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The Current Status of Working Conditions in Public Hospitals at a Selected Province, South Africa: Part 1

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ABSTRACT The purpose of this two-part paper was to explore and describe the status of working conditions in public hospitals at a selected province in South Africa. An explorative, descriptive, qualitative design was used for this study. Purposeful sampling was used to select the 32 participants comprising senior managers, middle managers, operational managers, occupational health and safety nurses and all employee representatives in the 27 public hospitals in the province. Data collection was achieved through individual in-depth interviews. The findings suggest that working conditions in public hospitals are poor and characterized by job dissatisfaction, high levels of psychological stress and burnout. The poor working conditions were attributed to poor infrastructure, budgetary constraints and unfair distribution of incentives, unsafe environment, poor interpersonal relationships, flawed communication channels, lack of support and lack of involvement in decision making. The results can inform development of policy and occupational health and safety measures.

INTRODUCTION

Health care personnel as employees of public hospitals are faced with numerous challenges in their workplace. These challenges impact negatively on their own occupational health and safety as well as the quality of service delivery. The poor working conditions in public hospitals have been attributed to factors such as budgetary constraints, infrastructural problems (Pillay 2009; Stuckler et al. 2011), lack of human and material resources, unavailability of drugs (Kotze and Couper 2006; Stuckler et al. 2011) and poor managerial skills at sectoral and health facility level (DPSA 2006; George and Rhodes 2012; van der Colff and Rothmann 2014).These problems have been expressed through job stress, job dissatisfaction, low morale, demotivation and burnout among employees (Breier et al. 2009; Songstad et al. 2011).

Public hospitals in the selected province are no exception as they have been under public scrutiny for many years. For example, there is evidence that patients are turned away or left unattended for longer than necessary in public hospitals due to situations such as long queues, inadequate personnel, and lack of admission beds, lack of water, and electricity failures which lead to the cancellation of surgeries. Poorly maintained equipment such as refrigerators which have allegedly caused diarrhea due to the consumption of food that was not fresh, had been reported by the media (Mpumalanga health care limps to aid of ailing poor, 2014: Para. 3-5; Patients turned away in hospital blackout, 2011: Para. 1-8; Several patients taken to other hospitals because of water crisis, 2014: Para. 1; Patients fed rotten food, 2013: Para. 3). The unavailability of crucial services like lifts, have far reaching implications for health care personnel, critically ill patients and for patients who need emergency care or surgery. The media has reported on stories of family members who had to carry their deceased relatives down flights of stairs due to lifts that were out of order (Man carries elderly relative's body out of hospital, 2014: Para.1). These examples of inadequate service delivery could be attributed to factors often beyond the control of health care providers such as infrastructural problems, electricity failures and lifts that are out of service.

The poor service delivery conversely impacts negatively on the physical and psychosocial safety of the health care personnel. For instance, poor service delivery is blamed on the health care providers. More strikingly, there is anecdotal evidence of nurses and doctors who have suffered or even lost their lives in the hands

of patients and their relatives in public hospitals (Anger at killing of doctor in Mpumalanga, 2011: Para. 2).

Despite all these challenges, there has not been any empirical study that has investigated the working conditions in public hospitals at the selected province in South Africa.

This paper seeks to explore and describe the current status of working conditions in public hospitals at a selected Province, and to propose recommendations that will be used to promote and protect the occupational health and safety of health care personnel thus contributing to improving the quality of patient care.

MATERIAL AND METHODS

A qualitative exploratory, descriptive research design was adopted for this study.

Population

The target population comprised all senior management (Chief Executive Officers, nursing managers, medical managers, and human resources managers), middle managers, operational managers, occupational health and safety nurses and all employee representatives in the 27 public hospitals in the selected province. However, the researcher managed to obtain responses from only 16 hospitals located in the 3 districts of the selected province. The hospitals in which the study was conducted render different levels of healthcare, namely: from level 1 to level 3.

Sample and Procedure

Purposeful sampling was used to select participants for this phase of the study.

A sample of 32 participants was drawn according to specific inclusion and exclusion criteria.

Data Collection

Permission was granted by the Provincial Health Research and Ethics Committee and the senior management of the respective hospitals, participants were then recruited through the matrons and heads of sections/departments. Each participant was sent a letter containing all the details of the study. Consent was sought from individual participants before data collection commenced. Once consent was granted, the process of data collection commenced.

Semi-structured in-depth individual interviews were used to obtain data from the participants.

Data Analysis

The audio-recorded data was transcribed verbatim (word for word). That was done immediately after the interviews in order not to lose information. Data was grouped into themes, categories and sub-categories (not described here), coded by the researcher and analysed according to Tesch's (1990) inductive, descriptive coding technique in Creswell (2007). The findings of the study were presented and interpreted in view of the research question and the existing literature. Interpretation of the results was undertaken in the discussion section of the report, as suggested in Creswell et al. (2011).

RESULTS AND DISCUSSION

Participants' Description of Current Status of Working Conditions in Public Hospitals

Participants revealed varied perspectives regarding working conditions in their hospitals. Most of the participants felt that their working conditions were unsatisfactory while a few gave positive descriptions of the working conditions. They described their working conditions as follows:

Psychological Stress Related to Poor Working Conditions

Participants described the working conditions in their hospitals as physically exhausting and psychologically traumatic, demotivating and demoralizing. They described how most of the time they were talked down and not given support in what they are doing. The managers were said to be inconsiderate and often pointed out mistakes made by the employees and this affected them negatively. They felt they were broken down psychologically and felt unsafe in the environment as they were not supported by their managers. They explained that dealing with very ill and dying patients was disheartening and affecting them psychologically as there were no debriefing programmes in place in their hospitals. They emphasised that managers expected too much from them without providing neces-

sary resources. They complained about too heavy a workload which they said, caused fatigue and absenteeism among staff members. This is what they said:

"The working environment is demotivating and demoralising, instead of being built up you are being broken down."

".....It is psychologically challenging due to stress of nursing very sick children and seeing dying patients with no debriefing done."

Burnout Syndrome Associated With Stress

Burnout was cited as a challenge by participants. They described how they were demotivated, frustrated and burned out as they felt that management did not consider the health and safety of employees as a priority. They felt that management did not have the interest of health care personnel at heart as they were not willing to attend to their complaints, inspection reports and employees' needs. This is what they said:

"Management does not value employees' well-being. Even though inspections are done and reports are written with recommendations, nothing is done about the situation. It is demotivating on the person who does the inspections."

"Management, particularly CEOs does not have interest of personnel at heart. They cannot handle problems and grievances properly."

Burnout syndrome associated with stress among health care workers has been well documented in literature. These high levels of burnout were associated with long hours of patient care and inadequate support from management (Carneiro 2013; Poncet et al. 2007). Carneiro et al. (2013), in his study of burnout among dentists in Fortaleza, Brazil, found that 32 percent of the 100 respondents were diagnosed with burnout syndrome.

Employee Dissatisfaction with Working Conditions

Employee job dissatisfaction was also cited by the majority of participants. Participants expressed their dissatisfaction regarding the appointment of people who do not have the necessary skills and qualifications to managerial posts. According to participants, such appointments led to management failures. They indicated that most of the managers did not have health related qualifications which, according to them, was causing many problems as they felt that such managers were taking too long to understand issues affecting health care settings. They also mentioned that unfair distribution of incentives and poor implementation of the OSD in certain hospitals in the province had caused dissatisfaction among employees. They suggested that qualifications must be recognised, incentives given and that there should be equal distribution of OSD incentives. This is evident in the following quotes by participants:

"There is poor management...no motivation or appreciation of work well done."

"The recruitment system to managerial positions does not appreciate people's skills and knowledge, but is done according to seniority in terms of the number of years in the service." Another one said:

"The problem is that some CEOs who are not trained as health professional do not understand hospital procedures."

"I have worked hard for this hospital... for many years but have never received a performance bonus."

Job dissatisfaction among hospital employees has been widely researched and reported both in the developing world and in Europe. For example, employee job dissatisfaction has been reported among nurses in Netherlands, Belgium, Norway, Sweden and Switzerland, England, Germany, Ireland, Spain and Greece (Aiken 2013). Job dissatisfaction among health professionals, particularly nurses and physicians has also been reported in Spain (Moñux et al. 2015), Istanbul (Kisa et al. 2013), India (Kaur et al. 2009), Ethopia (Lindelow and Serneels 2006) and in South Africa (Pillay 2009; Songstad et al. 2011; van der Doef 2012).

Job dissatisfaction among these nurses was attributed to a poor working environment particularly arising from low salaries, lack of promotions and shortage of staff.

Poor Infrastructure

Most of the hospitals visited were old and dilapidated although in most of them there were revitalizations or constructions going on. The construction was either renovating or adding new wards. Almost all participants who were working in hospitals which were either old or under construction or revitalisations were un-

happy about the infrastructure and described lack of office space as a challenge. They mentioned that in some sections of the hospital there was only one toilet which was used by both male and female personnel. They described how they were affected by these factors as some of these institutions had been under construction for close to ten years with no progress. Construction work was also said to interfere with electricity and water supply, which disrupted their day to day work. They said:

"...construction of the hospital has led to offices and units, like casualty, being reshuffled in small spaces... like casualty is overcrowded."

"We have only one toilet which we share with our female colleagues in this section. We either have to use this toilet or to leave this one to the ladies and walk for a long distance to another building."

"...More often, operations have to be cancelled because of lack of electricity. It is worse in maternity section; we have to use buckets to get water for patients to bath and for us to wash hands."

"The temporary entrances and exits are causing a lot of inconvenience to our clients and personnel; there is also no parking space for visitors and staff..."

The findings of this study give credence to several earlier reports which revealed that most buildings in public hospitals in South Africa are old and dilapidated. For example, DPSA (2006) reported that most buildings in most hospitals were very small, old and needed total replacement.

The results of this study further concur with a report released in November 2012 by Dr Pillay, the Director General in the Eastern Cape Health Department, in which he echoed the problem of poor infrastructure in South African public hospitals. In the report, he lamented that about 17 hospitals and 168 clinics in the Eastern Cape did not have piped water, 42 health facilities had no electricity, 68 percent of hospitals lacked essential equipment, while 16 percent had no telephones and were only accessible by road when the weather was good (Bateman 2012). In the same article, the National Minister of Health, Dr Aaron Motsoaledi, expressed his concerns about poor infrastructure of South African public hospitals. He attributed the infrastructure problems to under spending due to late awarding of tenders, rolling over of budgets and poor performance of contractors which later lead to termination of contracts. Other contributing factors were related to lack of experienced engineers and architects to undertake public works projects. The current systems used for awarding tender have seen tenders being awarded to either inexperienced contractors who do not have capacity to complete the project or to politically connected individuals (Bateman 2012).

Unsafe Environment Exposing Employees to Infections

The majority of participants felt that the poor infrastructure was a risk factor for transmission of airborne diseases, particularly TB. They stated that their chances of contracting TB were increased due to lack of isolation rooms which have led to mixing of highly infectious MDR-TB patients and those with non-infectious diseases. The following are some of the statements from the participants:

"There is poor ventilation in waiting areas which is a TB hazard as all waiting areas have recently been enclosed with glass which has increased the hazard of TB."

"The nature of patients has changed, the wards are overflowing with TB and AIDS patients, we are afraid for our lives."

"The hospital need to be extended by extra wards like paeds (paediatric ward), maternity and psychiatric because is accommodating more than 30 clinics."

The employees' fears for contracting infectious diseases particularly TB and MDR-TB are justified as literature confirms that caring for people with infectious diseases invokes feelings of fear and anxiety (Jo et al. 2013.)

A substantial number of other studies on tuberculosis have also revealed that a significantly large numbers of smear positive patients in health facilities increases the risk for transmission of Mycobacterium tuberculosis (TB) to other patients and to health-care workers (Jo 2013; O'Donnel et al.2010; Hashemi et al. 2014).

The risk factors to nosocomial infections among health care personnel in public hospitals in China and South Africa have been associated with working in hospital settings which provide care to TB patients, inadequate TB infection control strategies, lack of knowledge of the National TB guidelines and the TB policies, poor adherence to standard operating and care pro-

cedures, closed ventilation system without natural ventilation or negative exhaust ventilation and lack of protective equipment (Hashemi et al. 2014; Malangu and Legothoane 2012; Sissolak et al. 2011). A study by Jo et al. (2013) on the prevalence of latent tuberculosis among health care workers in Korea revealed that duration of employment as a health care worker (HCW) and experience of working in a TB-related department were significantly related to positive QuantiFERON-TB GOLD In-Tube QFT-GIT result.

Cross Infections among Patients Related to Poor Infrastructure

A majority of participants in this study cited bad infrastructure in public hospitals as a reason for overcrowding in the wards. They stated that overcrowding in the wards caused cross infections. These had been further aggravated by the lack of facilities to prevent cross infections. These statements are illustrated by the following quotes:

"There is no isolation ward and patients with TB are nursed in general wards where all patients and staff are exposed."

"There is structural overcrowding, the wards are too small. Some patients who have MDR Tuberculosis take very long to be transferred from the medical wards to the TB center ..."

The media also confirms the findings of the study that real unsafe conditions which predispose hospital employees and patients to infectious diseases particularly TB, really do exist in the selected province. For example a recently published paper reported an incident in which patients were unceremoniously removed from the wards by a contractor in demand for payment for the services he had rendered. The paper reported that patients spent freezing nights on stretchers under inhumane conditions in an overcrowded ward and in passages while some negotiations were going on between government and the contractor. It was also revealed that patients with contagious diseases such as X-treme drug resistant TB were sharing wards with uninfected ones, which compromised their increased risk of exposure to TB infection (Contractor locks wards over R12m bill, 2013: Para.1-2).

These findings suggest that there is a need for intervention to protect health workers and provide safer working environment for hospital employees.

Fear for Personal Safety Related To Lack of Security

Participants stated how they feared for their lives as they perceived lack of security in public hospitals. They expressed their concerns about the unguarded multiple entrances that according to them, led to criminals and unauthorized persons gaining entrance to the hospitals. According to the participants, there were not enough security measures taken to protect staff from being assaulted. They expressed a lack of confidence in the current security system as they felt it was not capable of protecting them from being assaulted while on duty. They felt that management was silent about the lack of safety and the risky working conditions that they were exposed to. They felt that provincial head office and management have to do more to improve the security systems in public health hospitals. The following quotes bear witness to these claims:

"… it is easy for an outsider to gain entrance to the hospital and easily assault an employee. There are too many entrances and exits around the hospital."

"The security system is too weak here, these guards at the gate are only armed with 'knobkieries' [A short stick with a knob at the top, traditionally used as a weapon by the indigenous peoples of South Africa] *and there is nothing serious. After all, we are told that they are only here to protect the hospital property and not us."*

A perceived lack of safety as a result of poor security coupled with exposures to biological hazards evokes feelings of fear, apprehension anxiety and helplessness among employees (Kish-Gephart et al. 2009; Gillespie 2013).

Lack of security in public hospitals is further confirmed by the press which reported an incident related to the killing of a health care provider in a hospital in the Mpumalanga Province. The incident left health care workers angry, disturbed and traumatised. The killing was said to have been related to the lack of security in public hospitals as well as to poorly trained security guards (Anger at killing of a doctor in Mpumalanga 2011: Para.4). Such an incident strongly suggests the importance of putting in place measures that will make employees feel safe in their working environment as the perceived lack of security has a negative influence on the psychological well-being of employees.

Poor Interpersonal Relations between Managers and Employees

Poor interpersonal relations between managers and employees was said to prevail in public hospitals as described by a majority of the participants. he poor interpersonal relations were attributed to factors such as negative attitudes of staff members towards each other, poor communication between managers and employees, and centralisation of decisions. Participants described how the strained interpersonal relationships were affecting them psychologically. They explained how according to them, such behaviours had led to demoralisation, low morale and absenteeism. They stated that the poor interpersonal relationships had caused divisions between the staff members and management. These claims are supported by the following quotes:

"...as staff members we are not treated in a decent way.... ".

"Negative attitudes of staff members towards each other and to patients are a problem, we don't respect each other ... we badmouth each other."

Dysfunctional and poor interpersonal relationships between management and employees have been reported in public hospitals, both in South Africa and abroad. For an example, a survey by Moñux (2014) reported poor relationships among managers and employees employed in public hospitals in Spain. De Villiers and De Villiers (2004) found that poor interpersonal relationships existed between doctors and management in some public hospitals in the Western Cape Province, South Africa. Moñux (2015) in her study of interrelationships and job satisfaction found that lack of interpersonal communication skills may lead to social and labor disputes, occupational stress and job dissatisfaction.

These claims suggest that good employee-manager relationships, coupled with effective communications, are central to the development and maintenance of a good working climate in the work place.

Flawed Communication Channels

A majority of participants complained about poor communications systems in their institutions. They indicated that they were not given information that affects them in the working place. They reported that they often received information through the "grapevine" and from friends. The following quotes bear witness to these claims:

"Managers of different departments are not working together; there is no proper communication between manager and staff members."

"Information must be disseminated to the lower levels of management and to the functional level employees."

Poor communications and lack of information flow between managers and employees and among line managers and senior managers were reported in Australian public hospitals (Stanton et al. 2010) in Tanzanian public hospitals (Leshabari et al. 2008) and in Spain (Moñux 2014).

According to the National Institute for Occupational Safety and Health (NIOSH 2008); Moñux (2014), poor communication is one of the challenges leading to poor quality of patient care as well as stress among health care personnel.

Budgetary Constraints

Participants expressed their frustrations regarding budgetary constraints. A majority of participants felt that the budgetary constraints emanated from mismanagement of funds, insufficient budget allocated to institutions, management's failure to plan and prioritise, and the sluggish processes of procuring material and equipment. According to the participants, budgetary constraints were the reasons for the lack of supplies in public hospitals. They blamed the supply chain department for neglecting their duties which, according to them, led to the shortage of equipment, supplies and protective clothing in hospitals which in turn compromised their safety. They also blamed the provincial government for the poorly maintained facilities and equipment such as lifts and air-conditioners. They attributed the malfunctioning air conditioners and lifts to non-payment of service providers by the provincial government. To deal with the budgetary constraints, they suggested that CEOs should be given financial powers. These concerns are illustrated in the following statements made by participants:

"...some top managers are not disciplined and are mismanaging the revitalization finances. The processes of procurement and approval of requests for resources are too long and causing shortage of stock and equipment to perform duties".

"... budget cuts are a problem; there is gross shortage of working materials. Where I work there are no protective clothing e.g. mask (N95) for staff working in OPD, casualty and the medical wards.

"Cost curtailment is a problem... and also the hospital wanting to save money instead of buying stocks. Sometimes government takes too long to pay service providers, causing them to withdraw their services."

"The procurement systems are abysmal..... give all head of institutions and CEOs all financial powers to be able to manage institutions according to their unique needs".

These findings are consistent with other studies which revealed that public health systems in low-and middle-income countries, including the South African public health system, are experiencing budgetary constraints. These budgetary constraints are said to be particularly associated with the technical and fund allocation inefficiencies which impact negatively on the use of available resources (Goddard 2013; van der Doef et al. 2012)

Budgetary constraints has serious implications for the running of the hospitals as highly experienced doctors have to take part-time private practice because the hospital cannot afford to pay them and as a consequence, hospitals have to be run by a few junior and less experience staff members who are overworked and stressed (Goddard 2013).

Unfair Distribution of Incentives

Unfair distribution of incentives, improper implementation of the performance management system and the occupational skills dispensation emerged as a challenge in public hospitals. Participants cited a number of reasons for not receiving incentives. These reasons include: budgetary constraints, unfairness of the selection of individuals qualifying for incentives which they said was based on friendships and on individuals' capabilities to write and fabricate good reports about themselves. They mentioned that those who were not able to write never received any incentives.

Shortage of Nursing Personnel

A majority of participants cited shortage of nursing personnel in the hospitals as a major challenge. According to participants, the shortage of nursing personnel was ascribed to high turnover rates, failure to replace nurses who had died or were retiring, and freezing of posts. They indicated that most employees were chronically ill and were always absent from work. To cope with the shortage, the hospital relied on getting those who were off-duty to come and "moonlight" or work overtime. It was also indicated that most of the time the hospital management relied on people who had retired to come and relieve the shortage. This was found to be inappropriate as it is believed that old people could not perform some of the heavy tasks. It was also suggested that managers should also improve human resources for the institutions as most Institutions were said to be operating on a "skeleton" staff as vacant posts had been frozen. Their concerns regarding shortage of staff and the causes thereof are evident in the following quotes:

"It is a rural area, so there is always shortage of staff and to work being one in a place of about four personnel, it really needs perseverance to cope with work and to deliver quality care service."

"There is gross shortage of personnel due to illness and a management structure and system that is not very keen on prioritising issues of personnel health and safety. The high rate of absenteeism causes stress and too much workload to other personnel."

"The hospital needs more staff... like specialist doctors to decrease the rate of overloading other hospitals".

The ability of a hospital to provide safe, high quality, effective patient care depends on the availability of adequate skilled and well-motivated staff (Savic and Robida 2013, Goddard 2013). Shortage of nursing personnel has been reported worldwide. For example, a study by Kingma (2007) revealed that gross shortages of nursing personnel in Western Australia led to patients spending up to two days in casualty departments before being admitted.

Shortage of nursing personnel in public hospitals has been attributed to a number of other factors such as the freezing and termination of posts, inadequate salaries, skills and expertise that are not rewarded, inadequate training capacity, skills mix deficits, weak management systems as evidenced by low levels of support, poor morale, fragmented systems and management's

failure to create an environment in which staff can grow (Hammett 2007; Hull 2010 Goddard 2013). Of particular importance, the National Minister of Health acknowledged that the public health system in South Africa is dysfunctional. According to the National Minister of Health, most of the management problems such as public hospitals actually being run by unqualified people such as junior nurses and clerks were attributed to staff shortages (Bateman 2010). Freezing of clinical posts was also cited as the main reason for the gross shortage of staff in South African public hospitals (Bateman 2010).

Involvement in Decision Making

There were varied responses regarding participants' descriptions of their involvement in decision making. A majority of participants stated that they were not involved in decision making meetings while others indicated that they were involved. However, they verbalized their discontentment regarding the outcomes of such meetings. They said that they considered attending such meetings as wasting their time and effort because their inputs are not seriously considered because decisions are still taken at provincial and managerial level. They felt that management was being disrespectful to them by making them believe that their contributions were important when they knew that they were not actually necessary. They felt that by inviting them to attend meetings, management wants to be seen to be observing protocol. This is illustrated in the following statements:

"*Employee representatives are sometimes co-opted to decision making processes only to legitimize the process, not necessarily to add value to the process as sometimes decisions are already taken at managerial level.*"

"*Not always, some decisions are taken at the provincial office without consultation, for instance, there was no involvement of personnel at the ground when plans were drawn for initiating (erecting) new structures.*"

"*There is lack of involvement in budget committees and bid committees... we don't have a say in budget things, hence we are given little budget that we can't even challenge it.*"

Lack of employee involvement in decision making has been reported among health care personnel in Poland (Pordoski 2005) and in South Africa (De Vries and De Vries 2004), despite the fact that OHSA18001 requires orgnisations to establish procedures to ensure involvement of employees in decision-making, De Villiers and De Villiers (2004) found that doctors who were not contacted on issues that affected their jobs were dissatisfied with their working conditions.

Poor Implementation of Decisions

Despite the negative descriptions of employee involvement in decision making by the majority of participants, a few participants acknowledged that they were being involved in decision-making meetings. However, they were not happy about the outcomes of those meetings because they felt that decisions taken were not being implemented. They blamed management for not making enough efforts to ensure that such decisions were implemented. The following statements confirm this claim of involvement in decision making by management. This is what they said:

"*As union representatives we get invited to meetings whereby decisions are taken, but they are poorly implemented, which leads to useless frequent meetings repeating the same things.*"

Bossert and Mitchell (2011) found that group decisions are often changed or not considered at higher organisational level. Furthermore, the claims made by this current study are consistent with a report by Benson and Dundis (2003), which revealed that failure to implement employee decisions and ideas leads to further withdrawal of employees from decision making meetings as they tend to feel misunderstood and unappreciated.

Despite all the negative descriptions of the working conditions in public hospitals, some participants indicated that they were satisfied with certain aspects of the working conditions as evidenced by the following statements:

"*The working conditions are good even though we are using the old structure and outdated equipment but we make sure that the equipment is serviced and structure is well maintained.*"

"Another one said: "*To me the working conditions are fair though I am overworked, but I am used to it.*"

CONCLUSION

The study confirms that health care personnel are dissatisfied with numerous aspects of the working conditions in public hospitals. The

findings also suggest that employees risk physical and emotional exhaustion psychologically trauma, burnout and demotivation in the workplace. Furthermore, the results show that health care personnel do not receive adequate support that they need to cope with the demanding working environment. Health care personnel also expressed fear of infection due to poor infrastructure and lack of protective equipment as well as fear for personal safety as a result of lack of insecurity. Poor communication channels, poor interpersonal relationships and lack of involvement in decision making were some of the important issues raised by health care personnel in this study.

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