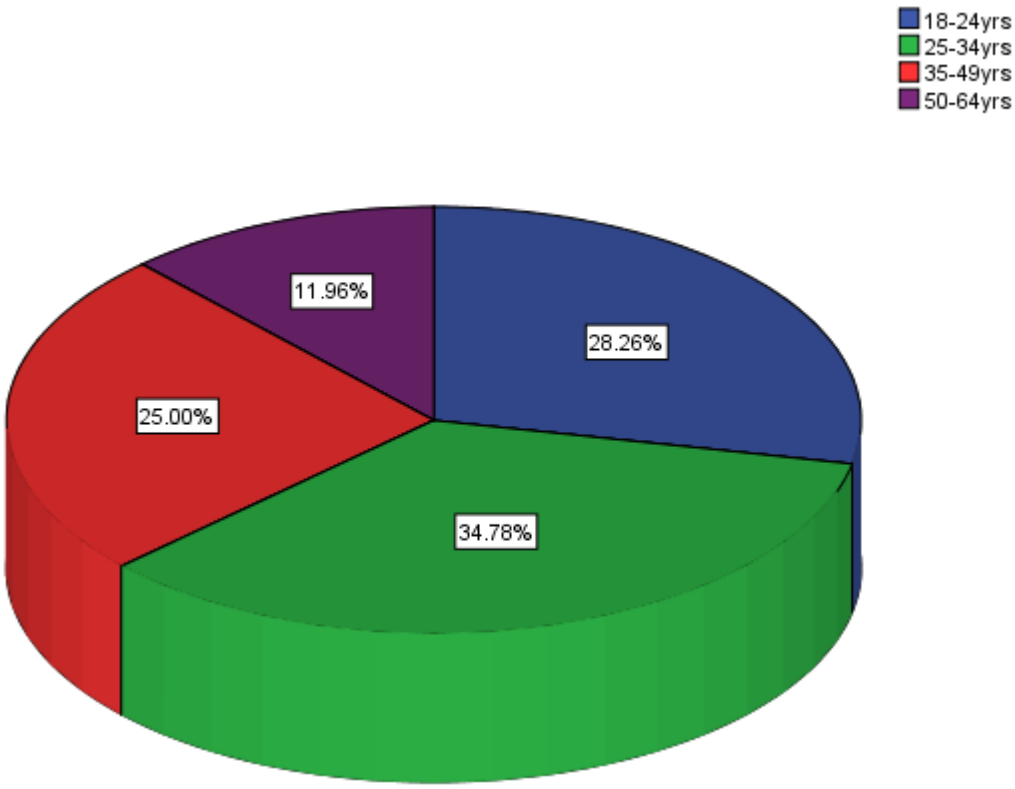


FIGURE 13: Respondents Age (Staff)

Population Group

The population distribution in Figure 14 depicts a clear misrepresentation of the other population groups in the public health facilities. One of the main reasons for this is the better working conditions that are offered in the private health sector. According to Largarde and Blaauw (2010), South Africa has a crisis where the supply of health care workers in the national labour market is unable to meet the demand for health services.

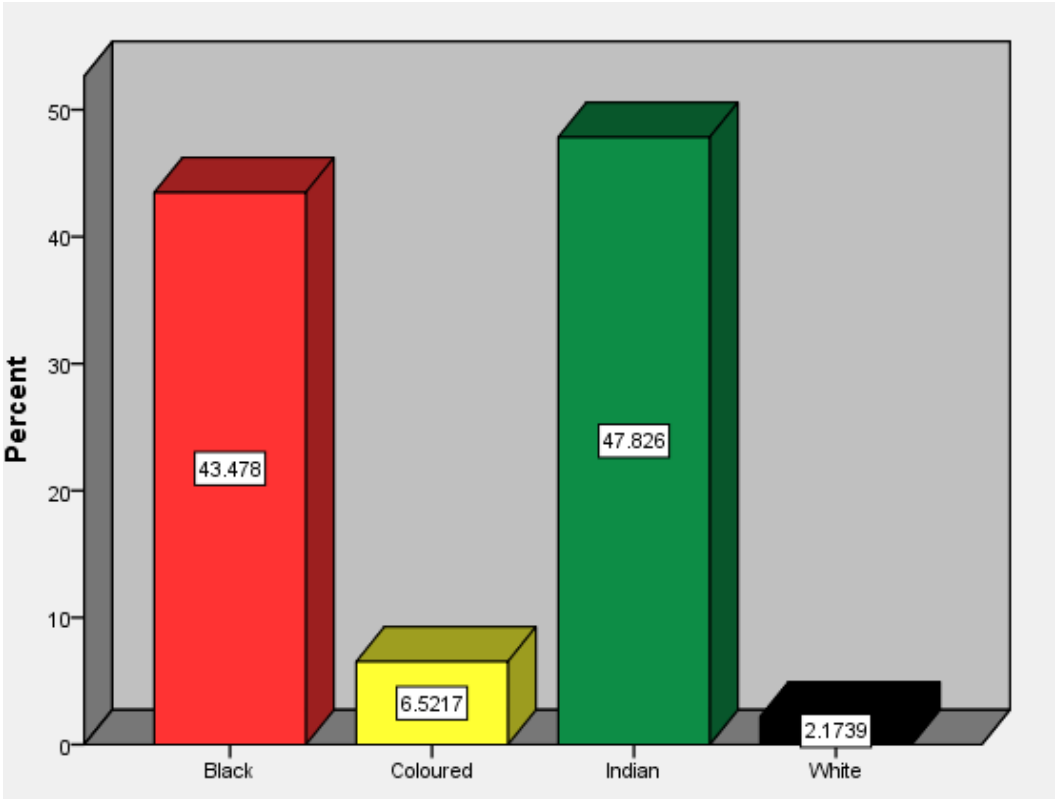


FIGURE 14: Population Groups of Staff members

Education level and Profession

The education level of the staff members at the public health facilities is highly relevant as it requires a certain level of training to endure, maintain and sustain the challenges facing health professionals daily. Blackmer (2007) defines this level of professionalism as the skills, attitudes, values and behaviours common to those undertaking the practice of medicine. It includes concepts such as the maintenance of competence for a unique body of knowledge and skill set, personal integrity, altruism, adherence to ethical codes of conduct, accountability, a dedication to self-regulation, and the exercise of discretionary judgment.

The values in Table 5 reveal that the majority of the nursing staff has received adequate (Diploma level) training in their profession. The level of training is important as the health sector in general has to operate at an optimal rate to avoid fatalities at the behest of negligence. Whilst 80 % satisfies the minimal qualification requirement it still leaves 20% lacking in training and knowledge. There should at all times be a zero percentage default rate. The external public places their confidence in the health professionals when they require medical assistance with the expectancy that the health professional is adequately trained.

		Profession				Total
		Doctor	Nurse	Admin	Other	
	Secondary	0	18	4	2	24
	Degree	6	1	0	2	9
	Diploma	0	43	3	1	47
	Other	0	11	0	1	12
Total		6	73	7	6	92

Table 5: Education level cross tabulated with Profession

DEMOGRAPHICS OF THE EXTERNAL PUBLICS [PATIENTS]

Before the results are interpreted according to the objectives of this study, the demographic information of the external publics will be summarized. The demographic variables pertinent to this study comprises of the following: Hospital, In or Out Patient, Gender and Age of the respondent.

Hospital

The patients and staff of the hospitals selected as the multi case study for this research will be analysed and cross tabulated according to the number of in patients, that is, patients that are admitted to the hospital and out patients, i.e. patients that are not admitted to the hospital, instead need medical attention or in need of the public health facilities use.

Table 6 reveals a total of 255 respondents for this study. One of the most challenging problems the researcher encountered was at R.K.Khan Hospital where majority of the in-patients were too ill to participate in the survey. The researcher was cautioned by the nursing sisters in charge over accessing certain parts of the wards of the hospital because of the high number of TB (Tuberculosis) patients that were admitted. The patients at Addington Hospital seemed more receptive and willing to participate in this study, hence the higher response rate from Addington Hospital.

		in or out patient		Total
		in	out	
Hospital	Addington	99	64	163
	R.K.Khan	53	39	92
Total		152	103	255

Table 6: Hospitals cross tabulated with in and out patients.

Gender of the Respondents - Patients

Figure 15 indicates a slightly higher percentage of females participated in this survey compared to their male counterparts. This was due to women being keener to contribute to this study as opposed to the men. The slight difference in the gender analysis will not disadvantage this study in any way.

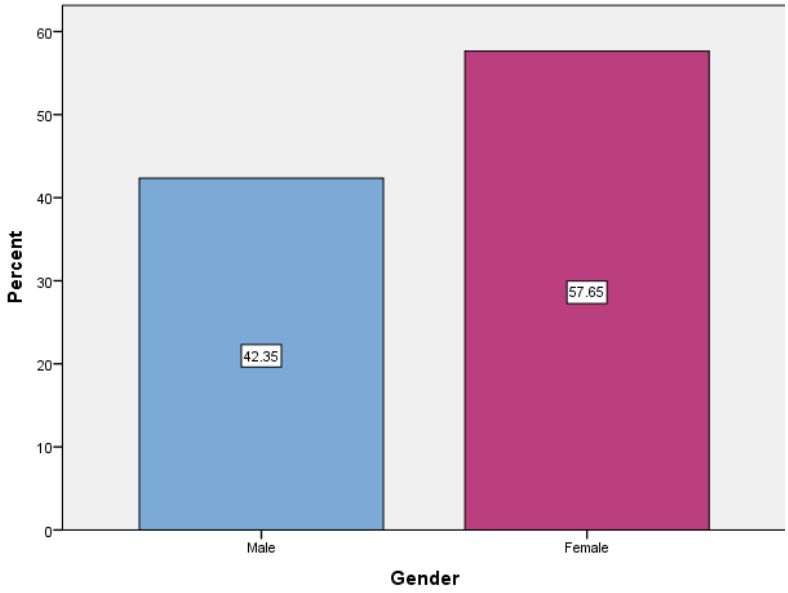


FIGURE 15: Gender of the respondents

Cross tabulation between Gender of the patients and in or out-patients

Table 7 provides a count of the gender of the patients according to their status at the hospital. In-patients have prolonged access to the services of the public health facilities depending on the duration of their stay. They experience the standard of services meted out to them more frequently than out-patients. It is for this reason that the researcher strived to ensure that a higher percentage of in-patients were interviewed. Many of the out-patients

were previous in-patients at the public health facilities and were able to provide an account of their experiences with the services rendered at these facilities.

		in or out patient		Total
		in	out	
Gender	Male	64	44	108
	Female	88	59	147
Total		152	103	255

Table 7: Cross tabulation of gender and in or out patients

Age of the Respondent

The demographic variable that pertains to the age of the respondents is explicated in figure 16. It shows a percentage of 10.59% for the age group of 18-24 years; 19.22% for the age group 25-34 years; 32.94 % for the age group 35-49 years; 24.71% for the age group 50-64 years and 12.55% for the age group of 65 years and over. As a result of the AIDS epidemic, the mortality rate for adults in South Africa has dramatically increased adding extra pressure to the public health sectors of South Africa. According to Knight (2006), a report on adult mortality (age 15-64) between 1997 and 2004 by Statistics South Africa, based on death certificates, shows a dramatic increase in the death rate, largely due to AIDS-related deaths.

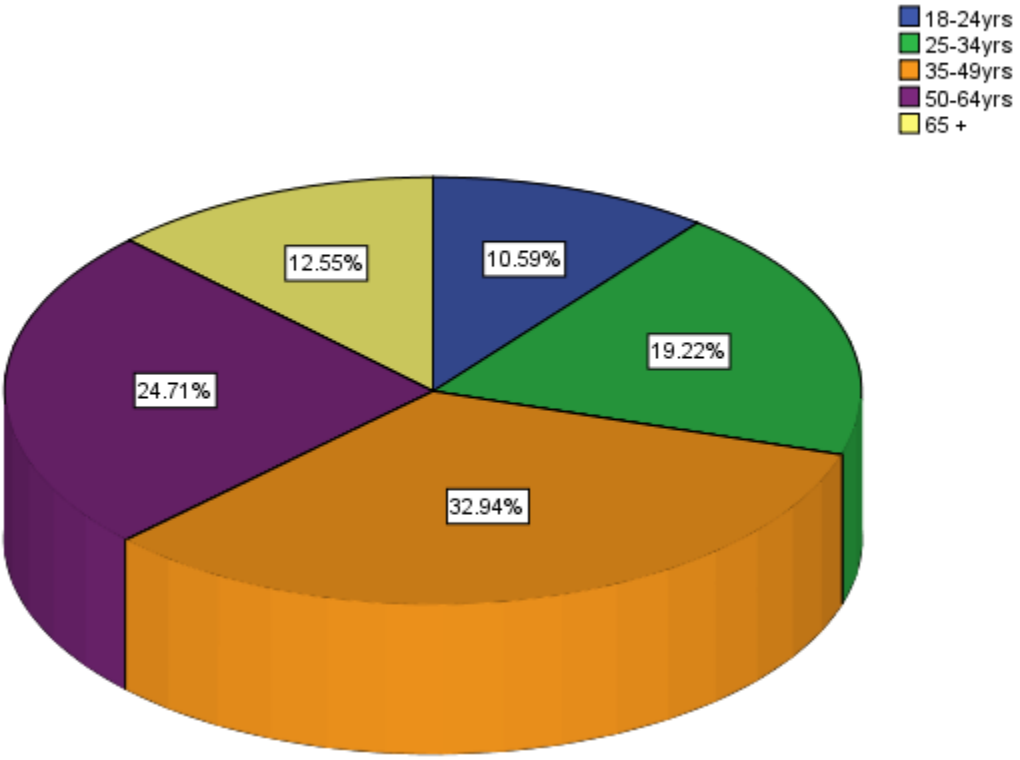


FIGURE 16: Age of the Respondents

Objective 1: To evaluate the effects of the challenges faced by key government sectors in the adoption and application of the Batho Pele Principles.

The challenges faced by staff members at the public health facilities are discussed at length in Chapter five. However a brief mention of the operational and management challenges is needed in order to properly gauge the effects of these challenges in the application and adoption of Batho Pele Principles. Table 9 below is an indication of the challenges experienced by management and operational staff members at the public health facilities. The effects of these challenges can be gauged through the staff's attitude towards the patients as well as through the effective performance of their duties. The questions that address these effects will now be discussed.

Management Challenges	Operational Staff Challenges
• Poor leadership • Acquisition of suitably qualified staff • Lack of accountability • Poor policy implementation • Lack of financial resources • Lack of communication • Lack of control • Lack of planning • Lack of organising • Poor decision making • Poor governance • Poor performance of workers	• Shortage of skilled staff • Poor working conditions • Lack of equipment • Lack of functional equipment • Inadequate facilities • Failure to uphold work ethic • Lack of basic supplies • Lack of communication • Theft within the organisation • Inadequate support system

Table 8: Service Delivery Challenges

Working Conditions

The effects of the challenges faced by the staff members of the public health facilities were addressed through a number of questions posed at the internal publics. The working conditions of the staff members are imperative to the successful operation of an organisation. According to Songstad et al. (2011), working conditions have been pointed out as a key factor in ensuring a motivated and well performing staff.

	Frequency	Percent
Poor	39	42.4
Satisfactory	42	45.7
Good	5	5.4
Excellent	3	3.3
DNA	3	3.3
Total	92	100.0

Table 9: Working conditions according to staff

Table 9 indicates that 42.4% of staff members found their jobs poor whilst there were other respondents who rated their working conditions as being satisfactory. Hall (2004) states that unsatisfactory working conditions in health facilities were mentioned as one of the key aspects responsible for the shortages in nursing staff at public hospitals. The public health facilities in South Africa are currently dealing with an uneven distribution of nurses at public health facilities in South Africa.

Staff members listed a number of reasons which contributed towards the poor working conditions at the public health facilities. The following qualitative responses will be analysed in respect of what contributes towards the poor working conditions experienced at the public health facilities:

- "Lack of supplies (72 respondents) such as soap, bed linen, liners, syringes, gloves, protective gear, and other basic supplies."
- "Staff shortages" (30 respondents).
- "Overcrowding" (47 respondents).
- "Breakdown in communication" (25 respondents).

The ability of staff members to perform at an optimal rate requires that the basic necessities be made available at all times, however experiencing such shortages will inhibit the quality of services rendered and perhaps even place the institute at the risk of losing lives as opposed to saving them. Khoza (2012) mentioned upon a recent visit (September 2012) to the Addington Hospital by the Kwa-Zulu Natal health portfolio committee headed by Lydia Johnson which found that there was no soap to bath patients and that some theatres were closed because there were no medical supplies. Figure 17 is a reflection of the number of staff members who experienced shortage of basic supplies during the course of carrying out their duties.

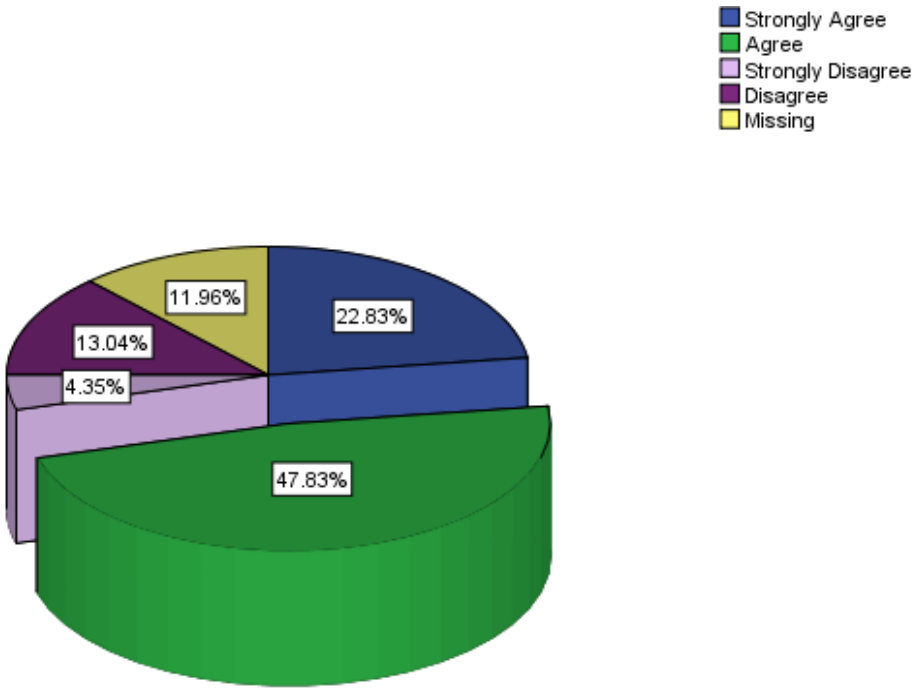


FIGURE 17: Shortage of basic supplies

Staff shortage is one of the biggest problems haunting the Department of Health. Kautzky (2008) explains an assessment by the WHO in 2003 which found that more than 60% of health care institutions in South Africa struggled to fill existing posts, with more than four thousand vacancies for general practitioners and more thirty two thousand vacancies for nurses throughout all provinces. This places enormous pressure on the public health system to deal with vast numbers of patients regularly. According to Joubert (2009), the public health sector of South Africa has too few registered nurses. This indicates a compromised capacity for service delivery, as well as a stressful working environment for nurses that are currently employed, which contributes to qualified nurses seeking other employment. Addington Hospital is yet to appoint a suitably qualified hospital manager which management reported will occur in November 2012 (Khoza, 2012). Table 10 shows a dire shortage of staff at the public health facilities. Of the responses received, 70.7% confirmed the shortage of staff within the public health sector.

	Frequency	Percent
Yes	16	17.4
No	65	70.7
Not Applicable	10	10.9
Did not answer	1	1.1
Total	92	100.0

Table 10: Staff Shortage

Another major problem experienced by the nurses was the issue of overcrowding. This means that an increasing number of people are utilising public services as the cost of private medical care sky rockets. An inquiry led by The South African Human Rights Commission in 2007 found that in private care, high costs appear to have been fuelled by unethical practices in which private hospitals overcharge on surgical supplies and materials.

The South African Human Rights Commission (2009) states that from 2006, 86% of the total population in South Africa was dependent on the public sector for health care. This supports the finding that the public health facilities have to deal with overcrowding of patients on an on-going basis.

According to the South African Human Rights Commission (2009), the HIV/AIDS epidemic has impacted harshly especially on poor urban and rural communities who are dependent on the public health care system. In addition, this is noted as one possible cause of escalations in the use of public health care.

Poor leadership experienced at the public health facilities was a challenge which could not be ignored as many staff members of Addington Hospital reported that a number of departments were left without a head. This alone has placed enormous stresses on staff members who have had no leadership and guidance at the hospital. The protocol required in organisational communication has completely collapsed due to the absence of such integral people within the public health facility. This means that the ability to effectively communicate problems and issues within the department becomes a challenge which staff members have to bear the brunt of. This inadvertently has reduced the morale of staff members.

The effects of poor working conditions

The effects of poor working conditions inadvertently jeopardises the quality of services or the service standards of the public health facilities. In order to gauge the service standards of the public health facilities, the external publics (patients) were asked a number of questions pertaining to the quality of service received. The analyses of these follow.

THE STAFF ANSWERS PATIENTS CONCERNS

This question was in relation to the Batho Pele Principle of courtesy. Respondents were asked to rate their experience with regard to: *The staff answers my concerns/queries in a polite manner*. This question qualifies as one of the effects of the challenges faced by staff members in that they are unable to provide courteous responses as a result of their working conditions. The data tabled shows 20% of respondents disagreed with this statement.

	Frequency	Percent
Agree	178	69.8
Disagree	51	20.0
Not Sure	24	9.4
Not Applicable	1	.4
DNA	1	.4
Total	255	100.0

Table 11: Staff member's response to patients concerns.

This is evidence of the results of the challenges faced by health care workers in the public health sector. Whilst 69.8% of respondents agreed to this statement, many of the respondents stated that their response was not definitive as they had prior experience of staff members not addressing their concerns.

3.3.1.3 NURSES INTOLERANCE TOWARDS PATIENTS

As a result of poor working conditions as highlighted in 3.3.1, many nurses find it difficult to sustain their tolerance levels towards patients. A total of 32.2% of respondents (external publics) in Table 12 found nurses to be intolerant towards them. This is relatively high considering the extensive training the nursing staff has to undergo.

	Frequency	Percent	Cumulative Percent
Strongly Agree	46	18.0	18.0
Agree	36	14.1	32.2
Strongly Disagree	146	57.3	89.4
Disagree	27	10.6	100.0
Total	255	100.0	

Table 12: Nurses intolerance towards patients

The cross tabulation of Nurses are intolerant and in or out-patient is important as the respondents that were admitted to the hospital had prolonged experience with the services rendered at the public health facilities. Table 13 is indicative of the number of patients that had to endure the intolerance of the nurses towards them. Many of the patients interact with more than one nurse.

		In or out patient		Total
		In	Out	
Nurses Intolerant	Strongly Agree	26	20	46
	Agree	20	16	36
	Strongly Disagree	89	57	146
	Disagree	17	10	27
Total		152	103	255

Table 13: Nurse Intolerance towards patients cross tabulated with in or out-patients.

I AM TOO TIRED TO BE NICE.

The pressure placed on the staff members of the public health facilities to deal with overcrowding and dealing with large numbers of patients daily makes it difficult for them to maintain their countenance. It is unfortunate that 21.7% of respondents - staff members (Table 14) are either *frequently* too tired to be nice or are *sometimes* too tired to be nice. The circumstances under which staff members of the public health facilities operate, makes it unavoidable that there are going to be some staff members that feel the pressure of the challenges they experience.

	Frequency	Percent	Cumulative Percent
Frequently	4	4.3	4.3
Sometimes	16	17.4	21.7
Never	66	71.7	93.5
NA	6	6.5	100.0
Total	92	100.0	

Table 14: Staff members rating i.r.o courtesy.

The efforts made by 71.7% of the staff members are commendable considering the working conditions under which they operate.

THE NURSES ARE QUICK AND EFFICIENT

When addressed about the Batho Pele Principle of timeliness, 31% of the patients recorded a response in which they expressed their disagreement to the statement of: *Nurses are quick and efficient*.

	Frequency	Percent	Cumulative Percent
Strongly Agree	144	56.5	56.5
Agree	32	12.5	69.0
Strongly Disagree	48	18.8	87.8
Disagree	31	12.2	100.0
Total	255	100.0	

Table 15: Patients rating of the speed and efficiency of nurses.

BED LINEN CRISES

As a result of a lack of basic supplies as cited by many nurses, patients have had to endure the consequences of it. One of the key drivers used to evaluate the service standards of the public health facilities was to address the issue of bed linen. This question was posed to the staff members as well as patients. Table 16 shows an alarming rate of patients from Addington Hospital who strongly disagreed that their bed linen was changed daily. Further to this research being conducted at the hospital, the problems the hospital encountered with the linen was subsequently reported by Hans (2012) in The Mercury that doctors at the public health facility threatened to stop operations due to a severe shortage of linen at the hospital. Upon

investigation it was found that the central provincial laundry had just one machine operational which caused severe backlogs of unwashed linen to many other health facilities which it services.

During the process of applying this questionnaire as an interview schedule to in-patients, patients complained of the bed linen that had not been changed for over a week. Observations of the bed linen during the patients interviews revealed that most if not all had been soiled by blood. The unhygienic bed linen in itself was a festering wound breeding germs and diseases that could lead to serious health issues within the health facility.

		Hospital		Total
		Addington	R.K.Khan	
Bed Linen Changed	Strongly Agree	19	22	41
	Agree	19	47	66
	Strongly Disagree	111	22	133
	Disagree	14	1	15
Total		163	92	255

Table 16: Patients views on bed linen

In order to engage the nurse's views on the bed linen, this question was also posed to them where they were required to rate themselves in respect to the following statement: *Bed linen is changed regularly*. Table 17 shows a count of 30 nurses from Addington Hospital who answered this question, of which 9 rated this statement as poor; whilst 11 others rated this statement as satisfactory. The issue of the linen was a management issue and one that was out of the control of the nurses on duty. However, this impacted seriously on the service standards at the public health facility.

		Bed linen is changed regularly					Total
		Poor	Satisfactory	Good	Excellent	DNA	
Hospital	Addington	9	11	5	3	2	30
	R.K.Khan	4	9	32	13	0	58
Total		13	20	37	16	2	88

Table 17: Nurses response to bed linen cross tabulated with hospital.

Lack of Equipment

The public health facilities chosen for this case study are the main public health conduits in KwaZulu Natal and are responsible for the great many lives that depend on their services. It is imperative that hospitals are adequately equipped to render services effectively. Khoza (2012) states that following a visit by Lydia Johnson, the KZN Health Portfolio chairperson in September 2012 (three weeks after the fieldwork for this study was completed), there were just two of the six theatres functioning because of malfunctioning air-conditioning systems.. In one theatre there was no anaesthetic machine and the oxygen analyser was not working.

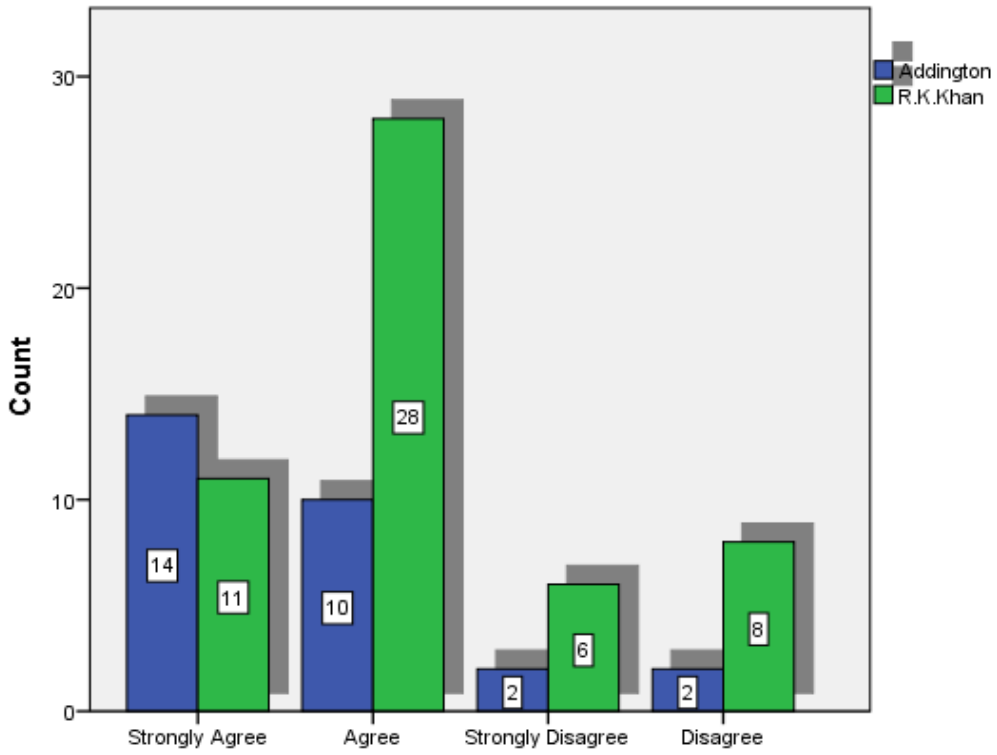


FIGURE 18: Lack of equipment cross tabulated with hospitals

Figure 18 is an indication that the lack of equipment is not experienced by just one hospital but by both. This is a reflection of dire shortages experienced by public health facilities in order to treat patients effectively. Without the access to proper functional equipment, it would be impossible to provide service delivery of an acceptable service standard.

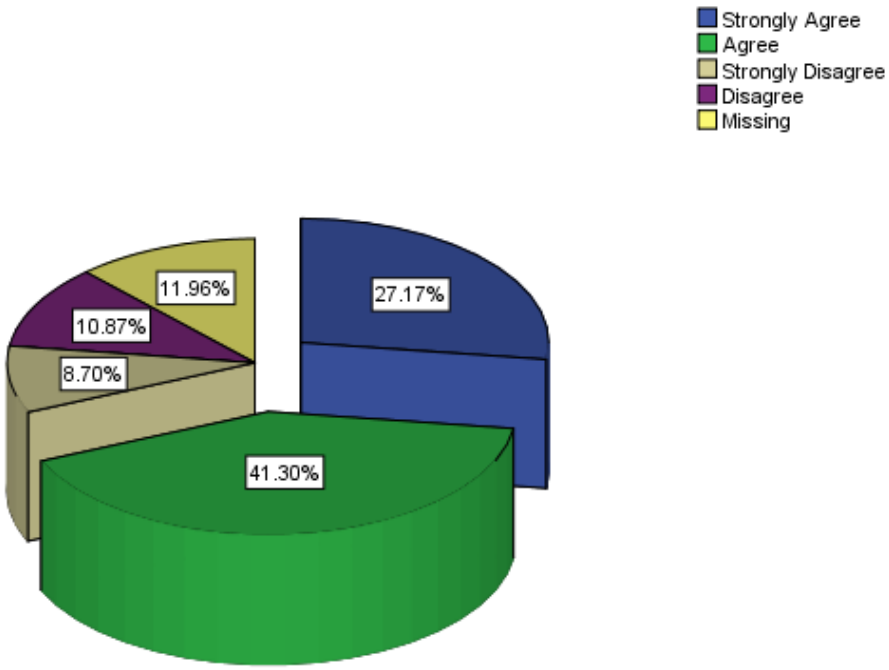


FIGURE 19: Lack of Equipment (Staff members' response)

Figure 19 shows 41.30% of the staff members strongly agreed with the statement "*I have experienced a lack of equipment that is necessary to effectively treat patients in my department"*. This implies that the standard of treatment for a patient is severely jeopardised, placing their lives at a serious risk. Many patients expressed deep concerns over being told by either the doctors or the nurses in attendance that their operations had to be delayed as a result of a lack of equipment. A number of patients confirmed they were referred to other hospitals to have surgical procedures carried out. The challenge of the lack of equipment and the impact this has on the staff members at the public health facility as well as the patients has contributed towards a total loss of confidence in the public health system. Some patients expressed concerns over receiving proper treatment as a result of this challenge of not having suitable equipment with which to treat them.

There are inadequate facilities at this hospital

The staff members at the public health facilities were asked to rate the above mentioned statement for which 86.95 % of the respondents in Figure 20, agreed that there the public health facilities are inadequately equipped. The burgeoning numbers of people that utilise the public health system as well as the progressively high numbers of people infected with HIV/AIDS has compromised the care for patients bearing other serious illnesses.

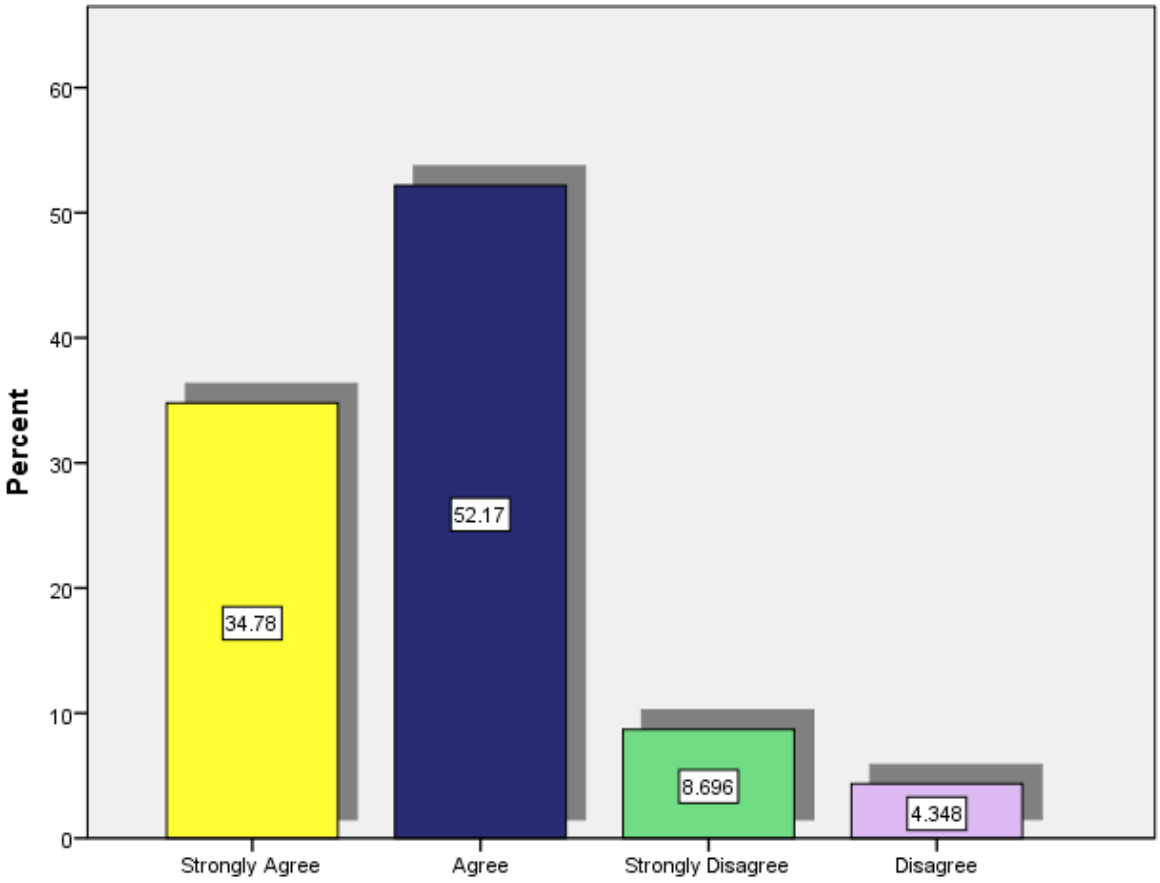


FIGURE 20: Inadequate facilities (Staff members' response)

There is an inadequate support system at the hospital to assist with internal issues

A combination of 'Strongly Agree' and 'Agree' shows more than 51% of staff members felt that there is an inadequate support system at the public health facilities to deal with internal issues. This creates a very poor impression of the leadership at the public health facilities as it reveals that more than half the respondents feel negatively towards its support structures. This was mainly attributed to the absence of proper management structures at one of the public health facilities, Addington Hospital, where they were still awaiting the appointment of a hospital manager, an engineering manager (Khoza, 2012). The finance manager was appointed in July 2012. Khoza (2012) states that the Health services manager of Addington Hospital, Thokozani Mhlongo complained of serious communication problems that plagued the hospital whereby within the pharmacy department members were sabotaging one another. Mhlongo was also quoted as saying there are racial, religious and different matters that the HR department is dealing with due to a lack of teamwork and information sharing.

Following the fieldwork, many patients complained at the pharmacy department at Addington Hospital whereby doctor's prescription of certain medication were deleted and replaced by the

pharmacy department. Although the researcher did not provide for this, it is a matter that needs further investigation.

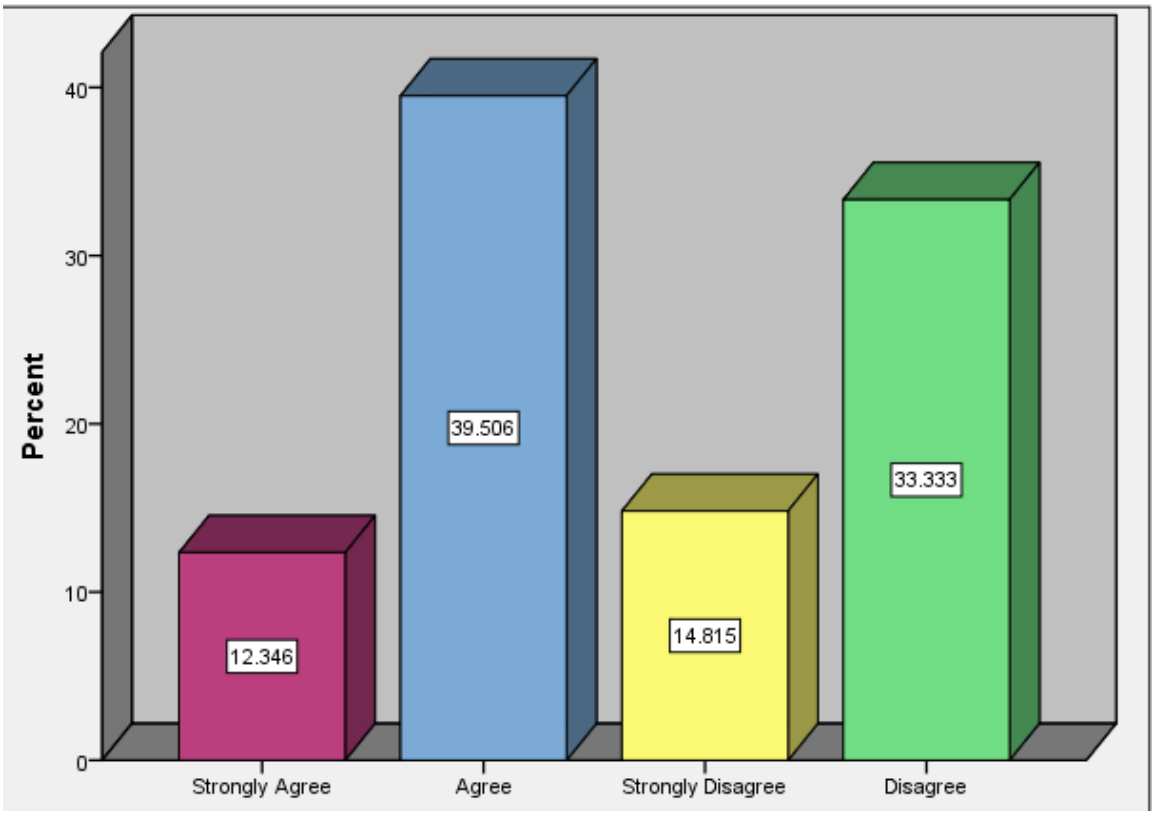


FIGURE 21: Inadequate support system at the hospital

OBJECTIVE 2: TO ANALYSE THE APPLICATION AND ADOPTION OF THE BATHO PELE PRINCIPLES TOWARDS THE IMPROVEMENT OF SERVICE DELIVERY IN KEY GOVERNMENT SECTORS.

The Batho Pele Principles implemented in key government sectors are discussed in Chapter four. In order to understand how these principles were implemented it is important to consider the way in which the principles were adopted by the internal publics and how it was applied to the external publics. For this objective, it was important to structure both questionnaires similarly which would address the adoption and the application of these principles appropriately. Each of the Batho Pele Principles will be interpreted according to the internal and external publics' responses.

Access

The first Batho Pele Principle of Access requires the public service to ensure that all citizens have equal access to the services to which they are entitled. Tables 18 and 19 provide a comparison between the responses received from the staff members and the patients. An

analysis of table 18 reveals that 13% of the staff members rated the accessibility of the public health facility as being poor whereas 87% of the patients agreed that the facility is very accessible to them.

	Frequency	Percent
Poor	12	13.0
Satisfactory	31	33.7
Good	36	39.1
Excellent	9	9.8
Not sure	4	4.3
Total	92	100.0

Table 18: Staff members' response to accessibility of facility

	Frequency	Percent
Good	222	87.1
Poor	22	8.6
Satisfactory	9	3.5
Excellent	1	.4
Not sure	1	.4
Total	255	100.0

Table 19: Patients response to accessibility of facility

Courtesy

The Batho Pele Principles of consideration requires that all citizens be treated with courtesy and consideration. Figures 22 and 23 represent pie charts to one of the questions that relate to courtesy. The results relate with each other as 76% of the internal publics (patients) agreed that the staff members are polite whilst 91% of the staff members confirmed that they greet and welcome patients.

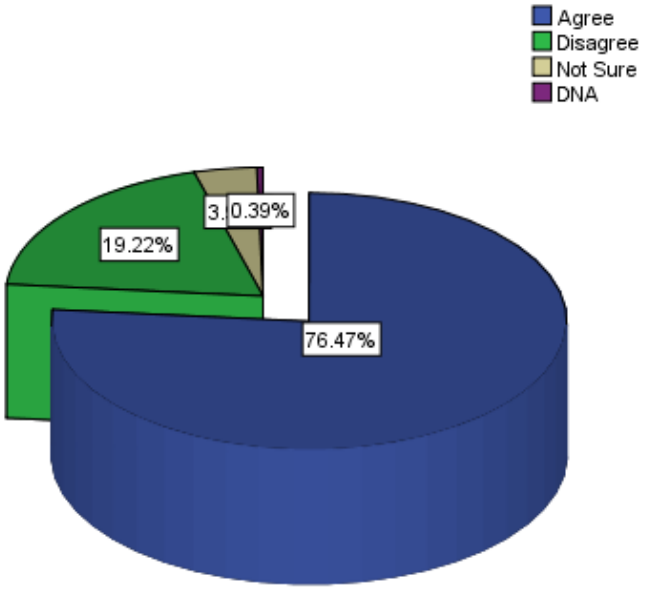


FIGURE 22: External publics' (patients) response to courtesy

POLITENESS OF STAFF

Figure 23 shows that 19% of the respondents (patients) disagreed with the politeness of staff members. Given that patients come into contact with a number of nurses, their responses will vary accordingly.

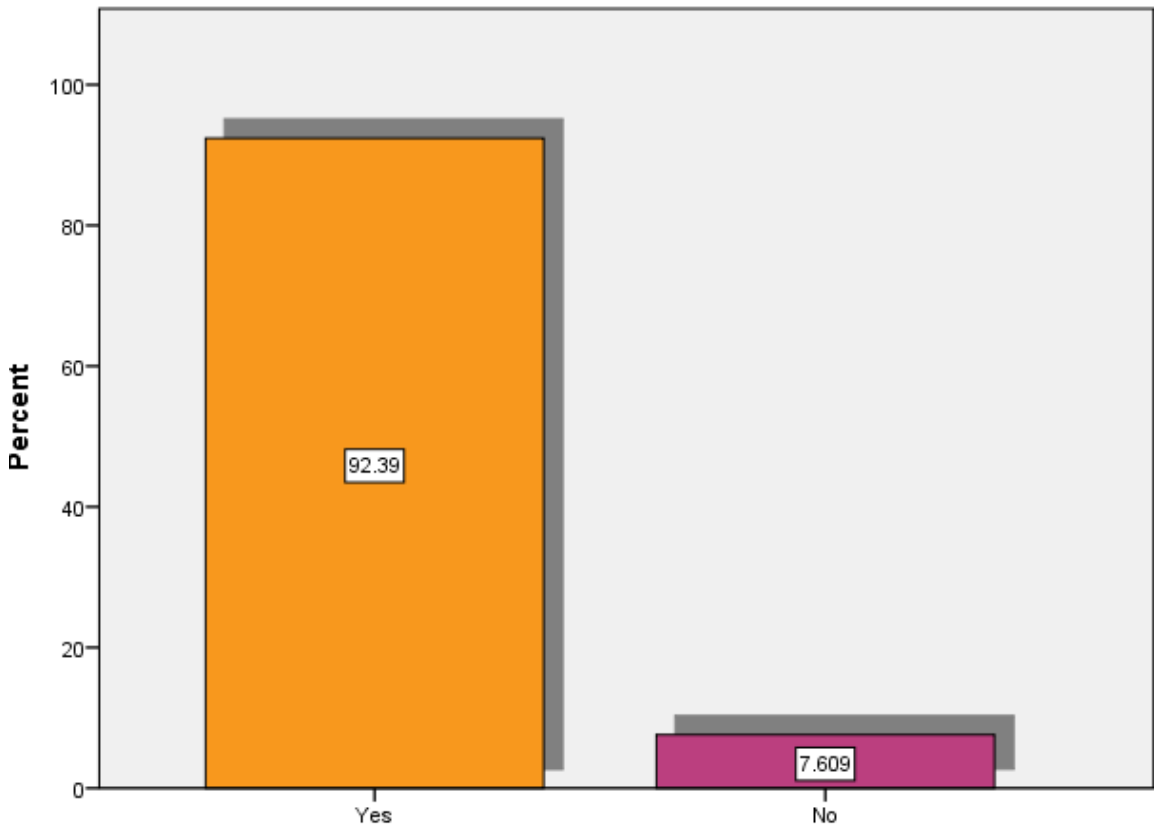


FIGURE 23: Internal (Staff members') publics rating on greeting.

Figure 23 indicates that 92.39% of the respondents (staff members) make an attempt to be courteous to the patients they encounter.

I AM TOO TIRED TO BE NICE

Figure 24 is representative of more than 90 % of the staff members who disagreed with this statement.

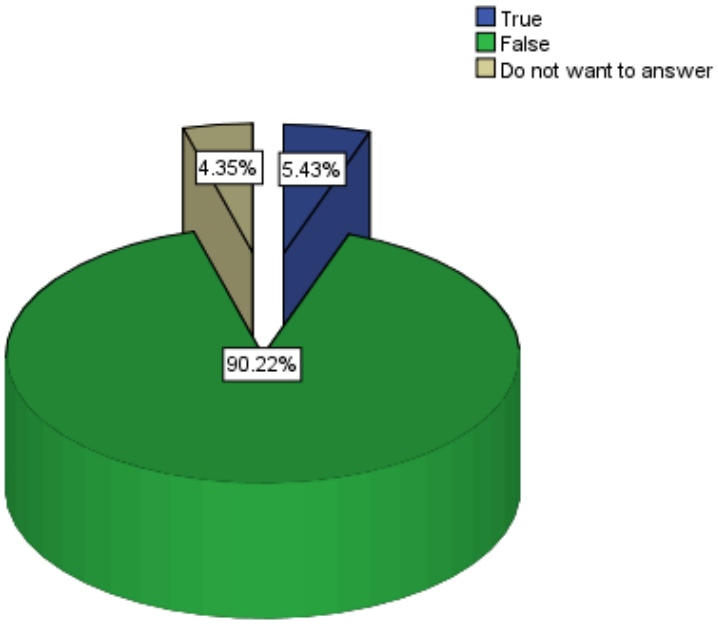


FIGURE 24: I am too tired to be nice to patients (Staff members' response)

I AM TOO BUSY TO BE COURTEOUS

The challenges faced by the staff members at the public health facilities such as overcrowding and staff shortages can impede their ability to be courteous, however Table 21 suggests that staff members ensure that they are courteous at all times despite the challenges they face.

	Frequency	Percent
False	83	90.2
Do not want to answer	3	3.3
Not Applicable	6	6.5
Total	92	100.0

Table 20: I am too busy to be courteous

SOME PATIENTS ARE TOO RUDE TO EVOKE A COURTEOUS RESPONSE

The staff members of the public health facilities display a definitive level of professionalism in the way in which they respond to patients. This can be seen in table 21 where 90% (n=83) of the respondents did not agree with this statement.

	Frequency	Percent
False	83	90.2
Do not want to answer	3	3.3
Not Applicable	6	6.5
Total	92	100.0

Table 21: Some patients are too rude to evoke a courteous response

IT IS DIFFICULT TO BE COURTEOUS DUE TO THE NATURE OF MY JOB

Table 22 reveals 7.6% of the respondents found this statement to be true whilst 81.5% of the respondents found this statement to be false. One of the reasons for high percentages in expressing courtesy to the patients is the fact that most of the staff members work different shifts. This means that they experience varying densities of patients at the hospital.

	Frequency	Percent
True	7	7.6
False	75	81.5
Do not want to answer	1	1.1
Not Applicable	9	9.8
Total	92	100.0

Table 22: It is difficult to be courteous due to the nature of my job

THE APPLICATION OF THE BATHO PELE PRINCIPLE OF COURTESY

The following are summaries of the external public's response to the way in which the Batho Pele Principle of courtesy is applied. This was done by analysing the responses from the external publics. Table 23 depicts 67.5% of the respondents who strongly disagreed with this statement whilst approximately 20% of the respondents either agreed or strongly agreed. These responses generate an impression that there are times that the doctors in attendance are fatigued to an extent that they are no longer polite to the patients.

	Frequency	Percent
Strongly Agree	36	14.1
Agree	15	5.9
Strongly Disagree	172	67.5
Disagree	32	12.5
Total	255	100.0

Table 23: Doctors are rude to me

Table 24 is an indication of how patients are treated by nurses. A total of 71% of the patients either strongly disagreed or disagreed with this statement. There were 28% of patients who felt the nurses were rude towards them.

	Frequency	Percent
Strongly Agree	45	17.6
Agree	28	11.0
Strongly Disagree	153	60.0
Disagree	29	11.4
Total	255	100.0

Table 24: Nurses are rude to me

Information

The Batho Pele Principle of information requires that citizens should be given full, accurate information about the services they are entitled to receive. This principle was evaluated through a series of statements which required a rating from the staff members as well as the patients. The principle of information was evaluated through the visibility of signage, the presence of an information desk and the rights of the patients in respect of health care.

SIGNAGE

Figure 25 shows more than 38 % respondents who was of the opinion that the relevant signage was visible to the patients whilst 13.4% respondents who rated the visibility of the signage as poor.

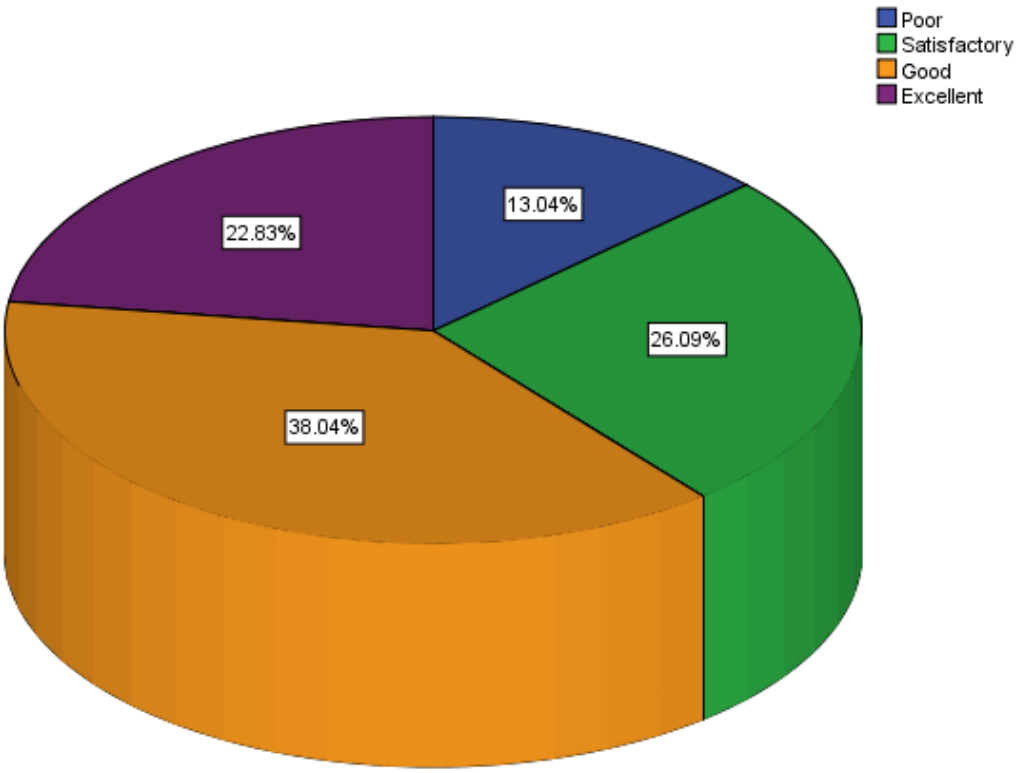


FIGURE 25: Signage to other departments (Staff members' responses)

Figure 26 shows more than 81% of the respondents found that the signs to other departments were always visible to them. The figure also indicates 13.04% of the respondents who found the signage to other departments were never visible to them.

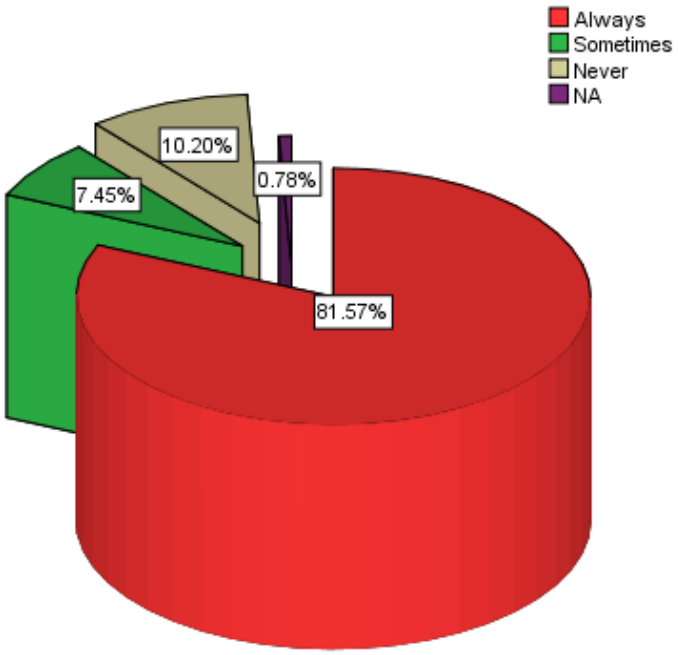


FIGURE 26: Visibility of signage to other departments (Patients response)

PRESENCE OF AN INFORMATION DESK

The importance of an information desk is to provide proper advice to patients who are ill informed about the services the public health facilities offer. Table 25 depicts a summary of the responses from staff members where 59% of the respondents rated this as either good or excellent.

	Frequency	Percent
Poor	8	8.7
Satisfactory	29	31.5
Good	34	37.0
Excellent	21	22.8
Total	92	100.0

Table 25: Presence of an information desk (Staff members' response)

Table 26 reflects 78% of the respondents who always found the information desk available to them. This augurs well for the public health facilities in terms of providing information to patients.

	Frequency	Percent
Always	199	78.0
Sometimes	14	5.5
Never	40	15.7
NA	2	.8
Total	255	100.0

Table 26: Presence of an information desk (Patient's response)

Informing patients about their rights with regards to health care

Table 27 depicts the staff members' response as to how they rate themselves with regards to informing patients about their rights to health care. The table indicates that 59.8% of the staff members rated themselves as either excellent or good at informing patients of their rights, whilst 5.4% of the staff members rated themselves as poor.

	Frequency	Percent
Poor	5	5.4
Satisfactory	32	34.8
Good	32	34.8
Excellent	23	25.0
Total	92	100.0

Table 27: Informing patients of their rights

Table 28 shows 32.5% of patients who were never advised of their rights by staff members prior to engaging in treatment, whilst 48.2% of patients claim that they are always advised of their rights to health care. There could be a number of reasons for the differences depicted in table 28 such as most patients are either too ill or unconscious upon admittance and will therefore not have knowledge of being advised of their rights to health care.

	Frequency	Percent
Always	123	48.2
Sometimes	46	18.0
Never	83	32.5
NA	2	.8
DNA	1	.4
Total	255	100.0

Table 28: Patients advised of their rights

PATIENTS PROVIDED WITH INFORMATION ON THEIR CONDITION

Figure 27 shows more than 41.30% of staff members rated themselves as good when it came to providing patients with up to date information on their condition whilst 7.61% of staff members rated themselves as poor.

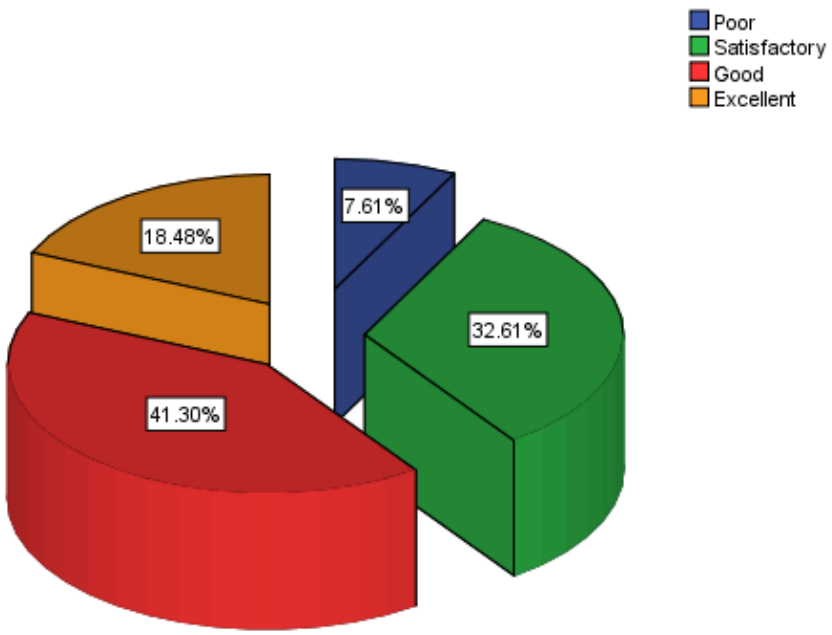


FIGURE 27: Patients provided with up to date information by staff members

Timeliness

The Batho Pele Principle of timeliness requires that services at the hospitals should be provided swiftly and within reasonable time. Table 29 depicts the staff members' response to the principle of timeliness. One of the biggest challenges facing patients are the long queues at public health facilities, this causes unprecedented delays for many patients. The table shows 50% of the staff responded as either good or excellent in rating the hospital with regards to

timeliness. However 40% of staff members recognised the performance of timeliness as being either poor or satisfactory.

	Frequency	Percent
Poor	16	17.4
Satisfactory	24	26.1
Good	41	44.6
Excellent	11	12.0
Total	92	100.0

Table 29: Services at the hospital are performed within reasonable time.

Table 30 represents the responses from the patients whereby 31% of the respondents either strongly disagreed or disagreed with this statement. One of the reasons for the delays facing patients could be as a result of overcrowding and staff shortages.

	Frequency	Percent
Strongly Agree	144	56.5
Agree	32	12.5
Strongly Disagree	48	18.8
Disagree	31	12.2
Total	255	100.0

Table 30: The nurses are quick and efficient (Patients responses)

Consultation

The Batho Pele Principle of consultation requires that all citizens should be consulted about the level and quality of the services they receive and where possible, should be given a choice of services they are offered.

PATIENTS ADVISED OF OTHER OPTIONS

Patients were asked if they were advised of other options that were available to them. Table 31 shows that 47.9% of the patients were not advised of other options available to them. 50.9% agreed that they were given other options that were available for their condition.

	Frequency	Percent
Strongly Agree	96	37.6
Agree	34	13.3
Strongly Disagree	103	40.4
Disagree	19	7.5
NA	3	1.2
Total	255	100.0

Table 31: Patients advised of other rights (Patients response)

THE ABILITY TO PROVIDE PATIENTS WITH SUITABLE OPTIONS FOR TREATMENT

The information tabled shows 68.5% of staff members who rated themselves as either good or excellent in their ability to provide patients with suitable options for treatment. However a discrepancy is evident if one compares the results in Table 32.

	Frequency	Percent
Poor	3	3.3
Satisfactory	26	28.3
Good	48	52.2
Excellent	15	16.3
Total	92	100.0

Table 32: Staff members' ability to provide patients with suitable options for treatment

THE ABILITY TO INFORM CITIZENS ABOUT THE QUALITY OF THE SERVICES RENDERED AT THE HOSPITAL

Table 33 is a depiction of how the staff members rated themselves with regards to informing the patients about the quality of services rendered at the hospital. The study reveals75.8% of the responses were rated as either good or excellent. 20.9% of respondents rated themselves as satisfactory and 3.3% as poor.

	Frequency	Cumulative Percent
Poor	3	3.3
Satisfactory	19	23.9
Good	50	78.3
Excellent	20	100.0
Total	92	

Table 33: Ability to inform patients about the quality of services at the hospital.

Service Standards

This Batho Pele Principle requires that citizens should be told what level and quality of services they will receive so that they are aware of what to expect. The principle of service standard was evaluated against a series of statements which patients and staff members' had to justify. It also provided a broad overview of the problems in-patients face at the public health facilities.

THE NURSES RESPOND WHEN I REQUIRE ASSISTANCE

Of the 152 in-patients interviewed for this study, 81 strongly agreed and 50 agreed that nurses respond when they require assistance. Of the 103 out patients interviewed, 51 respondents did not have the need for the nurse's assistance, whilst 37 strongly agreed and 6 agreed that nurses do respond. However the concern lies with the 16 in-patients who strongly disagreed with this statement as there is no telling the consequences that could have followed had the patients been seriously ill.

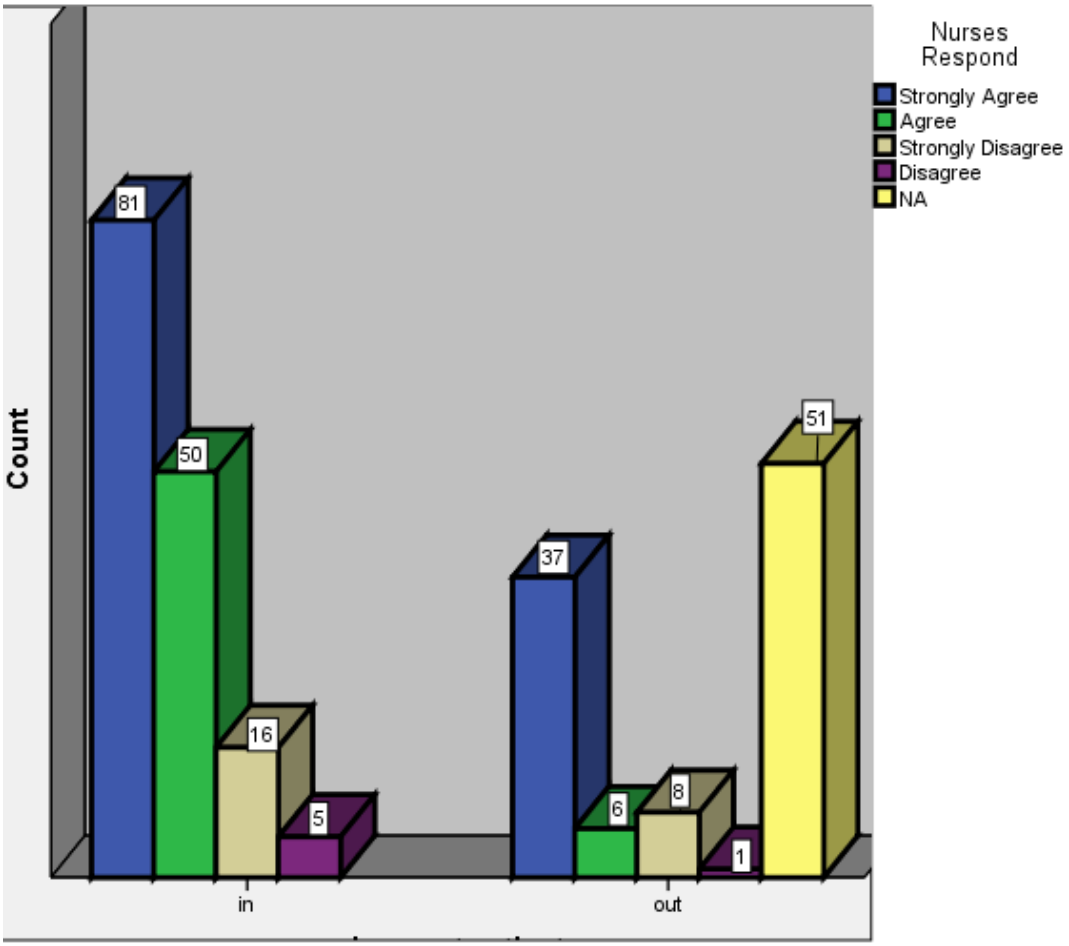


FIGURE 28: In and out patients cross-tabulated with nurses response to patients

VISITING TIMES ARE ADHERED TO

Table 34 represents a cross tabulation of in and out-patients with the adherence of visiting times at the public health facilities. Visiting times are applicable only to the in-patients. At least 96 patients strongly agreed and 50 agreed that visiting times are adhered to. The control of this is important as it would enable the medical personnel to carry out their duties accordingly.

	Visiting Times Adhered					Total
	Strongly Agree	Agree	Strongly Disagree	NA	DNA	
In-patient	96	50	4	0	2	152

Table 34: Visiting times are adhered to (Patients response)

CLEAN EQUIPMENT IS USED

The importance of hygiene at a public health facility is vital towards the well-being of the patients and the prevention of an outbreak of any deadly disease that could inadvertently place staff members as well as other patients at risk of being infected. Figure 29 represents 60% of patients who observed clean equipment was used to treat them, however the disconcerting data here lies with the fact that 5.88% of patients strongly disagreed that clean equipment was used to treat them. This is cause for concern as the public health facility ought to have a zero percentage response. It takes just one piece of unsterile equipment to infect hundreds if not thousands of people.

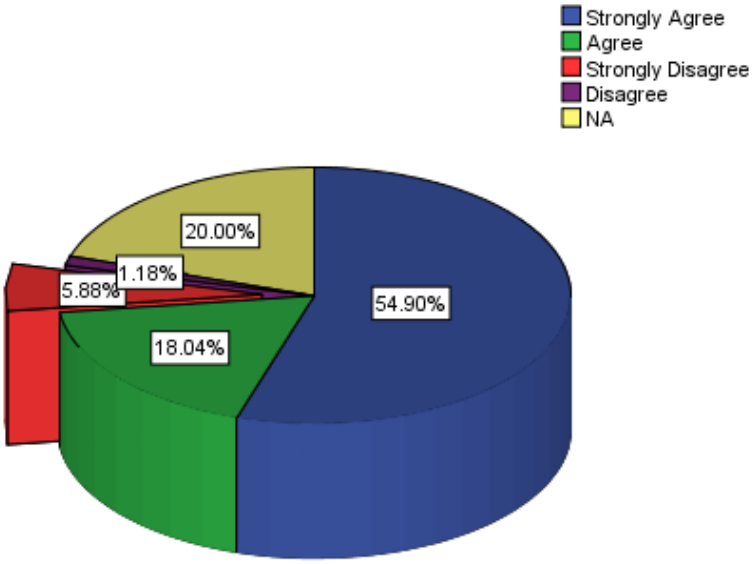


FIGURE 29: Clean equipment is used (Patients' response)

Figure 30 represents the staff members' response to the same statement posed to the patients. According to their responses, 10.87% confirmed that clean equipment is not used to treat patients whilst 17.39% of the respondents cited 'sometimes' as their option to this statement.

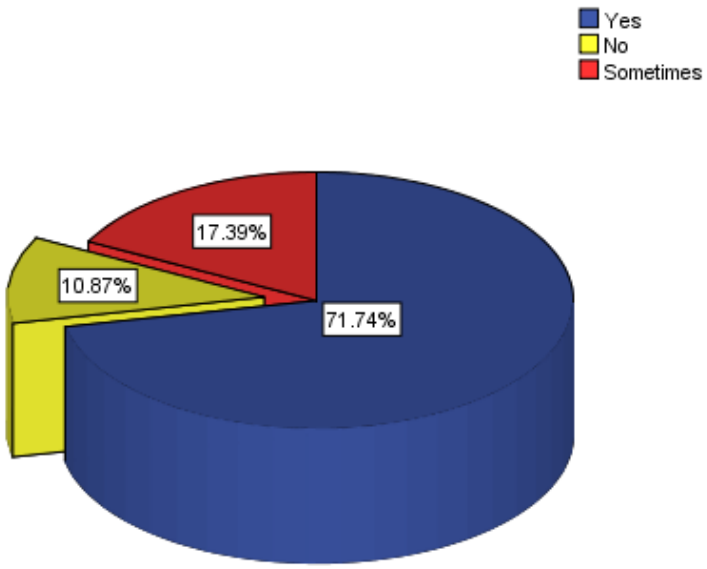


FIGURE 30: Clean equipment is used (Staff members' response)

BED LINEN IS CHANGED REGULARLY

Part of maintaining a high and also healthy service standard of a public health facility is to ensure the regular changing of bed linen, as these are easily soiled.

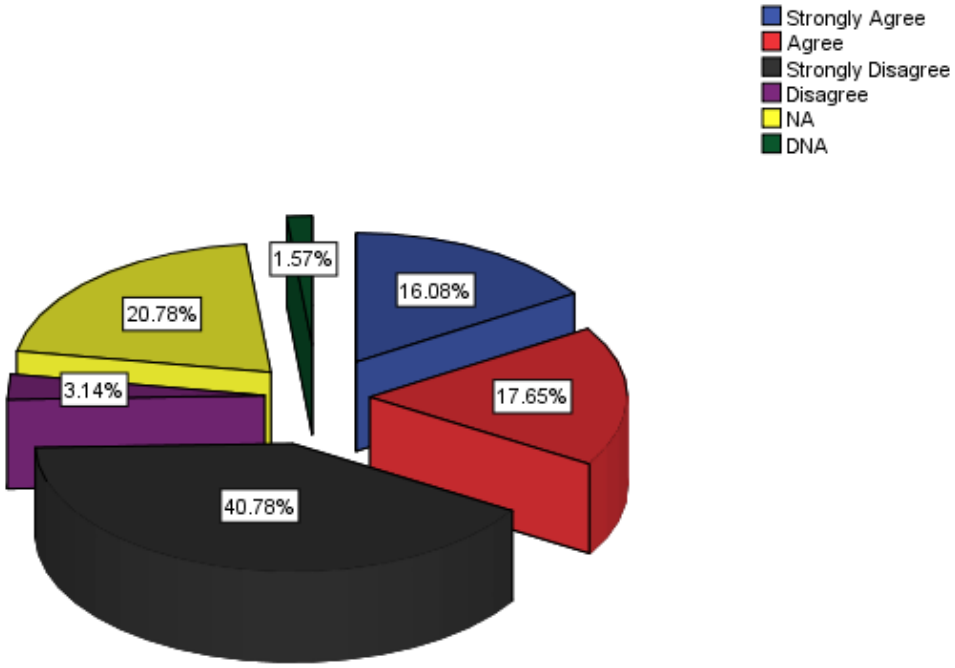


FIGURE 31: Bed linen is changed regularly (Patients response)

Figure 32 is a graphical representation of the responses generated from the staff members of the public health facilities. The respondents who chose the affirmative could not even compare with the affirmative response generated in figure 31. This disparity shows a problem within the health care system. During the course of this study, Addington Hospital (one of the hospitals in this multi case study) was featured in the media with claims of a serious shortage of linen whereby doctors threatened not to perform operations on patients until this matter was resolved. The reflection that more than 65% of bed linen is changed regularly can only mean that during the rotation of staff members during their shift assume the previous nurses on duty changed the linen.

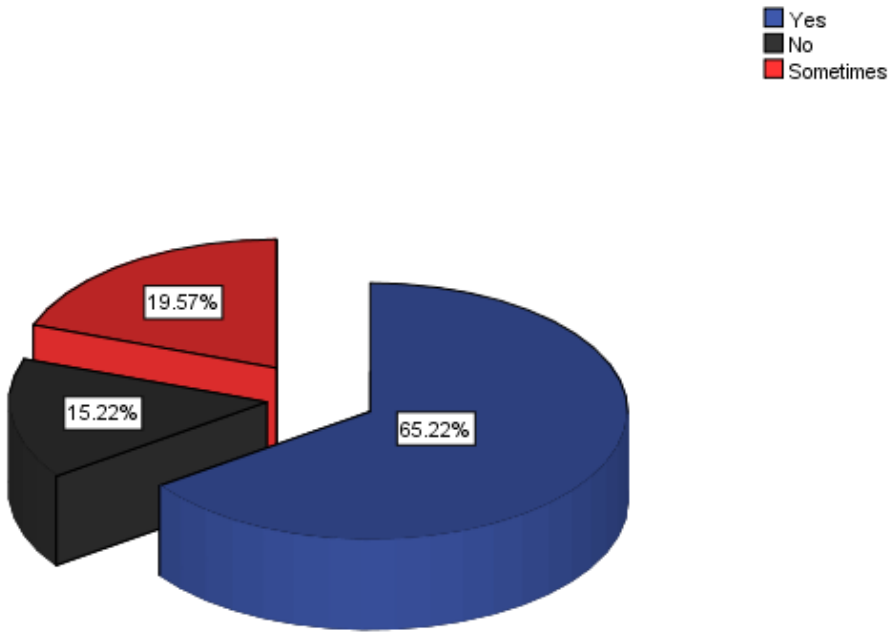


FIGURE 32: Bed linen changed regularly (Staff members' response)

Redress

The Batho Pele Principle of redress requires that if the promised standard of service is not delivered, citizens should be offered an apology, a full explanation and a speedy and effective remedy, when complaints are lodged.

DID YOU HAVE THE OPPORTUNITY TO APOLOGISE OR UNDERTAKE CORRECTIVE ACTION TO A PATIENT AT THE HOSPITAL

Table 35 shows that 63 % of the respondents answered in the affirmative which augurs well for the Batho Pele Principle of redress. This means that the staff members' are taking responsibility for their actions and it also shows a level of commitment toward the improvement of service delivery within the public health sector.

	Frequency	Percent
Yes	58	63.0
No	33	35.9
Did not answer	1	1.1
Total	92	100.0

Table 35: Staff members' response to redress

The summaries provided in Table 36 shows that 71.7% of the respondents confirmed that they had provided feedback to a patient with regards to a problem that might have occurred. This is evidence of staff members' cognisance of the patients need for information especially in the light of a problem that would have taken place. Once again, the staff members have taken responsibility in their capacity as health professionals to keep the patients abreast and updated with whatever situation that might have happened.

	Frequency	Percent
Yes	66	71.7
No	25	27.2
Did not answer	1	1.1
Total	92	100.0

Table 36: Staff members' response to providing feedback to patients

HAVE YOU EXPERIENCED PROBLEMS WITH THE SERVICES OR PRODUCTS FROM THIS HOSPITAL?

Figure 33 shows the responses from patients who were addressed on the principle of redress. 85.88% of the respondents did not experience problems with the services or products from the public health facility whilst 12.55% of respondents confirmed they had experienced problems with the public health facility. This implies that patients are either too tired of complaining or have become totally complacent to lodge a complaint.

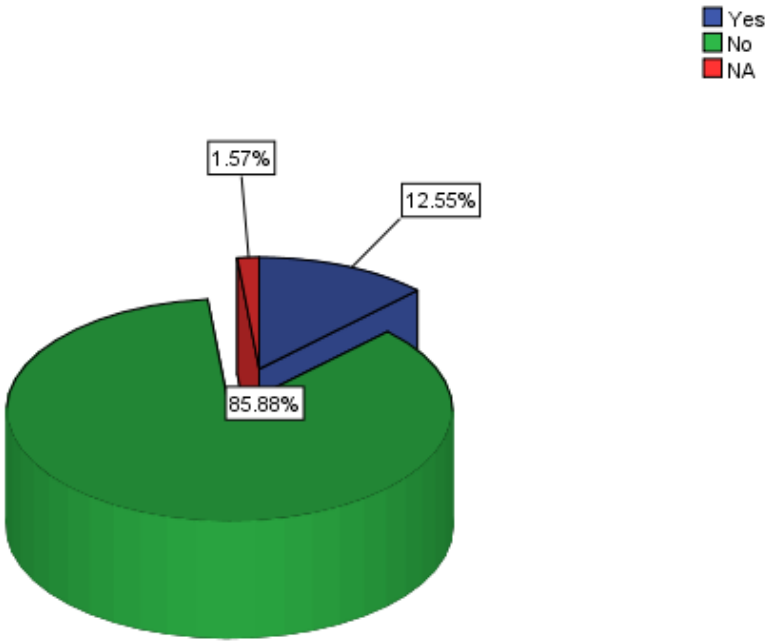


FIGURE 33: Patients response to redress

The tabled information shows that nearly all of the patients, who experienced a problem with the public health facility, suffered the same problem again. Table 37 shows 11.8 % of the respondents who answered in the affirmative to this question whilst Figure 33 shows 12.55% of patients who had experienced a problem of some nature at the public health facility.

	Frequency	Percent
Yes	30	11.8
No	177	69.4
NA	48	18.8
Total	255	100.0

Table 37: Patients response to having experienced the same problem before.

HAVE YOU EVER LODGED A COMPLAINT FOR ANY INCONVENIENCE OR PROBLEM YOU ENCOUNTERED AT THE HOSPITAL?

Table 38 shows that 7.1% of the patients had lodged a complaint for either a problem or inconvenience they might have experienced at the public health facility. When one compares table 38 and figure 31, there is a discrepant percentage of around 5% of the respondents who had experienced problems with the public health facility but chose not to report it.

	Frequency	Percent
Yes	18	7.1
No	184	72.2
NA	52	20.4
DNA	1	.4
Total	255	100.0

Table 38: Patients response to lodging a complaint

Value for money

The Batho Pele Principle of value for money requires that public services should be provided economically and efficiently in order to give patients the best possible value for money.

THE SERVICES I RECEIVED FROM THIS HOSPITAL WERE EFFICIENT

Table 39 shows that 72.6 % of the respondents satisfied with the services received from the public health facility whilst more than 27.4% disagreed. This implies that patients hold valid reasons for the dissatisfaction of the services rendered at the hospital.

	Frequency	Percent
Strongly Agree	131	51.4
Agree	54	21.2
Strongly Disagree	24	9.4
Disagree	46	18.0
Total	255	100.0

Table 39: Patients responses to services received from the hospital

I AM SATISFIED WITH WHAT THESE SERVICES COST ME.

Table 40 shows that 88.6% of patients were happy or satisfied with the cost of the services whilst 10.9% of patients disagreed. With the rising cost of medical aid expenses more people utilise the public health services offered, as it is far cheaper.

	Frequency	Percent
Strongly Agree	165	64.7
Agree	61	23.9
Strongly Disagree	20	7.8
Disagree	8	3.1
NA	1	.4
Total	255	100.0

Table 40: Patients response to value for money

OBJECTIVE 3: TO DETERMINE THE EFFECTIVENESS OF THE COMMUNICATION STRATEGIES IMPLEMENTED IN THE ADOPTION AND APPLICATION OF BATHO PELE PRINCIPLES

Edwards and Sharkansky (1978:295) state that the first requirement for effective implementation is that those responsible for carrying out a decision must know what is required of them. The internal publics of the public health facilities are fully aware of the Batho Pele Principles which is aimed to offer a guide towards the improvement of service delivery.

The internal publics of the public health facilities had to utilise a number of different communication strategies in order to implement the Batho Pele Principles. These strategies were facilitated by the use of interpersonal and organisational communication. This objective evaluates responses gauged from the external publics as well as the internal publics to determine the effectiveness of the communication strategies implemented. Much of the application of the Batho Pele Principles is done via verbal communication.

Organisational communication

Organisational communication examines the efforts made by the organisation, in this case the public health facilities, to train and promote the Batho Pele Principles thereby adequately equipping staff members' accordingly.

INTERNAL PUBLICS' AWARENESS OF THE BATHO PELE PRINCIPLES

Figure 34 is a graphical representation of the internal public's awareness of the Batho Pele Principles. The pie chart shows 70.65% of the staff members that have been made aware of the Batho Pele Principles whilst 29.35% of the staff members who participated in this study confirmed they had not received training in the principles of Batho Pele. The implementation of the Batho Pele Principles at key government sectors with special emphasis on the public

health sector began in 1997 and at the time of this study, it had already been more than fifteen years in the operation. Government should be cognisant of the need to provide adequate training to staff members in order for proper implementation to occur.

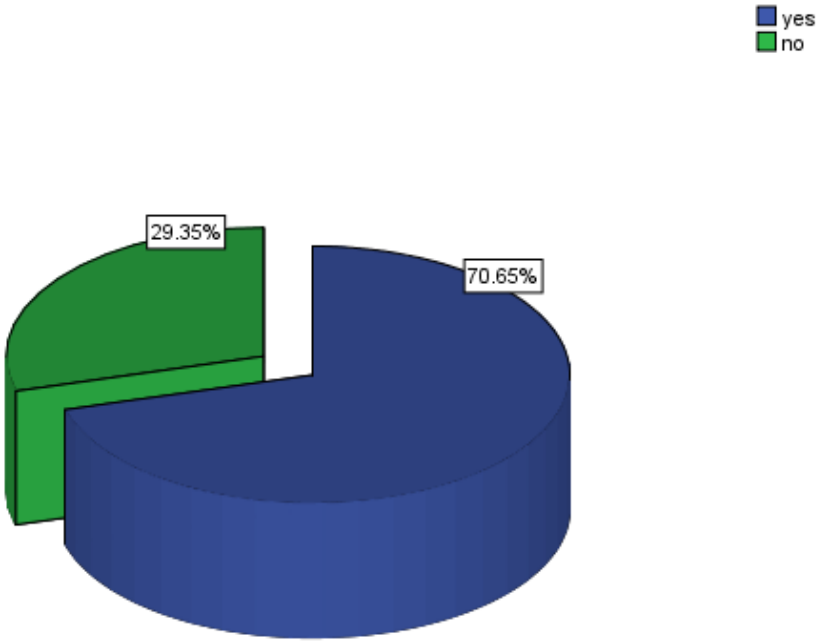


FIGURE 34: Staff members' response to training in Batho Pele Principles

Only once adequate training is received, staff members will be able to implement the Batho Pele Principles effectively in their quest to improve service delivery.

FREQUENCY OF TRAINING IN BATHO PELE

Public health facilities can enable their staff members to improve their performance through training and development workshops. This provides the platform for the effects of the challenges experienced by staff members to be addressed. Figure 35 depicts a varied response from staff members that are from two public health facilities. 23.91% of the staff members claimed their institution never held training and development workshops whilst 27.17% of the staff maintained that the workshops are held at least once a year; 17.39% of the staff members claimed that the workshops are held every six months whilst 23.91% of the staff members indicated that the workshops are held on a monthly basis.

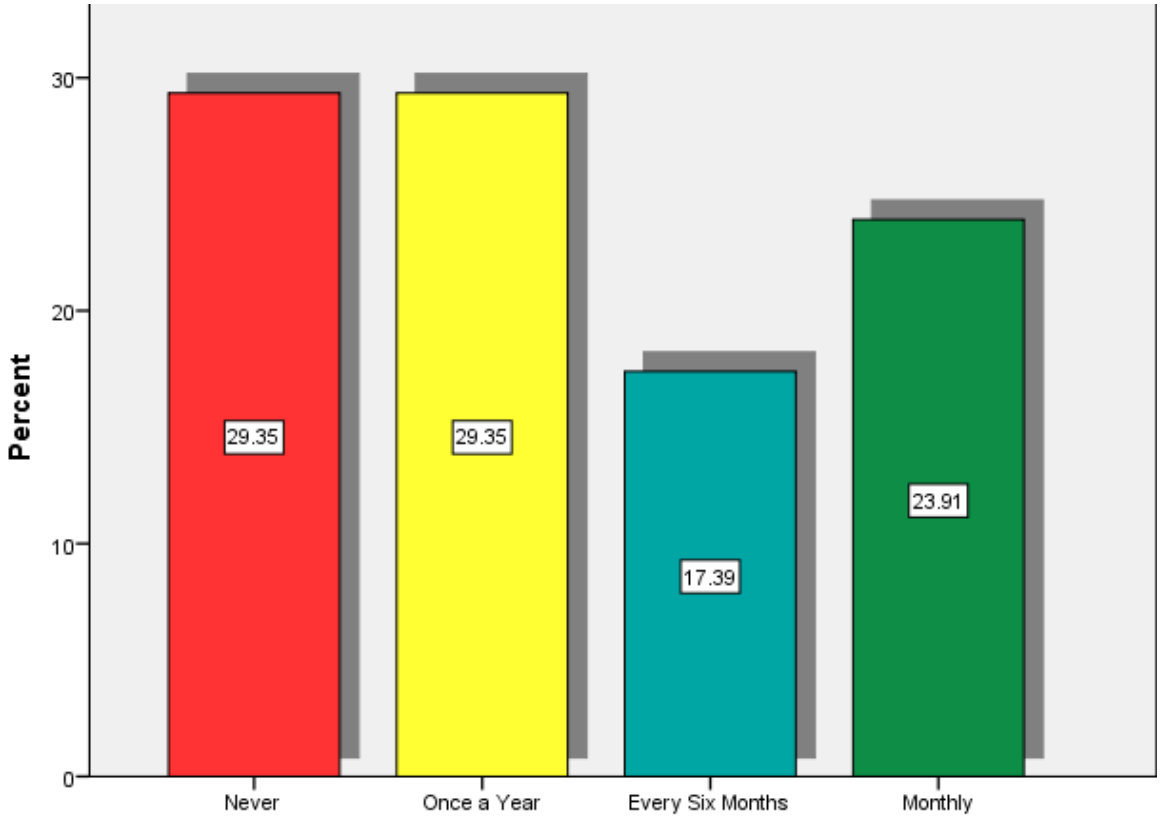


FIGURE 35: Staff members' response to the frequency of training and development

The public health facilities responsibility towards the various publics it engages with is to ensure that information is communicated effectively.

Interpersonal Communication techniques

The communication strategy used in the application of the Batho Pele Principles in public health facilities was primarily through efficient and effective communication. The process of a patient being attended to upon admission or consultation entailed verbal communication which meant that staff members had to exercise patience with the patients. This entails a certain level of tolerance and assistance from the nursing staff.

The knowledge and competence of staff members is transmitted during a communication encounter with the patient. Many patients are already aware of the nature of their illnesses but there is still a need to communicate that information to the staff members and for the staff members to reciprocate the understanding back to the patients.

Doctors are impatient with me

Table 41 shows that 80.7% of the respondents disagreed that the doctors were impatient with them. This study reveals a drastic shortage of skilled workers at public health facilities more especially doctors who usually have to work a double shift to deal with the backlogs in the hospitals. Despite their working conditions they are still able to maintain their composure and function in their capacity. The interpersonal skills of doctors are important as it is through this that the service standards of a hospital are evaluated.

	Frequency	Percent	Valid Percent	Cumulative Percent
Strongly Agree	35	13.7	13.7	13.7
Agree	14	5.5	5.5	19.2
Strongly Disagree	173	67.8	67.8	87.1
Disagree	33	12.9	12.9	100.0
Total	255	100.0	100.0	

Table 41: Interpersonal skills of Doctors

Nurses are impatient with me

The interpersonal skills of nurses are important towards the effective transmission of information to patients. Table 42 represents a response from patients which shows that 31% of respondents agreed that nurses are impatient with them. This is an alarmingly high percentage of patients who did not appreciate the nurses' attitudes towards them. Upon observation at the public health facilities it was noted that many of the younger nurses are impatient with patients. A number of patients also asserted that the non-verbal communication skills of the staff members were very poor. A patient complained about the way in which a nurse looked at him when he asked her to repeat what she was saying. He became very afraid thereafter to ask her about anything else. The findings in Table 22 support this, where 7.6% of the nurses responded in the affirmative when asked to validate this statement: *It is difficult to be courteous due to the nature of my job.*

	Frequency	Percent
Strongly Agree	42	16.5
Agree	37	14.5
Strongly Disagree	148	58.0
Disagree	28	11.0
Total	255	100.0

Table 42: Interpersonal skills of Nurses

THE STAFF ANSWERS IN A POLITE MANNER

Table 43 is an indication of how effective interpersonal communication strategies are at the public health facilities. The study reveals that 70.2% of the patients agreed that the staff members answer their concerns in a polite manner. This is evident of effective communication skills practiced by the staff members. The tabled information also depicts 21.2% of patients who disagreed with this statement which means that there is a need for on-going interventions at public health facilities to improve on the interpersonal communication skills of staff members.

	Frequency	Percent
Agree	179	70.2
Disagree	54	21.2
Not Sure	21	8.2
Not Applicable	1	.4
Total	255	100.0

Table 43: Staff answers questions in a polite manner

Communication of Batho Pele Principles at public health facilities through the use of posters.

It was observed at both of the public health facilities that each ward had posters depicting the Batho Pele Principles in the hallways. These were available in English and in isiZulu. This in essence meant that patients had to be mobile in order to read these posters which were not an effective means of communicating with patients who were seriously unwell and were not mobile. Most of the patients claimed they were asleep, unconscious or too unwell to read the hallways of the wards as they were being wheeled in. The only effective means of

communicating Batho Pele Principles to the patients were through verbal communication with patients.

Objective 4: To ascertain the effectiveness of the practice of Batho Pele Principles in key government sectors.

The final objective of this study was to gauge the effectiveness of the practice of Batho Pele Principles within the public health sector. The contributions made by the internal and external publics of the public health facilities enabled a comprehensive evaluation of how effective the Batho Pele Principles are within the public health facilities. Ultimately what will be determined will be the impact the Batho Pele Principles has had towards the improvement of service delivery.

Practice of Batho Pele Principles by internal publics

An assessment of the implementation of the Batho Pele Principles by staff members will be done to determine the effectiveness of the practice of these principles towards the improvement of service delivery.

The Batho Pele Principles has made staff members more sensitive to patients' needs

Table 44 leads the analysis of the efficacy of the Batho Pele Principles. The table shows over 92.4% of the respondents who agreed that as a result of the implementation of Batho Pele, they have become more sensitive to patient's needs. Only 5% disagreed with this statement. Based on this intervention, the practice of Batho Pele Principles has indeed had a positive impact on staff members as this will spiral into more commitment by staff workers and a heightened degree of sensitivity towards patients.

	Frequency	Percent
Strongly Agree	29	31.5
Agree	56	60.9
Strongly Disagree	1	1.1
Disagree	4	4.3
NA	2	2.2
Total	92	100.0

Table 44: Batho Pele Principles has made staff members more sensitive to patients' needs

The Batho Pele Principles has made staff members jobs more complex

Table 45 shares a mixed reaction from the staff members. The table shows that 54.3% agreed that their job became more complex as a result of the practice of Batho Pele Principles whilst 42.4% of staff members disagreed. This implies that some staff members have been able to adapt more easier than others to the policy of Batho Pele; also previously staff members were devoid of patients' needs and treated them as objects but as a result of this policy, they had to change their perception of their jobs.

	Frequency	Percent
Strongly Agree	11	12.0
Agree	39	42.4
Strongly Disagree	15	16.3
Disagree	24	26.1
NA	3	3.3
Total	92	100.0

Table 45 Batho Pele Principles has made the staff members' job more complex

The Batho Pele Principles has created more problems between staff and patients

Table 46 provides a summary of the above mentioned statement. The analysis reveals that 65.2% of staff members disagreed with this which is a promising response as this contributes towards an improved service delivery. Further, 31.5% of respondents agreed that the Batho Pele Principles had in fact created more problems between staff and patients. This analysis is evident that more and more people are learning what their rights are as patients and are not afraid to voice their concerns or conflicts with staff members.

	Frequency	Percent
Strongly Agree	4	4.3
Agree	25	27.2
Strongly Disagree	21	22.8
Disagree	39	42.4
NA	3	3.3
Total	92	100.0

Table 46: Batho Pele has created more problems between staff and patients

The Batho Pele Principles has not helped to improve service delivery in the public health sector

Table 47 depicts responses that show an overwhelming majority of staff members who disagree with the above mentioned statement. The table shows that 69.6% of the respondents disagreed whilst 27.2% agreed. When one examines the challenges faced by the public health sector, it is easy to understand why there will be some staff members who will feel that the implementation of the Batho Pele Principles did not improve service delivery in the public health sector. These challenges are discussed earlier in this chapter.

	Frequency	Percent
Strongly Agree	2	2.2
Agree	23	25.0
Strongly Disagree	24	26.1
Disagree	40	43.5
NA	3	3.3
Total	92	100.0

Table 47: Batho Pele has not helped to improve service delivery in the public health sector

I do not implement the Batho Pele Principles as I do not believe in them.

The tabled information reveals an interesting find as 75% of the staff members disagreed with this statement which goes to show that the Batho Pele Principles have been embraced and adopted by many staff members. Further, 21.8% of staff members agreed which can answer for unchanged attitudes of certain staff members.

	Frequency	Percent
Strongly Agree	3	3.3
Agree	17	18.5
Strongly Disagree	34	37.0
Disagree	35	38.0
NA	3	3.3
Total	92	100.0

Table 48: I do not implement the Batho Pele Principles as I do not have the time to do so

The practice of Batho Pele Principles – the impressions of the external publics

Ultimately it is the external publics or citizens who experience the improvement in service delivery. The analysis of the external public's response is important as it will provide this study with concrete evidence to support the implementation of Batho Pele Principles at key government sectors. The analyses will be done according to each of the Batho Pele Principle.

Access

Objective two has already addressed the issue of the public health facility been made available to all patrons. An analysis of this was provided in Table 19 which showed a majority of patrons (n=222) who found the public health facility easily accessible whilst just 8.6% disagreed that the facility was accessible. Since the implementation of the Batho Pele Principles more focus has been given to ensuring that all citizens are provided with access to adequate health care.

Courtesy

The principle of courtesy was evaluated against a number of statements which the external publics had to justify with: strongly agree, agree, strongly disagree and disagree, true and false. Many of the statements were already analysed in objective two, however the remaining statements that can be used to ascertain the effectiveness of the practice of the principle of courtesy follows.

Figure 36 represents an analysis of patient's response to the statement "Doctors are intolerant of me". It shows that 67.45% strongly disagreed with this statement whilst 18.83% agreed with this statement.

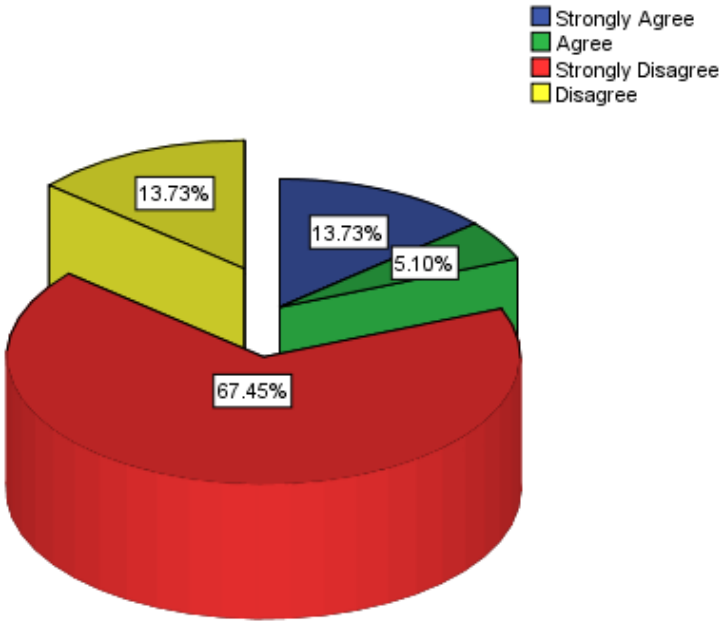


FIGURE 36: Doctors are intolerant of me

Figure 37 shows 57.25% of the respondents strongly disagreed with the statement that nurses are intolerant of them. However, 32.16% of the respondents agreed with this statement. This is evident that the principle of courtesy is interdependent with other factors at the public health facilities. The challenges of overcrowding and staff shortages create enormous pressure on the already burdened staff members.

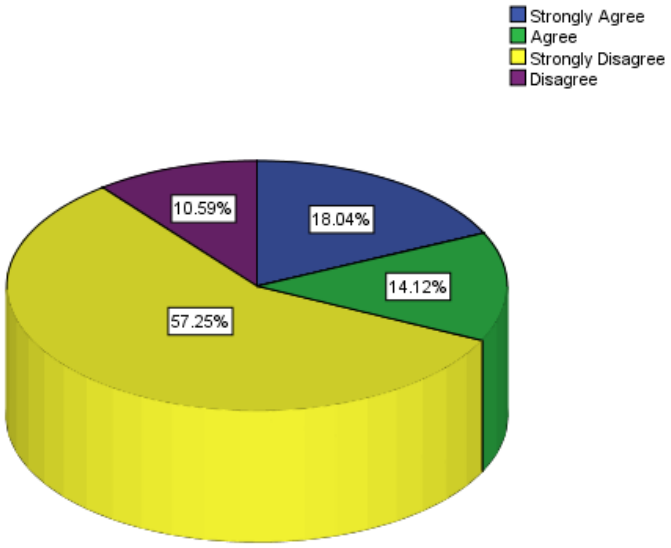


FIGURE 37: Nurses are intolerant of me

The impression given in Figure 38 shows that 67.84% of respondents strongly disagreed with the statement , *'Doctors are unhelpful towards me'*. This is evident that the doctors' effort in treating patients especially within public health sector is highly recognised by patients themselves. Further, 19.22% of the patients found doctors to be unhelpful. One of the reasons that could contribute towards this negative response is the dire shortage of equipment needed to treat patients.

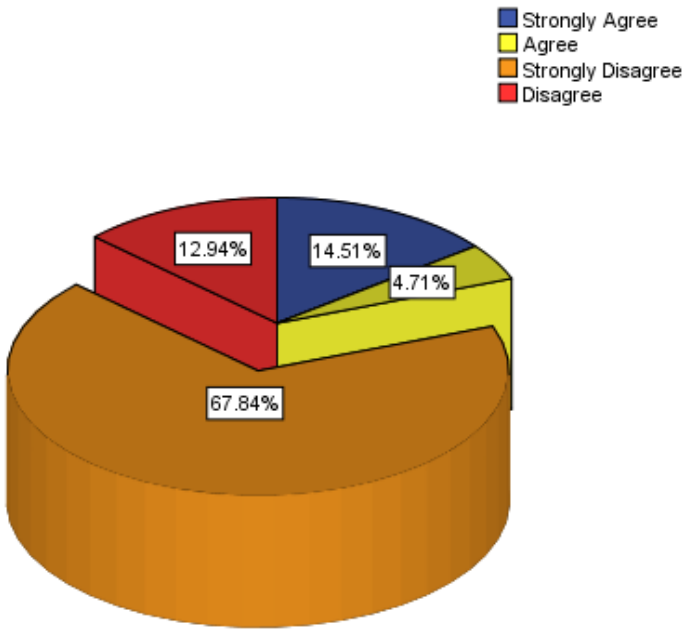


FIGURE 38: Doctors are unhelpful towards me

The awareness of the Batho Pele Principle of courtesy has made a difference to how patients are treated at public health facilities, thereby improving service delivery in this sector.

INFORMATION

The Batho Pele Principle of information is very relevant towards the improvement of service delivery within the public health sector. The presence of a manned information desk, the analysis of which is shown in Table 27, creates confidence in patients who are unsure about where certain departments are. More than 199 respondents rated this as very good which means the principle of providing information to the relevant publics contributes significantly towards the improvement of service delivery within the public health sector. However the concern of informing patients of their rights to health care exists which needs to be addressed. Table 22 shows that over 32% of respondents disagreed that they are advised of their rights upon admission.

Timeliness

One of the major problems encountered by patients upon observation at both public health facilities were the long queues and subsequently long waits. However Table 31 reveals that more than 56.5% of the respondents confirmed that the nurses are quick. The main reasons for the long queues and long waits can be attributed to various other problems within the hospital.

Consultation

The evaluation of the principle of consultation in Table 31 showed that more than 40% of the respondents strongly disagreed that they were advised of other options available for their condition. This means that public servants ought to give this principle more consideration in their quest towards improving service delivery.

Service Standards

The Batho Pele Principle of service standards as well as courtesy are the two major contributors towards the improvement of service delivery. This study shows that the principle of service standard is something that will continually evolve and change according to the challenges the public health sector faces. More often, it is through the service standards of any organisation that the level of service delivery can be measured and it is for this reason that managers or key role players will have to pay careful attention to factors that inhibit improved service standards. The effectiveness of the practice of the Principles of Batho Pele is that it can point out very well a lack or a shortfall within the public service system.

The service standard principle was evaluated against a string of statements which staff members and patients had to justify. One of the most concerning analysis was that of figure 29 which showed more than 40% of patients strongly disagreed that their bed linen was changed regularly. This variable alone automatically discredits the level of service standard at the public health facilities and immediately places a strong doubt over whether the practice of Batho Pele Principles has aided the public health sector or not.

Research Findings

The findings of this research are outlined according to the objectives discussed in this chapter.

Objective 1: To analyse the application and adoption of the Batho Pele Principles towards the improvement of service delivery in key government sectors.

The analysis of data that contributed towards the findings of this objective included responses from staff members as well as patients at both public health facilities. The

government's efforts at creating a policy for the improvement of service delivery at key sectors of the government cannot be ignored, however it can be scrutinised to determine its shortfalls. The findings of the analysis of the application and adoption of Batho Pele Principles follow:

Access: The government's aims at providing access to the public health facilities were very successful as 87% (Table 19) of the patients agreed that the facilities were easily accessible. In terms of making the facility accessible to the disabled and the elderly, more than 66% (n=170) of the patients agreed whilst 23% (n=59) disagreed with this. Many of those who disagreed cited the need for more porters to assist them at the hospital during their consultation.

Courtesy: This principle along with the principle of service standards alone could provide valuable feedback from patients and staff members to evaluate the level of service delivery at key government sectors. Courtesy is expected to be extended at various levels of treatment to the patients. This study evaluated each of these levels and found that against being polite to patients, more than 76% (Figure 22) patients agreed that staff members were polite whilst 91% (Figure 23) of the staff members confirmed that they greet and welcome patients. Against the variable *I am too tired to be nice* more than 90% (Figure 24) disagreed with this statement. This is proof that staff members do take extra initiative to promote courtesy at the public health facility. Against the variable *it is difficult to be courteous*, more than 81% of the staff members disagreed with this statement, however at least 7% of staff members agreed. This is primarily due to the extreme work pressures and challenges they have to contend with daily. The patient's response towards the application of the Batho Pele shows a more fractured analysis. Against the variable *Doctors are rude to me*, 67.5% (Table 23) strongly disagreed whilst 19.10% (n=51) agreed to this statement. This was little compared to the response of the variable *Nurses are rude to me* where more than 28% (table 25) agreed to this statement. The effects that the challenges faced by the staff members will inadvertently rear its ugly head one way or another. There will be some patients who will not be treated as fairly as the others due to the working conditions that nurses and doctors find themselves in.

Information: The visibility of signage to various clinics and departments were clear to patients as only 10% (Figure 26) found the signage poor. At least 78% (199) in table 27 agreed over the presence of an information desk. However when it came to informing patients about their rights with regards to health care, more than 59% (Table 27) of staff

members rated themselves as either good or excellent whereas 32.5% of the patients rated this as never whilst at least 18%(n=46) rated this as sometimes. Health workers must at all times inform patients of their right to absolve them from further problems that may occur.

Timeliness: Staff members were required to rate themselves when it came to the adoption of the principle of timeliness. The variable, *Services at the hospital are performed within reasonable time*, received fragmented response from the staff members. At least 17.4% (n=16) rated themselves as poor; 26.1% (n=24) rated themselves as satisfactory; 44.6% (n=41) rated themselves as good and 12% (n=11) rated themselves as excellent. This analysis shows that staff members are aware of the delays patients face but due to circumstances beyond their control, they are unable to assist further. The patients were required to rate the nurses and doctors when it came to the application of the principle of timeliness. The variable, *Nurses are quick* was surprisingly favoured by at least 144 patients who strongly agreed to this statement, whilst 32 patients agreed; at least 18.8% (n=48) strongly disagreed and a total of 31 patients disagreed. Many patients experience varying levels of contact with the nursing staff at the hospital as they are sent from one department to the next therefore the result revealed here are an overall impression of the staff members.

Consultation: Patients were asked if they were advised on other options that were available to them for their condition to which more than 47% of the patients disagreed. This is in stark contrast to the response generated from the staff members which at least 52.2% (Table 32) rated themselves as good when it came to their ability to provide patients with suitable options for treatment. At least 28% of the staff members rated themselves as satisfactory whilst 3.3% rated themselves as poor in this regard.

Service Standards: The service standard of the public health facility was evaluated against a number of variables. Of the 152 in patients interviewed for this study, 81 strongly agreed and 50 agreed that nurses respond when they require assistance. Of the 103 out patients interviewed, 51 respondents did not have the need for the nurse's assistance, whilst 37 strongly agreed and 6 agreed that nurses do respond. At least 16 in patients strongly disagreed with this statement. It takes the negligence over just one patient for the public health facility to face the wrath of a nation via the news media that will immediately question the level of service delivery at that facility. Against the variable, *clean equipment is used*, at least 60% of the patients agreed to this statement. However Figure 29 shows a little over 5.88% of patients strongly disagreed that clean equipment was used to treat them. The response from the staff members showed that more than 10% confirmed that clean

equipment was not used to treat patients whilst 17.39% of the staff members selected the option *sometimes*. The response from patients to the variable, *Bed linen is changed regularly* showed more than 43% of the patients strongly disagreed to this statement. The response from the staff members generated 65% who agreed that bed linen is changed regularly clearly conflicted with the patient's response.

Redress: The principle of redress requires that staff member take responsibility for their actions or to take corrective action. At least 63% of the staff members agreed which prompts the conclusion that staff members are becoming more and more responsible. More than 71% of staff members provided feedback to a patient with regard to a problem that they might have experienced. More than 85% of patients did not experience any problems with the products or services from the hospital however 12.55% of patients experienced a problem of which 11.8% had experienced the same problem previously.

Value for money: At least 185 patients felt the services they received from the hospital were efficient and more than 87% agreed that they were satisfied with what the services cost them.

The application and adoption of the Batho Pele Principles has led to a marginal improvement in service delivery. The responses from patients vary as patients are treated for different illnesses and varying degrees of it. The presence of the Batho Pele Principles has created a certain level of responsibility by staff members to throw caution to the wind when they encounter a patient. The improvement of service delivery does not lie entirely in the hands of nurses and doctors at the hospital as they are the operational staff members who inadvertently carry out instructions meted out by management.

Objective 2: To evaluate the effects of the communication challenges faced by key government sectors in the application and adoption of the Batho Pele Principles.

The analysis of the data for this objective showed the challenges that the public health sector experienced and the effects of these challenges faced by the public health sector in the application and adoption of Batho Pele Principles. The impact of the effects of these challenges has seriously compromised the government's attempt to improve service delivery at key sectors of the government.

The working conditions that were rated as poor by over 42% of the staff members is core to this study as it became the focal point of concern. The variable of working conditions is that it

is seen as a challenge as well as an effect of the challenges faced by the public health sector. When seen as a challenge the working conditions in the public health sector is one of the reasons why it is very difficult to secure adequately trained staff members.

Poor working conditions can be seen as an effect of the challenge that the public health facilities face when:

- There is a shortage of basic supplies and a lack of equipment to treat patients: More than 68% of the staff members cited serious shortages in basic supplies that seriously compromised health care at the hospitals. Without proper supplies, it is impossible for staff members to treat patients effectively without jeopardising the patients' health. The shortage of linen experienced at the public health facilities cannot be ignored due to the high rate of infection poor hygiene carries. Over 100 respondents complained of bed linen not being changed regularly. This place the public health facilities staff at serious risk of infection should one break out as a result of the linen shortage. The lack of equipment places pressure on staff members who will either have to lie or make excuses for the unavailability of equipment needed to treat patients. More than 62% of the staff members that participated in this study agreed that the lack of equipment has had a negative impact on how they perform their duties.
- There are inadequate facilities: As a result of overcrowding the public health facilities was forced to turn patients away once they were stabilised. The lack of wards, operating theatres and other important facilities needed to treat patients has placed enormous pressure on doctors and nurses at the hospital. More than 79% of the staff members said that the inadequacies at the hospital have negatively impacted on how they perform their duties.
- Inadequate support system: Staff members are demoralised when there is no one prepared to listen and take appropriate action to remedy a situation. More than 44% of the staff members who participated in this study agreed that there is an inadequate support system in place to deal with internal issues.
- Shortage of skilled staff: More than 70% of staff members agreed there was a serious shortage of skilled staff at the public health facilities. The staff shortages mean that there are patients who will not receive the desired care and support they need from the public health facility. It also means that existing staff members have to make up for the shortage of other staff.

The findings of the effects of the challenges faced by key government sectors in the application and adoption of Batho Pele Principles suggest that the level of service delivery has improved marginally. Batho Pele Principles were implemented in 1997; fifteen years later and there are still major challenges that plague the public sector. Evaluation of the Batho Pele Principles is only effective when corrective action is implemented.

Objective 3: To determine the effectiveness of the communication strategies implemented in the adoption and application of Batho Pele Principles.

The third objective of this study examined the effectiveness of communication strategies used in the adoption and application of Batho Pele Principles. The data used for this analysis originated from the responses received from the staff members as well as the patients. An important variable that contributed towards the staff member's knowledge of Batho Pele Principles (the adoption of Batho Pele Principles) in order for them to practice it was the provision of training in the principles of Batho Pele. More than 70% of the staff members agreed that they had received training which equipped them to apply the principles in practice; however a shocking discovery was that more than 29% of the staff members did not receive training in Batho Pele. This is an alarmingly high percentage considering Batho Pele has been implemented since 1997. If the staff are not adequately trained then there will be no cognisance of the principles when treating or consulting with patients.

The organisational communication strategy used to implement the Batho Pele Principles were not effective because when staff were asked to rate the training they received, a little more than 57% of the staff members rated the training as either very good or adequate. The interpersonal communication strategies were evaluated against the patients response to variables that could gauge the effectiveness of the communication strategies used to implement the Batho Pele Principles. The variable that tested the interpersonal skills of a doctor was a statement which required the rating of the patient. *Doctors are impatient with me*, was the variable which captured the essence of the verbal communication strategies used. More than 79% of patients disagreed with this statement whilst 18% of patients agreed. A similar variable was applied in respect of the nurses that communicate with patients. *Nurses are impatient with me,* generated a response from 30% of patients who agreed that nurses were impatient with them.

Further, the use of posters of the Batho Pele Principles in the hallway of the wards was ineffective as patients were not mobile to read them. Many of them were blissfully unaware of

their rights which were not effectively communicated to them through the staff members at the hospital.

This means that the communication strategies implemented by the nurses needs to be revisited in terms of their interpersonal communication skills and their use of verbal and non-verbal communication techniques.

Objective 4: To ascertain the effectiveness of the practice of Batho Pele Principles in key government sectors.

To ascertain the effectiveness of the practice of Batho Pele, an assessment of the staff members attitude towards the Batho Pele Principles had to be analysed. The variable, *Batho Pele Principles have made staff members more sensitive to patients' needs* revealed an overwhelming 90% of staff members who agreed that Batho Pele has created an awareness of patients' needs. Against the variable, *Batho Pele Principles have made staff members jobs more complex*, a fragmented response was received whereby 42% of the staff disagreed whereas more than 50% of the staff members agreed. The complexity that staff members have to deal with is the awareness that they need to perform their duties according to the Batho Pele Principles. Further, the variable, *Batho Pele Principles has created more problems between staff and patients* received a rather mixed response where 27% agreed, 22% disagreed and 39% strongly disagreed.

Most patients no longer remain quiet about the shoddy service they receive. More and more people are becoming aware of their rights as a citizen as well as their rights to health care. The staff members attitudes previously contributed towards the poor service delivery that was experienced at different sectors in the public service, however since the implementation of Batho Pele, it means staff have to exercise caution knowing that they could be brought to book for their irresponsible actions. The White Paper on Transformation of Public Services was aimed at improving and thereby transforming the state of service delivery within South Africa. This meant that this new approach or ideology which public servants had to subscribe to placed enormous pressures on systems, behaviours and attitudes.

The variable that tested the staff member's belief in the Batho Pele principles received a resounding majority who disagreed (75%) with the statement *I do not implement the Batho Pele Principles as I do not believe in them.* This is evident of the majority of staff members who actually believe that Batho Pele is embraced and practiced by majority of the respondents. Just over 21% of staff members felt otherwise which means that their attitudes will remain unchanged

and this could seriously impede the level of service delivery within the departments these staff members are employed in.

The impressions of the external publics towards the practice of Batho Pele Principles have been promising to an extent. This study revealed many shortcomings which patients were able to voice. The two principles of Batho Pele that stand out are courtesy and service standards. Here the researcher was able to gauge the extent to which the implementation of Batho Pele was successful. The variable, *Nurses are intolerant of me* tested the patients impression of how the nurses treated them. More than 32% of the respondent agreed with this statement. This is representative of over one third of all the patients who participated in this survey. There are many reasons that can be attributed for the nurses' intolerance of patients, one of which can be the overcrowding that occurs at the public health facilities that places enormous pressures on the existing staff members as well as the shortage of staff in certain departments within the public health facilities.

The variable, *Doctors are unhelpful towards me*, attracted at least 18% of patients who agreed with this statement. This is one of the effects of the challenges faced by the public health facilities where as a result of a dire shortage of skilled staff, existing staff members have to bear the burden and fill the gaps of others. As long as the problems are left unattended, the effects will continually be felt and experienced by the general public.

The Batho Pele of information revealed a drastic negligence by the staff members in advising the patients of their rights with regards to health care. More than 32% of the patients said that they were never advised of their rights as a patient with regards to health care. It is imperative that patients are advised of their rights so they understand what level of care they can expect. Timeliness is a principle that will always be debateable as long as there is a shortage of staff as well as a shortage of health facilities. This study reveals that just more than half (56%) of the patients that participated in this research said the nurses were quick, meaning they were not unnecessarily delayed by the nurses.

On the principle of consultation it was found that 37.6% strongly agreed they were advised of other options available for their condition, however more than 40% were not advised of other options available for their condition. This finding strongly suggest that staff members are very negligent as a result of challenges such as overcrowding and shortage of staff or that patients were far too ill to remember they were in fact advised of other options. The principle of value for money was greeted with a majority of 70% of patients who felt the services they received

from the hospital were in fact efficient considering what it cost them. Whilst more than 87% of the respondents were satisfied with what the services cost them.

The findings in this study suggest the challenges faced by key government sectors in the application and adoption of Batho Pele Principles will elicit divided impressions of the level of service delivery from the external publics as long as they go unattended. The challenges of shortage of basic supplies and equipment and overcrowding at the public health facilities will continue to haunt the efforts made to improve service delivery.

Conclusion

The process of analysing the data in this study was unpacked before the interpretation of the data was made. The researcher related the importance of the demographic information to this study and proceeded to interpret the data collected from the internal and external publics according to graphs, tables and charts. The data was interpreted according to the objectives of the study. Each objective was carefully analysed using the data that was collected to address the objective. The researcher then summarised the findings of this study by carefully unpacking the important results extracted in the process of data analysis according to each of the objectives of the study. In the next chapter the researcher makes recommendations on the challenges faced by key government sectors and conclusions are discussed.

CHAPTER NINE

RECOMMENDATIONS

INTRODUCTION

The main objective of this study was to identify what challenges are faced by key government sectors in the application and adoption of Batho Pele Principles. This was achieved by presenting extensive literature which was explored to gather more information about the level of service delivery within one of the government sectors which was the public health sector. The recommendations that follow in the final chapter of this research are as a result of the findings from the extensive research that was conducted using a multi case study approach which satisfied the objectives of this study.

RECOMMENDED WAY FORWARD

Further to the recommendations mentioned in the subsequent pages, the researcher provides an overhaul of the recommendations to each of challenges experienced. The following recommendations that have been constructed and adapted specifically to South Africa, are proposed to address the challenges currently being faced by the public health sectors in South Africa.

1. In order to address the challenge of management failures and lack of management within the public health sector, it is recommended that an evaluation of the structure and management of the public health facility be carried out to correctly assess inefficiencies.
2. To correctly evaluate the standard of services within the public health sector, Chawla and Govindaraj (1996) recommends an assessment of the performance of the hospital which will address key challenges experienced within the management structures and thereby expose inefficient management within key departments of the public health facility.
3. To address the challenge of a lack of equipment and lack of functional equipment that the public health sector experiences, Preker and Harding (2003) recommends a complete reformation of the technological capacity of the public health facility be done to ensure the enhancement of medical equipment and the maintenance of such.

4. In order to attract and retain suitably qualified staff members within the public health sector, Preker and Harding further recommends a payment reform that is designed to create financial incentives which will promote efficiency, quality and improved working conditions.
5. To overcome the lack of financial resources within the public health sector, Chawla and Govindaraj (1996) proposes estimates of the sum total of government resources each hospital consumes, both in absolute numbers as well as a percentage of total government expenditure in the health sector should be done.
6. To ensure proper monitoring of the level of service delivery within the public health sector, Chawla and Govindaraj further recommends a list of hospitals must be compiled that are performing poorly in terms of how they meet the criteria of efficiency, equity, accountability, quality of care, and revenue mobilization.
7. If there are many hospitals that are believed to be performing poorly, rate the hospitals according to criteria such as consumption of government funds so as to choose a manageable number of hospitals that can be targeted for reform.

Strategies to reduce the challenges faced by key government sectors in the application and adoption of Batho Pele Principles

The challenges faced by the public service departments will continue to progress until service delivery is at its worst in South Africa unless the challenges are addressed and dealt with effectively. The serious challenges encountered at the public health facilities in this research were as the findings suggested:

- Poor working conditions;
- Shortage of basic supplies;
- Shortage or lack of equipment;
- Inadequate facilities;
- Inadequate support system and
- Shortage of skilled staff

The researcher identified them as serious challenges as these strongly impacted on the level of service delivery at the public health facilities. Identifying the challenges does not necessarily solve the problem, it merely pin points key areas that have become visible that need to be acted on. The question arises: Who then is responsible to fix these problems? Fixing the blame does

not fix the problem; instead it merely identifies the parties responsible for the problem in the first place. To assist government in dealing with these challenges, the researcher devised a model which can be used to recognize the origin of the challenge. This table can also be used to attribute responsibility of the challenges faced to the relevant bodies. The table below presents the various challenges experienced by key government sectors that were compiled throughout this research.

Management Challenges	Operational-Staff Challenges
• Poor leadership • Acquisition of suitably qualified staff • Lack of accountability • Poor policy implementation • Lack of financial resources • Lack of communication • Lack of control • Lack of planning • Lack of organising • Poor decision making • Poor governance • Poor performance of workers	• Shortage of skilled staff • Poor working conditions • Lack of equipment • Lack of functional equipment • Inadequate facilities • Failure to uphold work ethic • Lack of basic supplies • Lack of communication • Theft within the organisation • Inadequate support system

Table 49: Service Delivery Challenges

The tabled information has categorised the various challenges that are frequently experienced within key government sectors. Management challenges refer to problems that are experienced by management that can lead to poor service delivery by public service departments. The operation staff challenges are those challenges that are experienced by staff members that have direct contact with the public whose action can lead to the impairment or improvement of service delivery.

Using this information, the researcher devised a model which is called the Service Delivery Challenge Model.

- A Proposed Service Delivery Challenge Model

The challenges faced by the sector in providing optimal services to its publics are on-going. No department within the sector is excluded from challenges that can affect the standard of its performance, thereby affecting the level of service delivery. This is due to the macro organisational factors which the organisation does not have control over.

The Service Delivery Challenge Model categorises these challenges in order to facilitate improved service delivery within the sector. The model categorises the challenges experienced within the organisation as Management Challenges and Operational-Staff Challenges. By applying the different challenges the sector may experience to the model, it can be clearly seen where the source of the problem lies thereby enabling appropriate action.

Management challenges refer to all those problems that the management of a sector experiences. The operational-staff challenges are those challenges that are experienced as a result of challenges that are not met with by management. This has a direct effect on the quality of service delivery being meted out by different sectors to its publics.

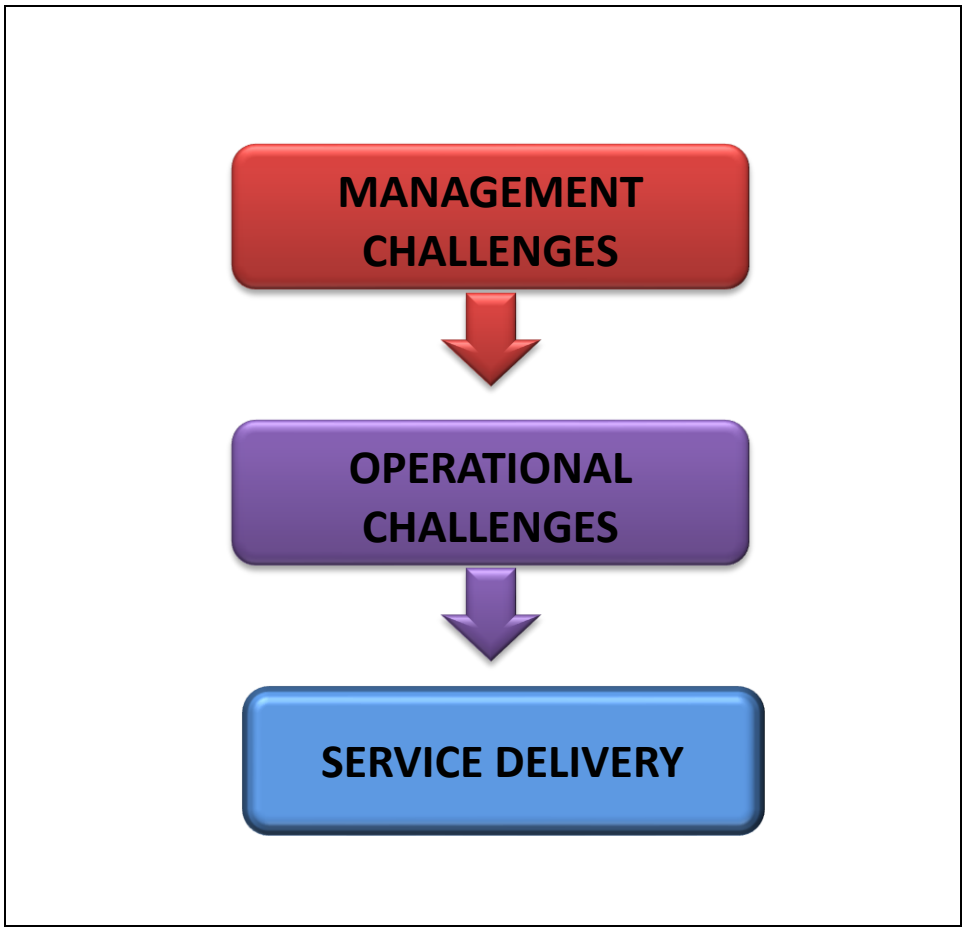


FIGURE: 39: Service Delivery Challenge Model

The model shows the impact of unmet challenges experienced by management on the operations of the organisation. Indirectly, the quality of service delivery is affected by unmet management challenges whilst the operational-staff challenges that are unmet has a direct effect on the quality of service delivery within the sector. Once management deals with each challenge effectively, then the operational challenges are minimised thereby allowing for a smooth if not problem free environment within which the organisation or sector can flourish and provide service delivery of an acceptable standard.

According to the model, for every management challenge, an operational staff challenge becomes evident which inhibits the quality of service delivery. The impact of each of the challenges experienced by management will now be discussed and how it affects the functionality within the sector:

- Poor Leadership: leads to poor working conditions; poor performance of workers; lack of basic supplies; lack of equipment; lack of functional equipment.
- Lack of suitably qualified staff: leads to shortage of skilled staff; creates poor working conditions; failure to uphold work ethic; poor performance of workers.
- Lack of accountability: leads to poor working conditions; theft; lack of equipment
- Poor policy implementation: leads to poor working conditions; poor performance of workers; lack of communication
- Lack of financial resources: leads to shortage of skilled staff; lack of equipment; lack of functional equipment; lack of basic supplies; poor working conditions; inadequate facilities.
- Lack of communication: leads to failure to uphold work ethic; poor performance of workers
- Lack of control: leads to poor working conditions, lack of communication; lack of basic supplies, theft; lack of equipment shortage of skilled staff; poor performance of workers.
- Lack of planning: leads to shortage of skilled staff; poor working conditions; poor performance of workers; lack of equipment; inadequate facilities; inadequate support system.

- Poor decision making: leads to shortage of skilled staff; poor working conditions; poor performance of workers; lack of basic supplies; lack of functional equipment; theft; failure to uphold work ethic.

The exceptional criteria of this model are that the effects of challenges faced by the public service sector are in fact other challenges within the sector. Based on this model, what does become visible is the cycle of operational-staff challenges that are created as a result of just one management challenge. This however does not create an immediate solution to the challenges; it merely directs the responsible parties to take appropriate action. The challenges unpacked in the findings of this study will not be solved instantly but over a period of time. Visitations by health MEC's at hospitals should be a means to evaluate progress made at these challenge ridden public health facilities and should not act as a means to window dress these facilities to save the reputation of incapable management.

Strategy to improve the communication strategies in the adoption and application of the Batho Pele Principles at key government sectors.

Despite government's efforts to improve the level of service delivery by implementing various policies, the negligence to update staff members on problems and progress made at various levels will be to its own detriment. The importance of training and development workshops at key sectors such as the health sector is to keep staff members abreast of the changing economic, social and political landscapes that inadvertently will affect public servants in their day to day operations. When information is communicated at organisational level, it is up to the encoder or the source of that message to ensure that the message is received and interpreted as the encoder intended. Shannon and Weavers model of communication depicts a very critical component which can distort the meaning or effect of any message. This component is identified as noise.

The conceptual framework of this study explores this in detail; however a mention of this is needed as it is very relevant to government adopting different strategies to communicate effectively with its various publics. The frequency of workshops and staff development programs which will incorporate interpersonal skills development, should be over regular intervals which will lead to the improvement of the way in which staff operations are carried out. The use of posters in the hallways of wards may only be useful to the staff on duty as most patients are immobile. In order to effectively communicate with patients, taking into

consideration the factors that would hinder effective communication, the government should consider printing valuable information such as patients' rights to health care and even the Batho Pele Principles on items such as curtains, gowns, bedding and even towels. The nurses on duty can also ensure upon admission of a patient, a hand-out is given to a patient informing him or her of their rights to health care.

The efficacy of improved communication will lead to improved relations with patients, the actions of which will ultimately impact positively on service delivery.

Conclusion

This chapter provided the main recommendations arising out of this study. The strategies recommended by the researcher were a means to improve areas that are currently hindering the quality of service within the public sector. The Batho Pele Principles have been an effective means towards improving the level of service delivery within South Africa however the challenges that besieged its efficacy has somewhat caused some of its principles to remain ineffective.

Given the fact that the Batho Pele Principles is not a new policy but has been implemented some 15 years ago and the fact that service delivery issues continue to spiral in various other sectors within the governments can only mean that those responsible has been slow to act in resolving these problems. The shortage of staff will continue to plague various other sectors within government; however the hardest hit will be the health sector where staff members will opt for better salaries and better working conditions. The way forward for the government will be to act proactively rather than be reactive to situations within the public sector. After all, every government department is a public body that exists to serve the public and therefore needs to communicate with the public it is designed to serve (Craythorne, 1990: 84).

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ADDENDA

ADDENDUM 1: Questionnaire To Internal Publics

- QUESTIONNAIRE – INTERNAL PUBLIC (Staff)

TOPIC:

A Communication Perspective on Challenges faced by Key Government Sectors in the Adoption and Application of Batho Pele Principles: A Case Study of Addington and R. K. Khan hospitals

RESEARCHER:

PADHMA MOODLEY (Student Number: 200906069)
Contact: 0027718712912

PROMOTER:

Prof. H. Rugbeer

INSTITUTION:

Department of Communication Science
University of Zululand

PURPOSE OF THE QUESTIONNAIRE:

This study aims to highlight the challenges faced by key government sectors in the adoption and application of Batho Pele Principles. Your honest and unbiased response will help gauge the current level of service delivery at key government sectors in South Africa, more especially the health sector. The data that is collected shall be used to compile a report that will be shared with the relevant stakeholders and will provide direct feedback to the departments concerned.

NOTE TO THE RESPONDENT:

- Participation is purely voluntary.
- If you do not desire to take part, please return the blank questionnaire at the end of the survey session.
- Your remarks in this questionnaire will remain private and confidential.
- Participants have the right not to answer any question they deem to be intrusive or otherwise.
- **I require written permission (consent) to use your responses. The consent form will be kept separate from the questionnaire.**

Respondent Number: IP_____

CONSENT

I hereby acknowledge the contents of this questionnaire and do hereby grant permission for the researcher to utilise my responses towards her research. I can withdraw from this survey at any point and do understand this process is purely voluntary.

Signed:……..

Respondent Number: IP_____

INSTRUCTIONS

1. Answer as honestly as possible. YOUR OPINION IS REQUIRED.
2. Please do not change any of your responses afterwards (for instance: do not scratch out or tippex any of your responses).
3. Please use a pen to mark your responses by placing a tick (✓) or a cross (X), in the appropriate numbered column, or by writing down the appropriate information, wherever required.

SECTION A

1. Which hospital are you working at?

Addington	1
R.K.Khan	2

2. DEMOGRAPHICS

2.1. Gender of respondent

Male	• 1
Female	• 2

2.2. What is your age?

18-24 yrs	1
25-34 yrs	2
35-49 yrs	3
50-64 yrs	4
65 + yrs	5

2.3. Population group

Black	1
Coloured	2
Indian	3
White	4
Other, specify:	5

2.4. Education level

Primary Schooling	1
Secondary Schooling	2
Degree	3
Diploma	4
Other, specify:	5

SECTION B

3. TRAINING and DEVELOPMENT

3.1. Has your employer provided you with training in the principles of Batho Pele?

Yes	No
1	2

3.2. Please rate the training you received.

Very Good	Adequate	Bad	Not Applicable
1	2	3	4

3.3. How often does your institute hold training and development workshops or programmes in respect of the Batho Pele Principles?

Never	Once a Year	Every Six Months	Monthly
1	2	3	4

3.3. Do you attend the training and development workshops offered your institute?

yes	No	Some times	Not Applicabl

3.4 Is it compulsory for you to attend training and development workshops?

Yes	No	Not Applicable
1	2	3

3.4. How would you rate the following?	Poor	Satisfactory	Good	Excellent
• 3.4.1. • Your salary	• 1	• 2	• 3	• 4
• 3.4.2. • Working Conditions	• 1	• 2	• 3	• 4
• 3.4.3. • Your Job Qualification	• 1	• 2	• 3	• 4

3.5. Are there adequate staff members per department to provide an acceptable level of service delivery?

Yes	No	Not sure
• 1	• 2	• 3

3.6. Have you ever been side-lined for a promotion for which you were adequately qualified for?

Yes	No	• Not Sure
• 1	• 2	• 3

3.7. Approximately how many hours of overtime work do you perform per week?

• 0	• 0 – 4	• 5 – 9	• 10 – 14	• 15 +
• 1	• 2	• 3	• 4	• 5

3.8. How many years have you been working in your current position?

• 0 – 4	• 5 – 9	• 10 – 14	• 15 – 19	• 20 +
• 1	• 2	• 3	• 4	• 5

4. SERVICE DELIVERY DRIVERS FOR PUBLIC SERVANTS

4.1. ACCESS - As a Batho Pele Principle, access requires the Public Service to ensure that ALL citizens have equal access to the services to which they are entitled.

How would you rate your department or institute in providing the following?	Poor	Average	Good	Excellent
4.1.1. Accessibility of hospital facilities.	1	2	3	4
4.1.2. Accessibility of operating hours.	1	2	3	4
4.1.3. Accessibility for disabled or elderly.	1	2	3	4
4.1.4. Accessibility via telephone.	1	2	3	4

4.1.5. What are the challenges you have experienced in providing Access to citizens at the hospital?

……

……

4.2 COURTESY- Citizens should be treated with courtesy and consideration.

How would you rate yourself with regards to implementing the following?	TRUE	FALSE	Do not want to answer	Not applicable
4.2.1. I am very courteous to patients.	1	2	3	4
4.2.2. I am very responsive to patients' salutations.	1	2	3	4
4.2.3. I greet and welcome patients				
4.2.4. We are too busy to be 'nice' to patients				
4.2.5. Batho Pele principles can work in theory only – it is NOT practical to implement in SA				

4.2.3. Justify the following statements:

	TRUE	FALSE	Do not want to answer	Not applicable
4.2.3.1 I am too tired to be nice	1	2	3	4
4.2.3.2 I am too busy to be courteous	1	2	3	4
4.2.3.3 Some patients are too rude to evoke a courteous response	1	2	3	4
4.2.3.4 It is difficult to be courteous due to the nature of my job	1	2	3	4
4.2.3.5 It is not in my character to be courteous	1	2	3	4

4.3 INFORMATION- Citizens should be given full, accurate information about the services they are entitled to receive.

	How would you rate the implementation of Providing Information to citizens at the hospital?	Poor	Average	Good	Excellent
4.3.1.	Visibility of relevant signage.	1	2	3	4
4.3.2.	Presence of an Information desk.	1	2	3	4
4.3.3.	Information of patients' rights with regards to health care.	1	2	3	4
4.3.4.	Providing citizens with up to date information on their condition.	1	2	3	4

4.3.5. How would you rate yourself with regards to the following?

		TRUE	FALSE	Do not want to answer	Not applicable
4.3.5.1	I am able to provide relevant information to patients most of the time	1	2	3	
4.3.5.2	Misunderstanding due to various languages is not a serious problem at this intuition	1	2	3	
	I am unable to provide relevant information because I am ill informed				

4.4 TIMELINESS- Services at the hospitals should be provided swiftly and within reasonable time.

	Justify the following statements:	TRUE	FALSE	Do not want to answer	Not applicable
4.4.1.	The services at the hospital are performed within a reasonable time frame.	1	2	3	4
4.4.2.	Most of us (staff) are punctual at work	1	2	3	4

4.4.3.

	Justify the following statements:	TRUE	FALSE	Do not want to answer	Not applicable
4.4.3.1	I cannot avoid delays with patients because I am always overworked and slow.	1	2	3	4
4.4.3.2	I cannot avoid delays with patients because I am always overworked and frequently ill.	1	2	3	4
4.4.3.3	I cannot avoid delays with patients because I am always	1	2	3	4

overworked and tired				

4.5 CONSULTATION- Citizens should be consulted about the level and quality of the services they receive and where possible, should be given a choice about the services that are offered.

	How would you rate yourself with regards to Consultation?	Poor	Average	Good	Excellent
4.5.1.	My ability to provide patients with suitable options for treatment.	1	2	3	4
4.5.2.	My ability to Inform citizens about the quality of the services rendered at the hospital	1	2	3	4

If you are asking people to rate themselves, then they will be rating ability. These questions are not geared to make a rating. See above.

4.5.3.	Validate the following statements:	TRUE	FALSE	Do not want to answer	Not applicable
4.5.3.1	I do not offer my patients choices in treatment because this is the trend in most provincial hospitals.	1	2	3	4
4.5.3.2	I do not offer my patients choices in treatment because there is insufficient time to discuss these options with patients.	1	2	3	4
4.5.3.3	I do not offer my patients choices in treatment because there are too many patients to examine.	1	2	3	4
4.5.3.4	I do not offer my patients choices in treatment because most patients do not have the ability to make a calculated choice timeously.	1	2	3	4

4.6 SERVICE STANDARDS- Citizens should be told what level and quality of services they will receive so that they are aware of what to expect.

	Validate the following activities at your hospital / department:	TRUE	FALSE	Sometimes	Not applicable
4.6.1.	Visiting times are adhered to by patients and gatekeepers.	1	2	3	4
4.6.2.	Ward rounds are carried out timeously by nurses and	1	2	3	4

	doctors.				
4.6.3.	Nurses respond timeously when approached for assistance.	1	2	3	4
4.6.4.	Proper procedures are carried out. (no nepotism)	1	2	3	4
4.6.5.	Clean equipment is used	1	2	3	4
4.6.6.	Bed linen is changed regularly.	1	2	3	4
4.6.7.	Bed baths are administered in according to general rules of cleanliness.	1	2	3	4
4.6.8.	General Standard of service is good	1	2	3	4

4.6.9. What are the challenges you have experienced with regards to the implementation of acceptable Service Standards at the hospital?

……

……

4.7 REDRESS- If the promised standard of service is not delivered, citizens should be offered an apology, a full explanation and a speedy and effective remedy; when complaints are made, citizens should receive a sympathetic, positive response.

		Yes	No	Not applicable
4.7.1.	Did you have the opportunity to apologise or undertake corrective action to a patient at the hospital?	1	2	3
4.7.2.	Did you have the opportunity to provide feedback to a patient with regards to a problem they might have experienced?	1	2	3
4.7.3.	Was the patient satisfied with the feedback?	1	2	3
4.7.4.	Was a complaint ever lodged against you or the hospital by a patient?	1	2	3

4.7.5. What are the challenges you have experienced with regards to REDRESS at the hospital?

……

……

4.8 KNOWLEDGE AND COMPETENCE OF STAFF- Citizens need to be served by staff members that are knowledgeable about the services they provide.

	Please rate yourself with regards to each of the following:	Poor	Average	Good	Excellent
4.8.1.	My knowledge about services offered at this hospital.	1	2	3	4
4.8.2.	My understanding of my job requirements.	1	2	3	4
4.8.3.	Your knowledge to be able to render services at the hospital.	1	2	3	4
4.8.4.	My knowledge about the duties I am required to perform.	1	2	3	4

4.9 FACILITIES- The condition of public facilities should always be welcoming and cater to the needs of the citizens.

	Please rate the following facilities in your surroundings:	Poor	Average	Good	Excellent
4.9.1.	Waiting area	1	2	3	4
4.9.2.	Cleanliness of facility	1	2	3	4
4.9.3.	Security/ Safety	1	2	3	4

4.9.4. What are the challenges you have experienced with regards to the FACILITY at the hospital?

……

……

4.10 OVERALL IMPRESSION

	Please rate your experience with regards to the following:	Strongly agree	Agree	Strongly Disagree	Disagree
4.10.1	The Batho Pele Principles has made me more sensitive to patients' needs.	1	2	3	4
4.10.2	The Batho Pele Principles has made my job more complex.	1	2	3	4
4.10.3	The Batho Pele Principles has created more problems between staff and patients.	1	2	3	4
4.10.4	The Batho Pele Principles has not helped to improve service delivery in the public health sector.	1	2	3	4
4.10.5	I do not implement the Batho Pele Principles as I do not believe in them.	1	2	3	4
4.10.6	I do not implement the Batho Pele Principles as I do not have the time to do so.	1	2	3	4
4.10.7	I do not implement the Batho Pele Principles as I am too	1	2	3	4

	tired.				
4.10.8	I do not implement the Batho Pele Principles as I think it is a fruitless effort to improve service delivery.	1	2	3	4
	I do not implement the Batho Pele Principles because they look good in theory but practically impossible to implement. This country is too corrupt to implement anything good.				

.....

.....

SECTION D

5. The following questions pertain to challenges faced by staff members in the application and adoption of the Batho Pele Principles.

	Please rate your experience with regards to the following:	Strongly agree	Agree	Strongly Disagree	Disagree
5.1	There is a shortage of skilled staff in the department I work in.	1	2	3	4
5.2	The shortage of skilled staff has negatively impacted on how I implement the Batho Pele Principles.	1	2	3	4
5.3	I work in very poor working conditions.	1	2	3	4
5.4	Poor working conditions at the hospital has negatively impacted on how I implement the Batho Pele Principles	1	2	3	4
5.5	There is insufficient equipment in my department ~~that is necessary~~ to effectively treat patients	1	2	3	4
5.6	Lack of equipment at the hospital has negatively impacted on how I perform my duties Lack of basic supplies	1	2	3	4
5.7	There are inadequate facilities (not enough wards, operating theatres, toilets etc.) at this hospital.	1	2	3	4
5.8	Inadequate facilities at the hospital have negatively impacted on how I perform my duties.	1	2	3	4
5.9	There is a shortage of basic supplies in my department ~~I work in.~~	1	2	3	4
5.10	Lack of basic supplies has negatively impacted on how I implement the Batho Pele Principles.	1	2	3	4
5.11	I have experienced poor communication between my peers and/or heads.	1	2	3	4
5.12	Poor communication has negatively impacted on how I implement the Batho Pele Principles.	1	2	3	4
5.13	I have noticed the theft of hospital equipment by other staff members.	1	2	3	4
5.14	There is an inadequate support system at the hospital to assist with internal issues.	1	2	3	4

5.15	The lack of a support system has negatively impacted on how I implement the Batho Pele Principles.	1	2	3	4
5.16	I feel that there is very poor leadership in the department I work in.	1	2	3	4
5.17	Poor leadership has negatively impacted on how I implement the Batho Pele Principles.	1	2	3	4

SECTION E

6. ONLY MANAGEMENT TO ANSWER

The following pertains to staff members that are employed on a more senior level at the hospital. This includes department heads.

6.1. MONITORING AND EVALUATION OF BATHO PELE PRINCIPLES (Part A)

		Yes	No
6.1.1.	Are you in Management at the hospital?	1	2
6.1.2.	Have you previously monitored staff members' performance in respect of the Batho Pele Principles?	1	2
6.1.3.	Do you provide training and development for your staff members regularly?	1	2
6.1.4.	Is there a strategy in place to track the performance of staff members in respect of Batho Pele Principles?	1	2
6.1.5.	Would you say your department is Batho Pele compliant?	1	2
6.1.6.	Are your training programmes under pinned by the "People First" principles?	1	2
6.1.7.	Do you monitor the satisfaction of your services rendered by your department?	1	2
6.1.8.	Do you provide staff motivation?	1	2
6.1.9.	Do you have programmes, policies or guidelines to support the implementation of Batho Pele Principles?	1	2
6.1.10.	Do you have an efficient communication infrastructure in particular information technology at service points to facilitate information sharing?	1	2

6.2. MONITORING AND EVALUATION OF BATHO PELE PRINCIPLES (Part B)

		Never	Once a year	Twice a year	More
6.2.1.	How often do you perform staff evaluations?	1	2	3	4
6.2.2.	How often do you monitor the satisfaction of services rendered by your department?	1	2	3	4
6.2.3.	How often do you monitor the satisfaction of your staff members in the duties they perform?	1	2	3	4

6.3. MONITORING AND EVALUATION OF BATHO PELE PRINCIPLES (Part C)

	The following challenges faced at the department/ hospital negatively impact on the implementation of Batho Pele Principles	Strongly Agree	Agree	Strongly Disagree	Disagree
6.3.1.	Inadequate facilities.	1	2	3	4
6.3.2.	Understaffed department.	1	2	3	4
6.3.3.	Absenteeism	1	2	3	4
6.3.4.	Severe budgetary constraints.	1	2	3	4
6.3.5.	Untrained staff.	1	2	3	4
6.3.6.	Incompetent staff.	1	2	3	4
6.3.7.	Inability to attract suitably qualified staff.	1	2	3	4
6.3.8.	Non responsiveness of other departments within hospital.	1	2	3	4
6.3.9.	Non responsiveness of government in addressing department or hospital inadequacies.	1	2	3	4
6.3.10.	Poor leadership	1	2	3	4
6.3.11	Lack of accountability	1	2	3	4
6.3.12	Poor policy implementation	1	2	3	4
6.3.13	Lack of financial resources	1	2	3	4
6.3.14	Lack of communication	1	2	3	4
6.3.15	Lack of control	1	2	3	4
6.3.16	Lack of planning	1	2	3	4
6.3.17	Lack of organising	1	2	3	4
6.3.18	Poor decision making	1	2	3	4
6.3.19	Poor performance of workers	1	2	3	4
6.3.20	Failure to uphold work ethic	1	2	3	4

What other challenges have you experienced in the implementation of the Batho Pele Principles within the health sector?

……

……

What other challenges have you experienced with staff members adoption and application of the Batho Pele Principles?

……

……

What is your overall impression of the standard of service delivery within your department?

……

……

THANK YOU FOR YOUR PARTICIPATION IN THIS SURVEY.

ADDENDUM 2: QUESTIONNAIRE TO EXTERNAL PUBLICS

- QUESTIONNAIRE FOR EXTERNAL PUBLIC (PATIENTS)

TOPIC:

A Communication Perspective on Challenges faced by Key Government Sectors in the Adoption and Application of Batho Pele Principles: A Case Study of Addington and R. K. Khan hospitals.

RESEARCHER:

PADHMA MOODLEY (Student Number: 200906069)
Contact: 0027769897913

PROMOTER:

Prof. H. Rugbeer

INSTITUTION:

Department of Communication Science
University of Zululand

PURPOSE OF THE QUESTIONNAIRE:

This study aims to highlight the challenges faced by key government sectors in the adoption and application of Batho Pele Principles. Your honest and unbiased response will help gauge the current level of service delivery at key government sectors in South Africa, more especially the health sector. The data that is collected shall be used to compile a report that will be shared with the relevant stakeholders and will provide direct feedback to the departments concerned.

NOTE TO THE RESPONDENT:

- Participation is purely voluntary.
- If you do not desire to take part, please return the blank questionnaire at the end of the survey session.
- Your remarks in this questionnaire will remain private and confidential.
- Participants have the right not to answer any question they deem to be intrusive or otherwise.
- **I require written permission (consent) to use your responses. The consent form will be kept separate from the questionnaire.**

Respondent Number: EP_____

CONSENT

I hereby acknowledge the contents of this questionnaire and do hereby grant permission for the researcher to utilise my responses towards her research. I can withdraw from this survey at any point and do understand this process is purely voluntary.

INSTRUCTIONS: Respondent Number: EP_____

1. Answer as honestly as possible.
2. Please do not change any of your responses afterwards (for instance: do not scratch out or tippex any of your responses).
3. Please use a pen to mark your responses by placing a tick (✓) or a cross (X), in the appropriate column, or by writing down the appropriate information, wherever required.

SECTION A

1. Which Hospital do you visit most often for treatment?

Addington	1
R.K.Khan	2

2. DEMOGRAPHICS

2.1. Indicate your gender:

Male	• 1
Female	• 2

2.2. What is your age?

18-24 yrs	1
25-34 yrs	2
35-49 yrs	3
50-64 yrs	4
65 + yrs	5

2.3. Population group

Black	1
Coloured	2
Indian	3
White	4
Other, specify:	5

2.4. Education level

Primary Schooling	1
Secondary Schooling	2
Degree	3
Diploma	4
Other, specify:	5

2.5. Employment status

Student	1
Employed	2
Unemployed	3
Retired	4
Other, specify:	5

SECTION B

3. SERVICE DELIVERY DRIVERS FOR EXTERNAL PUBLICS (Citizens)

3.1. The Batho Pele Principle of <u>access</u> requires that ALL citizens have the right to use to the services to which they are entitled to.

How would you rate this hospital in providing the following?	Agree	Disagree	Not sure
3.1.1. The facilities at the hospital are always available to all patrons	1	2	3
3.1.2. All departments are open 24hours a day.	1	2	3
3.1.3. The disabled and elderly are well taken care off	1	2	3
3.1.4. The hospital has a phone-in service	1	2	3

3.2 COURTESY - The Batho Pele Principle of Courtesy requires that all citizens be treated with courtesy and consideration

How would you rate your experience with regards to the following?	Agree	Disagree	Not sure
3.2.1. The staff are very polite and receive us well.	1	2	3
3.2.2. The staff answers my concerns /queries in a polite manner	1	2	3

3.2.3 How would you rate your experience with regards to the following?	Strongly Agree	Agree	Strongly Disagree	Disagree
3.2.3.1. Doctors are rude to me	1	2	3	4
3.2.3.2 Doctors are impatient with me.	1	2	3	4
3.2.3.3 Doctors are intolerant of me.	1	2	3	4
3.2.3.4 Doctors are unhelpful towards me.	1	2	3	4
3.2.3.5 Nurses are rude to me	1	2	3	4
3.2.3.6 Nurses are impatient with me.	1	2	3	4
3.2.3.7 Nurses are intolerant of me.	1	2	3	4
3.2.3.8 Nurses are unhelpful towards me.	1	2	3	4

3.3 INFORMATION - Citizens should be given full accurate information about the services they are entitled to receive.

	How would you rate your experience with regards to the following at the hospital?	Always	Sometimes	Never
3.3.1.	The directions (signs) to other departments which I need to attend are clearly visible to me.	1	2	3
3.3.2.	There is an information desk which I can use for information I require.	1	2	3
3.3.3.	I am advised of my rights as a patient with regards to health care.	1	2	3

3.4. TIMELINESS - Services at the hospitals should be provided swiftly and within reasonable time.

	How would you rate your experience with regards to Timeliness?	Strongly Agree	Agree	Strongly Disagree	Disagree
3.4.1.	The nurses are quick and efficient.	1	2	3	4
3.4.2.	I am not unnecessarily delayed.	1	2	3	4
3.4.3.	The doctors are quick and efficient.	1	2	3	4

3.5 CONSULTATION - Citizens should be consulted about the level and quality of the services they receive and where possible should be given a choice about the services that are offered.

	How would you rate your experience with regards to Consultation?	Strongly Agree	Agree	Strongly Disagree	Disagree
3.5.1.	I am advised of other options that are available for my condition.	1	2	3	4

3.6. SERVICE STANDARDS - Citizens should be told what level and quality of services they will receive so that they are aware of what to expect.

	How would you rate your experience with regards to Service Standards at the hospital?	Strongly Agree	Agree	Strongly Disagree	Disagree
3.6.1.	Visiting times are adhered to.	1	2	3	4
3.6.2.	The nurses carry out ward rounds regularly.	1	2	3	4
3.6.3.	The nurses respond when I require assistance.	1	2	3	4

3.6.4. The nurses carry out necessary procedures.	1	2	3	4
3.6.5. Clean equipment used.	1	2	3	4
3.6.6. Bed linen is changed regularly.	1	2	3	4
3.6.7. Bed baths are given when I am unable to leave the bed.	1	2	3	4

3.7. REDRESS - If the promised standard of service is not delivered, citizens should be offered an apology, a full explanation and a speedy and effective remedy; when complaints are made, citizens should receive a sympathetic, positive response.	Yes	No
3.7.1. Have you experienced problems with the services or products from this hospital?	1	2
3.7.2. Have you experienced the same problem before?	1	2
3.7.3. Have you ever received an apology for any mistakes made by the doctors, nurses or dispensary?	1	2
3.7.4. Have you ever lodged a complaint for any inconvenience or problem you encountered at the hospital?	1	2
3.7.5. Were you happy with the manner in which your complaint was handled?	1	2

3.8. VALUE FOR MONEY - Public services should be provided economically and efficiently in order to give citizens the best possible value for money.

Please rate your experience with regards to the following:	Strongly Agree	Agree	Strongly Disagree	Disagree
3.8.1. The services I received from this hospital were efficient.	1	2	3	4
3.8.2. I am satisfied with what these services cost me.	1	2	3	4

3.9 KNOWLEDGE AND COMPETENCE OF STAFF - Citizens need to be served by staff members that are knowledgeable about the services they provide.

Please rate your experience with regards to the following:	Strongly Agree	Agree	Strongly disagree	Disagree
3.9.1. The nurses understood what they were doing.	1	2	3	4
3.9.2. The doctors understood what they were doing.	1	2	3	4
3.9.3. The doctor understood what I needed to be treated for.	1	2	3	4
3.9.4. The nurses understood what I needed to be treated for.	1	2	3	4
3.9.5. The doctors were able to render their services properly.	1	2	3	4
3.9.6. The nurses were able to render their services properly.	1	2	3	4

3.10. FACILITIES - The condition of public facilities should always be welcoming and cater to the needs of the citizens.

Please rate your experience with regards to the following:	Poor	Average	Good	Excellent
3.10.1. Waiting area	1	2	3	4
3.10.2. Cleanliness of facility	1	2	3	4
3.10.3. Security/ Safety	1	2	3	4

THANK YOU KINDLY FOR YOUR INVALUABLE PARTICIPATION.

ADDENDUM 3: ETHICAL CLEARANCE FROM THE UNIVERSITY OF ZULULAND

UNIVERSITY RESEARCH ETHIC COMMITTEE
(Reg No: UZREC 171110-30)

UNIVERSITY OF ZULULAND
Website: http://www.uzulu.ac.za

Private Bag X1001
KwaDlangezwa 3886

Tel: 035 902 6645
Fax: 086 604 5820
Email: dviljoen@pan.uzulu.ac.za

ETHICAL CLEARANCE CERTIFICATE

Certificate Number	**UZREC 171110-030 PGD 2012/1**							
Project Title	**A Communication Perspective on Challenges faced by Key Government Sectors in the Adoption and Application of Batho Pele Principles: A Case Study of Addington and R K Khan Hospitals**							
Principal Researcher/ Investigator	P Moodley							
Supervisor and Co-supervisor	Prof H Rugbeer							
Department	Communication Science							
Nature of Project	Honours/4th Year		Master's		Doctoral	x	Departmental	

The University of Zululand's Research Ethics Committee (UZREC) hereby gives ethical approval in respect of the undertakings contained in the above-mentioned project proposal and the documents listed on page 2 of this Certificate. Special conditions, if any, are also listed on page 2.

The Researcher may therefore commence with the research as from the date of this Certificate, using the reference number indicated above, but may not conduct any data collection using research instruments that are yet to be approved.

Please note that the UZREC must be informed immediately of

- Any material change in the conditions or undertakings mentioned in the documents that were presented to the UZREC
- Any material breaches of ethical undertakings or events that impact upon the ethical conduct of the research

The Principal Researcher must report to the UZREC in the prescribe format, where applicable, annually and at the end of the project, in respect of ethical compliance.

The table below indicates which documents the UZREC considered in granting this Certificate and which documents, if any, still require ethical clearance.

Documents	Considered	To be submitted	Not required
Ethical clearance application form			
Project proposal	x		
Informed consent from participants	x		
Informed consent from parent/guardian			x
Permission for access to sites/information/participants		x	
Permission to use documents/copyright clearance			x
Data collection/survey instrument/questionnaire	x		
Data collection instrument in appropriate language			x
Other data collection instruments			

Please note that this is not a closed list and should new instruments be developed, these should be submitted for approval.

Special conditions: *Documents marked "To be submitted" must be presented for ethical clearance before any data collection can commence.*

The UZREC retains the right to

- Withdraw or amend this Certificate if
    - Any unethical principles or practices are revealed or suspected
    - Relevant information has been withheld or misrepresented
    - Regulatory changes of whatsoever nature so require
    - The conditions contained in this Certificate have not been adhered to
- Request access to any information or data at any time during the course or after completion of the project

The UZREC wishes the researcher well in conducting the research.

Professor Rob Midgley
Deputy Vice-Chancellor, Research and Innovation
Chairperson: University Research Ethics Committee
20 May 2012

ADDENDUM 4: Letter to the KZN Provincial Department of Health Requesting Permission To Engage In Fieldwork

University of Zululand
Department of Communication Science

University of Zululand **Box 85**

Tel: (035) 902 6166 **University of Zululand**

Fax: (035) 902 60 82 **Private Bag X1001**

E-mail: pmoodley@pan.uzulu.ac.za **Kwadlangezwa**

3886

01 August 2012

MEC for HEALTH – KwaZulu Natal

Pietermaritzburg

Dear Sir,

I am a lecturer at the University of Zululand currently studying towards my PhD. I am undertaking scientific research in the area of the adoption and application of Batho Pele Principles at key government sectors. My area of study is the health sector, more specifically I have selected Addington and R.K.Khan hospitals as my case studies for my research.

The objectives of my study are to:

- Evaluate the effects of the challenges faced by the key government sectors in the application and adoption of Batho Pele Principles.
- To analyse the application and adoption of the Batho Pele Principles towards the improvement of service delivery in key government sectors.
- To determine the effectiveness of the communications strategies implemented in the adoption and application of Batho Pele Principles.

- To ascertain the effectiveness of the practice of Batho Pele Principles in key government sectors.

In order to achieve these objectives, I request your permission to:

- Interview Staff (during lunch breaks) at Addington and R.K.Khan Hospitals
- Engage staff members to fill out a questionnaire.
- Interview in/out patients at Addington and R.K.Khan hospitals
- Engage in/out patients to fill out a questionnaire.

This process is purely voluntary and each participant will be clearly advised prior to the commencement of the survey. No member of staff (or the patients) will be harassed into participating in the research. Patients who are in 'high care' or other seriously ill patients will not be asked to participate in the survey.

This research is by in no means an attempt to discredit or undermine the efforts of the hospitals. Together, we can encourage government to ensure challenges are dealt with in order to improve service delivery at the public health sectors in South Africa.

The findings of this study will be made available to you as well as the management of Addington and R.K.Khan hospitals.

Your participation in this research study is highly anticipated.

Yours faithfully

P.Moodley (Mrs)

NB: I have included the following documentation:

Budget and Timeline	Pg 3
Research Proposal	Pg 5
Ethical clearance letter	Pg 13
Permission from District Managers	Pg 15 and 16
Informed consent forms are included in the information sheet	
Information sheet (on a separate attachment to this email.)	

University of Zululand
Department of Communication Science

University of Zululand **Box 85**

Tel: (035) 902 6166 **University of Zululand**

Fax: (035) 902 60 82 **Private Bag X1001**

E-mail: pmoodley@pan.uzulu.ac.za **Kwadlangezwa**

3886

01 August 2012

To whom it may concern

BUDGET and TIME LINE

The proposed budget to conduct fieldwork is estimated to cost R 8000.00. This includes travel and subsistence. This has been approved by the University's research committee together with my budget for the entire project for 2012 as per attached confirmation letter.

The timeline to undertake the fieldwork at both hospitals is envisaged to be carried out between August 2012 and December 2012 or sooner until such time the sample size of 400 is reached**.**

ADDENDUM 5: Ethical CLEARANCE FROM THE KZN Department Of Health

health

Department:
Health
PROVINCE OF KWAZULU-NATAL

Health Research & Knowledge Management sub-component
10 – 103 Natalia Building, 330 Langalibalele Street
Private Bag x9051
Pietermaritzburg, 3200
Tel.: 033 – 3953189
Fax.: 033 – 394 3782
Email.: hrkm@kznhealth.gov.za
www.kznhealth.gov.za

Reference : HRKM 105/12
Enquiries : Mr X Xaba
Tel : 033 – 395 2805

Dear Mrs P. Moodley

Subject: Approval of a Research Proposal

1. The research proposal titled **'A communication perspective on challenges faced by key government sectors in the adoption and application of Batho Pele principles: A case study of RK Khan and Addington hospitals'** was reviewed by the KwaZulu-Natal Department of Health.

   The proposal is hereby **approved** for research to be undertaken at RK Khan and Addington Hospitals from approval until January 2013.

2. You are requested to take note of the following:
   a. Make the necessary arrangement with the identified facility before commencing with your research project.
   b. Provide an interim progress report and final report (electronic and hard copies) when your research is complete.

3. Your final report must be posted to **HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200** and e-mail an electronic copy to hrkm@kznhealth.gov.za

For any additional information please contact Mr X. Xaba on 033-395 2805.

Yours Sincerely

C E Lutge

Dr E Lutge
Chairperson, Health Research Committee
KwaZulu-Natal Department of Health
Date: 09/08/2012

ADDENDUM 6: Permission Letter From R.K.Khan Hospital

HEALTH
KwaZulu-Natal

R.K. Khan Hospital
Private Bag X004,
CHATSWORTH, 4030
Tel.: 031 4596001, Fax.: 031 4011247
Email.:reena.ramcharan@.kznhealth.gov.za
www.kznhealth.co.za

ENQUIRIES: P.S. SUBBAN

17 July 2012

Mrs P. Moodley
University of Zululand
Dept of Communication Science
Private Bag X1001
ZULULAND

Dear Madam

PERMISSION TO CONDUCT STUDY : A COMMUNICATION PERSPECTIVE ON CHALLENGES FACED BY KEY GOVERNMENT SECTOR IN THE ADOPTION AND APPLICATION OF BATHO PELE PRINCIPLES

Permission is granted to conduct your study at this institution.

Please note the following:

1. Please ensure that you adhere to all the policies, procedures, protocols and guidelines of the Institution with regards to this research.
2. This research will only commence once this office has received confirmation from the Provincial Health Research Committee in the KZN Department of Health.
3. Please ensure this office is informed before you commence your research.
4. The District Office/Facility will not provide any resources for this research.
5. You will be expected to provide feedback on your findings to this institution.

Yours faithfully

HOSPITAL CEO

ADDENDUM 7: Permission Letter From Addington Hospital

HEALTH
KwaZulu-Natal

ADDINGTON HOSPITAL
OFFICE OF THE HOSPITAL MANAGER
Postal Address: P.O. Box 977, DURBAN, 4000
Physical Address: 16 Erskine Terrace, South Beach
Tel.: (031) 327-2970, Fax.:(031) 368-3300
Email.: addington.management@kznhealth.gov.za
www.kznhealth.gov.za

AD/9/2/3/R

Enquiries: Dr E.R Masilela
Extension: 2970/2568

31 July 2012

Mrs P. Moodley
University of Zululand
Department of Communication Science
Private Bag X1001
ZULULAND

Dear Mrs Moodley

PERMISSION TO CONDUCT RESEARCH AT ADDINGTON HOSPITAL: "A COMMUNICATION PERSPECTIVE ON CHALLENGES FACED BY KEY GOVERNMENT SECTOR IN THE ADOPTION AND APPLICATION OF BATHO PELE PRINCIPLES "

I have pleasure in informing you that permission has been granted to you by Addington Management to conduct research on "A Communication Perspective on Challenges faced by Key Government Sector in the adoption and application of Batho Pele Principles"

Please note the following:

1. Please ensure that you adhere to all the policies, procedures, protocols and guidelines of the Department of Health with regards to this research.
2. This research will only commence once this office has received confirmation from the Provincial Health Research Committee in the KZN Department of Health.
3. Please ensure this office is informed before you commence your research.
4. Addington Hospital will not provide any resources for this research.
5. Your will be expected to provide feedback on your findings to Addington Hospital.

MEDICAL MANAGER / ACTING CEO
DR E.R. MASILELA
ADDINGTON HOSPITAL