

Workplace Counselling and Organizational Productivity in a Ghanaian District Hospital: Evidence from Shai-Osudoku

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Abstract

Healthcare workers carry clinical responsibilities alongside repeated exposure to suffering, resource constraints, shift disruption, and emotionally demanding encounters. This study examined the relationship among workplace counselling awareness, occupational stress, and organizational productivity at Shai-Osudoku District Hospital in Ghana. A quantitative cross-sectional survey was conducted among 200 clinical and non-clinical employees selected across professional categories. A structured questionnaire measured awareness of and confidence in workplace counselling, occupational stress, and self-reported productivity. The scales demonstrated acceptable-to-strong internal consistency (Cronbach's alpha = .79-.88). Descriptive statistics, independent-samples testing, one-way analysis of variance, correlation, and multiple regression were used. Respondents reported moderate counselling awareness ($M = 3.02$), high occupational stress ($M = 3.40$), and comparatively low productivity ($M = 2.63$). Clinical employees reported higher stress than non-clinical employees ($M = 3.61$ versus 2.80 , $p < .001$), and stress differed significantly by shift pattern, $F(3, 196) = 75.76$, $p < .001$. Occupational stress was strongly and inversely associated with productivity ($r = -.94$). Counselling awareness correlated negatively with stress ($r = -.47$) and positively with productivity ($r = .43$), although it was not an independent predictor after stress and covariates entered the regression model ($p = .32$). The findings suggest that counselling may support productivity chiefly by helping employees manage stress; however, formal mediation cannot be inferred from this cross-sectional analysis. Hospital leaders should establish confidential, shift-accessible employee assistance, strengthen psychosocial safety, train supervisors, and address structural sources of overload. In pastoral-counselling terms, staff care should uphold dignity, compassion, confidentiality, and shared responsibility while remaining clinically sound and culturally responsive.

Keywords: workplace counselling; occupational stress; organizational productivity; employee assistance programme; healthcare workers; Ghana

1. Introduction

Healthcare depends on the competence of its workforce, but competence cannot be separated from psychological well-being. Doctors, nurses, midwives, administrators, and support personnel

are expected to sustain attention, empathy, accuracy, and sound judgment while working under time pressure and responding to human suffering. When these demands exceed available personal and organizational resources, stress may develop into exhaustion, disengagement, presenteeism, absence, error, and intention to leave. The World Health Organization and International Labour Organization have therefore urged employers to prevent psychosocial risks, protect and promote mental health, and support workers who experience distress (World Health Organization & International Labour Organization, 2022).

Workplace counselling is one practical expression of that duty of care. It offers employees a confidential setting in which to understand distress, process difficult experiences, strengthen coping, and identify appropriate clinical, social, spiritual, or organizational support. Contemporary employee assistance programmes (EAPs) may also provide assessment, short-term counselling, referral, manager consultation, crisis response, and preventive education. Evidence suggests that workplace interventions can improve well-being, resilience, and engagement among healthcare professionals, although outcomes vary according to programme design, organizational climate, and the extent to which structural stressors are addressed (Bouzikos et al., 2022; Cohen et al., 2023).

The issue is particularly urgent in settings where staffing, equipment, and mental-health resources are constrained. Ghanaian healthcare workers may contend with heavy caseloads, shift work, occupational exposure, emotional labour, and limited control over systemic problems. Studies conducted in Ghana have linked inadequate workplace preparedness and constrained resources with stress and burnout, while qualitative evidence from nurses shows that occupational stress affects health, family life, and professional functioning (Afulani et al., 2021; Dartey et al., 2023). Yet structured, employee-focused psychological support remains uneven, and concern about stigma or confidentiality may discourage help-seeking.

Shai-Osudoku District Hospital (SODH), situated at Dodowa in Ghana's Greater Accra Region, provides an important setting in which to examine these relationships. The hospital serves a growing population through clinical, maternity, emergency, diagnostic, administrative, and support services. Sustaining safe care requires not only facilities and technical knowledge but also a workforce that is emotionally supported and able to recover from occupational strain. This study therefore examined whether awareness of workplace counselling is associated with lower occupational stress and stronger organizational productivity among SODH staff.

2. Problem Statement and Study Purpose

The psychological burden of healthcare work is often normalized until it appears in staff exhaustion, interpersonal conflict, reduced concentration, sickness absence, or declining quality of care. At SODH, existing wellness provisions offer a foundation for support, but moderate awareness, uncertainty about confidentiality, shift-based access difficulties, and the absence of a comprehensive employee-focused EAP may limit their reach. If distress remains largely private and untreated, employees may continue working while depleted, thereby placing their own health, patient experience, and institutional performance at risk.

The study's purpose was to investigate the relationship between workplace counselling and organizational productivity at SODH. Specifically, it sought to: (a) assess employees' awareness of and confidence in workplace counselling; (b) determine levels of occupational stress and perceived productivity; (c) compare stress across staff roles and shift patterns; (d) examine relationships among counselling awareness, stress, and productivity; and (e) identify practical implications for a culturally responsive staff-support programme.

The guiding questions were: What levels of counselling awareness, occupational stress, and organizational productivity are reported by SODH staff? Do stress levels differ by professional role and shift pattern? How are counselling awareness and occupational stress associated with productivity? What organizational and pastoral-counselling responses are indicated by the findings?

3. Literature Review and Conceptual Framework

Occupational stress arises when perceived demands exceed the resources available to meet them. In healthcare, demands include workload, role conflict, emotional exposure, patient acuity, time pressure, shift disruption, and resource scarcity. Prolonged imbalance can culminate in burnout, classically expressed through exhaustion, cynicism or depersonalization, and reduced professional efficacy. Burnout among nurses is associated with poorer safety, quality, and patient satisfaction, demonstrating that staff well-being is inseparable from care outcomes (Li et al., 2024).

The Job Demands-Resources (JD-R) theory provides the principal framework for this study. It distinguishes job demands, which require sustained effort, from job resources, which help employees achieve goals, reduce demands, or develop professionally. Resources such as supportive supervision, role clarity, fair schedules, peer support, and counselling may interrupt the health-impairment process and sustain engagement (Bakker & Demerouti, 2024). Conservation of Resources theory adds that people seek to retain valued emotional, cognitive, social, and material resources; persistent loss or threatened loss produces stress. Counselling can serve as a resource-gain mechanism, but it cannot permanently compensate for chronic understaffing, unsafe systems, or unmanageable workloads.

Psychosocial Safety Climate (PSC) directs attention from the individual to the organization. A psychologically safe organization communicates through policy and practice that employee mental health matters. In such a climate, managers respond respectfully, confidentiality is credible, and seeking support does not threaten reputation or advancement. Bouzikos et al. (2022) found that organizational climate shaped the effectiveness of EAP counselling, reinforcing the principle that counselling works best when it is part of an institution's culture rather than an isolated service.

Workplace counselling may influence productivity through several pathways. It can help employees name and regulate emotion, reframe unhelpful thoughts, resolve interpersonal strain, improve coping, and obtain timely referral. These processes can restore attention, decision-making, empathy, and confidence. EAP studies report improvements in psychological health and

work functioning, but the evidence base remains methodologically uneven, with many cross-sectional or uncontrolled studies (Long & Cooke, 2023). Accordingly, counselling should be understood as a promising component of a wider occupational-health strategy, not as a substitute for organizational reform.

Culture shapes whether employees recognize distress, disclose it, and accept counselling. Ghanaian workplaces often draw strength from communal solidarity, faith, respect for authority, and commitment to family. These same values may complicate disclosure when distress is interpreted as weakness, spiritual failure, disloyalty, or inability to cope. Hierarchical relationships may heighten fear that personal information will reach supervisors. Effective services should therefore protect professional ethics while communicating in culturally intelligible ways. Peer support, appropriate spiritual sensitivity, proverbial wisdom, and family-aware practice may enhance engagement, provided these elements are offered with consent and do not replace evidence-based assessment or referral.

A pastoral-counselling perspective adds a moral vocabulary of dignity, compassionate presence, stewardship, and hope. It recognizes the employee as a whole person rather than merely a unit of labour. Yet pastoral sensitivity must never blur clinical boundaries. Competent practice requires informed consent, confidentiality, non-discrimination, careful risk assessment, referral when needs exceed the counsellor's competence, and respect for employees of every faith or none. Theologically informed care is most credible when it protects freedom, refuses blame, and joins personal support with advocacy for just working conditions.

4. Materials and Methods

A quantitative cross-sectional survey design was used to examine relationships among counselling awareness, occupational stress, and organizational productivity at one point in time. This design was appropriate for estimating patterns and associations but could not establish temporal order or causation.

The study population comprised approximately 510 employees at SODH, including medical doctors, nurses, midwives, administrative staff, and ancillary personnel. Cochran's initial estimate for a large population at 95% confidence, 5% precision, and maximum variability ($p = .50$) is 384. Applying the finite-population correction to $N = 510$ gives approximately 220, not 200. The achieved analytic sample was 200 respondents. Because the manuscript did not provide the number invited or reasons for non-participation, a response rate could not be calculated and should be reported in the final submission if available.

Stratified sampling was intended to preserve representation across professional groups, followed by random selection within strata. The achieved sample included nurses (40.0%), midwives (23.0%), doctors (11.5%), ancillary staff (15.0%), and administrators (10.5%). Rotating-shift staff constituted 51.0% of respondents, and 29.0% worked day shifts; the remaining respondents worked night or fixed administrative schedules.

Data were collected with a structured self-administered questionnaire. The instrument contained demographic items and three composite scales: Awareness of Workplace Counselling (AWC),

Occupational Stress (OS), and Organizational Productivity and Performance (OPP). Items were rated on five-point agreement scales. AWC assessed knowledge of services, accessibility, management promotion, confidentiality, perceived career safety, stigma, and psychological safety. OS assessed workload, exhaustion, inability to detach, workplace conflict, resource scarcity, emotional demand, and intention to leave. OPP assessed timeliness, accuracy, empathy, concentration, reliability, errors, absenteeism, and presenteeism. Negatively keyed productivity items should be reverse-scored before a composite score is calculated; confirmation of this scoring step is essential because an unreversed composite would be difficult to interpret.

Internal consistency was assessed with Cronbach's alpha. Descriptive statistics summarized key variables. An independent-samples comparison examined stress by clinical versus non-clinical role, and one-way ANOVA examined stress across shift patterns. Pearson correlations assessed bivariate relationships. Multiple linear regression estimated productivity from counselling awareness and stress while controlling for age and staff type. Statistical significance was evaluated at $\alpha = .05$. Assumptions, confidence intervals, effect sizes, missing-data handling, and diagnostic statistics were not supplied in the source manuscript and should be added before journal submission.

Administrative permission and ethics approval were to be obtained before data collection. Participation was voluntary, informed consent was required, and respondents could decline questions or withdraw without penalty. No directly identifying information was linked to responses, and findings were reported in aggregate. Because questions concerned stress and intention to leave, the protocol should also specify a confidential route for immediate support and referral.

5. Results

The three composite scales showed acceptable-to-strong internal consistency: AWC, $\alpha = .88$; OS, $\alpha = .79$; and OPP, $\alpha = .88$. These coefficients support score consistency, although reliability alone does not establish construct validity.

Counselling awareness was moderate ($M = 3.02$ on a five-point scale), occupational stress was high ($M = 3.40$), and organizational productivity was comparatively low ($M = 2.63$). These interpretive labels depend on the study's chosen cut-points, which should be reported explicitly in the final article.

Clinical staff reported greater occupational stress than non-clinical staff ($M = 3.61$ versus 2.80 , $p < .001$). Stress also differed significantly across shift patterns, $F(3, 196) = 75.76$, $p < .001$, with rotating-shift employees reporting the greatest strain. Group standard deviations, confidence intervals, the t statistic, ANOVA effect size, and post-hoc comparisons were not available and should be supplied from the original analysis output.

Occupational stress had a very strong negative correlation with productivity ($r = -.94$). Counselling awareness was moderately associated with lower stress ($r = -.47$) and higher productivity ($r = .43$). The regression model was statistically significant, $F(7, 192) = 208.9$, $p < .001$, and explained 88.4% of the observed variance in productivity ($R\text{-squared} = .884$).

Occupational stress was the dominant negative predictor (reported $\beta = -.99$, $p < .001$), whereas counselling awareness was not independently significant ($p = .32$) after stress and covariates were included.

The magnitude of $r = -.94$ and $\beta = -.99$ is unusually large in organizational research and merits careful verification. Before publication, the authors should inspect scatterplots, outliers, multicollinearity, item overlap between the stress and productivity scales, reverse-scoring, common-method variance, and regression assumptions. If the reported β is unstandardized, it should be labelled B rather than β . A formal indirect-effect analysis with bootstrapped confidence intervals would be required to test mediation; the present regression does not confirm it.

Table 1. Summary of principal study variables and findings

Measure or test	Statistic	Value	Interpretation
Counselling awareness	Mean	3.02/5	Moderate awareness
Occupational stress	Mean	3.40/5	High stress
Organizational productivity	Mean	2.63/5	Comparatively low
Stress: clinical vs non-clinical	Group means	3.61 vs 2.80	Clinical staff higher; $p < .001$
Stress by shift pattern	ANOVA	$F(3, 196) = 75.76$	Significant; $p < .001$
Stress and productivity	Pearson r	-.94	Very strong inverse association
Counselling awareness and stress	Pearson r	-.47	Moderate inverse association
Counselling awareness and productivity	Pearson r	.43	Moderate positive association
Productivity model	R-squared	.884	88.4% variance explained
Counselling awareness in full model	p value	.32	Not independently significant

Note. Interpretive categories and all reported statistics are reproduced from the supplied manuscript. Missing dispersion estimates and diagnostics should be added from the original analysis output.

6. Discussion

The findings portray a workforce carrying substantial occupational strain. High average stress alongside lower self-reported productivity is consistent with the JD-R health-impairment pathway: sustained demands consume emotional and cognitive resources, making it harder to concentrate, regulate emotion, complete tasks accurately, and remain fully present. The strong inverse association should be interpreted cautiously, yet its practical message is clear: productivity cannot be protected merely by urging staff to work harder when the workforce is already depleted.

The greater stress reported by clinical staff is understandable in light of direct patient responsibility, exposure to suffering, rapid decision-making, moral complexity, and the consequences of error. Rotating shifts add circadian disruption and can interfere with sleep, family responsibilities, worship, social connection, and recovery. These findings support targeted support for doctors, nurses, and midwives while affirming that ancillary and administrative staff also require access to care.

Counselling awareness was associated with lower stress and higher productivity at the bivariate level. Once occupational stress entered the regression, awareness no longer contributed independently. A plausible interpretation is that counselling matters to work functioning when it helps reduce or contain stress. This is theoretically consistent with JD-R and resource-conservation perspectives. It is not proof of mediation, however, because awareness is not the same as actual counselling use, the variables were measured concurrently, and the study did not estimate an indirect effect.

Moderate awareness also suggests an implementation gap. Employees may know that some form of support exists without believing it is confidential, accessible during their shift, independent of performance management, or intended for ordinary occupational strain. A service becomes trustworthy through repeated experience: clear privacy rules, competent practitioners, predictable availability, respectful leadership, and visible protection from retaliation. Communication should therefore move beyond announcing a clinic to explaining who may use it, for what concerns, how records are protected, what exceptions apply, and how referrals are managed.

From a pastoral-counselling standpoint, the data call the institution to compassionate stewardship. Healthcare workers who routinely care for vulnerable people also need spaces in which their own grief, fear, fatigue, and moral distress can be heard without shame. Compassion must be organizational as well as interpersonal. Prayer, spiritual reflection, or faith-informed coping may be helpful when chosen by the employee, but they should accompany—not replace—clinical assessment, workload reform, rest, referral, and professional accountability. The ethical centre of the response is the dignity and safety of the worker.

7. Implications for Policy and Practice

First, SODH should develop a clearly governed, employee-focused assistance programme rather than rely solely on patient-oriented wellness structures. The programme should offer confidential assessment, brief counselling, referral, crisis support, and manager consultation through qualified practitioners whose records are separated from routine personnel files.

Second, access should reflect hospital life. Appointments should be available across day, night, and rotating schedules, with secure remote options where feasible. High-risk units and post-incident periods may require proactive check-ins or facilitated peer support, while participation remains voluntary except where a lawful fitness-for-duty process applies.

Third, hospital leadership should strengthen psychosocial safety. A written confidentiality protocol, non-retaliation commitment, and clear boundaries between therapy and performance management are essential. Managers should be trained to notice changes in functioning, conduct

supportive conversations, respond to suicide or self-harm concerns, and refer appropriately without diagnosing employees.

Fourth, counselling must be paired with prevention. Management should review workload distribution, staffing gaps, shift rotation, rest periods, role ambiguity, equipment shortages, exposure to violence, and procedures following adverse clinical events. Aggregate, de-identified service trends may inform prevention, but individual counselling records must never be used as a surveillance tool.

Fifth, the programme should be culturally responsive and spiritually sensitive. Employees should be able to discuss faith, family, communal obligations, and culturally meaningful coping when relevant. Spiritual care providers and peer supporters may collaborate within a defined referral network, while clinical governance, consent, competence, and inclusion remain non-negotiable.

Finally, evaluation should be built into implementation. Indicators may include service awareness, utilization, satisfaction, perceived confidentiality, stress, burnout, psychological safety, sickness absence, turnover intention, patient-safety events, and data quality. Baseline and follow-up measurement should combine anonymous employee reports with carefully governed organizational indicators.

8. Limitations

The study was conducted in one district hospital, limiting generalizability to other Ghanaian facilities. Its cross-sectional design prevents causal conclusions and does not establish temporal order. All principal variables were self-reported in one questionnaire, increasing susceptibility to recall error, social desirability, common-method variance, and conceptual overlap. Awareness of counselling was measured rather than verified service utilization, counselling dose, modality, practitioner competence, or outcome. The achieved sample was smaller than the corrected target of approximately 220, and the response rate was unavailable. Several statistical details required for complete reporting—including dispersion estimates, confidence intervals, effect sizes, post-hoc results, missing-data procedures, and assumption checks—were not provided. The exceptionally strong stress-productivity relationship therefore requires replication and audit against the original dataset and syntax.

9. Conclusion

At Shai-Osudoku District Hospital, occupational stress was high, counselling awareness was moderate, and self-reported productivity was comparatively low. Stress was concentrated among clinical and rotating-shift staff and was strongly associated with poorer productivity. Awareness of counselling was related to lower stress and better productivity at the bivariate level, but it did not independently predict productivity after stress was considered. The safest conclusion is that workplace counselling may contribute to productivity by helping employees manage strain, while stronger longitudinal and mediation analyses are needed to establish the pathway.

The practical lesson extends beyond statistics. A hospital cannot sustainably heal the public while neglecting the inner burden of those who provide care. Ethical, confidential, culturally

responsive counselling—joined to supportive leadership and structural improvement—can help create a workplace where staff are heard, restored, and enabled to serve with competence and compassion.

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Declarations

Ethics approval and consent to participate: Insert the approving ethics committee, approval number, and approval date before submission. Written informed consent was obtained according to the study protocol.

Consent for publication: Not applicable; no identifiable individual data are reported.

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