Workers' Security threats in Healthcare Facilities: A Study of Selected Hospitals in Lesotho

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DECLARATION

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I declare that "Workers' Safety Concerns in Healthcare Facilities: A Study of Selected Hospitals" is my own work and that all sources that I have used or quoted have been indicated and acknowledged by means of complete references.

____________________________ ______________________

Signature Date

CERTIFICATION

This is to certify that this dissertation has been read and supervised as having met the requirements of the Faculty of Social Sciences, National University of Lesotho, for the award of the Degree of Master of Science in Sociology.

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ABSTRACT

The pervasive nature of uncertainty, particularly in the context of security threats, has become a defining feature of contemporary public and private sector organisational environments. While the study of uncertainty as a phenomenon has garnered significant attention in its own right, its impact on professionals and their daily practices remains underexplored. The study delves into the complex landscape of security threats faced by healthcare professionals, particularly coined with how uncertainty related to security threats, has re-shaped the everyday experiences and workflows of professionals, offering an extensive analysis that significantly advances an understanding of this critical issue. This study aims to comprehensively investigate the pressing issue of workers' security concerns within the healthcare sector in Lesotho, with the focus on healthcare professionals in Mafeteng Hospital and Mohlomi Psychiatric Hospital. The aim is to investigate security threats that healthcare professionals face; identify the multifaceted drivers influencing these concerns; assess the effects of existing security threats on workers' disposition to work; and to evaluate the institutional measures in place to protect employees from harm at healthcare facilities. Employing a mixed-methods exploratory approach, this study combines quantitative surveys and qualitative interviews to gather data. For the quantitative aspect, a stratified sampling approach was used to select respondents from the sample population. From each stratum, individuals were selected based on their roles and departments within the healthcare setting. On the qualitative front, however, the study employs a purposive sampling to select 20 participants. These individuals were stratified into different departments, including maternity, psychiatry, laboratory, pharmacy, paediatrics and administration departments. Data was collected through in-depth interviews with participants using an interview guide and a thematic analysis was employed for data analysis. The findings reveal that security threats in healthcare settings are not isolated incidents but are deeply embedded in the complex interactions and structural characteristics of the healthcare environment. According to the findings, the psychological and emotional toll on healthcare professionals is profound, necessitating the development of comprehensive support systems to address these challenges. Current interventions aimed at mitigating these threats are often perceived as ineffective, highlighting the need for a re-evaluation of existing strategies. The study also underscores the limited confidence in community engagement initiatives and the differential impact of threats across the two healthcare environments. Therefore, the study advocates for paradigm shift from reactive to proactive security management, emphasising the need for predictive analytics, early warning systems, and comprehensive risk assessments. The implications of this research are far-reaching, offering valuable insights for enhancing communication channels.

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BACKGROUND OF THE STUDY

1.1 Introduction

In the intricate weave of global healthcare, the resilience and functionality of healthcare systems fundamentally rest upon the well-being of their frontline warriors- the healthcare professionals (Billings, Chi Fung Ching, Gkofa, Greene & Bloomfield, 2021; Klevens, Edwards, Richards, Horan, Gaynes, Pollock & Cardo, 2002). Yet as we navigate the dynamic challenges of the 21st century, a perturbing reality surfaces: the safety concerns of these indispensable professionals are a global challenge echoing from the global stage, to the heart of local communities. In this context, Africa, with its unique healthcare landscape, becomes a microcosm of the broader global challenge, where the safety and occupational well-being of healthcare workers are both paramount and, often, under-addressed (Clarke, Rockett, Sloane & Aiken, 2002).

In consonance with Kandel, Chungong & Omaar (2020), healthcare workers' safety dialogue has gained prominence, magnified by the crucible of the COVID-19 pandemic. The discourse has extended beyond traditional concerns to encompass attacks, assaults, mental health strains, and broader occupational risks (WHO, 2020). Pursuant to Adams, Walls & Supporting Healthcare Workforce (2020), it is imperative to fortify healthcare systems against future pandemics and this has illuminated the vulnerabilities of healthcare professionals and underscored the necessity of robust safety measures. This global dialogue propels the current write-up to examine the micro-ecology of healthcare workers' safety within the African context.

In Africa, where healthcare infrastructures and resource availability vary widely, the challenges experienced by healthcare professionals are notably distinct (WHO, 2016). As expressed by Braveman & Gottlieb (2014), occupational risks intertwine with socio-economic factors, creating complex requirements to smooth service delivery in the health sector. The importance of understanding and addressing these challenges becomes ever more apparent, as these healthcare workers stand at the forefront of combating endemic diseases, emerging health threats and the daily exigencies of healthcare delivery (Patel, Bachu, Adikey, Malik & Shah, 2018). Lesotho, a nation nestled in the heart of Southern Africa, becomes the focal point for this study- an emblematic representation of the broader African narrative.

In harmony with Smith (2022), Lesotho, like many other African nations, grapples with the convoluted task of safeguarding the well-being of its healthcare professionals amid resource constraints and evolving healthcare demands. The country's healthcare landscape is marked by dynamic interplay of factors, encompassing geographical constraints, resource limitations, and the persistent burden of communicable and non-communicable diseases (Mugomeri, Khama, Seshea, Bekele, Mojai, Maibvise & Nyoni, 2017). The safety concerns of healthcare workers in Lesotho, which encompass issues such as occupational risks caused by safety hiccups and psychosocial stressors, constitute a critical, yet often overlooked facet of the nation's healthcare narrative (WHO, 2021; Solvold, Naslund, Kousoulis, Saxena, Qoronflens, Grobler & Munter, 2021). The expectation for healthcare professionals to deliver effective and efficient care persists, yet the means towards creating a habitable work environment often lag behind.

In delving into this study, the focus on Lesotho magnifies the broader imperative - ensuring that the occupational safety of healthcare professionals is not a mere luxury but an integral component of sustainable and effective healthcare delivery. Again, this write-up eventually bridges gaps in understanding, uncovers intricacies of workers' safety concerns, and paves the way for targeted interventions that resonate with the unique context of Lesotho's health sector. Lessons learned from international experiences provide valuable insights, yet the effectiveness of interventions hinges on their alignment with the specific challenges and dynamics of the local context. The contrast between global aspirations and local capacities underscores the need for an elaborate approach - a strategy that marries evidence-based global principles with a deep understanding of Lesotho's healthcare complexities. Navigating the rich fabric of global, African, and local dimensions, the goal of this study is not merely to elucidate challenges but also to illuminate a path toward a safer, more resilient healthcare environment in Lesotho.

1.2 Statement of the Problem

In the realms of health and social care, practitioners and researchers alike frequently invoke the concept of risk, as they endeavour to deepen their understanding and intervene in the probabilistic relationships between multitude of apparent casual factors and the manifestations of morbidity, mortality, or harm (Brown & Gale, 2018). In other professional domains, these outcomes might encompass criminal activity, financial losses, or the radicalisation of young people among others. Furthermore, policymakers and managers are increasingly inclined to frame the rationale and legitimacy of their restructuring efforts within healthcare contexts in terms of risk management and reduction (Rothstein, 2006). In response to these trends, health and medicine sociologists have produced an extensive body of research that critically examines and elucidates the development of risk knowledge and its application within healthcare organisations.

These studies, similar to broader sociological research on risk and uncertainty, have primarily focused on several key areas; the creation of risk knowledge (Jasanoff, 2004; Moller & Harrits, 2013); its dissemination and application across healthcare and other public sector organisations through governance systems (Flynn, 2002; Power, 2004, 2016; Rothstein, 2006); the ways in which risk is perceived and communicated (Engdhal & Lidskog, 2014; Scamel, 2011), and most notably, the various ways in which risk shapes or redefines the patient as a subject (Castel, 1991; Novas & Rose, 2000; Peterson, 1997).

The experiences of client-facing practitioners - who, with varying degrees of autonomy, apply risk knowledge and risk-framed policies within and between health and social care organisations (Lipsky, 1980; Gale et al., 2017), and in interactions and relations with these patient subjects - have largely been overlooked. This is particularly pronounced in the context of Lesotho, where healthcare professionals' lived experiences, the dynamics of healthcare delivery, organizational culture and well-being of healthcare professionals warrant a dedicated investigation. This is because, risk, once introduced into commercial or new public management contexts, tends to expand and multiply (Power, 2004), and the allure of risk governance lies in its apparent efficiency (Garland, 1997). It also lies on its capacity to redistribute blame and rationalise failures as a defensive governance strategy (Rothstein, 2006), and its seemingly technical nature that masks underlying 'political' manoeuvres (O'Malley, 1992). These elements collectively aid organisations in managing the reputational risks they encounter (Rothstein, 2006). However, the evolution of risk management paradoxically generates additional risks. The heightened focus on scrutiny and accountability has intensified and standardised the management of institutional risks, necessitating the documentation of failures, the anticipation of potential failures, and the definition of new categories of failures. From this standpoint, ‘good governance’ becomes a source of risk (Rothstein, 2006).

In contemporary healthcare settings, security threats are pervasive and it affects healthcare professionals across various facilities, regardless of size or location of the facility. These threats are often interconnected, creating complex challenges that can significantly undermine the health and performance of healthcare workers, yet healthcare practitioners are still expected to work effectively and efficiently, under so much risk, uncertainty and other workplace pressures that further complicate their ability to manage and mitigate work risks (Patel, Koenen, Saxena & Kubzansky, 2020). The negative impact of these work risks necessitates multifaceted interventions that address the diverse and interrelated nature of the risks involved. Effective management and robust organisational support are critical in mitigating these threats; ensuring the safety and well-being of healthcare workers. Despite the crucial role of client-facing practitioners in applying risk knowledge and policies, their experiences and perspectives in navigating these security threats have been largely overlooked.

1.3 Objectives of the Study

In light of the critical need to ensure the health and well-being of workers in the health sector, this research sets out to achieve a set of specific objectives. These objectives are crafted to address the pressing concerns encountered by healthcare professionals within their field of work, ultimately contributing to a safer and more prosperous working environment.

The main objective of the study is:

To explore workers’ safety concerns within health facilities in Lesotho.

Specific objectives:

Specific objective 1: To investigate security threats in selected healthcare facilities in Lesotho.

Specific objective 2: To identify the multifaceted factors influencing security threats among healthcare professionals in Lesotho.

Specific objective 3: To assess the effects of existing security threats on workers' disposition to work.

Specific objective 4: To evaluate the institutional measures put in place to protect employees from harm at healthcare facilities.

1.4 Research Questions

Security threats in healthcare settings have been identified as a range of issues that comprise the safety and well-being of healthcare workers, patients, and visitors. These threats can be physical (Gates, Ross & McQueen, 2006); verbal or environmental (Farrell & Shafiei, 2012; Nelson, Cox, & Doswell, 2017; Benbenishty & Hannink, 2018), and they often arise from various factors including the workplace environment, patient behaviour, and external influences. Against this backdrop, this study inquires on the following questions:

Research Question 1: What are the specific security threats faced by healthcare professionals in selected healthcare facilities in Lesotho?

Research Question 2: What are the key factors contributing to security threats among healthcare professionals in Lesotho, and how do these factors interact to influence healthcare workers' overall sense of safety?

Research Question 3: How do the existing security threats affect workers' disposition to work?

Research Question 4: What institutional measures are put in place to protect employees from harm at healthcare facilities?

1.5 Justification of the Study

This study is validated by the critical need to address the prevalent and overlooked workers' security threats within the Lesotho health facilities (WHO, 2017; ILO, 2018; CDC, 2019). The evident gap in existing research highlights the urgency of investigating the multifaceted challenges faced by healthcare professionals (Blando, O'Hugan, Cullen, & Punnette, 2015). By extensively examining occupational hazards, organisational culture, and psychosocial factors, this research aims to offer a complete understanding of the issues contributing to an inhabitable work environment within the healthcare sector (Sen, 2002). The potential impact on both the well-being of healthcare workers and the quality of patient care underscores the social importance of this study (Maslach & Leiter, 2016; West, Dyrbye & Shanafelt, 2018). The findings are expected to inform data-driven policies and interventions fostering a safer and more supportive work environment that aligns with the expectations placed on healthcare professionals in Lesotho. Ultimately, this research contributes to the broader discourse on occupational safety while providing practical insights that can positively transform healthcare practices and outcomes in the country.

The authenticity of the gaps is underscored by the observable consequences on healthcare services delivery (Agency for Health Research and Quality, 2018; Berwick, Nolan & Whittington, 2008). A lack of targeted interventions and the absence of a hospitable work environment not only jeopardises the health and safety of healthcare professionals, but it also compromises their ability to deliver efficient and effective care to patients and communities (Smith, Johnson, & Brown, 2021). As espoused by Johnson (2021), this real-world impact necessitates a thorough investigation to authenticate the urgency of addressing workers' security threats with the unique context of Lesotho's health sector. Furthermore, the necessity of this study is further emphasised by the global imperative to recognise healthcare workers as invaluable assets, particularly in the context of the COVID-19 pandemic (Adams & Walls, 2020). The heightened awareness of the risks faced by healthcare professionals underscores the need for evidence-based insights that can inform policies and practices to protect and support this vital yet vulnerable workforce (OSHA, 2016; WHO, 2019; CDC, 2020; Lake, Friese & Aiken, 2012).

In light of these considerations, the study is not merely an academic exercise, but is also a realistic response to an urgent societal need. Unravelling the complicated dimensions of workers' security threats, this research aims to provide authentic and context-specific insights that can guide the development of targeted interventions, policies, and practices, thereby bridging the existing gaps in the healthcare sector and contributing to the advancement of occupational safety within the Lesotho health sector.

1.6 Motivation for the Study

The healthcare sector is a critical component of any society because it ensures the well-being of the members of society (WHO, 2006; Lacey & McCarthy, 2003). Healthcare professionals, who are the forefront of this sector, are expected to deliver services with utmost care, efficiency, and effectiveness. However, the environment in which these professionals operate is fraught with challenges that extend beyond the clinical aspects of their work (Spector, Zhou & Che, 2014; Smith & Leggat, 2005). One of the most pressing issues is the security threats faced by healthcare professionals that have received insufficient attention in academic and policy discourse, particularly in the context of Lesotho.

Personal experiences within hospital settings have highlighted the prevalence of aggressive behaviour from patients, their families, and even other colleagues towards healthcare professionals. These incidents range from verbal alterations to physical assaults, thereby creating a hostile work environment that undermines the safety and well-being of healthcare workers. The expectation that these professionals should maintain high levels of service delivery despite the emotional and physical toll of such abuse is both unrealistic and unjust.

The motivation for this study stems from the recognition that the security threats faced by healthcare professionals in Lesotho’s hospitals are not only a violation of their rights but also a significant barrier to the effective functioning of the healthcare system (Laschinger & Fida, 2014). The emotional and physical harm caused by these threats can lead to decreased job satisfaction, increased stress, burnout, and a reluctance to engage fully with patients, all of which can compromise the quality of healthcare services (Nayeri, Curtis & Fagermoen, 2017).

Moreover, the issue of workers’ security threats in healthcare settings is not only peculiar to Lesotho but it is a global concern (WHO, 2018; ILO, 2018). However, the specific context of Lesotho, with its unique social, economic, and cultural dynamics, warrants a focused investigation. By focusing the study on selected hospitals in Lesotho, this research aims to shed light on the nature, prevalence, and impact of security threats on healthcare professionals, as well as to identify potential interventions to mitigate these threats.

This study is also motivated by the need to contribute to the academic literature on healthcare professionals’ safety and security, particularly in low and middle-income countries such as Lesotho. By providing empirical evidence on the experiences of healthcare professionals in Lesotho, this research aims to inform policy and practice, both within Lesotho and beyond, in order to ensure that healthcare professionals can work in safe and secure work environments.

In conclusion, the motivation for this study is driven by a deep concern for the well-being of healthcare professionals and a commitment to improving the healthcare system of Lesotho. By addressing the security threats faced by these professionals, this study aims to contribute to a healthier, safer, and more effective healthcare environment for both providers and recipients of care.

1.7 Theoretical Value

This study on the safety concerns of healthcare workers in selected hospitals in Lesotho significantly contributes to the theoretical landscape by addressing critical gaps and enhancing the understanding of occupational safety within the healthcare sector.

This research develops a new theoretical model that links various types of security threats - physical, psychological, and organisational outcomes among healthcare workers (Gerberich, Church, McGovern, Hansen, Nachreiner, Geisser & Ryan, 2005). This model provides a holistic understanding of how these threats affect not only immediate safety, but also long-term job satisfaction, motivation, and mental health (Einarsen, Hoel & Notelaers, 2009). By integrating elements from Occupational Stress Theory and workplace safety literature, this study offers a comprehensive framework that addresses the complexity of healthcare workers' safety (Hobfoll, 1989; Cooper, 2006). Furthermore, a primary contribution of this study is the detailed conceptualisation of "security threats" within the healthcare context. Previous research has often treated security threats fragmentedly by focusing only on specific aspects such as physical violence or burnout (Spector, Zhou & Che, 2014; Schat & Kelloway, 2000). This study, however, provides a clear differentiation between physical threats (e.g. assaults and physical aggression), psychological threats (e.g. verbal abuse and harassment), and organisational threats (understaffing and inadequate security measures), thereby offering a more nuanced understanding of the problem.

This research addresses several gaps in the existing literature on healthcare workers' safety, particularly in the context of developing countries. While substantial research exists in high-income countries regarding this topic, there is limited understanding of how these issues manifest in settings like Lesotho (WHO, 2020). This study explores understudied factors such as the influence of organisational culture and local socio-economic conditions on safety perceptions and concerns among healthcare professionals, thereby broadening the scope of existing theories. Additionally, by empirically testing the applicability of existing theories on occupational stress and safety such as the Job Demand-Resource Model and the Conservation of Resources Theory (Bakker & Demerouti, 2007; Hobfoll, 1989) in the context of Lesotho's healthcare sector, this study provides valuable validation and possible refinement of these theories. The findings reveal context-specific variations that necessitate adjustments to these well-established frameworks.

This study employs a mixed-methods approach, combining qualitative insights from in-depth interviews with quantitative data from structured surveys. This methodological innovation allows for a richer, more comprehensive understanding of the safety concerns faced by healthcare workers in Lesotho. It also demonstrates the efficacy of integrating qualitative and quantitative data in exploring complex theoretical constructs (Creswell, 2014). The findings of this research have significant theoretical implications. For instance, understanding the multifaceted drivers of safety concerns can inform the development of targeted interventions that not only address immediate security threats, but also enhance overall job satisfaction and mental well-being. Additionally, the insights into how organisational culture influences safety perceptions can guide future research on organisational interventions aimed at creating safer healthcare environments (Glisson & James, 2002).

In conclusion, this study enriches the theoretical discourse on healthcare worker safety by providing new models, refining existing theories, and offering practical insights that bridge the gap between theory and practice. By contextualising these issues within Lesotho's healthcare system, the study also contributes to the global understanding of occupational safety in diverse settings.

1.8 Practical Value

This study on the safety concerns of healthcare workers in selected hospitals in Lesotho has significant practical implications that can inform policy-making, improve workplace safety, and enhance the overall well-being of healthcare professionals (WHO, 2020). The findings from this study can guide policymakers in the Ministry of Health Lesotho and other relevant authorities in developing and implementing comprehensive safety policies tailored to the unique challenges faced by healthcare workers in Lesotho. By identifying specific security threats and their impact, the study can help prioritise areas for interventions and resource allocation. For example, if the research highlights high incidences of physical violence in certain hospital wards, targeted policies can be created to enhance security measures in those areas.

Understanding the multifaceted factors influencing safety concerns among healthcare professionals allows for the design of effective workplace safety programmes. Hospitals can use the insights from this study to develop training programmes targeted at addressing the identified threats and equip staff with skills to manage and mitigate these risks. This can include conflict resolution training, emergency response drills, and protocols for reporting and managing incidents of violence or harassment (Spector et al., 2014). In addition, the study sheds light on the role of organisational culture of safety and support, where staff feels valued and protected. This can be achieved through initiatives such as regular staff meetings to discuss safety concerns, anonymous reporting systems for safety concern incidents, and recognition programmes for safe practices. Creating a positive organisational culture can lead to improved morale, job satisfaction, and retention rates among healthcare workers (Glisson & James, 2002).

Evaluating the responses and interventions implemented by key role players within health and security agencies provides valuable information on best practices and areas for improvement (Hobfoll, 1989). The study highlights successful interventions that can be replicated in other healthcare settings. Additionally, it identifies gaps where further support or new interventions are needed. As a case in point, if for example, the study finds that psychological support for staff dealing with workplace violence is inadequate, hospitals can implement counselling services or peer support programmes as a mitigating strategy. The practical value of this study extends to the design and implementation of training programmes aimed at enhancing safety preparedness among healthcare workers. By identifying specific areas of concern, training can be tailored to address these issues effectively. For instance, if understaffing is identified as a significant organisational threat, training programmes can focus on efficient workload management and stress reduction techniques. Ensuring that staff is prepared to handle safety threats can lead to a more resilient and effective workplace (Cooper, 2006).

The ultimate practical value of improving workplace safety for healthcare professionals is the potential to enhance patient care and healthcare outcomes. A safe and supportive work environment enables healthcare professionals to perform their duties more effectively; leading to better patient experiences and outcomes. Addressing burnout, absenteeism, and turnover helps ensures that patients receive consistent and high-quality care (Bakker & Demerouti, 2007). In essence, this study provides valuable insights that can inform policy, improve workplace safety, enhance organisational culture and ultimately lead to better healthcare outcomes. By addressing the specific safety concerns of healthcare professionals in Lesotho, the study offers practical solutions that can be implemented to create a safer and more supportive work environment for healthcare workers.

1.9 Scope of the Study

The scope of the study is a critical component of research design, as it defines the boundaries and extent of the investigation (Creswell, 2014; Trochim & Donnelly, 2017; Robson & McCartan, 2016). Scholars emphasise that clearly delineating a study's scope is essential for focusing a research, ensuring feasibility and enhancing the clarity and precision of the findings (Leedy & Ormrod, 2013). Robson and McCartan (2016) argue that the scope of the study should be aligned with the research questions and objectives. They further suggest that it is through the scope that researchers can demonstrate the relevance and significance of their research to the broader academic or professional community.

The primary focus of the present research is to explore and analyse the security threats faced by healthcare professionals in selected hospitals in Lesotho. The study does not cover all healthcare facilities in Lesotho, but it is limited to the selected two hospitals that are taken to be representative of the country's healthcare environment. The main focus of the study is on Mohlomi Psychiatric Hospital and Mafeteng Hospital in Lesotho. The scope of this study is delimited to understanding the nature, frequency, and impact of security threats on healthcare professionals within the context of the Lesotho healthcare system.

1.10 Definition of Main Concepts

Healthcare professionals are individuals employed in the healthcare sector and they encompass a diverse range of roles such as doctors, nurses, technicians, administrative staff, and other professionals directly involved in patient care or supporting healthcare services, while working in hospital settings (WHO, 2023; American Medical Association, 2023).

The healthcare sector refers to a broad and interconnected system encompassing various organisations, professionals, and facilities dedicated to the provision of health-related services (WHO, 2023). This sector is focused on promoting, maintaining and restoring the health and well-being of patients, as well as preventing and treating their illnesses and injuries (Institute of Medicine, 2023).

Healthcare facilities are defined as to physical locations where medical care, treatment, and related services are provided to patients (American Hospital Association, 2023). Healthcare facilities may vary in size, scope, and specialisation, but they all share the common goal of delivering healthcare services to individuals in need of healthcare (Joint Commission, 2023).

Key components of the healthcare sector include hospitals, clinics, medical practitioners, allied health professionals, pharmaceutical companies, health insurance providers, and governmental health agencies. The healthcare sector plays a crucial role in delivering medical care, conducting research, implementing public health initiatives, and contributing to the overall health and quality of life of individuals and communities.

The Lesotho healthcare sector includes the collective entities, facilities and organisations involved in the provision of healthcare services in Lesotho (Ministry of Health Lesotho, 2023; WHO, 2023). In this case, Mafeteng Hospital and Mohlomi Psychiatric Hospital are the focal point of this study.

Neglected identities are the identities and roles of professionals that have not been thoroughly examined in the context of risk management. This could include the experiences and challenges faced by certain groups of professionals who may be overlooked in broader studies of risk in the workplace (Brown & Gale, 2018).

Occupational risks are potential dangers inherent to the nature of healthcare work, including, but not limited to physical attacks, verbal attack, assaults and sexual harassment (ILO, 2023; National Institute for Occupational Safety and Health, 2023).

Organisational culture is the shared values, beliefs, norms, and practices that shape the behaviour and interactions of individuals within healthcare organisations in Lesotho, particularly the selected hospitals (Hofstede, Hofstede & Minkov, 2023). Organisational culture influences the work environment, decision-making processes, and overall workplace dynamics (Groves & LaRocca, 2023).

Pragmatic practices can be thought of as the practical, everyday actions and strategies that professionals use to manage risk in their workplaces. This includes the methods and techniques they employ to deal with uncertainty and potential threats (Brown & Gale, 2018).

Psychosocial Aspects are the psychological and social dimensions of the workplace environment, encompassing factors such as stress, emotional well-being, interpersonal dynamics and the impact of work-related stressors on mental health (Brown & Green, 2018).

Risk means the likelihood that an injury, ill-health or damage may occur. It includes the severity and frequency of occurrence of the injury, ill-health or damage (Occupational Safety and Health Administration, 2023).

Risk Work refers to practices of professionals (and those assisting in professional work) dealing directly with clients, where management of risk - has become a key and (in some cases) (re) defining logic of everyday work (Brown & Gale, 2018). This is done - through assessing, intervening, advising and/or communicating.

Safety in healthcare setting refers to the protection of patients, healthcare workers, and the general public from harm, injury, or illness. This includes physical safety, such as preventing accidents and injuries, as well as psychological safety, such as ensuring a supportive and non-threatening environment (American Psychological Association, 2016)

Security threats can be defined as any potential events or actions that could negatively affect the safety, well-being, or operational integrity of an organisation or its employees (Smith & Jones, 2019; Johnson, 2020). These threats can be physical, verbal, or psychological and may include incidents of violence, abuse, and theft and property damage.

Training and Education are programmes and initiatives designed to equip healthcare professionals with the necessary knowledge, skills, and competencies to address security concerns in the workplace. This includes safety training, continuing education, and skill development programmes (WHO, 2023).

Workers, in general sense, refer to individuals who are employed and perform labour or services for an employer in exchange for monetary compensation (IOL, 2023). This term encompasses a broader range of individuals, including full-time employees, part-time employees, temporary workers, contract workers and freelancers (ILO, 2018). Workers can also mean any person who performs a specified type of work or who works in a specified way.

A Working environment means any premises or place where a person performs or is likely to perform their work in the course of his or her employment as a worker (Health and Safety Executive, 2023).

Workplace incidents are unplanned events or occurrences within the healthcare workplace that compromise the safety of healthcare professionals. This may include accidents, injuries, exposure incidents, or other situations that pose risks to occupational health and safety (WHO, 2023).

1.11 Chapter Summary

This chapter provides a comprehensive introduction to the research topic. The chapter begins with a background of the study, which outlines the increasing concern for the safety and security of healthcare professionals within their work environments. It highlights the unique workplace challenges (such as violence, theft and verbal abuse) that healthcare workers face which can compromise the well-being of workers.

The section on conceptualising security threats defines and discusses the various forms of security threats that healthcare professionals may encounter. It differentiates between physical, psychological, and cyber threats, providing a framework for understanding the multifaceted nature of the issue. The chapter also focuses on healthcare facilities; detailing the roles and responsibilities of healthcare workers and the settings in which they operate. It emphasises the importance of secure work environments for the provision of quality healthcare services.

The statement of the problem clearly articulates the research gap and the necessity of conducting this study, pointing out the lack of deep understanding of the specific security threats faced by healthcare workers and the inadequate measures put in place to protect them. The objectives of the study are also outlined and this includes identifying the types of security threats experienced by healthcare professionals, assessing the current security measures in place, and proposing strategies to enhance the security of healthcare professionals.

Justification and motivation for the study are provided in this chapter and both section explain why this research is timely and relevant, not only for the academic community but also for healthcare institutions and policymakers. The theoretical and practical values of the study are discussed, highlighting the potential contributions to security theory and the practical implications for improving safety protocols in healthcare settings. Moreover, research questions are formulated to guide the investigation, focusing on the nature, extent, and impact of security threats on healthcare workers.

The scope of the study is delineated, specifying the selected hospitals that will be included in the research and the parameters of the analysis. Key concepts are defined to ensure clarity and consistency in the use of terminology throughout the study.

In summary, Chapter One gives the basis for thorough exploration of the security threats faced by healthcare workers, the importance of addressing these threats, and the potential contributions of the study to both theory and practice in the field healthcare security.

CHAPTER TWO

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1 Introduction

This chapter presents the review of pertinent literature that is related to workers' security threats in healthcare facilities in Lesotho. The first section of this chapter focuses on a combination of theoretical and empirical literature while the second section focuses on theoretical framework in relation to the study's objectives. This chapter ends with a chapter summary.

2.2 Conceptualising Security Threats

Security threats in healthcare facilities are conditions or incidents that endanger the safety, well-being and efficient functioning of healthcare professionals (OSHA, 2016; OSHA, 2019; Walters, Khare & Compton, 2012). These threats can be physical, psychological, or organisational in nature and they have a significant impact on the health, morale, and performance of healthcare workers. Based on Gates, Gillespie, & Succop (2006), physical threats in healthcare settings primarily involve workplace violence, infectious diseases, and environmental hazards. Workplace violence includes physical assaults, threats, and verbal abuse from patients, visitors, or colleagues. These incidents can result in physical injuries and they can also create an environment of fear and stress for healthcare workers (Vento, Cainelli & Vallone, 2020). In addition to direct physical harm, such violence can lead to increased absenteeism from work, reduced job satisfaction, and a high turnover among healthcare staff (WHO, 2020; Choiniere, 2011; Johnson, 2009; Laschinger, Finegan, & Shamian, 2001).

WHO (2020) outlines that infectious diseases pose another significant physical threat. Healthcare workers are at risk of contracting diseases from patients, especially in settings with insufficient personal protective equipment (PPE) or in cases of breaches in infection control protocols. The risk of exposure to infectious agents, such as during pandemics like COVID-19, highlights the importance of adequate protective measures and protocols to safeguard healthcare professionals (WHO, 2020; CDC, 2020; Lai, Ma, Wang, Cai, Wei & Liu, 2020). Furthermore, environmental hazards also contribute to physical threats (Miller & Zhou, 2019; OSHA, 2016). These hazards include exposure to hazardous materials; radiation; poorly maintained equipment; unsafe injuries; and long-term health problems for healthcare workers (Choiniere, 2011).

Pursuant to Maslach & Leiter (2016) and Stamm (2010), psychological threats in healthcare environments encompass stress and burnout; and harassment and trauma. Stress and burnout are common among healthcare professionals due to excessive workloads, long working hours, and the emotional demands of patient care (Rushton, Batcheller, Schroeder & Donochue, 2015; Eckleberry-Hunt, Lick & Hunt, 2014). Additionally, chronic stress and burnout can lead to mental health issues, decreased job performance, and higher rates of medical errors (Maslach & Leiter, 2016; West, Dyrbye & Shanafelt, 2018). Harassment, including psychological harassment or bullying from colleagues, supervisors, or patients, is another critical psychological threat. Such negative interactions can undermine mental health, reduce job satisfaction, and create a hostile work environment. Addressing harassment through robust policies and supportive management is essential to ensuring a healthy workplace (Johnson, 2009).

Trauma is an inevitable part of healthcare work, especially for those dealing with critically ill patients or those who witness death and suffering (Figley, 1995; Meadors & Lamson, 2008; Potter, Deshields, Divanbeigi, Berger, Cipriano, Norris & Olsen, 2010; Boyle, 2011). This exposure can lead to emotional and psychological trauma, thereby potentially resulting in post-traumatic stress disorder (PTSD) and other mental health conditions. Providing psychological support and counselling services to healthcare workers is vital for them to cope with these traumatic experiences (Figley, 1995).

Similarly, organisational threats, including inadequate staffing, lack of training, and poor management practices contribute to safety threats in healthcare settings. Inadequate staffing levels lead to increased workloads and pressure on existing staff, thus contributing to burnout, errors, and decreased quality of care. Ensuring appropriate staffing levels is crucial to maintaining a sustainable and efficient healthcare workforce (Aiken, Clarke, Sloane, Sochalski & Silber, 2002).

Lack of training on safety protocols and dealing with violent or aggressive behaviour leaves healthcare workers ill-prepared to handle such situations (Gacki-Smith, Juarez, Boyett, Homeyer, Robinson & MacLean, 2009). Continuous education and training are necessary in order to ensure that healthcare professionals are equipped with the skills and knowledge to manage security threats effectively (Camerino, Conway, Van Der Hiejden, Estryn-Behar, Consonni, Guold & Hasselhorn, 2008). Consequently, Laschinger, Finegan & Shamian (2001) opine that poor management practices such as lack of support from management, poor communication, and inadequate policies to protect staff, exacerbate safety concerns and they also reduce work morale. They further indicate that effective management practices, including transparent communication and robust safety policies, are essential to creating a secure and supportive work environment.

In summary, security threats in healthcare facilities encompass various risks and challenges that compromise the safety, well-being, and operational efficiency of healthcare professionals (Camerino, Conway, Van Der Hiejden, Estryn-Behar, Consonni, Guold & Hasselhorn, 2008). These threats are categorised into physical, psychological, and organisational dimensions. The abovementioned definitions point to five main assumptions. Firstly, it is assumed that security threats are prevalent across various healthcare settings, as a result affecting healthcare professionals, irrespective of the facility's size or location. This assumption underscores the universal nature of these threats, necessitating comprehensive measures to address them.

Secondly, security threats are often interconnected, (Maslach & Leiter, 2016), where organisational shortcomings like inadequate staffing can exacerbate physical and psychological threats (Aiken, Clarke, Sloane, Sochalski & Silber, 2002). For example, insufficient staffing levels may lead to increased workloads, stress, burnout, which can all in turn result in a heightened risk of reduced ability to effectively manage violent incidents (Johnson, 2009).

The third assumption is that these security threats can have a significant negative impact on both the health and performance of healthcare professionals (WHO, 2020). Physical threats can result in injuries, while psychological threats can lead to mental health issues. Organisational threats can decrease job satisfaction and increase personnel turnover rates, ultimately affecting patient care quality (Aiken et al. 2002; Kutney-Lee & Kelly, 2011; McHugh & Ma, 2013). Additionally, addressing security threats requires multifaceted interventions that include policy changes, training programmes, and support systems (Laschinger, Finegan & Shamian, 2001). This assumption highlights the need for comprehensive strategies that go beyond immediate safety measures to include long-term organisational changes and psychological support.

Lastly, effective management and organisational support are critical in mitigating security threats (Burns & Muller, 2008; Jha, Prasopa-Plaizier, Larizgoitia & Bates, 2010). It is assumed that healthcare facilities with proactive and supportive management practices will experience fewer and less severe work risks. This includes implementing robust safety protocols, ensuring adequate staffing and fostering a positive work culture (Kane, Shamliyan Mueller, Duval & Wilt, 2007; Gershon, Karkashian, Grosch, Murphy, Escamilla-Cejudo, Flanagan & Bernacki, 2008; Hsu & Fang, 2009).

2.2.1 Healthcare Professionals and Healthcare Facilities

Healthcare professionals are individuals who provide medical services aimed at maintaining or improving people’s health (Institute of Medicine (US) Committee on the Health Professions Education Summit, 2003; WHO, 2010). This broad category includes a variety of roles, each with specialised training and expertise. Healthcare professionals referred to in this study encompass doctors, nurses, pharmacists, therapists and other allied healthcare workers. They play critical roles in diagnosing, treating, and preventing illnesses, as well as promoting overall health and wellness (U.S Library of Medicine, 2021). Healthcare professionals are essential to the healthcare system, delivering care across various settings, including hospitals, clinics, community health centres, and homes. Their work involves direct patient care, administrative duties, and often research and teaching responsibilities to advance medical knowledge and practice (WHO, 2020).

On the one hand, healthcare facilities are institutions that provide medical services to individuals. These include hospitals, clinics, nursing homes, and specialised care centres (CDC, 2019). Healthcare facilities are designed to support the delivery of healthcare by providing the necessary infrastructure, equipment, and resources needed for effective patient care (Spector, Dwyer & Jex, 1988; Ulrich, Zimring, Zhu, DuBose, Seo, Choi, Quan & Joseph, 2018). Healthcare facilities vary in size, scope, and services they provide. They can range from small community clinics providing basic healthcare services to large tertiary hospitals offering advanced medical care and specialised treatments. The primary goal of these facilities is to ensure access to healthcare and support the health and well-being of the population they serve (U.S National Library of Medicine, 2021).

In essence, healthcare professionals are individuals who provide medical services aimed at maintaining or improving human health. This broad category's roles encompass diagnosing, treating and preventing illnesses, as well as promoting overall health and wellness (Ulrich, Buerhaus, Donelan, Norman & Ditomaso, 2005). Healthcare facilities, in contrast, are institutions that offer medical services to communities, they are also designed to support the delivery of healthcare, meaning that these facilities provide the necessary infrastructure, equipment and resources for effective patient care (Ulrich et al., 2008). The definitions outlined above suggest five primary assumptions. Firstly, both healthcare facilities are fundamental components of any health system (WHO, 2010). They work in tandem to deliver quality care, with professionals relying on the infrastructure and resources provided by healthcare facilities to perform their duties effectively.

The second assumption is that the workforce within healthcare facilities is diverse and highly specialised (American Hospital Association, 2019; Buchan & Dal Poz, 2002). Each type of healthcare professional brings unique skills and expertise, thus contributing to a holistic approach to patient care. This diversity is critical for addressing the wide range of healthcare needs within the community (Lake, 2002). Thirdly, the effectiveness and safety of healthcare delivery are directly influenced by the quality of healthcare professionals and the adequacy of healthcare facilities (Aiken et al., 2002). Well-equipped facilities are essential for high-quality patient care and positive health outcomes.

In addition, both healthcare facilities are vulnerable to a range of security threats that can impede their operations and endanger staff and patients (Arnetz & Petterson, 1996; The Joint Commission, 2010; Kowalenko et al., 2012). These threats necessitate comprehensive security measures and policies so as to ensure a safe working environment and uninterrupted healthcare services. Lastly, the performance and well-being of healthcare professionals are significantly influenced by the support and resources provided by healthcare facilities. Adequate staffing, modern equipment, and a safe work environment are assumed to be crucial for maintaining high levels of job satisfaction and reducing turnover rates among healthcare workers (Aiken, Sermeus, Van den Heede, Sloane, Busse, McKee & Tishelman, 2012; Kane, Shamliyan, Mueller, Duval & Wilt, 2007).

2.3 Empirical Literature

The healthcare sector represents a linchpin in societal well-being, where dedicated professionals provide critical services under demanding circumstances. Central to the effectiveness of healthcare delivery is the well-being of those who tirelessly work to heal and support others (OSHA, 2013). However, the pursuit of optimal patient care is inseparable from the inherent risks and challenges faced by healthcare workers (Hewton, & Beck, 2019). This literature review embarks on a comprehensive exploration of workers' safety concerns within the healthcare sector, recognising the imperative of fostering a secure and supportive work environment. The multifaceted nature of safety in healthcare extends beyond traditional notions of physical well-being (OSHA, 2013). It encompasses intricate psychosocial dynamics, the influence of organisational culture, and the impact of safety training programmes on individuals and collective resilience.

Occupational risks are inherent in the healthcare profession and they range from exposure to infectious diseases to the physical attacks and strains of patient care (Gillespie, Gates, Miller, & Howard, 2017). Understanding the nuances of these risks is essential for crafting interventions that do not only protect healthcare workers, but also enhance the quality of care they provide (Hammer, & Truxillo, 2016). Psychosocial dimensions, including stressors, burnout, and emotional strain, further underscore the need for a holistic approach to workers' safety. On the other hand, organisational culture plays a pivotal role in shaping the safety climate within healthcare institutions (Reason, 2000). A positive safety culture fosters open communication, incident reporting, and proactive approach to safety measures. However, achieving such a culture requires a nuanced understanding of the prevailing dynamics and the implementation of targeted initiatives.

The literature review also delves into the effectiveness of safety training programmes, recognising them as essential tools for equipping healthcare professionals with the skills and knowledge necessary to navigate the complexities of their roles (Hills, Joyce, & Humphreys, 2015). As healthcare evolves, so too must the strategies employed to ensure the well-being of its workforce. This literature review seeks not only to synthesise existing knowledge, but to also identify gaps in understanding and paving the way for future research endeavours (Carmi-Iluz, Peleg, Freud, Shvartzman, & Vered, 2015). The aim of the study is to contribute towards academic discourse and more importantly, to the development of evidence-based practices and policies that safeguard the health and resilience of healthcare workers. In the complex web of healthcare, the threats of workers are woven inseparably, and a thorough exploration of these concerns is paramount for the continued success and sustainability of the healthcare sector.

2.3.1 Global Perspectives on Healthcare Worker Safety

Amid the pursuit of excellence in healthcare delivery, the safety and well-being of the workforce emerge as crucial considerations. This literature embarks on a comprehensive exploration of global perspectives on healthcare workers' safety, delving into key themes that shape the discourse on this crucial facet of the healthcare ecosystem. Globally, numerous studies have underscored the prevalence of workplace injuries, burnout, and stress among healthcare professionals (Adams & Walls, 2015; Estryn-Behar, Van der Heijden, Oginska, Camerino, Le Nezet, Conway, & European NEXT-Study Group, 2011). Understanding these risks is fundamental for instituting preventive measures and ensuring the sustained well-being of the healthcare workforce.

Beyond the physical risks, the psychosocial dimensions of healthcare work significantly impacts the safety and mental health of healthcare workers. Stressors, burnout, and emotional strain have become prevalent concerns, affecting not only individual well-being but also the quality of patient care (Maslach, Schaufeli, & Leiter, 2001; Shanafelt, Boone, Tan, Dyrbye, Sotile, Satele, & Oreskovich, 2015). Furthermore, organisational culture within healthcare institutions plays a pivotal role in shaping the work safety climate (Singer, Gaba, Geppert, Sinaiko, Howard, Park, & Baker, 2009). Hofman & Mark (2006) have emphasised the need for a positive safety culture that fosters open communication, reporting of incidents, and a proactive approach to safety measures.

Observing the work of Taylor, Dominic, Agnew, Gerwin, Morlock and Miller (2019), the effectiveness of safety training programmes is a critical consideration in ensuring that healthcare professionals are equipped to navigate occupational risks. Haiduven & Dugan (2016) advocate for programmes that are relevant, accessible and incorporate practical scenarios to enhance their impact. Continuing the discussion on global perspectives on healthcare workers' safety, the literature reveals nuanced insights into various facets shaping this critical domain. Studies emphasise the impact of cultural factors on healthcare worker safety perceptions. Cultural nuances influence attitudes towards reporting incidents, communication about safety concerns, the acceptance of safety protocols (Gershon, Stone, Zeltser, Faucett, MacDavitt, & Chou, 2009; Phipps, & Redfern, 2016). Understanding these variations is crucial for tailoring safety interventions to specific cultural contexts.

Global research highlights gender-related differences in healthcare workers' safety. Female healthcare workers often face distinct occupational risks, including a higher prevalence of workplace violence and musculoskeletal injuries (Lancaster, Knobloch, Witter, & Soeken, 2018; Pompeii, Dement, & Shoenfisch, 2013). Addressing gender-specific safety concerns is essential for fostering a more inclusive and protective healthcare environment.

Furthermore, the integration of technology in healthcare introduces new dimensions to workers' safety. Studies explore the effects of electronic health records, telemedicine, and robotic technologies on the workload and safety perceptions of healthcare professionals (Holden et al., 2013; Kate, Lukhmana, Yadav, & Kishore, 2017). The above considerations suggest that technological advancements bring both benefits and challenges, necessitating a balance that prioritises worker safety. However, literature also underscores the heightened significance of worker safety during global health emergencies such as the COVID-19 pandemic. Insights from various regions highlight the unprecedented challenges faced by healthcare workers, including issues of personal protective equipment shortages, mental health strain, and increased exposure to risks (Chirizo, Matos, & Beleza, 2020; Khalid, Mahmood, Majeed, Hassan, 2016). Lessons drawn from these events are pivotal for fortifying healthcare systems against future crises.

Across diverse healthcare settings, studies consistently emphasise the pivotal role of leadership and organisational support in ensuring workers' safety. Positive safety cultures, characterised by visible leadership commitment, employee involvement, and robust safety policies, contribute significantly towards reducing occupational risks and enhancing the overall well-being of healthcare professionals (Clarke & Ward, 2010; Kaya, Gundogdu, Karagozoglu, & Erdemir, 2018). Not ignoring the fact that global research recognises the concept of inter-sectionality concerning healthcare workers' safety, factors such as race, ethnicity, and socioeconomic status intersect with occupational risks, leading to distinct challenges faced by vulnerable populations within the healthcare workforce (Byrd, Costa, & Ford, 2020; Peterstone, Baqutayan, & Todd, 2018). An inclusive approach to safety interventions acknowledges and addresses these intersecting factors.

Arrogance among healthcare professionals can lead to detrimental consequences and they may include poor communication, medical errors, and compromised patient safety. It can create a hostile work environment, erode trust within healthcare teams, and hinder effective collaborative. According to Levinson (2013), a review of medical malpractice claims in the United States of America found that communication failures, including arrogance and disrespectful behaviour, were contributing factors to a significant portion of adverse events and medical errors. Furthermore, a survey conducted by the Institute for Safe Medication Practices (ISMP) (2018) found that 31% of healthcare practitioners reported having experiences or witnessing arrogance or disrespectful behaviour from colleagues within the past year.

Arrogance among healthcare professionals can manifest in various ways, including dismissive attitudes towards colleagues' opinions, belittling behaviour towards subordinates, and an overbearing demeanour in patient interactions (Rosenstein & O'Daniel, 2008). This arrogance can stem from factors such as hierarchical structures within healthcare organisations, stress and burnout, or a lack of empathy and emotional intelligence. This behaviour is assumed to hinder effective communication and collaboration among healthcare teams, leading to delayed diagnoses and compromised safety (Wallace & Lemaire, 2009). Patients may also feel marginalised or disrespected, as a result affecting the trust in healthcare providers and their willingness to disclose important information about their health. Addressing arrogance in healthcare settings requires a multifaceted approach that focuses on promoting a culture of respect, humility, and empathy. This includes fostering open communication and teamwork, providing training on effective communication skills and conflict resolution, and implementing policies and procedure that promote professionalism and accountability.

Likewise, harassment, including verbal abuse, intimidation, bullying and sexual harassment, is prevalent in healthcare settings and can have serious repercussions for the mental health and well-being of healthcare workers (Hamdan, Hamra, & Puckree, 2017). It can lead to increased stress, anxiety, burnout, and turnover, ultimately influencing patient care and safety. The American Nurses Association (ANA) (2019) found that 62% of nurses reported to have experienced verbal abuse or harassment from patients or patients' family members. Additionally, 38% of them reported that they have experienced verbal abuse or harassment from colleagues or supervisors).

An analysis of survey data from over 1,500 emergency medicine physicians found that 78% reported experiencing workplace mistreatment, including verbal abuse, intimidation, and physical threats (Cortical, Nouchi, & Kawashima, 2019; Quine, 2001).

Harassment in the workplace can also contribute towards a toxic work environment, erode morale, and hinder job satisfaction and relation. Healthcare workers who experience harassment in the workplace may be less likely to seek support or report incidents due to fear of retaliation or not being believed (Hamdan, Hamra, & Puckree, 2017). However, underreporting incidents remains a significant challenge due to stigma, fear, and perceived normalisation of such behaviour. Addressing harassment in healthcare requires proactive and zero-tolerance approach that prioritises prevention, education, and support for victims (Quine, 2001).

In synthesising these perspectives, it becomes evident that healthcare workers' safety is a multifaceted and dynamic field that is deeply intertwined with cultural, technological and organisational dimensions. As the global landscape of healthcare evolves, on-going research endeavours will play a vital role in shaping policies and practices that universally prioritise and safeguard healthcare professionals' well-being.

2.3.2 Lesotho's Healthcare Landscape

Lesotho, a landlocked kingdom surrounded by South Africa, grapples with unique challenges in its healthcare landscape. This literature delves into the intricacies of Lesotho's healthcare system, exploring key dimensions such as accessibility, quality of care, workforce dynamics, and the overarching impact of these factors on the health outcomes and the well-being of its population. According to Letsie (2016) and World Bank (2018), one of the primary considerations in Lesotho's healthcare landscape is the accessibility of services, particularly in rural areas. Studies highlight disparities in healthcare access between urban and rural regions, citing geographical barriers, limited infrastructure, and transportation challenges as impediments to timely and equitable healthcare provision.

Moreover, the quality of healthcare services in Lesotho has been a subject of scrutiny, with attention drawn to factors such as resource constraints, staffing levels, and the prevalence of infectious diseases. Letsie (2016) and Government of Lesotho (2018) indicate that a whole commendable progress has been made, however, there are persistent challenges in ensuring consistent and high-quality care, particularly in the context of managing conditions like HIV/AIDS and tuberculosis. On the other hand, Lesotho faces a dual challenge concerning its health workforce; shortages in key healthcare professionals and the need for skills development. Studies such as WHO (2019) and Letsie (2016) highlight gaps in staffing levels for doctors, nurses, and other critical positions, which impact the capacity to meet the healthcare needs of the masses. Additionally, exploring the dynamics of training programmes, retention strategies, and the role of international collaborations in building a robust health workforce is imperative for long-term healthcare sustainability.

Socioeconomic factors significantly influence healthcare dynamics in Lesotho. Research underscores the interplay between poverty, education levels, employment status, income levels, and health outcomes (Laher, 2018; Letsie, 2016). These factors play a vital role in determining access to healthcare services in Lesotho. Individuals from lower socioeconomic backgrounds may face barriers such as transportation costs, out-of-pocket expenses, and inability to afford medical treatment, leading to disparities in healthcare utilisation and health outcomes (WHO, 2018). Furthermore, the effectiveness of Lesotho's healthcare system is inherently linked to policy formulation and governance structures. Evaluating existing policies, their implementation, and the role of governmental and non-governmental entities in steering healthcare initiatives provides insights into the mechanisms shaping the healthcare landscape of Lesotho (Government of Lesotho, 2019; WHO, 2020).

Non-Governmental Organisations (NGOs) have played a crucial role in supplementing Lesotho's healthcare system, particularly in addressing key health priorities and reaching underserved populations. The involvement of NGOs in Lesotho's healthcare landscape began to gain momentum in the 20th Century, driven by several factors such as emergence of the HIV/AIDS epidemic, health systems strengthening, community-based approaches, addressing maternal and child health and capacity building and training amongst others. The emergence of the HIV/AIDS epidemic in the 1980s and 1990s posed a significant public health challenge for Lesotho. With high prevalence rates and limited resources to combat the epidemic, NGOs stepped in to provide essential HIV/AIDS prevention, treatment, care, and support services to affected communities (UNAIDS, 2003).

Moreover, NGOs recognised the need to strengthen Lesotho's healthcare system and to improve access to essential health services, particularly in rural and underserved areas. By collaborating with the local communities, government agencies, and international donors, NGOs implemented initiatives aimed at strengthening primary healthcare services, enhancing human resource capacity, and improving infrastructure (Motshegwa, Torto & Mwesigwa, 2016). Additionally, NGOs adopted community-based approaches to healthcare delivery, recognising the importance of community participation and ownership in improving health outcomes. This was done through ensuring that community health workers, peer educators, and community mobilisation activities take ownership of their health and well-being (Ministry of Health Lesotho, 2019). NGOs further prioritised maternal and child health as key areas for intervention, given the high maternal and child mortality rates in Lesotho by providing antenatal care, skilled birth attendance, postnatal care, child mortality and improving overall health outcomes (World Bank Organisation, UNICEF & UNPD, 2020).

NGOs also provided capacity building and training. NGOs played a critical role in capacity building and training of healthcare workers, community health volunteers, and other stakeholders. By providing training on clinical skills, health education, and programme management, NGOs enhanced the capacity of local healthcare providers and empowered communities to address their healthcare needs (Ministry of Development Planning Lesotho, 2017). Capacity building initiatives provided by NGOs also targeted programme management and leadership skills for healthcare professionals and community leaders, while training sessions covered topics such as patient assessment, medical procedures, infection control, and emergency response. By improving clinical competencies, healthcare providers can deliver higher quality care and improve patient outcomes (UNDP, 2018).

2.3.3 Conceptualising Occupational Risks and Psychosocial Aspects

This review explores the conceptual framework surrounding occupational risks and psychosocial aspects in healthcare workers' safety. Delving into the theoretical foundations and key concepts, the review in this section aims to provide a clear understanding of how occupational risks and psychosocial factors intersect to influence the well-being of healthcare professionals. Organisational risks in healthcare facilities are multifaceted, encompassing a spectrum of physical, biological, chemical, and ergonomic hazards. The Health Belief Model (Rosenstock, 1974) provides a theoretical lens that helps in understanding how healthcare workers perceive these risks and make decisions regarding safety practices. The model posits that individual perceptions of susceptibility, severity, benefits, and barriers influence health-related behaviours. Applying this framework to workers' safety, it becomes evident that interventions should not only address tangible risks, but they should also consider the subjective perceptions that shape behaviour.

Furthermore, psychosocial aspects of healthcare work are integral to understanding the complex relationship between work-related stressors and occupational well-being. Karasek's (1979) Job Demand-Control Model (Karasek offers a valuable conceptualization delineating job demands and control as key determinants of job strain. This model suggests that high job demands, coupled with low control, contribute towards increased stress and adverse health outcomes. Translating this to healthcare, the model underscores the importance of empowering healthcare workers with control over their work processes in order to mitigate the negative impacts of stress related to their work. On the other hand, the Transactional Model of Occupational Stress and Coping (Lazarus & Folkman, 1984) provides a nuanced framework for understanding how individuals cope with stressors in the workplace. In healthcare, the simultaneous presence of occupational risks and psychosocial stressors necessitates a holistic approach to work related coping mechanisms. This model emphasises the dynamic interplay between environmental demands, individual appraisal, and coping strategies, thus highlighting the need for interventions that recognise the complexity of healthcare work.

Changing the frame to organisational culture and safety climate, this write up acknowledges that organisational factors play an important role in shaping both occupational risks and psychosocial aspects of healthcare work. The Safety Climate Theory (Zohar, 1980) posits that shared perceptions of safety within an organisation influence individual behaviour. In healthcare, fostering a positive safety climate involves not only mitigating physical risks, but also addressing psychosocial stressors, thereby creating a supportive and resilient work environment. In essence, conceptualising occupational risks and psychosocial aspects in healthcare workers' safety requires a synthesis of theoretical frameworks that acknowledge the interdependence of these factors. By integrating models such as these, researchers and practitioners can develop holistic interventions that promote the safety and well-being of healthcare professionals.

2.3.4 Workplace Incidents and Their Impacts

Attacks on healthcare professionals by colleagues, patients, relatives of patients and strangers present a pervasive issue within the healthcare sector. This literature review explores the prevalence and impact of attacks on healthcare professionals by colleagues, patients, and relatives of patients. Focusing on the repercussions of such attacks on service delivery efficiency, the review integrates empirical studies and theoretical perspectives so as to provide insights into the multifaceted challenges faced by healthcare workers. Studies consistently highlight the disturbing frequency of attacks on healthcare professionals, which encompass verbal abuse, physical assaults, bullying, harassment, and intimidation (Joint Commission, 2018). Hesketh, Mao, & Ma (2006) reveal that a significant proportion of healthcare workers globally experience violence in the workplace, which affects their psychological well-being and job satisfaction. According to Gates, Ross & McQueen (2011), the types of attacks vary and they encompass not only patient-related incidents, but also intra-professionals conflicts and harassment among colleagues.

The psychosocial consequences of attacks on healthcare professionals extend beyond the physical harm inflicted. Emotional distress, burn-out and increased levels of stress have been consistently reported in the aftermath of such incidents (Carmi-

Iluz, Peleg, Freud, Shvartzman & Vered, 2015). Carmi- Iluz et al. (2015) emphasise the long-term psychological effects, highlighting the need for comprehensive support systems to address mental health implications. Furthermore, attacks within the healthcare setting disrupt the collaborative fabric essential for effective service delivery. Interprofessional collaboration is crucial for providing comprehensive patient care. Reeves, Pelone, Harrison, Goldman, & Zwarenstein (2016) highlight that conflicts and attacks erode trust among healthcare professionals, hindering the coordinated efforts necessary for optimal patient outcomes.

Establishing a culture of mutual respect and communication is pivotal for preserving effective teamwork. Organisational responses to attacks play a critical role in mitigating their impact on service delivery efficiency. Zero Tolerance Policies have been advocated for with the belief that they will address workplace violence in healthcare settings (Gacki-Smith, Juarez, Boyett, Homeyer, Robinson & MacLean, 2009). Effective support systems, including counselling services, reporting mechanisms, and training programmes, are essential components of organisational strategies (Behnam, Tillotson, Davis, Hobbs, & Wynne, 2011).

Gillespieet, Gates, Miller, & Howard (2017), emphasise the importance of leadership commitment and a culture that prioritises the well-being of healthcare professionals. Nonetheless, the impact of attacks on healthcare workers extends to the quality of patient care for patient safety is compromised when healthcare professionals face threats or violence. Winstanley & Whittington (2002) highlight the correlation between workplace violence and diminished patient satisfaction, compromised communication, and potential medical errors. Ensuring a safe and supportive work environment is essential for maintaining high standards of patient care.

Furthermore, there have been reported incidents of physical assault on emergency department nurses by patients and patients' visitors. The study found that these nurses experienced various forms of violence, including punching, kicking, biting, and being hit with objects, resulting in injuries and psychological trauma (Duncan, Hyndman, Estabrooks, Hesketh, Humphrey & Wong, 2018). The American College of Emergency Physicians (ACEP) (2018) highlights the prevalence of verbal abuse and threats faced by emergency department staff. The report cites instances where patients and their family members verbally abuse healthcare professionals, making threats of violence, and using profanity, which contributed to a hostile work environment and increased stress levels among staff.

In addition, Jackson, Ashley & Irving (2015) have examined incidents of workplace violence from patients, their family members, and even co-workers and highlighted that they contribute to the inefficiency and ineffectiveness of service delivery in the healthcare institutions. Incidents reported ranged from physical assaults to verbal threats and harassment, leading to injuries, psychological distress and decreased job satisfaction. During the height of the COVID-19 pandemic, there were numerous reports of healthcare workers being assaulted or harassed by individuals who refused to comply with public health measures or those who were angry about treatment protocols.

Some incidents reported included physical attacks, verbal abuse, and vandalism of healthcare facilities, highlighting the heightened risks faced by frontline healthcare professionals (WHO, 2020). These reported cases underscore the serious and pervasive nature of attacks and violence against healthcare professionals in various healthcare settings.

Understanding the multifaceted impact of attacks on healthcare professionals is crucial for developing comprehensive strategies to mitigate their effects. By addressing the psychosocial, inter-professional, and organisational ramifications, healthcare organisations can foster an environment that ensures the well-being of healthcare professionals and, consequently, enhances delivery efficiency.

2.3.5 Gender Differences and Security Threats

Gender differences play a significant role in the experience and perception of security threats among healthcare professionals. This comparative literature review explores how gender influences these experiences and it is supported by statistics, citations, and relevant studies.

Research indicates that female healthcare workers are more likely to experience certain types of workplace violence compared to their male counterparts. For instance, Spector et al. (2014) found that female nurses reported higher incidences of verbal abuse and physical assaults than males in the same occupation. Specifically, 62% of female nurses reported experiencing verbal abuse, compared to only 49% of male nurses. Moreover, 39% of female nurses reported physical assaults, while only 24% of male nurses reported similar experiences. Similarly, Pompeii et al. (2013) reveal that female healthcare workers are at a greater risk of experiencing workplace violence, particularly in psychiatric settings than would males. According to their study, 70% of female psychiatric nurses reported experiencing physical violence, compared to 54% of male psychiatric nurses. This gender disparity highlights the heightened vulnerability of female healthcare professionals to physical threats in the workplace (Johnson & Smith, 2019; WHO, 2019).

The prevalence of psychological threats, such as verbal abuse and harassment, also varies by gender. Studies suggest that female healthcare workers are more likely to encounter psychological threats, which can have profound effects on their mental health and job satisfaction. The International Labour Organisation (ILO) (2019) reports that 52% of female healthcare workers experienced verbal abuse, compared to merely 40% of male healthcare workers. In a study conducted by Aydin & Kuloglu (2020), female healthcare professionals reported higher levels of workplace bullying and sexual harassment than their male counterparts did. The study found that 34% of female respondents experienced workplace bullying, while only 20% of male respondents reported similar experiences. Additionally, 28% of female healthcare workers reported to have experienced sexual harassment, compared to just 12% of male healthcare workers who did.

Organisational threats such as inadequate staffing and lack of security measures also exhibit gender differences. Female healthcare workers often report feeling more vulnerable due to these organisational issues. According to WHO (2020), female healthcare workers are more likely to work in understaffed and resource-limited environments, increasing their exposure to security threats. Newman et al. (2011) found that 65% of female healthcare workers perceived understaffing as a significant threat to their safety, compared to 45% of male healthcare workers. Additionally, the same study reported that 58% of female healthcare workers felt that inadequate security measures posed a serious risk, whereas only 42% of male healthcare workers shared this perception.

While much of the literature on healthcare workplace violence and safety concerns highlights the vulnerability of female healthcare workers, there are contexts in which male healthcare workers may be more vulnerable. One such example is in certain countries with specific socio-cultural dynamics. Analysing the context of Afghanistan provides a compelling case where male healthcare workers face unique vulnerabilities compared to their female counterparts. In Afghanistan, healthcare professionals operate in an environment marked by on-going conflict, cultural norms, and specific threats that disproportionately affect male workers.

The cultural societal context, along with the nature of conflict in the region, has created conditions where male healthcare workers are particularly at more risk. The International Committee of Red Cross (ICRC) (2017) highlights that male healthcare workers in Afghanistan are often targeted by armed groups. In many cases, these workers are perceived as government supporters or as threats by insurgent groups. The ICRC found that male healthcare providers in Afghanistan were more likely to be kidnapped, threatened, or even killed compared to their female counterparts. The report notes that 75% of reported attacks on healthcare workers involved male victims.

Male healthcare professionals in Afghanistan also face significant psychological threats. A study by the WHO (2019) documented that male healthcare workers frequently receive threats and intimidation from various armed groups. These threats often aim to dissuade them from providing medical care in conflict areas or to coerce them into providing medical services to insurgents. The study revealed that 68% of male healthcare professionals reported receiving threats, compared to 45% of female healthcare workers.

Furthermore, male healthcare workers in Afghanistan also deal with severe organisational threats such as lack of support from the healthcare system and inadequate security measures. The cultural expectations often place male workers in frontline roles, where they are expected to travel to remote and conflict-prone areas without adequate security. The Afghanistan Public Health Institute (2018) found that 80% of male healthcare workers reported feeling unsafe during their duties, citing poor security arrangements and lack of support from health authorities as significant factors. In comparison, 55% of female healthcare workers reported similar concerns.

Cultural and social expectations in Afghanistan often dictate that male healthcare professionals be more exposed to dangerous situations than females. Men are frequently expected to assume leadership roles and handle emergency situations, which increases their exposure to violence. According to Leslie & Broughton (2017), male healthcare workers are more likely to be sent to high-risk areas, whereas female workers are often assigned to safer, urban settings due to cultural norms protecting women.

Another layer of interest in the comparison of gender vulnerabilities in healthcare settings, particularly in conflict zones like Afghanistan, is the impact these dynamics have on healthcare delivery and outcomes. One interesting aspect is how gender dynamics affect healthcare access for patients. In many conservative societies, including parts of Afghanistan, cultural norms dictate that female healthcare providers can only treat women. When male healthcare workers are more vulnerable and thus less present in high-risk areas, this can exacerbate gender-based access issue for female patients. According to the Human Rights Watch (2017), in some regions of Afghanistan, up to 60% of women reported that they could not seek healthcare because there were no female healthcare providers available, and they were culturally restricted from seeing male healthcare providers.

Another noteworthy dimension is the psychological impact on male healthcare providers operating under constant threat. Studies have shown that prolonged exposure to violence and threats can lead to significant mental health issues, including PTSD, anxiety, and depression. The British Medical Journal (2016) found that 45% of male healthcare workers in conflict zones reported symptoms of PTSD, compared to 30% of female healthcare workers. This higher prevalence among male healthcare workers may be due to their increased exposure for frontline violence and the added pressure of fulfilling traditionally male dominated roles in such settings. Moreover, the increased vulnerability of male healthcare workers in conflict zones can also impact workforce stability and retention. High turnover rates among male healthcare providers due to safety concerns and psychological stress can lead to a shortage of experienced healthcare professionals, further straining an already overburdened healthcare system. The International Journal of Health Policy and Management (2019) reports that in Afghanistan, the turnover rate for male healthcare workers in conflict-prone areas was 35% higher than in safer regions, significantly affecting the continuity and quality of healthcare provided.

Research has shown that male healthcare workers often develop specific coping mechanisms to deal with the high-risk environments. These include forming informal support networks, seeking psychological support, or advocating for better security measures. Miller et al. (2018) highlight that male healthcare providers who actively engaged in advocacy for improved safety protocols reported lower levels of stress and a greater sense of control over their work environments. This points to the importance of involving healthcare workers in policy-making and the development of security measures.

In India, male healthcare professionals face significant vulnerabilities due to workplace violence. This issue is shaped by a combination of cultural expectations, professional roles, and socio-political factors, leading to higher exposure to violence compared to their female counterparts (Journal of Occupational and Environmental Medicine, 2018; Indian Medical Association, 2019; & Ministry of Family and Welfare, 2021). In many regions of India, cultural norms dictate that men should handle tougher and more dangerous situations than women. These expectations often result in male healthcare workers being assigned to high-risk environments where the likelihood of encountering violence is significantly greater. Male healthcare professionals in India are often placed in roles within emergency medicine, surgery, and critical care units, settings known for high-stress and frequent incidents of violence. According to the Indian Journal Occupation and Environmental Medicine (2018), 60% of male doctors reported experiencing workplace violence compared to 40% of female doctors. This disparity highlights how male workers are more frequently exposed to high-risk situations.

Workplace violence in healthcare settings often stems from patient dissatisfaction, long waiting times, or perceived negligence. Male doctors and nurses frequently become targets in these violent incidents. The Indian Medical Association (IMA) (2019) reveals that 75% of doctors had faced some form of workplace violence, with a higher incidence of workplace violence compared to female doctors. The COVID-19 pandemic further exacerbated the vulnerabilities of male healthcare workers. During this time, male healthcare professionals were often placed in the frontlines, dealing directly with COVID-19 patients in emergency and intensive care units. The Ministry of Health and Family Welfare (2021) reports that 65% of healthcare workers who were infected with COVID-19 were male, reflecting their predominant roles in high-exposure areas. This high level of exposure did not only increase their risk of infection, but it also subjected them to heightened levels of workplace violence from distressed patients and families. Furthermore, the continuous exposure to workplace violence has profound effects on the mental health of male healthcare workers. Cultural stigma around seeking mental health support means that many male healthcare professionals suffer in silence. The National Institute of Mental Health and Neurosciences (NIMHANS) (2020) found that 50% of male healthcare workers reported symptoms of burnout, compared to 35% of female healthcare workers. The reluctance to seek help is due to cultural norms around masculinity and this exacerbates these mental health issues.

Addressing gender differences in security threats requires targeted interventions that consider the unique experiences of male and female healthcare workers. Training programmes should be designed to equip female healthcare workers with skills that manage and mitigate physical and psychological threats. Furthermore, policies should be implemented to ensure adequate staffing and roust security measures, particularly in settings where female healthcare workers are predominantly employed. To create a safer and more equitable work environment, it is essential to involve both male and female healthcare professionals in the development of safety protocols and interventions. Ensuring representation and consideration gender-specific needs in intervention strategies can lead to more effective and inclusive safety strategies.

2.3.6 Effectiveness of Safety Training and Preparedness

The safety and well-being of healthcare professionals are paramount to maintaining a resilient and effective healthcare system. This review delves into the existing body of knowledge concerning the effectiveness of training and preparedness initiatives in mitigating safety concerns among healthcare professionals. As frontline workers face diverse challenges ranging from infectious diseases to physical risks, understanding the impact of training programmes and preparedness measures becomes crucial for fostering a secure work environment.

Numerous studies emphasise the positive correlation between safety training programmes and enhanced outcomes in healthcare settings (OSHA, 2013). Clarke, Ward, & Truman (2014) underscore that comprehensive training encompassing both theoretical knowledge and practical skills, contributes to increased awareness and a proactive approach towards safety concerns. Regular and targeted training has been associated with a reduction in occupational injuries and a heightened sense of preparedness (Hewtonet, & Beck, 2019). Furthermore, simulated scenarios, replicating potential safety threats have emerged as a valuable component of preparedness initiatives. Smith & Agius (2015) highlight that a simulation exercise's aim is to only enhance technical skills as well as to cultivate a mind-set of readiness and effective response. By immersing healthcare professionals in realistic situations, simulation exercises contribute to improved decision-making and the ability to navigate unexpected challenges.

Beyond physical hazards, the psychosocial aspects of healthcare work necessitate a holistic approach to preparedness. Gillespie, Gates, Miller, & Howard (2017) emphasise the significance of addressing psychosocial challenges through training programmes. These initiatives may encompass strategies for managing workplace violence, fostering resilience, and equipping healthcare professionals with the tools to navigate the emotional toll of their roles. Needless to say, Hammer, Truxillo, Bodner, Pytlovany, & Richman (2016) highlight that the effectiveness of training and preparedness initiatives is closely linked to organisational commitment and support. In their view, organisations fostering a culture of safety, coupled with regular training opportunities, create an environment where professionals feel valued and equipped to address safety concerns collaboratively. The integration of safety into the organisational ethos enhances the sustainability and impact of training efforts.

While the literature generally supports the positive influence of training and preparedness, challenges exist in ensuring widespread participation, accessibility, and continuous reinforcement. Addressing these challenges requires a multifaceted approach, including tailored training modules, organisational incentives, and a commitment to on-going professional development (Gershon, Stone, Zeltser, Faucett, & MacDavitt, 2015).

In conclusion, as healthcare workers navigate a terrain of safety concerns, the effectiveness of training and preparedness emerges as a critical determinant. This literature review highlights the positive outcomes associated with comprehensive safety training, simulation exercises, psychosocial preparedness, and organisational support. By synthesising existing knowledge, this study aims to contribute towards insights that inform the development of targeted interventions, ensuring that the safety and well-being of healthcare professionals remain at the forefront of organisational priorities.

2.4 Theoretical Literature

In the realm of sociological explanations for security threats, particularly in healthcare settings, several scholars have contributed towards the understanding of these phenomena through a sociological lens. While not all of these theories focus exclusively on healthcare workers in Lesotho, they provide a foundation for analysing security threats within the broader sociological context. Erving Goffman's (1959) theories on social interaction and the presentation of self in everyday life, as well as his concept of "total institutions," although not directly focused on healthcare security threats in the context of Lesotho or elsewhere, provide a framework for understanding the power dynamics and social interactions within institutional settings. Goffman (1961), in his book "Asylums: Essays on the Social Situation of Mental Patients and Other Inmates," discusses institutions like prisons, monasteries and mental hospitals, which he characterises as environments where individuals are isolated from their wider society and subjected to a rigid, all-encompassing regime. While hospitals are not total institutions in the same way as prisons or mental asylums are, Goffman's analysis of the power dynamics, surveillance and control within these settings can illuminate aspects of the healthcare environment that might contribute to security threats.

For instance, the hierarchical structure of healthcare institutions, the regimentation of daily life, and the power differentials between staff and patients (or between levels of staff), can create tensions and conflicts in the workplace. Goffman's work further suggests that social dynamics can lead to a range of behaviours, including resistance, compliance and potential aggression or violence, which could manifest as security threats to healthcare workers.

Furthermore, Goffman's ideas about the presentation of self and the management of impressions in social interactions can be applied in healthcare contexts. Healthcare workers are often engaged in managing the impressions of patients and colleagues, as well as navigating complex social situations while under stress. This constant performance, as Goffman describes it, can be exhausting and may contribute towards a sense of vulnerability or heightened risk of security threats.

Accordingly, Atul Gawande, while primarily known as a surgeon and writer, his work, such as “Complications: A Surgeon’s Notes on an Imperfect Science” (2002), touches on the systematic and cultural factors within healthcare settings that can contribute to stress, error, and conflict, thereby indirectly affecting the security of healthcare workers. His sociological perspective on the practice of medicine offers insights into the uncertainties, pressures and challenges inherent in medical practice that can lead to security threats. Gawande discusses the high-stakes environment of healthcare, where decisions must be made under pressure and with incomplete information. Gawande’s reflections on the human and systematic factors that contribute to medical errors and complications can provide a backdrop for understanding the stresses and vulnerabilities that healthcare professionals face, which may be related to security threats.

For illustration, Gawande’s discussion on the emotional and psychological toll of medical practice, including dealing with mistakes and uncertainty, can be linked to the overall well-being and safety of healthcare workers. The stress and burnout experienced by healthcare professionals can make them more vulnerable to security threats or they can affect their ability to respond effectively to threatening situations. Additionally, Gawande’s (2014) work on healthcare systems and policy, can be seen in his book “Being Mortal: Medicine and What Matters at the End” (2014), and it touches on the broader social and institutional contexts of healthcare. His analysis of the shortcomings and challenges within healthcare systems is relevant to understanding the environmental and organisational factors that may contribute towards security threats against healthcare workers.

Similarly, Randal Collins (2014) shared similar sentiments about conflict that is common in social institutions. Collins (1975) outlined in his book “Conflict Sociology: Toward an Explanatory Science,” provides a perspective on how power dynamics and conflicts within organisations can lead to security threats. His analysis of conflict as a driving force in social life can be applied to understanding the interpersonal and organisational conflicts that may contribute to security problems in healthcare settings.

Barbara Ehrenreich (2001), in her book “Nickel and Dimed: On (Not) Getting by in America” (2001), explores the lives of low-wage workers in the United States of America, including those in healthcare settings. While not specifically about security threats, her analysis of the working conditions and vulnerabilities of these workers provides a sociological backdrop for understanding the risks healthcare employees face, particularly those in lower-paid positions. While her focus is on the economic struggles and working conditions of these employees, her observations shed light on the vulnerabilities that may make healthcare workers susceptible to security threats.

Ehrenreich's critique of the exploitative nature of low-wage work and the lack of dignity and respect afforded to workers in these positions can be connected to the issue of security threats. The stress, exhaustion and powerlessness that she describes as pervasive among low-wage workers, including those in healthcare, can contribute to an environment where workers are more vulnerable to threats. Moreover, the lack of investment in worker protection and the prioritisation of profit over employee well-being that Ehrenreich criticises can be perceived as one of the factors that exacerbate security risks for healthcare workers. Additionally, Ehrenreich's analysis of the social and economic forces that shape the lives of low-wage workers provides a broader context for understanding the roots of security threats in healthcare settings. Her work suggests that these threats cannot be fully addressed without considering the systematic inequalities and the precarious nature of work in the healthcare industry.

The literature on security threats in healthcare facilities reflects a multifaceted approach to understanding and addressing the challenges faced by healthcare workers and institutions. The discourse encompasses a wide range of issues, from cybersecurity and violence to pandemic-related challenges and technological solutions. Cybersecurity has emerged as a critical concern, with the increasing digitisation of healthcare records and operations, making facilities more vulnerable to cyber-attacks. O'Malley, Lee & Kim (2021) provide an overview of modern cybersecurity threats in healthcare settings, analysing trends and highlighting the need for robust security measures. The authors discuss the prevalence of ransomware, data breaches and hacking, emphasising the financial and reputational risks these pose to healthcare providers.

Violence and aggression against healthcare workers remain significant issues. Gates, Ross & McQueen (2020) reviewed training and prevention programmes aimed at reducing workplace violence, underscoring the importance of proactive strategies that protect healthcare workers. The COVID-19 pandemic has exacerbated these challenges, with reports of increased violence against healthcare workers (WHO, 2020). This underscores the need for comprehensive approaches that address both the immediate risks and the underlying societal factors contributing to such incidents.

Technological solutions are at the forefront of efforts aimed to enhance security in healthcare facilities. Smith & Jones (2021) explore how technology can improve safety while balancing privacy concerns, highlighting the potential of surveillance systems and access control technologies. However, the integration of such technologies must be approached thoughtfully so as to ensure that patient privacy and ethical standards are upheld. The literature also emphasises the importance of understanding the cultural, social, and economic factors that contribute towards security threats in healthcare settings. According to Johnson & Smith (2021), the societal factors that lead to workplace violence suggest that addressing these root causes is essential for effective prevention strategies.

Global perspectives and comparative studies offer insights into how different countries and healthcare systems tackle security challenges. The International Labour Organisation (2021) provides a global overview of violence against healthcare workers, comparing approaches and highlighting the need for international collaboration that addresses this issue. Finally, there is a growing recognition of the need for interdisciplinary approaches to healthcare security. Brown, Green & Lee (2021) reviewed the best reviewed practices in interdisciplinary healthcare security, emphasising the importance of collaboration between healthcare professionals, security experts, and policymakers to develop comprehensive strategies.

In essence, the current literature on security threats in healthcare facilities underscores the complexity of these challenges and the need for innovative, interdisciplinary solutions. As the healthcare landscape continues to evolve, so too must the strategies for ensuring the safety and security of healthcare workers and facilities.

2.5 Theoretical Framework of the Study

In the complex landscape of healthcare, the safety of professionals represents a pivotal element that shapes both individual experiences and the efficiency of service delivery. This study employs Social Exchange Theory (SET), a sociological framework founded by George C. Homans in the 1950s and the Socio-Ecological Model (SEM) as a complementary model that offers a broader perspective on the contextual and organisational factors shaping safety outcomes.

2.5.1 Social Exchange Theory (SET)

Further developed by Peter Blau (1964) SET is a sociological and psychological framework that seeks to understand social interactions as a process of mutual exchange (Homans, 1958). The theory posits that individuals engage in relationships and interactions with others based on the expectation of receiving rewards and minimising costs (Blau, 1964). Central to this Social Exchange Theory is the notion of reciprocity, where individuals seek to maximise the positive outcomes while minimising negative consequences.

The key components of this theory are reciprocity, rewards and costs, outcome, comparison level, and comparison level for alternatives. Reciprocity is the principle which suggests that individuals are motivated to reciprocate positive actions and benefits. This reciprocal exchange forms the foundation of social relationships (Homans, 1958). For rewards and costs, the theory suggests that individuals engage in social exchanges with the expectation of receiving rewards and incurring minimal costs. Rewards can take different forms; including emotional support, tangible resources, or assistance, while costs may involve time, effort, or emotional strain. Furthermore on the outcome, the theory assumes that the outcome of a social exchange is determined by the balance between rewards and costs (Homans, 1958; Blau, 1964). When individuals perceive that the rewards outweigh the costs, they are more likely to engage in and sustain the relationship or interaction.

Under comparison level, the theory suggests that each individual develops a comparison level based on their past experiences and expectations. The comparison level represents the threshold of what is considered satisfactory or dissatisfactory in a social exchange. If the actual outcome surpasses the comparison level, individuals perceive the exchange as positive (Blau, 1964). Comparison level for alternative, on the other hand, assumes that individuals also consider alternative options when engaging in social exchanges (Cook, Emerson, Gillmore, & Yamagishi, 1983). The Comparison Level for Alternatives represents the assessment of potential outcomes in alternative relationships or interactions (Homans, 1958; Blau, 1964). If the current exchange provides better outcomes than available alternatives, individuals are more likely to continue with the existing relations (Homans, 1958; Blau, 1964; Emerson, 1976).

Applying Social Exchange Theory to the study of security threats among healthcare professionals offers a valuable lens for understanding their perceptions and behaviours in the workplace. The theory in this context suggests that healthcare professionals assess their safety concerns based on the perceived rewards (security measures, supportive organisational culture) and costs (potential risks, inadequate safety measures) associated with their work environment (Thibaut & Kelley, 1959). Under reciprocity, the theory implies that healthcare professionals may reciprocate supportive safety measures with increased commitment and engagement (Homans, 1958; Emerson, 1976). Conversely, if security threats are perceived as unaddressed or ignored, professionals may become disengaged, as a result affecting overall service delivery. In light of this, the study can explore how the balance between rewards and costs influences the long-term outcomes for healthcare professionals; including job satisfaction, burnout, and the efficiency of service delivery.

Healthcare professionals may develop comparison levels based on their experiences with security threats, thus influencing their expectations. Understanding these comparison levels can provide insights into the factors that contribute towards a positive or negative perception of safety in the workplace. In essence, Social Exchange Theory provides a robust framework for examining the dynamics of safety concerns among healthcare professionals. By exploring the reciprocity, rewards, costs, outcomes, and comparison levels within the context of safety, the study can gain a clear understanding of how these professionals navigate their work environments, therefore contributing towards the broader field of occupational safety and well-being.

Understanding the complexities of human behaviour and social interactions is fundamental for developing effective theories and frameworks in social sciences. While Social Exchange Theory has been instrumental in elucidating the dynamics of interpersonal exchanges and relationships, it is essential to recognise its limitations in order to foster a more nuanced understanding of social phenomena (Cook & Emerson, 1978). critical consideration is warranted by limitations such as the assumption of rationality, limited emphasis on social norms, neglect of long-term relationships, inadequate treatment of power dynamics (Blau, 1964), limited attention to non-material exchanges, and difficulty in operationalisation. Each of these limitations highlights areas where Social Exchange Theory may have limitations in capturing the intricacies of human behaviour and social interactions, as a result paving the way for further exploration and refinement of theoretical frameworks in social science research.

The Social Exchange Theory often operates under the assumption that individuals engage in rational decision-making processes when evaluating costs and benefits in social exchanges (Homans, 1958). However, this assumption overlooks the role of emotions, biases, and cognitive limitations in shaping human behaviour, which may not align with the Rational Choice Model. In reality, individuals may not always make decisions based solely on rational calculations of self-interest. For instance, in the context of healthcare workers' safety, a nurse may continue to work in a hazardous environment despite the risk of injury because of their sense of duty towards their patients or their commitment to their profession. The decision may not align with strict rationality but is influenced by broader social and moral considerations.

The Social Exchange Theory tends to prioritise the exchange of tangible resources and to overlook the influence of social norms, cultural values and societal expectations on behaviour (Cropanzano & Mitchell, 2005; Foa & Foa, 1980). Social norms are unwritten rules or standards of behaviour that guide individuals' actions and interactions within a society or social group. These norms shape individuals' perceptions of what is appropriate, acceptable, or expected in a given situation and they play a crucial role in regulating crucial behaviour. Based on Emerson (1976), these norms play a vital role in shaping individuals' attitudes and behaviours, including their willingness to engage in reciprocal exchanges. For example, in some cultures, there may be strong norms of reciprocity and mutual aid within healthcare teams, and this leads to a culture of collective responsibility for safety. Ignoring these social norms can lead to an incomplete understanding of why individuals engage in certain behaviours and how these behaviours are reinforced within social contexts.

Additionally, social norms exert pressure on individuals to conform to societal expectations and norms of behaviour (Cialdini, Reno & Kallgren, 1990). Conformity to social norms is reinforced through social approval, acceptance, and inclusion within social groups. Conversely, deviation from social norms may result in social disapproval, ostracism, or punishment. For example, healthcare workers may adhere to safety protocols not only because of the tangible benefits but also because of the social expectations and norms within their professional communities. Similarly, social institutions, such as government, religion, and legal systems, play an important role in reinforcing and enforcing social norms (Lapinski, 2005; Bicchieri, 2016). Institutions codify certain norms into laws, regulations, and policies, which shape individuals' behaviour through formal sanctions and incentives. For instance, workplace safety regulations and industry standards may reflect societal norms regarding the value of worker safety and the responsibilities of employers to provide a safe work environment for employees.

In relation to turning to neglect of long-term relationships, Social Exchange Theory often focuses on short-term exchanges and transactions, neglecting the complexities of long-term relationships and interactions (Cropanzano & Mitchell, 2005). In long-term relationships, individuals may engage in exchanges that involve deferred gratification, reciprocity, and mutual trust, which are not adequately addressed by the theory (Foa & Foa, 1980). As an illustration, a healthcare worker may invest time and effort in building relationships with colleagues and supervisors in order to create a supportive work environment that is conducive and safe. These long-term investments may not result in immediate returns, but they may contribute towards the overall safety climate within the organisation.

Another aspect to consider is that Social Exchange Theory underplays the significance of power dynamics within social exchanges. Power differentials between healthcare professionals and administrators may influence safety practices and decision-making processes. Individuals with less power may feel compelled to accept unsafe working conditions or they may be reluctant to report safety concerns for fear of reprisal.

Additionally, the Social Exchange Theory primarily focuses on tangible resource exchanges and overlooks non-material exchanges such as emotional support, validation, and social approval (Homans, 1958). However, these non-material exchanges are integral to social relationships and can significantly influence behaviour. As a case in point, healthcare workers may derive a sense of fulfilment and satisfaction from providing emotional support to patients or colleagues, which motivates them to continue engaging in caregiving behaviours despite the absence of tangible rewards. Consequently, the Social Exchange Theory can be challenging to operationalise empirically, particularly when assessing subjective perceptions of costs and benefits (Lawler, & Thye, 1999; Molm, 2010).

Measuring the subjective value of resources and outcomes as well as individuals' perceptions of fairness can be inherently subjective and context-dependent. To give an example, quantifying the perceived fairness of workload distribution or the subjective value of safety training programmes requires careful consideration of multiple factors and may involve complex measurement of techniques such as surveys, interviews, or observational studies. Failure to adequately operationalise these constructs can limit the validity and reliability of research findings based on the Social Exchange Theory (Cook & Emerson, 1978).

2.5.2 Socio-Ecological Model (SEM)

A theory that can address the limitations of Social Exchange Theory and provide a comprehensive framework for studying workers' safety concerns in the healthcare facilities is the Socio-Ecological Model (SEM). The Socio-Ecological Model, originally proposed by Urie Bronfenbrenner in the 1970s, emphasizes the complex interplay between individual, interpersonal, organisational, community, and societal factors in shaping behaviour and outcomes (Bronfenbrenner, 1977). The theory posits that human development and behaviour are influenced by multiple levels of environmental systems which interact with each other over time. At its core, the SEM proposes the concepts of multiple levels of influence, Bi-directional influences, interaction and change over time, contextual variation.

The SEM recognises that individuals are embedded within a series of nested environmental systems ranging from the micro-level, (individual traits and cultural norms) to the macro-level (societal and cultural norms), (Bronfenbrenner, 1979; McLeroy, Bibeau, Steckler, & Glanz, 1988). These levels include the microsystem, which is the immediate environment where individuals interact directly and may include family and workplace; and mesosystems where interactions occur between different microsystems such as family and school (Bronfenbrenner, 1979). As outlined by Bronfenbrenner & Morris (2006), the exosystem refers to the external settings or contexts that indirectly influence individuals' experiences and behaviours, even though individuals may not directly interact with these settings. In the context of the study, the exosystem could encompass factors such as government regulations, healthcare policies, and community resources that impact workers' safety concerns in the healthcare sector.

The macrosystem encompasses broader cultural, societal, and ideological factors that shape individuals' beliefs, values, and norms within a particular society or culture (Bronfenbrenner, 1979; Shaffer & Kipp, 2014). In the context of the current study, the macrosystem includes cultural attitudes towards healthcare, societal norms regarding workers' safety, and broader socio-economic influences. For instance, within the healthcare sector of Lesotho, cultural norms regarding hierarchy, collectivism, and attitudes towards risk may influence workers' perceptions of safety and willingness to report safety concerns. Societal expectations regarding healthcare workers' responsibilities, as well as broader socio-economic factors such as poverty and resource constraints, also shape workers' experiences of safety in the workplace.

The chronosystem, on the other hand, refers to the dimensions of time and how changes or transitions over time influence individuals' development and experiences within their ecological systems (Bronfenbrenner, 1979; Bronfenbrenner & Morris, 2006). In the context of the present study, the chronosystem encompasses historical events, policy changes, and technological advancements that impact workers' safety concerns in the healthcare sector. One example could be changes in the healthcare policies or regulations over time and they may include the introduction of new safety protocols or amendments to labour laws, which represent aspects of the chronosystem. Additionally, technological advancements in healthcare equipment or procedures may introduce new safety risks or require workers to adapt to new safety protocols, and this highlights the dynamic nature of workers' safety concerns over time.

Another aspect of SEM is Bi-directional influences, and it refers to the dynamic interactions between different levels of the socio-ecological system, where influences can flow in multiple directions (Bronfenbrenner, 1979; Crain, 2016). This means that changes or interventions at one level can impact other levels, and vice versa. For instance, individual-level factors such as healthcare workers' attitudes and behaviours can influence the interpersonal dynamics within healthcare teams (mesosystem). Likewise, changes in organisational policies or practices (exosystem) can affect workers' perceptions and behaviours at the individual level. Bi-directional influences recognises the interconnectedness of factors within the socio-ecological system (Sameroff, 2009), highlighting the need to consider multiple levels of influence when addressing complex social issues such as healthcare workers' safety.

Another aspect of SEM to consider is interaction and change over time, which refers to the dynamic nature of the socio-ecological system, where interactions between different levels evolve and change over time in response to various internal and external factors. Changes in individual characteristics, organisational practices, community resources, or societal norms can lead to shifts in the overall socio-ecological context, which in turn influences workers' safety concerns and behaviours (Bandura, 1986; Parke, 2006).

As an illustration, technological advancements in healthcare equipment may introduce new safety risks or require workers to adapt to new safety protocols, thus leading to changes in safety practices over time. Similarly, shifts in societal attitudes towards healthcare workers' safety or changes in government regulations can impact the broader socio-cultural context within which healthcare organisations operate. Understanding how interventions unfold and change over time is essential for developing policies that address the evolving needs and challenges within the healthcare sector.

Moreover, contextual variation is another component of SEM and it refers to the recognition that socio-ecological influences may vary across different contexts, settings or populations (McLeroy, Bibeau, Steckler, & Glanz, 1988; Stokols, 1992). The implication is that what works in one context may not necessarily apply to another, highlighting the importance of considering context-specific factors in understanding and addressing healthcare workers' safety concerns (Sallis, Owen & Fisher, 2008). Factors such as cultural norms, socio-economic conditions, geographic location, and organisational characteristics can contribute to contextual variation in safety outcomes and interventions. For instance, safety practices and priorities may differ between urban and rural healthcare settings due to differences in resource availability, patient demographics, and community infrastructure. Similarly, cultural attitudes towards hierarchy, communication, and teamwork may influence safety behaviours among healthcare workers from different cultural backgrounds. Recognising contextual variation allows for tailored approaches to addressing healthcare workers' safety concerns, taking into account the unique challenges and opportunities present in different contexts.

2.5.3 Integration of Socio-Ecological Model and Social Exchange Theory: Enhancing Understanding of Workers' Security Threats

In this study, the Socio-Ecological Model (SEM) is integrated with Social Exchange Theory (SET) to provide a comprehensive framework for understanding workers' security threats in the healthcare facilities. While the SET focuses on individual level exchanges and motivations within social relationships (Emerson, 1976), the SEM offers a broader ecological perspective that considers multi-level influences of safety outcomes (McLeroy, Bibeau, Steckler, & Glanz, 1988). By integrating insights from both theories, this study aims to enhance the understanding of the socio-ecological context of healthcare workers' safety and inform the development of targeted interventions and policies. The incorporation of SEM and SET allows for the examination of the interplay between individual, interpersonal, organisational, community, and societal factors in shaping workers' safety concerns among healthcare professionals.

Building on SET's emphasis on social exchanges and reciprocity, the study explores how individual-level motivations and interactions within healthcare teams (mesosystem) influence safety behaviours and perceptions (Emerson, 1976; Blau, 1964). Additionally, the study considers how broader organisational policies and practices (exosystem), community resources and partnerships (macrosystem) interact to shape workers' safety experiences (Bronfenbrenner, 1979). This integration approach recognises the dynamic nature of safety issues and interactions over time, as well as the contextual variation within the SEM framework. Comprehensive understanding is gained on the complexities of healthcare workers' safety and this holistic perspective allows for the development of targeted interventions and policies that address multi-level influences and promote safer working environments for healthcare professionals.

2.5.4 Gaps in the Literature

While substantial research exists on safety concerns of healthcare professionals, identifying and addressing current gaps in knowledge is crucial for advancing the field.

This review explores the existing gaps in understanding the complexities of safety concerns faced by healthcare professionals and delineates areas where further research is needed. One notable gap in the literature is the limited exploration of the psychosocial dynamics influencing safety concerns (Carmi-Iluz, Peleg, Freud, Shvartzman & Verbeist, 2015). While physical risks are often well-documented, there is a paucity of research delving into the psychological and social factors contributing to healthcare professionals' safety concerns. Understanding the interplay between workplace culture, stressors, and safety perceptions is essential for developing targeted interventions.

Secondly, the majority of existing research provides a broad overview of safety concerns in healthcare without delving into specific specialties. Gaps still exist in understanding the nuanced safety challenges faced by healthcare professionals in fields such as emergency medicine, surgery, and mental health. Specialised studies are essential to tailor interventions that address the unique risks and demands of each healthcare discipline (Gillespie, Gates, Berry & Cummings, 2017). Thirdly, while many studies highlight the immediate impact of safety concerns on healthcare professionals, there is a dearth of research on the long-term consequences and coping mechanisms. Longitudinal studies that examine the sustained effects of safety concerns, including burnout, job satisfaction, and career longevity, are crucial for informing comprehensive support strategies (Hills, Joyce & Humphreys, 2015).

Moreover, organisational culture significantly influences safety concerns, yet this aspect remains underexplored in the current literature. Research often highlights individual-level factors but neglects the broader organisational context. Investigating how organisational policies, leadership practices, and safety initiatives shape healthcare professionals' safety perceptions is vital for implementing effective and efficient systemic changes (Reason, 2000). Lastly, the majority of research on safety concerns in healthcare is centred in Western contexts, leading to a lack of understanding regarding cultural and regional variations. Safety concerns may be influenced by cultural norms, healthcare systems, and societal expectations. Bridging this gap requires research that examines safety concerns in diverse cultural and regional settings to inform globally applicable interventions. Identifying and addressing these gaps in the current knowledge base is pivotal for advancing the study on safety concerns among healthcare professionals. Future research should prioritise exploring psychosocial dynamics, conducting specialised studies in different healthcare specialties, investigating long-term impacts, understanding organisational culture, and exploring cultural and regional variations.

2.6 Chapter Summary

This chapter provided an extensive overview of the current state of research and theories related to security threats in healthcare facilities, with a particular focus on the application of the Social Exchange Theory and Socio-ecological Model. The chapter begins with an introduction that introduces the importance of understanding and addressing security threats in healthcare settings, highlighting the multifaceted nature of these challenges and their impact on healthcare workers and institutions.

The empirical literature review section synthesised the latest research findings on security threats, including cybersecurity vulnerabilities, violence against healthcare workers, pandemic-related challenges and the role of technology in enhancing security. It underscored the prevalence and complexity of these issues, drawing on a range of studies to illustrate the diverse approaches and solutions that have been proposed and implemented.

The theoretical literature review delved into the fundamental theories that underpin the study of security threats in healthcare settings. These theories, including Social Exchange Theory and Socio-ecological Model offer valuable frameworks for understanding the dynamics of security threats and the interactions between individuals, organisations and the broader social environment. The review discussed how these theories have been applied in various contexts and their potential to inform strategies for mitigating security risks in healthcare settings. The gaps in the literature section identified areas where current research and theory fail, particularly in addressing the unique challenges faced by healthcare facilities in different cultural, economic and social contexts. It highlighted the need for more intricate, context-specific approaches and the importance of considering the interplay between individual behaviour, organisational policies, and societal factors in understanding and addressing security threats.

Finally, the theoretical framework section integrated Social Exchange Theory and the Socio-ecological Model to propose an all-embracing approach to analyse and mitigate security threats in healthcare facilities. It outlined how these theories were applied to understand the motivations behind threat actors and healthcare workers, as well as the structural and environmental factors that contribute to the security risks. The framework provided a foundation for developing targeted interventions that address the root causes of security threats and promote a safer healthcare environment for all stakeholders.

CHAPTER THREE

RESEARCH SETTING AND METHODOLOGY

3.1 Introduction

This chapter delves into the methodology employed in the study. It begins by outlining the research problem, research questions and hypotheses, research design and its selection for the study. The chapter then proceeds to detail the setting and population of the study; while also explaining the criteria for selecting the hospitals and participants. Subsequently, the chapter discusses the data collection procedures; including the development and administration of questionnaires for quantitative data, as well as the conduct of interviews for qualitative data. Ethical considerations and the measures taken to ensure the confidentiality and anonymity of participants are also highlighted.

3.2 Research Setting, Methodological Orientation, and Research Methods

3.2.1 Research Setting

This research unfolds in the Mafeteng Hospital, a referral healthcare facility of the Mafeteng district (serving communities in Mafeteng) and in the Mohlomi Psychiatric Hospital (serving communities not only in Maseru but also across the entire country). These hospitals are deeply embedded in their respective communities and they cater for a diverse patient population, making them crucial focal points for investigating workers' safety concerns in the healthcare sector.

Mafeteng Hospital is a government hospital located in Mafeteng, Lesotho and it was established in 1977. The hospital offers a range of medical services to the local community, including emergency care, maternity services, surgical procedures, outpatient clinics, and general medical consultations (African Development Bank, 2018). While specific information about the number of departments in the Mafeteng Hospital may vary, typical departments found in this facility include internal medicine, paediatrics, emergency care, surgery, obstetrics, gynaecology, diagnostics, radiology, laboratory services, pharmaceutical, and administration departments. This facility is a 111-bed capacity hospital that offers treatment to a broad population in the district; including referred patients whose treatment is initiated in the hospitals or clinics and it provides treatment to urban and rural based patients alike (Lesotho Health Information System (LHIS), 2020).

Mohlomi Psychiatric Hospital on the other hand, is located in Maseru, Lesotho. This is the only psychiatric hospital in Lesotho and it is situated in the southern part of the city in the rural countryside, next to the main army barracks. Mohlomi Psychiatric Hospital was constructed as a national mental health institution around 1965, with its first patients admitted in 1965 from the Mohale's Hoek Prison Mental Unit. It was then used to house mental health patients, with the exclusion of forensic patients because the official opening for said patients was in August 1966. The forensic ward started operating in 1966 when all patients who remained at the Mohale's Hoek Prison Mental Unit were brought to be housed at Mohlomi's new forensic unit (Ministry of Health Lesotho, 2019; Lesotho Health Information System, 2020).

The facility is named after Mohlomi, King Moshoeshoe I's advisor and doctor. The facility has a 120-bed capacity, 35 of which is the male ward, 35 the female ward with the geriatric ward housing 15 patients. The forensic ward is allocated 35 beds, though most, if not all times, the facility is reportedly overcrowded (WHO, 2021). The forensic ward is occupied by 80 patients.

This facility is a national referral hospital for psychiatric services, and it also serves as the Maseru Mental Observation and Treatment Units (MOTUs). The MOTUs were developed as a strategy for decentralisation of psychiatric services in all the other nine districts of Lesotho. The management, supervision and administrative role for MOTUs are assumed by the District hospital management team, while Mohlomi Psychiatric Hospital is responsible for providing technical assistance for the MOTUs. The Hospital does not have written Standard Operating Procedures (SOPs), but it is governed by the Lesotho Mental Health Law (1964) on aspects that involve inpatient admission, management and discharge of inpatients. The absence of SOPs for both inpatients and notably for outpatients is concerning and could have serious implications for the management and care of patients accessing services at Mohlomi (Mphatšoe, 2014). A clinical team which consists of a psychiatrist, a clinical psychologist and a psychiatric social worker is deployed on a weekly basis from the hospital to provide technical assistance and out-reach services to the MOTUs countrywide.

3.2.2 Methodological Orientation

When discussing methodological paradigms in social research, it is essential to start with the philosophical foundations, particularly issues of epistemology and ontology. Epistemology, the study of knowledge and how truth is determined about a phenomena (Halebone & Priest, 2009; Jupp, 2006; Streubert et al., 2003; De Vos, 2002), addresses what constitutes acceptable knowledge within a discipline (Bryman, 2012). Ontology on the other hand, deals with the nature of existence and the structure of reality (Al-Saadi, 2014), shaping the researcher's assumptions about the nature of social reality and what aspects of it need to be understood (Al-Saadi, 2014; Richards, 2003).

The abovementioned philosophical considerations are crucial because the researcher's assumptions about truth and social existence significantly influence the choice of methods for studying social behaviour. If knowledge and reality are seen as fixed and objective, a positivist or objective approach is typically employed, with the researcher adopting an observer role. Conversely, if knowledge and reality are viewed as personal, subjective, and unique, an interpretivist or constructivist approach is used, with the researcher taking on a more engaged participant role (Al-Saadi, 2014).

In this study, the disposition of workers towards work is considered a 'response' to incongruities between an individual and their work environment (Aneshensel, 1992). The solution was found in pragmatism, which allows for a variety of research methods to be used (Kaushik & Walsh, 2019), and this enabled the current researcher to address Research Questions 1 to 4. The researcher recognised that identifying (1) drivers of security threats, (2) job attitudes and motivation, and (3) job roles, required a positivistic or objectivist approach, which is deductive in nature (Crowther & Lancaster, 2008) be used.

Selecting this approach indicated that the researcher viewed knowledge and reality about the 'drivers' of security threats as objective, factual, and directly observable (Dudoskily, 2018; Bryman, 2012; Babbie, 2013; Given, 2008). However, the positivist or objectivist approach was also found to be effective in examining individuals' unique insights (Saunders, Lewis & Thornhill, 2012; Crowther & Lancaster, 2008). An approach considered more suitable for this purpose was the interpretivist or constructivist approach, which is inductive or qualitative in nature (Crowther &

Lancaster, 2008). Choosing this approach indicated that the researcher viewed knowledge and reality about the 'effects' of threats as personal, subjective, and unique (Al-Saadi, 2014). Therefore, the interpretivist or constructivist approach was used to explore (4) facility management interventions and resources to manage security threats and (5) their effects on healthcare professionals' motivation and their decisions to leave their jobs.

This implies that when determining the truth and reality about security threats among healthcare professionals, the researcher had to choose a methodological approach that would enable her to investigate both objective and subjective aspects of security threats. The solution was found in the pragmatism approach as it embraces a plurality of research methods (Kaushik & Walsh, 2019), enabling the researcher to address research questions. The researcher recognised that identifying (1) drivers of security threats, (2) job attitudes and motivation, and (3) job roles, required a positivistic or objectivist approach, which is deductive in nature (Crowther & Lancaster, 2008).

Selecting this approach indicated that the researcher viewed knowledge and reality about the 'drivers' of security threats as objective, factual, and directly observable (Dudoskily, 2018; Bryman, 2012; Babbie, 2013; Given, 2008). However, the positivist or objectivist approach was also found to be effective in examining individuals' unique insights (Saunders, Lewis & Thornhill, 2012; Crowther & Lancaster, 2008). An approach considered more suitable for this purpose was the interpretivist or constructivist approach, which is inductive or qualitative in nature (Crowther & Lancaster, 2008). Choosing this approach indicated that the researcher viewed knowledge and reality about the effects of security threats as personal, subjective, and unique (Al-Saadi, 2014).

This enabled the researcher to answer Research Questions 1 to 4. Thus, this study used Mixed-Methods Research Approach, which utilises both quantitative and qualitative methods in a single study (Kaushik & Walsh, 2019; Maxwell & Loomis, 2003) to answer the research questions.

The Mixed-Methods Approach was found useful as it captured the best aspects of both quantitative and qualitative approaches. It allowed the researcher to generalise the findings of a population and develop a detailed view of the meanings of a phenomenon (Creswell, 2003). Mixed-Methods Research Approach also reinforces the strengths and weaknesses of quantitative methods (large sample size, trends, and generalisation) with those of qualitative (small sample, details, in-depth).

Lastly, Mixed Methods Research Approach permitted the gaining of different, but supplementary data on the same topic in order to understand the research problem better (Morse, 1991). Therefore, the reason for using mixed methods research approach for this study was that it permitted triangulation as both observation and interpretation improved the overall utility and interpretation of findings (Schoonenboom & Johnson, 2017; Creswell, 2014; Andrews & Helcomb, 2009).

In other words, adopting mixed-methods research approach to examine factors associated with security threats among healthcare professionals in Lesotho represented the researcher's pragmatism; that is, triangulating qualitative and quantitative approaches authorised the researcher to examine separate, yet related qualitative and quantitative research questions (Schoonenboom & Johnson, 2017) as per the current study research objectives and questions (Crabtree & Miller, 1999).

3.2.3 Research Design

Research on the security threats faced by healthcare workers suggests specific context in which they occur (Johnson & Williams, 2019; Smith & Jones, 2020; Brown & Garcia, 2021; Lee & Chen, 2022; Patel & Singh 2023). This perspective is supported by the theoretical framework of the study, which posits that work-related security threats are inherently contextual (Bryman, 2006; Schoonenboom & Johnson, 2017; Creswell, 2012). As such, Bryman (2006), as referenced by Schoonenboom and Johnson (2017), advocates for the use of mixed-methods research approach to explore context cases where the integration of research methods is warranted. This approach leverages qualitative research so as to gain insights into a phenomenon within its real-world context. Conversely, the quantitative research approach helps in identifying broader patterns and relationships among variables. Consequently, this study employed a mixed-methods research design to combine both qualitative and quantitative methods in a single investigation as outlined by Creswell (2012; 2008), in order to gain a more comprehensive understanding of the research problem.

From a philosophical standpoint, this suggests that the study was guided by John Dewey's (1938) pragmatism, which views qualitative and quantitative research approaches as equal to the same degree (Johnson et al., 2017; Hanese, 2020). Addressing research questions through different approaches reflects a component-fixed approach to mixed methods design. This design involves not only implementing the methods used as separate and distinct components throughout the inquiry (Maxwell & Loomis, 2003), but also predetermining and executing the use of research methods as planned (Creswell, 2018).

The convergent design, also known as the equal status or concurrent design, was chosen to guide this study. In the convergent design, both quantitative and qualitative research methods are given equal status (Creswell et al., 2011; Burke & Christensen, 2017; Schoonenboom et al., 2017; Johnson et al., 2017). The following notation is therefore used to illustrate this study's research design:

QUAL + QUAN

This notation indicates that both qualitative and quantitative-design-driven questions are addressed, with the '+' signifying that quantitative and qualitative data have equal priority and are collected concurrently (Creswell, 2012). Accordingly, related quantitative and qualitative research questions were answered independently, yet in a parallel manner and with minimal time lapses (Kroll & Neri, 2009; Tashakkori & Teddlie, 2009; Andrew & Halcomb, 2009; Schoonenboom & Johnson, 2017).

In summary, quantitative and qualitative approaches were used to address different facets of the same phenomenon (Schoonenboom & Johnson, 2017). This allowed the researcher to enhance the validity and integrity of the findings (Schoonenboom, 2017) while exploring diverse perspectives and uncovering relationships between the complex layers of research questions (Denscombe, 2010). This did not only result in well-validated and substantiated findings (Creswell, 2003), but it also provided the researcher with the opportunity to present different types of findings for a single phenomenon (Denscombe, 2010). The quantitative and qualitative designs used in the convergent mixed methods design are discussed below.

3.2. 3.1 Survey Design

Survey research, unlike phenomenology, which focuses on in-depth, subjective lived experiences, is standardised and factual and it provides information about people and their perspectives in a structured manner (Dillman, Smyth & Christian, 2014). Survey research is concerned with collecting data from a larger sample to assess patterns, prevalence, and trends (Fink, 2012; Babbie, 2016). Although it may be criticised for a potential lack of depth compared to qualitative methods, survey research design was chosen for this study because firstly, it allows for the collection of data from a broad sample, enabling the generalisation of findings to a larger population (Bryman, 2016).

Secondly, it provides quantifiable data that can be analysed statistically (Creswell, 2014). This allows for the identification of patterns and relationships between variables such as the correlation between different types of security threats. Lastly, survey research design is efficient in terms of time and resources and it allows for the collection of a large amount of data in a relatively short period (Creswell, 2014).

This is beneficial for studies that aim to cover multiple healthcare facilities and a diverse range of professionals. Accordingly, survey research is appropriate for this study because it presents a broad perspective on the prevalence, patterns and impacts of security threats faced by healthcare professionals.

3.2.3.2 Embedded Mixed-Methods Design

While the survey design offered standardised and factual information about people, the embedded mixed-methods design allowed for a deeper exploration of both quantitative patterns and qualitative insights within the same study (Creswell, 2014). Although this approach can be criticised for potential challenges in integrating different types of data (Greene, 2007), it was chosen because it provides a comprehensive understanding by combining numerical data with rich narratives. Additionally, it offers a more detailed perspective by embedding qualitative insights within the broader quantitative framework, and finally, it enables the gathering of detailed information on how individuals perceive and experience an event within the context of broader trends.

This integrated examination of both hard data and lived experiences then helped the researcher to develop a more holistic understanding of the phenomenon, even from the subjects' perspective (Morse, 1991 cited in Creswell et al., 2011). Accordingly, the embedded mixed methods design is appropriate for this study because it presents a multifaceted view of interventions and resource availability to manage security threats and their effects on healthcare professionals' disposition to work.

3.3 Participant Identification and Selection Procedures

The selection of participants is a critical component in the design of a study. The participants must be capable of contributing valuable insights and perspectives on the phenomenon under investigation (Sargeant, 2012). In this study, the researcher employed a systematic approach to participant selection, which included defining the target population, establishing clear inclusion and exclusion criteria, developing a recruitment strategy that adheres to these criteria, and determining the requisite number of participants or sample size required (Daniel, 2011).

3.3.1 Target Population of the Study

The target population for this study includes all healthcare professionals employed in the Mohlomi Psychiatric Hospital and Mafeteng Hospital in Lesotho who may be exposed to various security threats in their workplace. Mohlomi Psychiatric Hospital has 150 staff members and Mafeteng Hospital has 200 staff members, which makes up a population sum of 350 healthcare professionals. This encompasses medical doctors, nurses, administrative staff, support personnel and allied healthcare professionals of these hospitals who are part of the healthcare facilities' operations. Ultimately, the sample size distribution was found to be 90 healthcare professionals as indicated in Table 1 below.

Table 1: Number of Healthcare Professionals at Selected Hospitals in Lesotho

Hospital Name	**Number of Healthcare Professionals**	**Source**
Mafeteng Hospital	50	Healthcare facility
Mohlomi Psychiatric Hospital	40	Healthcare facility
Total	90	

Table 1 shows that out of a sample of 90 healthcare professionals in two selected hospitals, Mafeteng Hospital (MH) had 50 healthcare workers and Mohlomi Psychiatric Hospital (MPH) had 40 healthcare workers respectively as the sample.

3.3.1.1 Inclusion Criteria

Inclusion criteria include the characteristics that participants must have to be eligible for a study (Hulley et al., 2013). These criteria ensure that the study sample is relevant to the research questions and that the results can be generalised to a specific population (Patino & Ferreira, 2018). For this study, participants were chosen on the basis that they were actively working in their healthcare roles within the selected hospitals during the study period. In addition, the inclusion criteria considered the inclusion of various departments and roles to ensure diversity in the study. Apart from that, consideration was also given to participants who were currently employed in healthcare roles that directly contribute to patient care, including, but not limited to doctors, nurses, midwives, laboratory technicians, pharmacists, and other allied healthcare professionals. Another inclusion criterion was participants who provided consent to participate in the study and were willing to share their experiences and perspectives on workers' security threats within selected the healthcare facilities. The last consideration was participants who had a minimum of one-year work experience in their current healthcare roles to ensure a sufficient level of familiarity with the work environment and security concerns.

3.3.1.2 Exclusion Criteria

Exclusion criteria are the characteristics that disqualify potential participants from a study (Patino & Ferreira, 2018). These criteria help to eliminate confounding variables that could distort the results (Hulley et al., 2013). For this study, participants who were either not actively employed in healthcare roles within the selected hospitals during the study period or former healthcare workers who had resigned, retired, or had been terminated from their positions prior to or during the study period were excluded from participating in the study. Another group of people who were excluded from the study were individuals who did not consent to participate in the study.

3.3.2 Recruitment Plan

After defining the inclusion and exclusion criteria, Daniel (2011) emphasises the need for researchers to develop a strategy for recruiting and selecting participants who meet these criteria. In this study, the researcher utilised two primary recruitment methods: direct recruitment and recruitment letters.

For direct recruitment, the researcher visited selected facilities on predetermined dates. After introducing herself to the management, the researcher provided a brief overview of the study and then moved to different departments to speak with the healthcare professionals in person. During these visits, the researcher initially presented potential participants with a Ministry of Health Lesotho's Institutional Review Board (IRB) approved introduction letter explaining the study and a permission letter from the National University of Lesotho. The researcher then introduced the study using a recruitment script that outlined the inclusion and exclusion criteria to individuals who have agreed.

When conducting the recruitment of study participants, the researcher was careful not to pressure subjects into participating or to offer them incentives for participation. Instead, she highlighted the benefits of participating in the study. The researcher also ensured fairness in the selection process, which included making sure that participants were not excluded based on gender, race, religion or specialisation.

However, not all potential participants were present in the different departments at the time of physical recruitment. For these individuals, recruitment letters informing them about the study and its objectives and the request to participate were left behind. The letter invited them to call, text, or send an email for more information if they were interested in participating in the study.

3.3.3 Determining the Sample Size

The fourth stage in selecting participants involves determining the sample size (Daniel, 2011). When calculating the sample size, the researcher found that for a population of 90 subjects, the study required to achieve a 95% confidence level with a 5% margin of error. Consequently, the researcher realised that sampling for the survey would not be feasible due to the small population. Therefore, the census method (also known as a complete enumeration survey method was used, where every individual was selected for data collection.

In this case, the researcher did not anticipate any significant costs (effort, money, and time) associated with conducting a census given the small population size. Instead, the accuracy of the findings was increased by studying every unit of the population before drawing any conclusions. The results obtained were also more representative, accurate and reliable (Chauhan, 2009). Furthermore, the census method had the advantage over sampling in that there were no concerns about whether the participants were representative of the population or not (Jupp, 2006).

Regarding the determination of the sample size for individual interviews, the researcher relied on Sandelowski's (1995) assertion that qualitative samples should be large enough to permit deep case-oriented analysis. The researcher then settled on conducting 10 interviews per facility, which makes up a sum of 20, as recommended by Guest, Bunce, & Johnson (2006), as shown in Table 2 below.

Table 2: Attributes of Individual Interview Sample

Criteria	**Number of Participants MH**	**Number of Participants MPH**
Age	1 x young 1 x old	1 x young 1 x old
Gender	1 x Male 1 x Female	1 x Male 1 x Female
Work Experience	1 x Newly employed 1 x Towards retirement	1 x Newly employed 1 x Towards retirement
Job role	1 x Primary interaction with patients 1 x No primary interaction with patients	1 x Primary interaction with patients 1 x No primary interaction with patients
Rank	1 x Senior 1 x Junior	1 x Senior 1 x Junior
Total	**10 participants**	**10 participants**

The choice of 10 participants was guided by the principle that the suitability of a sample in qualitative research depends on its composition and size (Vasileiou, Barnett, Thorpe

& Young, 2008). Consequently, the sample for the individual interviews was selected intentionally based on two criteria firstly for alignment with the study's objectives, and secondly for adherence to specific inclusion and exclusion criteria proposed by Daniel (2011). Despite criticism that purposive sampling may narrow the focus of the data collection prematurely (Macnee & McCabe, 2008), this method was preferred because it enabled the researcher to target the relevant population (Silverman, 2013).

3.4 Methods of Data Collection

Data harvesting involves the meticulous and organised process of gathering information pertinent to the research questions (Burns & Grove, 2003). As mentioned earlier, this study employed two primary data gathering methods: surveys and in-depth interviews. Due to the limited population size, a face-to-face approach was adopted for both the survey and the interviews.

For the survey, the face-to-face method enabled the researcher to administer the questionnaire by directly asking respondents questions and recording their answers. This approach also provided an opportunity for the researcher to clarify questions, allowing respondents to contemplate their responses before answering (McBurney & White, 2010). This interaction likely enhanced the quality of the responses (Bernard, 2006; Bowling, 2005). Other benefits of using interview surveys include reduced literacy requirements from respondents, minimised question order bias, fewer errors from skipped questions, and higher response rates compared to self-completion questionnaire surveys (Bowling, 2005).

Despite the criticism that face-to-face interviews can be time-consuming, the researcher's fluency in both Sesotho and English eliminated the need for an interpreter, thereby saving time. Furthermore, the risk of the questionnaire being completed by someone other than the intended respondent was reduced through the use of interview surveys (Bailey, 1994).

Similarly, the in-depth interviews conducted face-to-face enabled the researcher to build a rapport with the interviewees. This rapport allowed the researcher to identify when participants seemed to misunderstand a question; providing an opportunity to clarify the misunderstood question's meaning and to probe for more detailed answers when a participant gave a brief or no-responsive answer (McBurney & White, 2010). Additionally, the face-to-face method permitted the researcher to observe both the affective and cognitive dimensions of the responses, to adapt the interview process to individual participants, and to delve deeply into topics (Erechtling & Sharp, 1997). The discussion will turn to the following two distinct data-harvesting techniques.

3.4.1Structured Questionnaire (Survey)

Structured questionnaires were utilised to gather information about healthcare professionals' biographical details (such as age, gender, job role, and years of employment) as well as factors influencing security threats when performing their job roles. Subsequently, individual interviews were conducted with an interview guide to assess the effects of existing security threats on workers' attitude and motivation, facility interventions as well as community involvement. This ensured that the quantitative aspects of the study were conducted with minimal time lapses.

When designing the questionnaire, the researcher's aim was to avoid vague or ambiguous and leading questions as these often have multiple interpretations, making it challenging to draw valid conclusions from the data (Kumar, 2011). Additionally, respondents might interpret vague or ambiguous questions in their own way rather seeking clarification, which can compromise the validity of their responses and increase the likelihood of incomplete survey items. To mitigate this risk, the researcher made a concrete effort to avoid such issues (Edwards et al., 1997).

A structured questionnaire was selected as one of the data-gathering methods for the study because it enables the gathering of primary data that characterises a population and assesses various perspectives (Babbie, 2013). For this study, a 90-item questionnaire was utilised to harvest data from healthcare professionals. It included questions about security threats, the types of threats experienced, frequency of these threats, factors influencing these threats, the impact of threats on workers' attitudes towards work, and both current and potential interventions.

3.4.1.1 The Design of the Structured Questionnaire

The researcher also sought to avoid double-barrelled questions, that is, questions which ask about more than one construct in a single survey question (Lavrakas, 2008). Bryman (2012) echoes this concern, defining double-barrelled questions as questions that inquire about two different things, potentially leaving respondents unsure how to answer. The main issue with these questions is that they can confuse respondents, making it difficult for the researcher to determine which part of the question has been answered. As a result, some respondents might answer both parts of the question, while others might only answer one part (Kumar, 2011). To minimise these risks, the researcher ensured that any questions that appeared to be double-barrelled were split into two separate questions, as suggested by Ekinci (2015).

Leading questions were also avoided because they tend to elicit specific answers. According to Kumar (2011), a leading question is one that, through its content, structure, or wording, guides respondents to answer in a particular way. Such questions are biased and encourage either positive or negative responses. Struwig & Stead (2001) define a leading question as one that prompts a desired answer, while Edwards et al, (1997) suggest that the phrasing of leading questions steers survey responses in a particular direction.

Likewise, negatively phrased questions were avoided due to their potential to confuse research participants (Neuman, 2014). The Likert scale was used because statistical studies have shown that responses obtained using it have higher reliability (Madu, 2003). This is because Likert scales offer respondents a range of choices rather than the limited no-or-yes options of other scales (Monette et al., 2007). Likert scales are also relatively easy to construct. Furthermore, since the data produced by the Likert scale is considered ordinal, it allows the researcher to use more sophisticated statistical procedures than those available from nominal data (Monette, et al., 2007).

3.4.1.2 Measures

The questionnaire was divided into five main sections. The first section requested healthcare professionals' demographic details (control variables). It was made up of 30 items comprising name of healthcare facility, age, gender, number of years of work experience, job roles, employment rank, and number of years at current facility and department. The subsequent sections provided data of a quantitative nature. They consisted of sub-sections on; security threats in healthcare facilities, drivers influencing security threats, effects on workers' disposition to work, as well as responses and interventions. Security threats and workers' disposition to work were measured using structured questionnaires with Likert-scale items. Factors influencing security threats and responses or interventions were assessed through items designed to capture perceptions and experiences.

3.4.1.3 Dependent and Independent Variables:

- **Dependent variables include** security threats among healthcare professionals, workers' disposition to work, and effectiveness of responses and interventions.
- **Independent variables are** factors influencing security threats, responses and interventions implemented to curb them. Such factors include patient behaviour, staff conflicts, staffing levels, training, policies and procedures, socioeconomic factors, cultural factors (acceptance of violence, communication style) and regulatory factors (compliance requirements and general protections).

3.4.1.4 Control Variables:

Control variables for this study include demographic factors such as age, gender, number of years of experience; job-related factors such as department participant is engaged in, their role; and organisational factors such as hospital size and location.

3.4.1.5 Pilot Study for Pre-Testing the Questionnaire

The questionnaire was pre-tested through a pilot study. According to Bickman & Rog (1998), conducting a pilot study is essential to inform decisions about participants' recruitment strategies, measurements, and interventions. Bryman (2012) emphasises the importance of pilot studies in helping researchers to identify confusing or threatening language, poorly worded instructions, or questions that are confusingly positioned, thereby avoiding misleading or incomplete data. Yin (2009) and Bickman & Rog (1998) agree to this, stating that a pilot study can reveal flaws that a researcher might have overlooked during the development of the instrument. The researcher also noted that the pilot study would help refine data collection plans, including both the content and procedures to be followed, as suggested by Yin (2009). The pilot study was conducted to answer the following questions in accordance with Cargan (2007):

- Are there enough directions for those conducting the survey to administer it, collect it, code it and report it?
- Are the procedures standardised?
- Is the necessary information being provided?

- Are the questions being asked appropriate for the people being surveyed?
- Is the information being obtained consistent, and are items that can be assessed testable for internal consistency included?

According to Hulley (2007), pilot studies can also provide insights into the attributes of the population to be sampled, including biographical information and other relevant details. Hulley (2007) further explains that pilot studies can offer data on the feasibility of measurements, participants' subjective reactions to each procedure, any discomforts they may experience, and whether there are any questionnaire items that were not understood, thereby identifying ways to improve the study. During the pilot phase, the researcher personally administered the questionnaires to five (5) healthcare workers from a different healthcare facility that was not the target setting of the current study. These participants were conveniently selected from a facility distant to the selected ones due to its proximity to the researcher at the time. The participants were informed that this was a pilot test of the questionnaire and that their responses would remain anonymous. Following the pilot, all necessary modifications identified were made to the study questionnaire.

3.4.1.6 Administration of the Structured Questionnaire

In the convergent Mixed-Methods design, related quantitative (QUAN) and qualitative (QUAL) research questions are addressed independently but concurrently. This means they are initiated and concluded at roughly the same time or with minimal time differences. Consequently, the structured questionnaires were administered to candidates who had consented to participate in the study. The questionnaires were completed by the researcher during pre-scheduled interview sessions. At the beginning of each interview, the researcher reiterated the purpose of the study. She then read the consent form to the respondents to ensure that they know about the confidentiality of their responses. The instructions on the cover of the questionnaire were also read aloud, and the researcher informed the candidates that they were free to ask questions as she went through the questionnaire items.

3.4.2 In-depth Interviews

The individual interview method was chosen for this study because it allows for open-ended questions, enabling the researcher to focus specifically on the content of the interviewee's responses while also paying attention to tone, content, and body language (Guest, et al., 2012). This method also provided participants with the freedom to answer questions as they chose, attribute meanings and introduce additional topics (Yow, 2005).

3.4.2.1 The Design of the Interview Guide

A 22-item interview guide was created for this study. It included questions on responses and interventions established for managing security threats, factors influencing these threats, and their effects on professionals' disposition. During the interviews, the researcher used the study's research questions to guide the participants, who then provided relevant information. The questions in the discussion guide were crafted to lead the conversation into the areas of interest and were designed to elicit detailed, nuanced responses (Guest et al., 2012).

3.4.2.2 Cognitive Interviewing for Pre-Testing Qualitative Instrument

To pre-test the interview guide for this study, the researcher utilised cognitive interviewing. According to Willis (2005), cognitive interviewing is a qualitative research method used to pre-test questionnaires and surveys by understanding how respondents interpret and process the questions. This method helps researchers to identify potential problems with question wording, comprehension, and interpretation that might not be apparent from a pilot study alone (Beatty & Willis, 2007; Collis, 2003). The researcher identified a small group of healthcare professionals who were representative of the target population. This group included individuals from different departments and levels of work hierarchy to ensure a diverse range of perspectives.

The researcher developed a cognitive interview protocol that included an explanation of the purpose of the cognitive interview and the study and guidance on how participants should verbalise their thoughts as they answer each question. The researcher observed, reviewed the interview answers and probed on specific questions to clarify participants' understanding and interpretation of the interview items.

Based on the findings from the cognitive interviews, the researcher made necessary adjustments to the questionnaire. This included clarifying and simplifying questions that were misunderstood, breaking down complex questions into simpler, more direct queries, and provided additional guidance and explanations where needed. Finally, the researcher reviewed the revised questionnaire to ensure that all identified issues had been adequately addressed. After all the changes were effected into the questionnaire, the revised questionnaire was then ready for use in the main study.

3.4.2.3 The Administration of Individual Interviews

Individual interviews were conducted shortly after the completion of the questionnaires. This was done because all healthcare professionals had participated in the questionnaire survey. However, the researcher was careful to avoid overlapping attributes when selecting participants. For instance, if a suitable candidate was the oldest, male, and had the longest years of service, the researcher would choose another candidate with the second-longest years of service and another male to ensure the sample was representative of all categories. Consequently, qualitative data collection only began once the researcher had identified candidates based on survey responses regarding age, gender, number of years of experience, duration of employment in the facility and job role.

After identifying suitable candidates, the researcher re-approached the potential participants and explained that they met the criteria to participate in the individual interviews. The aim and purpose of the study were re-explained to the participants, and they were informed that their participation in the study was voluntary. The participants were told that the individual interviews would take approximately 15 to 25 minutes to complete and that they would be recorded using an audio recorder. They were further assured of confidentiality and privacy concerning the information they shared. Following Lincoln & Guba's (1985) criterion of informational redundancy, sampling for interviews was stopped when no new information was obtained.

3.5 Criteria of Measurement Quality

In this study, the criteria for measurement quality were determined based on the data collection tools used. For structured questionnaire, validity and reliability were assessed. For the individual interviews, trustworthiness and authenticity were emphasised. These criteria are now being discussed in detail.

3.5.1 Structured Questionnaire

Quantitative measurement involves using an instrument to obtain numerical values that represent the attributes of the research subjects. These numerical values are then summarised and reported as findings of the study. Therefore, the quality of the measurement directly affects the quantitative findings of a study. If the measurement is weak or biased, the results will as well be so and vice versa (McMillan & Schumacher, 1997). In this study, reliability and validity were employed to assess the quality of the questionnaire.

3.5.1.1 Validity of the Structured Questionnaire

Validity is the degree to which a measurement tool accurately captures the concept it is designed to measure, (Babbie, 2013; Kumar, 2011; Langbridge, 2004). Validity is crucial for the integrity of research conclusions, as emphasised by Bryman (2012), and it is the most fundamental aspect in evaluating any measurement tool for research quality, (Haradhan, 2017).

For this study, validity was established by ensuring that the sample was representative of the target population and that it is free from bias, with all potential respondents having the chance to participate. The content validity of the questionnaire was ensured by having it reviewed by external experts from a different Faculty, as recommended by Graham & Bond (2008). Face validity, which assesses whether the questions effectively cover the study topic, was ensured by checking for common errors such as double-barrelled, confusing, and leading questions. Additionally, the questionnaire's validity was further ensured through conducting a pilot test.

3.5.1.2 Reliability of the Research Questionnaire

Reliability is concerned with the question of whether the results of a study are repeatable or not (Bryman, 2012). When defining reliability, Babbie (2013) and McMillan & Schumacher (1997) opine that it is a matter of whether a particular technique, applied repeatedly to the same object, yields the same result each time or not. Thus, reliability is the quality of measurement method; it suggests that the same data would have been collected each time, in repeated observations of the same phenomenon. To achieve this, the researcher employed several strategies.

Firstly, the questionnaire was designed based on a thorough review of the literature and input from experts in the field, as a result ensuring that it covered all relevant aspects of the research topic (Wiles, 2012). The questions were clear and unambiguous, reducing the likelihood of misinterpretation by the respondents (Miller, Metheringham, & Maxine, 2012). Secondly, the researcher conducted a pilot test of the questionnaire with a small group of participants who had similar qualities to the target population. This pilot test allowed the researcher to identify and rectify any concerns with the questionnaire. These include issues such as unclear questions or potential biases before the main data collection phase (Klenke, 2008).

Additionally, the researcher ensured that the data collection process was standardised, with all participants receiving the same instructions and completing the questionnaire under similar conditions (Hammersley & Traianou, 2012). This consistency helped to minimise variability in the data and to enhance the reliability of the findings. The researcher also considered the internal consistency of the questionnaire by examining the inter-item correlations and Cronbach's alpha, which are statistical measures of reliability (Wiles, 2012). A high Cronbach's alpha value indicates that the items in the questionnaire are measuring the same construct, thereby increasing the overall reliability of the instrument.

Finally, the researcher ensured that the data entry and analysis processes were meticulous and accurate, therefore minimising the risk of errors that could affect the reliability of the data (Mechling, Gast & Lane, 2014).

Table 3: Interpreting Cronbach's Alpha

Cronbach's alpha	**Internal consistency**
$\alpha \geq 0.9$	Excellent
$0.9 > \alpha \geq 0.8$	Good
$0.8 > \alpha \geq 0.7$	Acceptable
$0.7 > \alpha \geq 0.6$	Questionable
$0.6 > \alpha \geq 0.5$	Poor
$0.5 > \alpha$	Unacceptable

The reliability of the scales used to measure security threats, motivation, attitudes and job roles of healthcare workers were assessed during data analysis, and the alpha scores were reported. Nonetheless, the researcher is confident in the reliability of

Holmgren et al.’s (2009); Sakai’s (2013), and Rizo et al.’s (1970) Root Cause Analysis (RCA) scales, as they have been previously validated by Frantz & Holmgren (2019) for the Work Stress Questionnaire; Sakai (2013) for the Non-Equilibrium Steady State (NESS) (with alpha scores ranging from 0.82 to 0.96), and Khan et al. (2014) for the RCA (with an alpha score of 0.85) respectively.

3.5.2 Interview Guide

Measurements are used to gain a deeper understanding of a phenomenon. The qualitative measure usually involves textual data and it helps in understanding the context of a phenomenon and how it affects individuals. Qualitative measures are also valuable for exploring topics about which little is known (Renata, 2020). In this study, individual interviews were employed as a method of measurement. Trustworthiness and authenticity of the interview data were ensured in the following approaches.

3.5.2.1 Authenticity of the Interview Guide

To assure the authenticity of the interview guide, the researcher employed several strategies. Firstly, the interview guide was developed based on a comprehensive review of the literature and theoretical frameworks relevant to the study’s objectives (Renata, 2020). This ensured that the questions were grounded in existing knowledge and that they aligned with the study’s aims. Additionally, the guide was cognitively interviewed, with a small group of participants who had the same qualities as the target population. This cognitive interviewing allowed the researcher to refine the questions, ensuring that they were clear, unbiased and elicited the necessary information (Klenke, 2008).

The researcher also sought feedback from an expert in the field of qualitative research to validate the content and structure of the interview guide. This expert’s review helped to ensure that the guide was comprehensive and appropriate for the study’s context (Wiles, 2012). Furthermore, the researcher maintained a flexible approach during the interviews, allowing for probing and clarification based on the participants’ responses. This flexibility ensured that the interviews remained authentic and responsive to the participants’ experiences (Miller, Metheringham, & Maxine, 2012). Finally, the researcher ensured that the interview guide was administered consistently across all participants, minimising variability and enhancing the reliability of the data collected

(Hammersley & Traianou, 2012). The measures employed collectively ensured that the interview guide was authentic and effective in capturing the depth and nuances of the participants' experiences.

3.5.2.2 Trustworthiness and Credibility of the Interview Guide

To ensure the trustworthiness of the interview guide, the researcher employed several rigorous strategies. Firstly, the development of the guide was grounded in a thorough review of the relevant literature and theoretical frameworks and this helped to ensure that the questions were well-informed and that they aligned with the study's objectives. This also helped with credibility of the guide. The researcher likewise conducted a cognitive interviewing with a small group of people who were considered as a representative of the target population. Additionally, the researcher sought peer review that helped to ensure that the guide was detailed, relevant, and appropriate for the study's context (Wiles, 2012). The involvement of external experts also added a layer of credibility to the guide.

The researcher maintained a transparent and consistent approach in administering the interview guide. This involved providing clear instructions about the purpose of the interview to participants and the nature of the questions they would be asked. Furthermore, the researcher ensured that the interview guide was flexible enough to allow for probing and clarification based on the participants' responses. This flexibility allowed for a more in-depth exploration of the participants' experiences and perspectives, enhancing the richness and authenticity of the data (Hammersley & Traianou, 2012).

3.5.2.3 Transferability

To ensure transferability of the interview guide, the researcher employed a transparent and systematic approach. The guide was developed based on a comprehensive review of the relevant literature and frameworks. According to Given (2008), transferability reflects the need to be aware of, and to describe the scope of one's qualitative study so that its applicability to different contexts can be readily discerned. Therefore, the knowledge acquired in one context is also relevant in another, and those who carry out the same research in another context can be able to apply certain concepts originally developed by other researchers (Holloway & Galvin, 2016). For

Tappen (2010), transferability can be defined as the applicability of the findings to other situations and other people. As a result, the researcher enhanced transferability by ensuring that the findings of this study could be applied to an alternative context by providing the thick background information about the research context, setting, and participants (Rubin & Babbie, 2009).

3.5.2.4 Dependability

Dependability in research refers to the consistency and stability of the data collected and the findings derived from both. To ensure the dependability of the interview guide and the resulting data, the researcher employed several strategies. This enables readers to evaluate the accuracy of the analysis through following the decision process of the researcher (Holloway & Galvin, 2016). In this regard, the researcher laid out the procedures and research instruments in such a way that others can attempt to collect data in similar conditions (Given, 2008). The idea here was to enable similar explanation for the phenomenon if similar conditions could be applied. Kumar (2011), in sharing the same sentiments, regards dependability as the possibility of obtaining the same results if the same phenomenon can be observed twice.

3.6 Data Analysis Technique

The research design for this study involved collecting data through a structured questionnaire and an interview guide; resulting in both numerical and non-numerical data. Therefore, the data analysis employed both qualitative and quantitative research methods. According to Creswell (2012), when using a convergent design, researchers should analyse the two data sets in isolation before integrating them during the data analysis and/or interpretation phase. The specific data analysis techniques utilised in this study are discussed below.

3.6.1 Quantitative Analysis

The data obtained from the questionnaires was manually inputted into SPSS (IBM 266), with careful attention made to ensure that each question was accurately answered. During the analysis, the researcher employed both descriptive and inferential statistics. Descriptive statistics were used to identify general patterns in the data (such as frequencies, means, and standard deviations) while inferential statistics enabled the examination of data to test relationships and derive conclusions about the sample (Babbie, 2010; Schumacher, 1997).

3.7.2 Qualitative Analysis

During data analysis, the researcher acts as the instrument, making decisions about coding, theming, decontextualising and the reframing of the data (Van Manen, 1990; Strauss & Corbin, 1998; Creswell, 2014; Nowell, Norris, White & Moules, 2017). To analyse the data from individual interviews, the researcher opted for thematic analysis, which is suitable for analysing data collected through embedded mixed methods (Tashakkori & Teddlie, 2010; Creswell, Plano Clark, 2011). Thematic analysis is a process for identifying meaning or themes in qualitative information (Glaser, 1992; Boyatzis, 1998; Charmaz, 2014) and is valuable for exploring the perspectives of different research participants, identifying similarities and differences, of how different participants view or experience the subject off the research, as well as uncovering unexpected insights (Braun & Clarke, 2006). It is also important for recognising, analysing and reporting patterns or themes within the data (Braun & Clarke, 2006; Watkins, 2017).

Immersion or Familiarisation was involved when the researcher personally transcribed the audio files and deeply engaging with the data during the transcription process. She then actively read and re-read the transcribed data, searching for meanings and patterns to gain a comprehensive understanding of its content, as recommended by Braun and Clarke (2006).

Generating Initial Codes was employed in the subsequent stage, the researcher identified and documented patterns in the data, noting where and how they occurred. This enabled the researcher to easily locate and understand the significance of specific data segments later in the analysis. Adhering to Attride-Striling's (2001) guidance, the researcher ensured that the codes were clearly defined and focused and avoided the over-coding of every sentence in the original text. To generate these codes, the researcher utilised the terminology used by participants during the interviews as these terms could serve as valuable reference points for their experiences, (Marks & Yardley, 2004; Saldana, 2009).

Searching for themes was also employed in the study. A theme is described as a pattern that highlights something meaningful or noteworthy about the data or the research question (Maguire & Delahunta, 2017). In this phase, the researcher examined the text segments within each code (or groups of related codes) and identified the prominent, common, or significant themes present in the coded text. The researcher then reviewed these selected themes and further honed them into themes that were specific enough to be distinct (not repetitive) yet broad enough to encompass a range of ideas found in multiple text segments, (Attride-Stirling, 2001; Sandoval, 2018).

The researcher also employed the reviewing of themes. At this stage, the researcher defined and refined the themes by returning to the collected data extracts for each theme and organised them into a clear and internally consistent account, accompanied by narratives as recommended by Braun & Clarke (2006) and Flick (2014). For each theme, the research crafted a detailed narrative that the theme conveyed and how it fit into the broader narrative related to the research questions. This ensured that there was no overlap between the themes. By the end of this stage, the researcher was able to clearly define what each theme entailed, with each theme explained in a few sentences (Braun & Clarke, 2006; Gibbs, 2007; Maxwell & Maxwell, 2013).

The next stage was presenting the data. This final stage begins the moment the researcher has set fully developed themes and involves the final analysis and write-up of the report (Braun & Clarke, 2006; Creswell, 2013). When writing the report, the researcher made deliberate choices about which themes contributed meaningfully to the understanding of the data. The research also provided sufficient evidence of the themes within the data (adequate data extracts) to demonstrate their prevalence (Ritchie, Lewis, McNaughton, Nicholls & Ormston, 2014).

3.7 Ethical Considerations

Research ethics refer to a set of principles that define what is good or right or help in identifying what is bad or wrong (Hammersley & Traianou, 2012). These ethics are concerned with moral behaviour in research contexts (Wiles, 2012). Researchers are also expected to uphold ethical standards as part of their membership in a professional community (Neuman, 2014). Therefore, the role of ethics in research is to ensure honesty and to protect the rights of individuals and groups affected by the research.

Ethical behaviour is essential for the appropriate application of research to reveal new knowledge (Wallace & Fleet, 2012). Nonetheless, acquiring ethical approval at the beginning of the study does not imply that ethical issues can be ignored; rather, they should be an on-going part of the research process (Hammersley & Traianou, 2012).

For this study, the following ethical considerations were taken into account: informed consent, confidentiality, anonymity and minimising harm. Each of these principles is discussed in more detail below.

3.7.1 Requesting Clearance

Researchers must seek and get permission to conduct research at a specific site (Polit & Beck, 2014; Oliver, 2010). Furthermore, throughout the study, a researcher must ensure that a respectful demeanour and good relations are maintained with subjects and the administration of study sites (Mechling, Gast & Lane, 2014). According to Mechling et al. (2014), this is crucial because the personal interactions between the researcher and others significantly influence whether other researchers will subsequently be allowed to work in that environment. Consequently, ethical clearance for this study was sought and acquired from the Department of Sociology and Social Work at NUL and from the Ministry of Health's Institutional Review Board (IRB) through the National University of Lesotho's Faculty of Health (see Appendix D).

3.7.1.1 Informed Consent Voluntary Participation

Regarding the healthcare workers who participated in this study, the researcher ensured that they were fully informed about the study's purpose, which enabled them to make informed decisions about whether to consent to participate (Miller, Metheringham, & Maxine, 2012). The researcher also ensured that participants' right to receive clear information about what participation in the study entailed was respected, thus providing them with the opportunity to decide whether they wished to participate or not, as stipulated by Wiles (2012). For this research, oral consent was obtained by the researcher. Written consent was not deemed appropriate since participants' names would not be recorded.

The justification for this waiver of signed consent was that by not having participants sign consent forms, the researcher was able to avoid collecting or retaining any identifiers. Given that this study had a small target population, the main risk to research subjects was a breach of anonymity and confidentiality or misunderstandings that the study findings would affect them in some way. The researcher took measures to prevent this through a rigorous informed consent process. The researcher also ensured that participation in this study was voluntary (Wallace & Fleet, 2012), meaning that participants were not forced to participate in the study. As espoused by Klenke (2008), they were instead informed that they could withdraw participation at any time during the research without penalties.

3.7.1.2 Anonymity and Confidentiality

According to Israel & Hay (2006), anonymity and confidentiality protect participants' privacy by ensuring that their identities and personal information are not disclosed without their consent. Protecting the privacy and confidentiality of participants is essential in research (Wiles, 2012). The obligation to maintain anonymity and confidentiality ensures that identifiable information about individuals involved in a research that is collected during the research process is not disclosed.

Additionally, specific information provided during the research should not be used if the research subjects request for it not to be used (Wiles, 2012). By ensuring confidentiality, the researcher agrees not to report private data that may identify participants (Klenke, 2008). According to Hammersley & Traianou (2012), researchers demonstrate their commitment to maintaining confidentiality in several ways, all of which were employed in this study. Firstly, when collecting data in the field, the researcher kept the recording device confidential. The researcher also ensured that the data were stored securely, making it difficult for others to (apart from the researcher and the supervisor) to access it, as suggested by Hammersley & Traianou (2012). Secondly, through the process of anonymisation, codes were used to replace the real identities of research participants (Wiles, 2012; Klenke, 2008).

3.7.1.3 Minimising Harm

In terms of minimising harm, the researcher took several precautions to ensure the well-being of the participants and the ethical integrity of the study. Firstly, the researcher ensured that the data collection process was non-invasive and did not cause any distress to the participants. This was achieved by designing the study in a way that minimised the potential for emotional or psychological discomfort (Wiles, 2012). Additionally, the researcher provided participants with clear information about their participation (Miller, Metheringham & Maxine, 2012).

The researcher also ensured that participants were informed about their right to withdraw from the study at any time without any penalties or repercussions (Klenke, 2008). This was communicated to participants both verbally and in writing, emphasising their autonomy and control over their involvement in the research. Furthermore, the researcher maintained a supportive and empathetic demeanour throughout the data collection process, ensuring that participants felt comfortable and respected (Mechling, Gast, & Lane, 2014).

Overall, the researcher's approach to minimising harm was guided by the principles of respect, beneficence, and justice; ensuring that the study was conducted in an ethical and responsible manner (Wallace & Fleet, 2012).

3.8 Limitations of the Study

While aiming to shed light critical issues within the healthcare facilities, the study acknowledges certain inherent limitations that may influence the research outcomes.

- The study is limited to selected hospitals in Lesotho and the selected hospital may not be representative of all healthcare facilities in the country. This could introduce selection bias, as the experiences of professional workers in the selected hospitals may differ from experiences of those who work in other healthcare settings (such as rural clinics or private hospitals).
- The number of healthcare professionals participating in the study may be limited, which could affect the generalisability of the findings. A small sample size may not capture the full range of security threats experienced by healthcare professionals across different departments in healthcare facilities.
- The study relies on self-reported data from healthcare professionals, which can be subjective. Workers' perceptions of security threats may vary based on their personal experiences, stress levels, and other factors, all of which could influence the accuracy of the data.
- The study was confined to a specific period, and the findings may not reflect long-term trends or changes in security threats over time. Additionally, seasonal variations or recent events had affected the prevalence of security issues during the study period.

- There were cases of underreporting of security incidents due to fear of reprisal, lack of trust in reporting mechanisms, and a perception that nothing will be done in response to the report. Specifically, participants feared negative consequences such as retaliation or punishment for reporting incidents.
- The study did not fully explore the impact of the national occupational safety of healthcare workers, which could be an important factor in understanding and addressing the threats they faced.
- Findings from the selected hospitals in Lesotho may not be generalised to healthcare facilities in other countries with different healthcare systems, cultural norms, and security challenges. This is because different countries have varying healthcare systems, which can include differences in funding, infrastructure, staffing and the availability of resources. Again, cultural differences can influence how security incidents are perceived and handled.
- The study did not fully account for the cultural and social contexts that influence security threats in healthcare facilities. For example, societal attitudes towards healthcare workers, patient confidentiality norms, and local crime rates could all impact the study's findings.
- This study is only guided by Social Exchange Theory (SET) and Socio-Ecological Model (SEM), which provide a specific lens through which to view the data. Other theoretical perspectives might offer different insights.

Acknowledging these limitations is important for a transparent discussion of the study's findings and for guiding future research that could address these gaps. It also helps in contextualising the results and avoiding overgeneralisation of the conclusions.

3.9 Chapter Summary

Chapter Three of the study provides a comprehensive overview of the research methodology employed to investigate security threats in selected healthcare facilities in Lesotho. The chapter begins with an introduction that that helps in the understanding the research setting, methodological orientation, and the specific research methods used to gather and to analyse data.

The research was conducted in selected hospitals, providing a real-world context for examining the security threats faced by healthcare professionals. This setting was chosen to ensure the relevance and applicability of the findings. The study adopted a mixed-methods approach, combining quantitative and qualitative data to provide a holistic understanding of the security threats. The approach allowed for the triangulation of data, as a result enhancing the validity and reliability of the findings.

The research methods included a survey design (using a structured questionnaire) to collect quantitative data and embedded mixed-methods design (incorporating in-depth interviews) to gather qualitative data. Participants were identified and selected through purposive sampling; targeting healthcare professionals who had experienced or were knowledgeable about security threats in their work facilities. The target population included nurses, doctors, and support staff employed in the healthcare sector at the time of data collection.

Inclusion and exclusion criteria for participating in the study were established to ensure that participants were willing and to share their experiences. A recruitment plan was developed to engage participants through the District Medical Officer, Medical Superintendent as well as hospital departments and professional networks. The sample size was determined using statistical methods to ensure repetitiveness and adequate power for analysis. Data collection methods included a structured questionnaire designed to measure key variables related to security threats, such as workplace violence as well as environmental and organisational threats. The questionnaire utilised Likert scales, closed-ended questions and open-ended questions (for qualitative purposes) so as to capture both quantitative and qualitative data. A pilot study was conducted to test the reliability and validity of the questionnaire.

The administration of the structured questionnaire was carried out in-person in order to maximise participants' response rate. In-depth interviews were conducted using an interview guide developed to ensure consistency and comprehensiveness in the qualitative data collection. Cognitive interviewing was employed to pre-test the qualitative instrument, ensuring clarity and relevance of the questions. The criteria for measuring quality were rigorously assessed, including the validity and reliability of the structured questionnaire and the authenticity, trustworthiness, and credibility of the interview guide. Data analysis involved both quantitative and qualitative techniques. Ethical considerations were paramount, thereby ensuring participant confidentiality and informed consent. The chapter concludes by acknowledging potential limitations that may influence the generalisability of the findings.

In summary, Chapter Three outlines the methodological framework of the study, ensuring a robust and comprehensive approach to investigating security threats in selected healthcare facilities in Lesotho. The chapter provides a clear roadmap for the research process, from participant selection to data analysis; ensuring that the study's findings are valid, reliable and applicable to the broader healthcare industry.

CHAPTER FOUR

DATA ANALYSIS AND INTERPRETATION OF FINDINGS

4.1 Introduction

This chapter outlines the outcomes of the study that explored security threats faced by healthcare professionals in selected healthcare facilities. It details the results obtained from quantitative phase (through a structured questionnaire) and the qualitative phase (through in-depth interviews).

4.2 Demographic Information

This section provides detailed information on the profile of the study participants and survey respondents.

4.2.1 Characteristics of Interview Participants

Twenty healthcare workers from two facilities participated in the interviews aimed at collecting data. The interviewees comprised of twelve females and eight males and of these people, the ages of the participants ranged between 29 years-old and 53 years old. Out of the total, nine participants were married, two were divorced, and nine were single. All participants had higher educational certificates ranging from Diplomas to Master’s degrees. Each participant was assigned a unique code that was structured to identify individuals from the two facilities. Participants from the Mafeteng Hospital were assigned codes prefixed “MH-Q” followed by sequential numbers from 01 to 10, while those from Mohlomi Psychiatric Hospital were given codes prefixed “MPH-Q” and each code was also followed by sequential numbers from 01 to 10.

Table 4 Characteristics of Interview Participants

No.	Code	Age	Gender	Marital status	Education	Hospital
1.	MH-Q01	38	Male	Single	Bachelor’s	Mafeteng
2.	MH-Q03	34	Female	Married	Bachelor’s	Mafeteng
3.	MH-Q04	42	Male	Married	Bachelor’s	Mafeteng
4.	MH-Q08	29	Female	Single	Diploma	Mafeteng
5.	MH-Q10	37	Male	Single	MBchB	Mafeteng
6.	MH-Q02	30	Female	Married	Bachelor’s	Mafeteng
7.	MH-Q05	35	Female	Married	Bachelor’s	Mafeteng
8.	MH-Q06	36	Male	Single	MBchB	Mafeteng
9.	MH-Q07	32	Male	Married	Bachelor’s	Mafeteng
10.	MH-Q09	38	Female	Married	Bachelor’s	Mafeteng

No.	Code	Age	Gender	Marital status	Education	Hospital
11.	MPH-Q01	34	Female	Single	MBchB	Mohlomi
12.	MPH-Q02	33	Female	Single	Diploma	Mohlomi
13.	MPH-Q03	39	Female	Single	MBchB	Mohlomi
14.	MPH-Q05	53	Female	Married	Bachelor's	Mohlomi
15.	MPH-Q06	36	Male	Divorced	Bachelor's	Mohlomi
16.	MPH-Q04	40	Female	Divorced	Master's	Mohlomi
17.	MPH-Q07	43	Male	Married	Master's	Mohlomi
18.	MPH-Q08	30	Female	Single	Bachelor's	Mohlomi
19.	MPH-Q09	48	Female	Married	MBchB	Mohlomi
20.	MPH-Q10	38	Male	Single	Bachelor's	Mohlomi

4.2.2 Profile of Survey Respondents

A total of 90 structured questionnaires were distributed in order to collect data on workers' security threats in healthcare centres. Out of that total, 81 questionnaires were fully completed and returned, resulting in a response rate of 90%.

This section on demographic information provides detailed profile of the respondents who participated in the research. The demographic information of the survey respondents is presented in (1) name of facility as it identifies the specific hospitals where the respondents are employed, (2) age distribution of the respondents, (3) gender breakdown of the respondents (to explore whether there are any gender-specific differences in the experience of security threats), (4) duration of employment and (5) occupation (since this includes categories such as doctors, nurses and support staff.

4.2.2.1 Gender, Health Facility, Age and duration of Employment

Table 5 presents the respondents' gender, age, health facility respondent is employed at, and duration of employment. The data shows a predominance of female respondents (n=51; 63%), and age group 18-35 years (38; 46.9%).

The findings also show that the majority of respondents (n=51; 50.6%) were employed at the Mafeteng Hospital and that the highest number (n=43; 49.4%) of numbers of years of employments is 0-5 years.

Table 5: Demographic Frequency Table

Demographic information	**Categories**	**Frequencies(n=81)**	**Percentage (100%)**
Gender	Males	29	35.8
	Females	51	63.0
	Non-Binary	1	1.2
	Total	**81**	**100**
Name of Health Facility	Mohlomi Psychiatric Hospital	40	49.4
	Mafeteng Hospital	41	50.6
	Total	81	100
Age range	18-35	38	46.9
	36-50	29	35.8
	51-64	14	17.3
	Total	**81**	**100**
Department	Out-patient	7	8.6
	Men's Clinic	0	0
	Mother and Child Health	1	1.2
	Adolescent Health	1	1.2
	ARV Centre	1	1.2
	Mental Health	36	44.4
	Male Medical	1	1.2
	Female Medical	1	1.2
	Maternity	12	14.8
	Paediatric	6	7.4
	Laboratory	8	9.9
	ICU	0	0
	Emergency	7	8.6
	Total	**81**	**100**
Number of years employed in the Facility	0-5	43	53.1
	6-9	19	23.5
	10-20	19	23.5
	Total	**81**	**100**

4.3 Framework of Analysis

The table provides a structured overview of the thematic analysis conducted in the study. The table is organised as follows:

- **Objectives of the study:** this column lists the study's primary objectives. These objectives outline the study's key areas of inquiry and the overall goals of the research.
- **Variables:** this column presents the main variables identified through the quantitative analysis. Each variable represents a significant pattern or category that emerged from the quantitative data.
- **Sub-variables:** this column breaks down the main themes into more specific sub-themes. These sub-themes provide further detail and nuance to the main themes; allowing for a deeper understanding of the data.
- **Description of themes:** this column provides a detailed description of each theme and sub-theme. The descriptions explain the essence and attributes of each theme, including examples from the data to illustrate their meaning.

Analysis of Themes: This column outlines the statistical methods and tools used to analyse the themes. It specifies the techniques employed for both descriptive and inferential analysis. Descriptive statistics are used to summarise the data, providing an overview of the themes and their distribution. Inferential statistics are used to make inferences about the population based on the sample data, the testing of hypothesis and identifying significant patterns.

Table 6: Table of Framework of Analysis

Objectives	Variables	Sub-variables	Description	Analysis
To investigate security threats in selected hospitals in Lesotho.	Security threats	Verbal abuse; physical aggression; theft of personal belongings and medical supplies; unauthorised access; electrical hazards; hazardous materials; harassment; faulty equipment; vandalism; workplace violence; work-related injuries; cybersecurity	Types of security threats faced by healthcare workers in selected healthcare facilities.	Descriptive statistics (Means and percentages)
To identify the multifaceted drivers influencing security threats among healthcare professionals in Lesotho.	Drivers of security threats	Staffing issues, inadequate training, poor infrastructure, poor lighting, socio-economic factors, lack of resources, community unrest, out-dated equipment, inadequate safety protocols	Factors contributing to security threats, including organisational, environmental, and personal factors.	Inferential statistics (Chi- square and percentages).
To assess the effects of existing safety concerns on workers' disposition to work.	Effects on work disposition	Reduced motivation, emotional stress, job dissatisfaction, low commitment to work, reduced productivity, bad attitude towards work, low enthusiasm, distorted work focus, mental health problems	Effects of safety concerns on healthcare professionals' attitudes, job satisfaction and performance.	
To evaluate the responses and interventions implemented by the key role players within the health and security agencies in addressing security concerns among healthcare professionals in Lesotho.	Interventions	Safety protocols, security measures, community involvement, staff training, funding challenges, partnerships	Measures taken by healthcare facilities and security agencies to address safety concerns.	Qualitative analysis (Individual interviews).

4.4 Overview of Security Threats in Healthcare Facilities

This section aims to provide an overview of the security threats that are prevalent in healthcare settings, thereby shedding light on the dynamic threats faced by healthcare professionals at work.

4.4.1 Security Threats in Healthcare Facilities: Quantitative Analysis

Aggressive behaviour or confrontations by patients (or their family members) is a threat that has the highest mean score of 3.04; indicating that it is perceived as the most prevalent security threat among the respondents. The significant disparity in responses (chi-square: 19.353, significance level: 0.022) suggests that while most respondents agree on its prevalence, there is some variation in their perceptions. The high mean score underscores the serious concern that respondents have regarding aggressive behaviour or confrontations by patients or their family members.

Intimidation by patients, visitors or co-workers is also a highly prevalent security threat (with a mean score of 2.91). The Chi-square value of 33.802 and a significance level of 0.000 indicate a strong consensus among respondents about the prevalence of intimidation. This suggests that it is a significant concern in the workplace, with most respondents acknowledging having experienced it.

Verbal abuse from patients, visitors or management is another significant work risk, with a mean score of 2.81, which indicates a general agreement of its prevalence. The Chi-square value of 14.764 and a significance level of 0.098 indicate a notable disparity in the responses. Despite this variation, the mean score suggests that verbal abuse is a prevalent issue that needs a resolution.

Physical assault by patients and their visitors is perceived as a considerable threat, with a mean score of 2.74, suggesting general agreement. The Chi-square value of 39.732 and a significance level of 0.000 highlight a strong consensus on its prevalence. This indicates that physical assault is a significant concern among respondents.

Additionally, vandalism is moderately prevalent, with a mean score of 2.43, which indicates some level of agreement on the existence of risk. The Chi-square value of 27.481 and a significance level of 0.001 confirm a significant difference in responses. Vandalism is not as prevalent as the other abovementioned threats. It however, it remains a concern that should not be overlooked, particularly in Mohlomi Psychiatric Hospital.

Theft of personal belongings is perceived as less prevalent, with a mean score of 2.35, indicating more disagreement than agreement from respondents. The Chi-square value of 11.834 and a significance level of 0.223 suggest that the theft of personal belongings is not a significant a concern compared to other safety issues.

Work-related injuries are also moderately dominant, with a mean score of 2.27, suggesting some level of agreement on their concern. The Chi-square value of 23.760 and a significant level of 0.005 indicate a significant inconsistency in responses. This suggests that while work-related injuries are a concern, they are not as prevalent as other threats.

Drug seeking behaviour by patients, on the other hand, is perceived less prevalent, with a mean score of 2.17, and this indicates a level of disagreement from respondents. The Chi-square value of 36.316 and significance level of 0.000 show a strong consensus on its lower prevalence. This indicates that drug seeking behaviour is not a major concern among respondents.

Furthermore, seductive behaviour is the least prevalent among the security risks, with a mean score of 2.15, indicating general disagreement. The Chi-square value of 7.359 and a significance level of 0.600 suggest that responses are highly varied. This indicates that seductive behaviour is not a significant concern in the workplace in both facilities.

Workplace violence stemming from disputes among staff members is a concern that is perceived as less prevalent, with a mean score of 1.95, indicative of more disagreement. The Chi-square value of 17.251 and a significance level of 0.045 show a notable gap in responses. This suggests that workplace violence stemming from disputes among staff is not a major concern.

Lastly, cybersecurity is less rampant threat, with a mean score of 1.81, signifying strong disagreement. The Chi-square value of 7.359 and a significance level of 0.600 suggest that responses are highly varied. This shows that cybersecurity is not perceived as a significant threat in this context.

In conclusion, the most predominant workplace risks are aggressive behaviour; confrontations by patients or their families; intimidation by patients, visitors or co-workers; and verbal abuse from patients, visitors, or management as well as physical assault by patients. The least prevalent concerns are cybersecurity, and workplace violence stemming from disputes among staff members.

Table 7 Respondents by Work Risk

Security Threats	S. Disagree	Disagree	Agree	S. Agree	Total	$\bar{x}$	σ	χ2	DF	Sig
Physical assault by patient or visit	11 (13.6)	22 (27.2)	25 (30.9)	23 (28.4)	81 (100)	2.74	1.02	39.732	9	0.000
Intimidation by patients, visitors, co-workers	5 (6.2)	18 (22.2)	37 (47.7)	21 (25.9)	81 (100)	2.91	0.85	33.802	9	0.000
Theft or robbery of personal belongings	14 (17.3)	34 (42.0)	24 (29.6)	9 (11.1)	81 (100)	2.35	0.897	11.834	9	0.223
Vandalism	16 (19.8)	28 (34.6)	24 (29.6)	13 (16.0)	81 (100)	2.43	0.99	27.481	9	0.001
Aggressive behaviour or confrontations by patients or their families	5 (6.2)	15 (18.5)	33 (40.7)	28 (34.6)	81 (100)	3.04	0.89	19.353	9	0.022
Seductive or sexual behaviour by patients, visitors or co-workers	18 (22.2)	38 (46.9)	20 (24.7)	5 (6.2)	81 (100)	2.15	0.84	9.991	9	0.351
Verbal abuse from patients, visitors or management	9 (11.1)	17 (21.0)	35 (43.2)	20 (24.7)	81 (100)	2.81	0.94	14.764	9	0.098
Drug seeking behaviour leading to conflicts or violence	17 (21.0)	45 (55.6)	7 (8.6)	12 (14.8)	81 (100)	2.17	0.93	36.316	9	0.000
Cybersecurity threats targeting patients	25 (30.9)	48 (59.3)	6 (7.4)	2 (2.5)	81 (100)	1.81	0.67	7.359	9	0.600
Workplace violence stemming from disputes among staff members	22 (27.2)	47 (58.0)	6 (7.4)	6 (7.4)	81 (100)	1.95	0.80	17.251	9	0.045
Work related injuries	15 (18.5)	44 (54.3)	7 (8.6)	15 (18.5)	81 (100)	2.27	0.97	23.760	9	0.005

4.4.1.1 Comparative Analysis of Mean Responses for Security Threats

Figure 1 illustrates a comparative analysis of the mean responses for each security threat, providing an average perception as well as their relevance and severity. This analysis supported the argument that threats with higher mean scores were of greater concern and therefore required immediate attention and mitigation strategies to address them effectively.

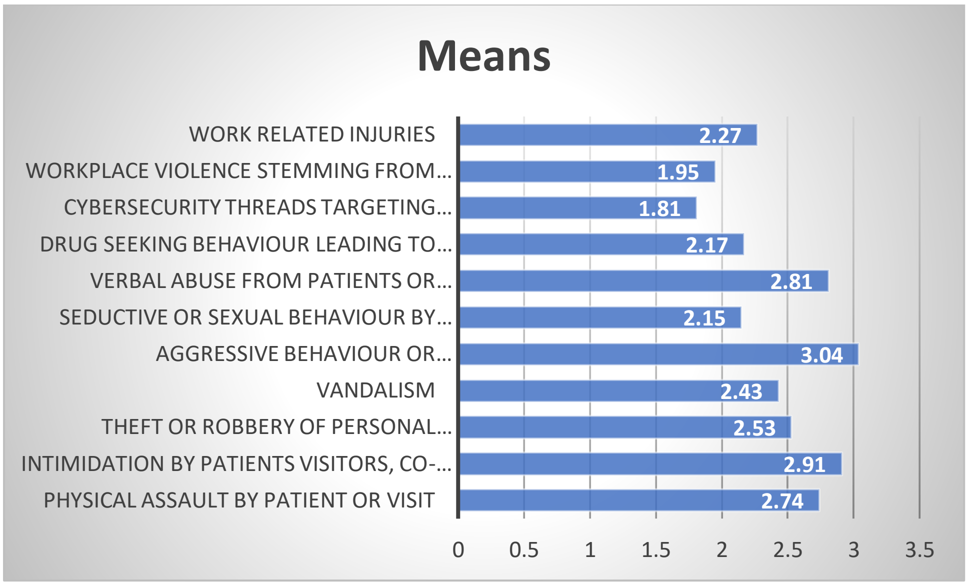

Figure 1*: Mean responses for security threats in healthcare facilities*

From this figure, it can be noticed that aggressive behaviour has the highest mean score (3.04), which means that it was perceived as the most significant and prevalent security threat by healthcare professionals. This suggests that aggressive behaviour is a critical issue that requires immediate resolution and effective mitigation strategies. Aggressive behaviour is followed by staff intimidation by patients, visitors and co-workers (Mean: 2.91), verbal abuse from patients (Mean: 2.81) and physical assault by patients and visitors (Mean: 2.74).

Cybersecurity, on the other hand, has the least mean score (1.81), indicating that it was perceived as the least significant threat among the listed security concerns. This could suggest that either cybersecurity measures employed were effective, there is a lack of awareness about potential cyber threats, or that other threats were more immediate and concerning to healthcare workers than it. It can also be perceived from this study that the sources of these threats are mainly external (patients and visitors) than internal. Additionally, while cybersecurity may not currently be perceived as a significant threat, it is essential to maintain vigilance where it is concerned and ensure that adequate measures are put in place to protect against potential cyber incidents.

4.4.1.2 Comparative Analysis of Mean Scores for Security Threats across the two Healthcare Facilities

This section seeks to assess the significance of the differences in mean scores for each work risk identified across facilities. This was done to determine whether the mean scores for each work risk significantly differed among facilities, thereby enabling the evaluation of specific measures that can be effectively implemented in each relevant healthcare setting.

For physical assault, the average mean score for the Mohlomi Psychiatric Hospital is 3.2500 while at the Mafeteng Hospital, the mean is 2.2439. A t-test conducted revealed a significant difference between the two hospitals, with degrees of freedom (DF=79), a t-value is found to be 5.067, and a p-value; 0.000. The mean difference of 1.00610 was found in the data, thereby indicating that on average, participants who work at the Mohlomi Psychiatric Hospital experienced approximately one unit more of physical assault than those at the Mafeteng Hospital.

Furthermore, intimidation or bullying by patients, visitors of patients or co-workers in the workplace, was higher at the Mohlomi Psychiatric Hospital, with a mean score of 3.1750, compared to a relatively lower mean score of 2.6585 at Mafeteng Psychiatric Hospital. A t-test indicated a significant difference between the two facilities (with 79 degrees of freedom, at a t-value of 2.837, and a P-value of 0.006). This signifies a statistically significant difference in intimidation incidents between the hospitals. The mean difference of 0.51646 suggests a moderate difference in intimidation incidents between the hospitals.

Moreover, aggressive behaviour and confrontations at work recorded the mean score of 3.4000 at the Mohlomi Psychiatric Hospital while the Mafeteng Hospital scored 2.6829. The t-test resulted in a t-value of 3.959 at 79 degrees of freedom and a P-value of 0.000, representative of a significant difference in aggressive behaviour in the hospitals. The mean difference of 0.71707 suggests that at least one facility encounters more aggressive confrontations than the other.

The analysis of verbal abuse within the workplace yielded a mean score of 3.2750 at Mohlomi Psychiatric Hospital and a mean score of 2.3659 at Mafeteng Hospital. A subsequent t-test produced a statistic of 4.972 with 79 degrees of freedom and a P-value of 0.000, demonstrating a statistically significant difference in the levels of verbal abuse experienced in these facilities. The mean difference of 0.90915 suggests that one group reported a higher incidence of verbal abuse compared to the other.

In conclusion, the analysis revealed notable differences in security threat levels across the two healthcare facilities. Variables such as aggressive behaviour, intimidation, physical assaults, and verbal abuse by patients, visitors or co-workers, recorded the highest mean scores, thereby becoming major work risks perceived prevalent in these healthcare facilities. Conversely, minimal or negligible differences were identified in areas such as seductive behaviour, cybersecurity, and workplace violence. These findings imply that specific threats exhibit considerable variation between the facilities, indicating the need for customised security strategies to effectively address the unique risks associated with each location.

Table 8 Comparative T-test Analysis of Security Threats in Healthcare Facilities

Threats	Variance	$\bar{x}$_Mohlomi	$\bar{x}$_Mafeteng	**T**	**Df**	**Sig.(2-tailed)**	**Mean difference**	**Std.error Difference**
Physical assault by patients or visitors	Equal variance assumed	3.2500	2.2439	5.067	79	.000	1.00610	.19856
	Equal variance not assumed			5.062	78.218	.000	1.00610	.19874
Intimidation or bullying by patients, co-workers or visitors	Equal variance assumed	3.1750	2.6585	2.837	79	.006	.51646	.18202
	Equal variance not assumed			2.830	74.841	.006	.51646	.18250
Theft of personal belongings	Equal variance assumed	2.5750	2.1220	2.336	79	.022	.45305	.19395
	Equal variance not assumed			2.332	77.029	.022	.45305	.19427
Vandalism	Equal variance assumed	2.8750	1.9756	4.592	79	.000	.89939	.19585
	Equal variance not assumed			4.577	72.989	.000	.89939	.19649
Aggressive behaviour or confrontations by patients or their families	Equal variance assumed	3.4000	2.6829	3.959	79	.000	.71707	.18113
	Equal variance			3.967	77.485	.000	.71707	.18076

Threats	Variance	$\bar{x}$_Mohlomi	$\bar{x}$_Mafeteng	T	Df	Sig.(2-tailed)	Mean difference	Std.error Difference
	not assumed							
Seductive or Sexual behaviour by patients or visitors or co-workers	Equal variance assumed	2.1750	2.1220	.283	79	.778	.05305	.18739
	Equal variance not assumed			.283	76.815	.778	.05305	.18773
Verbal abuse from patients or visitors or management	Equal variance assumed	3.2750	2.3659	4.972	79	.000	.90915	.18287
	Equal variance not assumed			4.977	78.657	.000	.90915	.18266
Drug-seeking behaviour leading to conflicts of violence	Equal variance assumed	2.4250	1.9268	2.480	79	.015	.49817	.20090
	Equal variance not assumed			2.459	53.399	.017	.49817	.20259
Cybersecurity threats targeting patients' data or hospital system	Equal variance assumed	1.8250	1.8049	.134	79	.894	.02012	.15047
	Equal variance not assumed			.133	74.728	.894	.02012	.15087
Work violence stemming from disputed among staff members	Equal variance assumed	1.9000	2.0000	-.557	79	.579	-.10000	.17961
	Equal variance not assumed			-.556	78.101	.580	-.10000	.17980
Work related injuries	Equal variance assumed	2.5250	2.0244	2.377	79	.020	.50061	.21061
	Equal variance not assumed			2.366	68.721	.021	.50061	.21157

4.4.2 Perceived Emerged Security Threats in Healthcare Facilities: Qualitative Analysis

Healthcare settings are increasingly susceptible to a wide range of security threats that can compromise the safety of patients, healthcare professionals, and the integrity of healthcare services (WHO, 2020; Healthcare Information and Management Systems Society (HIMSS), 2023). These threats include physical violence, cyber-attacks, data breaches, verbal abuse and other forms of criminal activity that can disrupt healthcare operations and endanger lives (CDC, 2022; Journal of Healthcare Protection Management (JHPM), 2024).

4.4.2.1 Verbal Abuse

The interview data unearthed similar patterns in the findings from both hospitals. Participants from Mohlomi Psychiatric Hospital and Mafeteng Hospital illustrated notable differences in their experiences with verbal abuse. Participants reported that verbal abuse often involved threats and derogatory language, reflecting the possible complex mental health issues suffered by participants, for example, MPH-Q07 submitted that "*patients here can be very aggressive, often using threats that feel very real. It's part of their condition, which makes it harder to take it personally"* A MH-Q02 added that "during a crisis, patients can become verbally aggressive. It is part of the job, but it's still terrifying." In contrast, participants from Mafeteng Hospital described verbal abuse as more general dissatisfaction with patient care. An example can be drawn from MH-Q05, who said *"patients often blame us for their pain and suffering, calling us names or saying we don't care about them"*. Also, MH-Q09 shared similar sentiments, adding that *"patients here often get frustrated with delays and take it out on us. It can happen anytime, not just during a crisis."*

Participants shared specific instances of verbal abuse:

- MPH-Q05 recounted that "a patient once yelled at me, calling me incompetent. It made me question my skills and dedication. That hurt more than any physical assault."
- MH-Q08 mentioned that "I had a patient who screamed at me for no reason, saying I was trying to poison him. It escalated to a point where I had to call for help."

- MPH-Q01 noted that “we try to remain calm, but it’s difficult when someone is shouting at you. Sometimes, I want to respond, but I know I have to hold back.”
- MH-Q03 explained that “patients often feel entitled to lash out at us.”

The environment in Mohlomi Psychiatric Hospital was described as a more supportive one, with a culture of understanding regarding the mental health challenges faced by the hospital’s patients. MPH-Q01 noted that “*we understand that the patients are struggling, which helps create a more empathetic atmosphere among staff.”* Conversely, participants from Mafeteng Hospital reported a more stressful work environment, where the persistent verbal abuse led to feelings of burnout and dissatisfaction. MH-Q04 state that *“it feels like every day is a battle. The constant negativity can wear you down. It’s hard to keep work morale high.”*

In summary, the experiences of verbal abuse among participants from Mohlomi Psychiatric Hospital and Mafeteng Hospital differ significantly in terms of their nature, frequency, and overall impact on the work environment. The Mohlomi Psychiatric Hospital’s context, influenced by the nature of psychiatric care, fosters a more empathetic approach among healthcare workers, while Mafeteng Hospital’s environment emphasised the challenges of general healthcare frustrations. Understanding these differences is crucial for developing tailored interventions and support mechanisms for healthcare workers in both settings.

4.4.2.2 Physical Aggression

Interview data also provided other valuable insights into the threat of physical aggression faced by healthcare workers from both facilities. Participants reported varying experiences with physical aggression, which not only endangered the safety of staff, but it also impacted the quality of care provided to patients. Participants across both facilities acknowledged the presence of physical aggression in their workplaces, though the frequency and context varied significantly between the two settings. According to participants at Mohlomi Psychiatric Hospital, incidents of physical aggression were often linked to acute psychiatric episodes, with participants exhibiting behaviours such as hitting, throwing objects, or attempting to harm staff. As illustrated by MPH-Q03, an example can be recounted from an incident where the following was said: "*we had a patient who became violent during a manic episode. He threw a chair at me. It was terrifying and unpredictable.*"

In contrast, physical aggression at Mafeteng Hospital was typically less severe but more frequent, often arising from frustrations related to treatment of perceived neglect *"We've had patients who shove us or throw things out of anger. It's not as intense, but it happens more regularly" (*MH-Q02). Furthermore, both groups reported significant psychological and emotional repercussions from experiencing physical aggression; however, the nature of these impacts differed.

For some participants, *physical aggression led to them develop negative attitudes towards patients, "After an incident of physical aggression, I feel anxious about returning to the ward. It changes how I interact with patients"* (MPH-Q09). Other participants disregarded patients' behaviours and continued with their work like it did not happen. For instance, MH-Q08 said *"while it's unsettling, I try to shake it off quickly. It's part of the job in this environment and I must stay focused on patient care" (*MH-Q08). Participants also reported specific instances of physical aggression:

- "I had a patient who was frustrated with the wait time for their treatment. They stood up and pushed over the window, shouting at me that we didn't care about them. It was unsettling but thankfully no one was hurt" (MH-Q01).
- Participant MPH-Q05 submitted that "injury! I experienced assault by patients who are physically aggressive. We have an improper building, patients abscond through the ceiling, break butler doors, and use those bars on us."
- MH-Q04 described an incident where a patient became aggressive during a routine examination: "As I was checking their vitals, the patient suddenly grabbed my arm and pulled me closer, insisting that I was trying to harm them. I had to call for security to intervene."
- MPH-Q09 reported that "I once had a patient who, after receiving a diagnosis they didn't like, started tearing up paperwork and threw it at me. While it wasn't a direct attack, it was still an alarming display of anger."
- Participant MPH-Q01 added that they experienced "violence or aggression from male patients. One of our patients who was in a

seclusion room was found having committed suicide, and that was so scary. It took many of us a long time to get over it. It was really sad and painful."

- MH-Q08 shared that "a gun-shot patient's relatives wanted to beat up a nurse in casualty, complaining of delays to assist their patient."

Besides patients and their relatives, other sources of physical aggression or violence included external individuals who entered the hospital premises. The patient, who had harboured grievances from their previous interactions with the medical staff, returned to the hospital with the intent to harm a specific nurse who had provided their care. This behaviour is said to have manifested in various forms, such as physical assault, threatening gestures, or aggressive language, and it posed a significant security threat to the healthcare professionals. This pattern of physical aggression thus highlighted the presence of physical and violent behaviour, which is challenging and potentially dangerous to workers' environment in which these professionals work. It also suggested that healthcare professionals were at risk of physical harm and psychological distress, which thus had a profound impact on their well-being and job performance. Participant MH-Q02 mentioned that "some patients are violent towards hospital staff but above all, we need proper cleaning of the environment. This can lead to risks like slip and fall hazards, pest infections, compromised emergency response, and many more."

4.4.2.3 Theft of Personal Belongings and Medical Supplies

The issue of theft, encompassing both personal belongings of healthcare workers' and medical supplies, emerged as a concern among participants in these facilities. According to the findings, theft of personal belongings and hospital medical supplies appeared as less common but as a significant threat in both Mafeteng Hospital and Mohlomi Psychiatric Hospital. This finding highlighted an issue that, while not as pervasive as other security threats, it still poses a concern for healthcare professionals and the hospitals' operational integrity. Theft reported included the theft of personal items such as wallets, keys, as well as unauthorised taking of medical supplies and equipment. This not only affected the individuals who experience these losses, but it also impacted the hospitals' ability to provide efficient and effective care to others. Participants from both hospitals reported that theft of personal belongings and medical supplies was not a highly recurring issue that affected their daily work environment. MPH-Q03 noted that “it is uncommon for us to find missing items after a shift. Personal belongings like wallets and phones sometimes go missing but they seldom do.

The impact of missing medical supplies extended beyond logistics; it affected patient satisfaction and behaviour. When patients learned that they had to seek medication elsewhere due to shortages, their annoyance and aggression often escalated. MH-Q04 explained that “patients get upset when we have to inform them that we don’t have their prescribed medications. Some even lash out, blaming us for the inconvenience and saying they will just buy their medication at a pharmacy instead.”

Theft of medical supplies lead to shortages of same supplies, which was said to compromise patient care. Theft of personal belongings, on the other hand, created a sense of insecurity and distrust among staff. The sporadic nature of theft incidents made it challenging to predict and prevent, requiring vigilance and proactive measures.

- Participant MPH-Q03 narrated that “I am particularly concerned about the theft of medical supplies. It directly affects our reliability to provide care.” Another interviewee alluded to an assertion that “when you can’t trust your environment, it affects how you work. I am sometimes worried about my things being stolen, which adds unnecessary stress.”
- MPH-Q07 mentioned that “there is a threat of theft in the workplace, which compromises our service delivery, as we sometimes let patients leave without their prescribed medications due to shortages. We experience this once in a while but it happens and it creates conflicts between us and patients.”
- “Theft is particularly problematic as it ranges from petty stealing of personal belongings to the more serious issue of stolen medical supplies. Aggressive behaviour is also a frequent issue, often stemming from individuals under the influence of alcohol or substance abuse, for males” (MPH-Q02).

In conclusion, theft of personal belonging and medical supplies was reported as an uncommon threat faced in both facilities. In Mafeteng Hospital, the theft and misplacement of medical supplies have had few direct repercussions on patient care, leading to frustrations and aggression among patients when medications were unavailable. Participants articulated their concerns regarding the prevalence of theft, the types of items affected, and the emotional toll it took on staff. Addressing these challenges requires a multifaceted approach, including enhanced security measures, better inventory management, and fostering a culture of trust and accountability within healthcare settings.

4.4.2.4 Unauthorised Access

Unauthorised access within healthcare facilities, while reported as a minor threat, remains a concern for the safety and security of both patients and healthcare providers. Participants from Mohlomi Psychiatric Hospital and Mafeteng Hospital reported that while incidents of unauthorised access are infrequent, they led to significant disruptions, particularly when patients in distress or in pain intrude into restricted areas. In Mohlomi Psychiatric Hospital, unauthorised access was often lined to patients in acute distress who may inadvertently enter restricted areas while seeking assistance.

- MPH-Q03 described that “sometimes, patients who are in pain or confusion will slip through doors meant for staff, thinking they will get help. It’s more about their state of mind than any malicious intent.”
- Participant MPH-Q02 added that “open access to the facility by villagers is a challenge. Some of these people are not ill or visiting for medical purposes. They are not patients, I think, but they like to come here and walk around. You try and ask them how you can help them, they are so blunt and verbally abusive. They can even throw objects at you.”
- MH-Q04 said that “controlling unauthorized access to the hospital and managing physically aggressive and abusive patients is a major problem. Patients get lost and frustrated and aggressive. As they become arrogant and aggressive, they end up having access to wrong places, invading other patients’ privacy. They get very angry when you redirect them to where they will get help. Patients often bypass security checks as well.”
- MH-Q05 explained that “we had a patient who, in a moment of panic, rushed into the medication room looking for someone to assist them. It startled us, but they weren’t trying to cause trouble, kannete (indeed).”

While unauthorised access was not of frequent occurrence, it can create moments of tension and anxiety for healthcare workers, who must remain vigilant about maintaining secure environments. For instance, MH-Q09 expressed that "even though it's not common, when it does happen, it can be unsettling. We have to be prepared to respond quickly to ensure that everyone is safe."

In closing, unauthorised access in Mohlomi Psychiatric Hospital and Mafeteng Hospital, while reported as a minor threat, still raised important considerations for patient and staff safety. Incidents, though infrequent, highlighted the challenges healthcare workers face in managing patient movements, particularly when individuals were in distress.

4.4.2.5 Electrical Hazards

Electrical hazards represented a critical safety concern within the healthcare facilities, posing potential risks to both patients and staff. Participants from Mohlomi Psychiatric Hospital and Mafeteng Hospital reported varying experiences with electrical safety issues, emphasising the need for immediate attention aimed at preventing accidents and ensuring a safe environment for all staff. Participants from Mohlomi Psychiatric Hospital reported that some electrical wires within the hospital were not properly connected, creating significant safety risks. Interviewee MPH-Q02 noted that, *"we have wires that are exposed or poorly connected. This is particularly concerning because patients sometimes pull them out during their psychological episodes, which could lead to serious accidents."* Furthermore, MPH-Q06 shared that *"when patients are agitated, they grab anything, including electrical cords. We [the staff] worry about potential electric shocks or fires if these issues aren't addressed."* Lastly, Mafeteng Hospital interviewees highlighted the need for maintenance on the hospital's electrical systems, reporting that some wires and plugs were not functioning correctly, yet current was still running in certain areas. MH-Q04 shared that *"there are areas where plugs have stopped working altogether, but we still have live wires nearby. It creates a dangerous situation, especially if someone could accidentally come into contact with them."*

Participants reported specific instances of electrical hazards:

- MH-Q01 shared that "in my unit, the overhead lights frequently flicker and sometimes go out of order completely. Even though the current is still passing through, the dim lighting creates a risk for both staff and patients, particularly during emergency situations."
- MH-Q03 stated that "we've noticed that some electrical plugs in patients' rooms are not functioning properly. When we attempt to use them, there's a risk of electric shock as the current seems to pass through inconsistently. I worry about patients who may accidentally touch these faulty plugs."
- MH-Q08 narrated that "I encountered a situation where a power strip overloaded because too many devices were plugged into it. Mind you, I was dealing with a gunshot patient who was accompanied by a crew of *banna ba likobo* (gang members), who would ruthlessly attack you for not being quick enough. The circuit was hot to touch, which was very dangerous. We reported it, but no immediate action was taken, and I am concerned about a potential fire hazard."
- MPH-02 mentioned that "in our facility, many patients have ripped out electrical cords, which creates a chaotic environment. *Re ba thiba joalo*! (we constantly keep reprimanding them!) These exposed wires pose a risk, as they can lead to both electrical shocks and potential injuries from the sharp, frayed ends."
- MPH-Q04 stated that "There was an incident where a patient used a ripped electrical cord to threaten another patient. We immediately secluded that patient because he was harmful to others."

The implication of these findings was multifaceted. Firstly, the existence of electric hazards compromised the safety of healthcare workers, who faced life-threatening situations due to unexpected power failures while performing their duties. This uncertainty is said to have led to increased anxiety and stress among staff, as they felt constantly on edge about the potential dangerous incidents that may occur. Moreover, a lack of reliable electrical systems disrupted patient care, particularly in emergency situations where timely access to medical equipment was crucial.

Secondly, the reports from Mohlomi Psychiatric Hospital regarding ripped electrical cords presented a unique and alarming threat to patient safety. In a psychiatric setting where patients may be vulnerable and at risk of self-harm or harming others, the presence of hazardous electrical material can exacerbate these risks. Patients could continue to use exposed cords as weapons or means of self-inflicted injury, highlighting a dire need for immediate intervention to rectify these hazards. This situation not only endangers patients but also places additional strain on healthcare workers who must navigate the complexities of managing both patient behaviour and safety concerns.

4.4.2.6 Hazardous Materials

Participants from Mohlomi Psychiatric Hospital reported several incidents involving hazardous materials, which illustrates the security threats present within the facility. These accounts highlighted the various ways in which patients had access and utilised harmful objects, posing risk to both healthcare workers and fellow patients. For instance, MPH-Q01 recounted an incident where a patient escaped from the hospital through the window, but returned with sharp objects, including a broken glass and metal pieces that they found nearby. This patient used the acquired items to threaten staff members during a confrontation, creating a scene that required immediate intervention from security personnel in order to ensure the safety of both staff and patients.

Other participants further reported specific incidents:

- MPH-Q03 recounted that “I saw a patient using ripped electrical cords to self-inflict harm. They got those cords from the hospital and this was alarming because we had already reported this issue before.”
- MPH-Q05 shared that “a patient brought in a piece of metal piping with him into the hospital. He used that metal to beat up another patient who was sitting next to him since patients are kept together in one room. We had to seclude him because he was becoming dangerous to others. We however did not know what he could do to himself, especially when secluded.”
- MPH-Q04 mentioned that “there was a moment when a patient with a history of self-harm picked up sticks and inflicted harm on self. It was terrifying for all of us. We need better training to handle these kinds of situations.”

- MPH-Q07 also mentioned that “I was almost hit with a stone because I had caught a patient trying to escape through the window that is used to pass food and medication.”
- MPH-Q10 narrated that “I don’t know how mental health conditions are perceived by our people. Once they are being referred here, they think they are mad, and that’s not really the case. Patients present different kinds of illnesses and I wish they could understand. *Their fights when they get here!* (they fight when they get here). We get injured almost every day.”

These reports illustrate the pressing security threats posed by hazardous material within Mohlomi Psychiatric Hospital. They underscore the need for swift action to address these vulnerabilities through improved safety protocols, enhanced staff training, and a thorough assessment of the hospital environment to mitigate the risks associated with hazardous materials.

4.4.2.7 Harassment

Participants from both facilities reported alarming instances of harassment, revealing significant concerns regarding the safety and well-being of both patients and staff in these facilities. At Mohlomi Psychiatric Hospital, participants noted several cases where patients exhibited nudity, which was described as unusual for the facility. MPH-Q06 stated that *“there have been times when a patient walked around without clothes, which made staff and other patients uncomfortable. It’s not something we usually see.”* Additionally, participants reported instances of physical harassment occurring during acute episodes of patients’ mental illnesses. MPH-Q07 recounted an incident where *“some patients, especially males, when they are having severe episodes, lash out physically. I’ve been pushed and hit by patients who were not in control of themselves, and this happens more often that you’d think.”*

From Mafeteng Hospital, participants shared similar concerns, particularly regarding harassment perpetrated by visitors of patients. MH-Q03 revealed that *“we’ve had situations where visitors linked to Famo music members physically harass staff, especially in the Casualty Department. It’s particularly bad when their members come in with gunshot wounds.”*

These incidents often escalate when visitors arrive at the hospital intoxicated.

- MH-Q02 noted that "on weekends and at the end of the month, we see more people coming in drunk, and it's during these times that harassment occurs more frequently. It creates a hostile environment for both patients and staff."
- MH-Q10 reported that "some patients usually threaten us by saying they will kill us. We fear for our lives."
- MH-Q03 mentioned that "the Mafeteng district is the home of Famo music people and they do not mind *taking you down* (killing you). When they say they will kill you, be sure that they actually will. We fear them so *bad* (much)."

These accounts from participants in both facilities highlighted a troubling pattern of harassment that poses significant risks to the safety and well-being of healthcare workers and patients alike. The reported incidents of patients acting out during mental health crises and the aggressive behaviour of visitors at Mafeteng Hospital underscored the urgent need for improved safety protocols and support systems within these healthcare environments.

4.4.2.8 Faulty Equipment

Participants from both facilities reported concerning instances related to faulty equipment, which significantly impacted the safety and quality of care in these healthcare facilities. At Mohlomi Psychiatric Hospital, participants expressed frustration with the condition of the equipment they rely on for patient care. MPH-Q08 stated that *"we have been dealing with broken medical devices for months. It's frustrating because we can't provide the care that our patients need when the equipment doesn't work."* Another participant (MPH-Q09)
added that *"there are times when the vital sign monitors fail during crucial moments. This puts patients at risk and creates a lot of stress for the staff."*
Similarly, participants from Mafeteng Hospital reported issues with faulty equipment that compromise their ability to deliver effective care.

- MH-Q03 highlighted that "the surgical lights in the operating room frequently go out of order during procedures. It's incredibly dangerous and puts both patients and staff at risk."

- MH-Q04 mentioned that "we have old equipment that often malfunctions, like the infusion pumps that sometimes stop working mid-treatment. This has led to delays in patient care and increased anxiety for every staff member involved."
- MPH-Q10 noted that "many beds in the wards are old and broken. Some don't even have proper mattresses, making it uncomfortable for the patients to sleep. This is a serious issue because it affects their recovery and overall well-being."

The reported issues not only threaten patient safety, but they also contribute to heightened stress and frustration among healthcare workers who are committed to providing quality care despite these challenges.

4.4.2.9 Vandalism

Participants from Mohlomi Psychiatric Hospital reported several instances of vandalism that have significant implications for both the safety and well-being of patients and staff, as well as the overall functioning of the facility. One participant (MPH-Q01) explained that *"patients have damaged furniture in the common areas. Tables and chairs are often broken or thrown around during conflicts, creating a chaotic environment that makes it hard for us to manage the ward."* This type of vandalism does not only led to a loss of resources, it but also created an unsettling atmosphere that can exacerbate the mental health challenges faced by patients. Furthermore, participant MPH-Q04 shared that *"several windows were shattered when a patient threw stones during violent outbursts. We were trying to get them admitted and he did not like it."* This act of vandalism does not only endanger the patient involved, but it also posed a risk to other patients and staff. Broken windows led to physical injuries and further escalated tensions within the ward, highlighting the urgent need for improved supervision.

Other participants also reported incidents of vandalism.

- MPH-Q06 shared that "the walls of the facility are often defaced with graffiti, which creates a negative and unwelcoming environment for the hospital. Our patients feel lost and upon their escape, it is always war, especially with men."

- MPH-Q03 mentioned that "*most patients don't understand their treatment and they usually end up not liking everything we offer here. They escape, and at worst, they harm others and destroy the little progress that we had already made here*."

The implications of these vandalism incidents were far-reaching. Firstly, the damage to property resulted in increased maintenance costs for the hospital as funds must be allocated for repairs and replacements rather than patient care and support services. Secondly, a chaotic and unsafe environment led to higher stress levels among staff, potentially contributing to burnout and decreased job satisfaction. When healthcare workers feel unsafe or unsupported in their environment, it usually negatively impacts the quality of care they provide to patients. Moreover, the prevalence of vandalism deterred patients from engaging positively with their treatment, as they felt that their safety and well-being were not prioritised. This led to a cycle of frustrations and aggression among patients, further perpetuating the issues within the facility.

4.4.2.10 Work-place Violence:

Participants from both facilities reported facing workplace violence, primarily perpetrated by patients and their visitors. While tensions between staff members exist, they are not perceived to be as severe as the threats posed by external parties. Work-place violence in these facilities is manifested in various forms, each posing significant risks to the safety and well-being of healthcare workers.

Physical assaults, where patients or their visitors inflict bodily harm on staff, represent one of the most alarming types of violence. Some of these incidents have led to serious injuries and they require immediate security interventions. Verbal assaults, which involved aggressive language or threats, created a hostile environment that impacted staff morale and mental health. Additionally, intimidation tactics - such as aggressive posturing or threatening gestures - further contributed to an atmosphere of fear and anxiety among healthcare workers.

Collectively, these forms of violence not only jeopardised the safety of healthcare personnel, but they also hindered their ability to provide compassionate and effective care for patients. For instance, participant MH-Q03 reported that "*a patient became aggressive during a routine examination, resulting in a physical altercation that* *required intervention. Luckily, my colleague was passing near my work station and came to my rescue."*

Other participant reported specific incidents of work-place violence.

- MPH-Q05 described that "on one occasion, a patient physically attacked a nurse during a medication administration, leading to injuries that necessitated medical attention."
- MPH-Q07 recounted that "*the family of a patient who had committed suicide threatened staff members. I think that was because they needed a solid explanation of what truly transpired. Kannete ke ile ka kena lieteng tsa bona (I truly empathised with them). The whole thing was scary, it left us all stressed out*."
- MH-Q10 reported that "*some threats are just made out of frustration. But with the kind of people we serve currently, you always have to be extra careful. Batho bana ba kotsi (these people are dangerous). One patient was agitated with some staff member and found it easy to intimidate her, I didn't like it*."

In summary, continuous exposure to violence and threats leads to increased fear and anxiety among healthcare workers, affecting their service delivery and the overall job performance. The fear of violence usually hinders healthcare workers' ability to perform their duties effectively, compromising the quality of care they provide to patients. A hostile work environment led to higher staff turnover rates. Frequent incidents of violence disrupts the normal functioning of both facilities Overall, addressing workplace violence in healthcare settings is crucial not only for the safety of staff, but also for maintaining a conducive environment for patient care and operational efficiency.

4.4.2.11 Work-related Injuries:

Another critical issue was work-related injuries that appeared to be more prevalent in Mohlomi Psychiatric Hospital than in Mafeteng Hospital. This finding highlighted a significant difference in the security concerns faced by healthcare professionals in the two facilities. The higher prevalence of injuries in Mohlomi Psychiatric Hospital suggested that the nature of psychiatric provided by the facility presented unique challenges that increased the risk of physical harm to staff. In Mohlomi Psychiatric Hospital, participants reported various injuries they sustained, which included bruising, abrasions, and in some cases, more serious injuries requiring medical attention. These injuries were a result of the physical altercations with patients that occurred due to the nature of their medical conditions. Participant MPHQ-01 reported that patients were injured while trying to escape through a broken window.

In contrast, participants from Mafeteng Hospital reported fewer work related injuries, with incidents primarily involving sprains, strains and cuts. These injuries are common in a general hospital setting due to the physical nature of patient care and the risk of exposure to sharp objects. The lower prevalence of work-related injuries in Mafeteng Hospital suggested that the security threats were less frequent compared to those happening in a psychiatric setting. Moreover, patients were reported to have attacked healthcare providers when they were being helped back into their rooms, leading to injuries sustained by the facility's healthcare professionals.

Participants shared harrowing stories of physical assaults, where bruises and cuts are stark reminders of the dangers they face daily.

- MPH-Q04 stated that the "*dilapidated hospital building is where patients get injured trying to escape. A patient experienced a severe episode of agitation and delusions and he attempted to escape from the facility. This patient, who was physically strong and highly agitated, became aggressive when a nurse tried to calm and redirect them back to the seclusion room. Re ne re ts'oere mathata (we were handling a tough situation). As the nurse attempted to guide the patient, the patient suddenly I charged forward, striking the nurse multiple times with fists. The patient's blows landed on the nurse's arms and torso, causing a really bad bruising*."
- Participant MPH-Q05 added that "*a patient who was placed in a seclusion room due to violent behaviour managed to escape through a window that was left slightly ajar. The patient was determined to flee and used a makeshift tool-like to widen the gap in the window frame, allowing them to squeeze through. Fortunately, the patient was spotted by a security guard who immediately alerted the nursing staff. A nurse approached the patient trying to guide the patient but the patient became defensive brandishing a sharp object they had found outside. As the nurse attempted to communicate, with the patient and*

persuade them to drop the object, the patient suddenly lunged forward, scratching the nurse's face with the sharp object on the left side."

- Interviewee MPH-Q05 further mentioned that "patients share rooms, so sometimes when a certain patient is desorbed, because they harm others, they harm themselves too because they are left alone."
- Participant MPH-Q06 added that "*most healthcare facilities are prone to danger due to how buildings are built in the facility. Some are old buildings where doors are broken, roofing is damaged and this makes an easy way for patients to escape and when they have escaped, they bring harmful objects or substances to harm other patients and staff*."
- MH-Q03 indicated that "*working in small consultation rooms which expose us to many infections*. We easily bump into each other."
- MH-Q02 reported that "some patients are violent towards hospital staff. We also lack of proper cleaning of the environment that poses heightened security risks, and increased infections." Adding on, the participant said that "*sometimes we spend months without cleaning materials which kill micro-organisms such as bacteria, viruses, fungi and parasites. Nurses are not insured by the government. Only a driver and patients are insured by the Ministry of Health*. Without insurance, we are more vulnerable to financial and legal risks in case of work-related injuries, illnesses, or accidents."
- MH-Q03 reported that "*working in small consultation rooms which expose us to many infections. These small working spaces hinder social distancing, increasing the risk of infectious disease transmission. Again, the confined space escalate tensions, posing threats to us."*
- MH-Q01 stated that "*infectious diseases, like airborne or waterborne can pose risks in our hospital due to potential contamination of water supplies, poor ventilation and inadequate sanitation. These conditions can lead to outbreaks among vulnerable patients and us healthcare workers. This workplace is very dirty considering that it is a hospital that's functional. Sometimes we spend months without cleaning materials which kill micro-organisms. Nurses are not insured by the government. Our drivers and patients are insured by the Ministry of Health, not us and that's the sad part."*

Lastly, the findings recorded cybersecurity having emerged as a prevalent threat in Mohlomi Psychiatric Hospital compared to Mafeteng Hospital. This finding highlighted a critical issue that requires attention and proactive measures to safeguard sensitive patient information and hospital operations. From this facility, cybersecurity included unauthorised access to health records, which compromised patient privacy and operational integrity.

Participant MPH-Q04 stated that "*a security threat is a malicious act that aims to corrupt or steal data or disrupt an organisation*. Some patients exhibited challenging behaviours that require careful management." This participant further explained that "*theft of patient and employee data occurred in Mohlomi Psychiatric Hospital. Patients who are able to read and write steal documents and scrutinise other people's treatments or medical reports. I found this awkward, especially because it was done by patients. I thought these people all came in to seek some help*."

However, while cyber security was a concern, it appeared to be insignificant, as its servicing and impact were little, and as the incident was reported by one participant, making it minor and easily resolved. It is not as concerning as if there were major breaches with significant consequences. Furthermore, trends for the duration of the study did not show any increase in such incidents, suggesting that it may not be a widespread or growing problem for the duration of the current study.

4.5 Multifaceted Drivers of Security Threats among Healthcare Professionals

This section aims to elucidate the key findings regarding the various factors that drove security threats within healthcare facilities. Additionally, descriptive statistics and relationship tests were employed to assess the significance of each identified influencer on security threats.

4.5.1 Drivers of Security Threats among Healthcare Professionals: Quantitative Analysis

Table 9 shows that 44.4% (n=36) of respondents agreed that inadequate security personnel in healthcare facilities contributed to work risks, thus acknowledging it as a considerable influence on the threats they encounter. Furthermore, an additional 28.4% (n=23) of respondents strongly concurred with the impact of this variable. In contrast, only 27.2% expressed disagreement, clearly indicating that a substantial majority (72.8%) shared a consensus on this issue, thereby validating the role this variable plays in influencing work risks.

A statistical analysis revealed a mean of 2.94, for the lack of security personnel influencer. This mean suggested that on average, respondents rated their agreement with this threat as 2.94. The Chi-square test demonstrated a significant relationship between this driver and the level of security threats, with a Chi-square value of 18.403 and a P-value of 0.031. This is indicating a significance at the 0.05 level. Thus, the results suggested a substantial correlation between the lack of security personnel and the prevalence of security threats faced by healthcare professionals.

It is worth noting that only 17.3% of respondents disagreed with the assertion that "insufficient safety protocols and procedures" pose a significant challenge while a substantial 82.7% of respondents collectively agreed that this variable is a major influencer on security threat levels. This overwhelming majority highlights the perceived importance of addressing insufficient safety protocols as a critical factor in enhancing workplace security.

The variable "insufficient safety protocols and procedures" garnered considerable agreement among respondents, with 48.1% of respondents indicating that respondents significantly encountered this threat in their workplaces. An additional 34.6% strongly concurred to this challenge. Only 12.3% of respondents expressed disagreement with this perspective. Statistical analysis yielded a mean score, standard deviation, and variance (M=3.12, SD=0.812, V=0.660). The mean score of 3.12 is indicative that, on average, a significant number of respondents found this issue to be pertinent. This finding implied that insufficient safety protocols and procedures significantly contribute to the overall security threat landscape.

Similar to the lack of security personnel, inadequate staffing is also a significant influence, bearing 2.94 mean score. This suggests that the current staffing levels in the facilities are not sufficient to effectively manage and mitigate security threats, which can lead to increased vulnerability and risk within the facilities. In addition, majority of respondents (72.8%) agreed that this threat contributes to security challenges; only 27.2% disagreed.

Conversely, high crime rates in surrounding areas recorded the lowest mean score of 2.83, which shows that respondents perceived high crime rates in the surrounding hospital areas as a less significant influence on security threats compared to internal factors. Likewise, the findings highlighted a notable consensus regarding the impact of these factors on security threats within healthcare settings. This suggested that while both factors were acknowledged as influencers of the risks, inadequate staffing is perceived as a more pressing issue among respondents, emphasising the need for strategic interventions in staffing within healthcare facilities.

Respondents identified inadequate training on handling threats and the overall safety and security culture at the hospital as one of the significant influencers. Inadequate training recorded the mean score of 3.04, making this influencer the second highest factor. This indicates that respondents from both facilities believed that a lack of training contributes significantly to security threats. On the other hand, overall safety and security culture scored the mean of 2.97, becoming the third highest one (M=3.04, SD=0.749, Sig= 0.009) and (M=2.97, SD=0.852, Sig= 0.000) for overall safety culture and security challenges.

In a nutshell, the analysis of the influencers of security threats reveals that insufficient safety protocols (mean: 3.12) and inadequate training (mean: 3.04) are the most significant security concerns, indicating a strong need for comprehensive safety measures and enhanced training programs. The overall safety and security culture (mean: 2.97) also requires improvement to foster a proactive attitude towards security. Additionally, the lack of security personnel (mean: 2.94) is perceived as one of the significant influencers, suggesting the need for increased hiring and resource allocation in order to ensure adequate staffing levels. However, high crime rates in areas surrounding healthcare centers (mean: 2.83) are considered less significant; they still warrant attention and collaboration.

Table 9 Descriptive Analysis of Factors Influencing Security Threats in Healthcare Facilities

Drivers of Threats	Strongly Disagree	Disagree	Agree	Strongly Agree	Total	Mean	SD	V	(X^2)	DF	Sig
Lack of Security personnel	6 (7.4)	16 (19.8)	36 (44.4)	23 (28.4)	81 (100)	2.94	0.885	0.784	18.403	9	0.031
Insufficient safety protocols and procedures	4 (4.9)	10 (12.3)	39 (48.1)	28 (34.6)	81 (100)	3.12	0.812	0.660	26.701	9	0.002
Inadequate staffing level	6 (7.4)	16 (19.8)	44 (54.3)	15 (18.5)	81 (100)	2.94	0.813	0.661	22.668	9	0.007
High Crime in surrounding area	14 (17.3)	14 (17.3)	27 (33.3)	26 (32.1)	81 (100)	2.83	1.058	1.120	23.376	9	0.005

Inadequate training on handling threats	3 (3.7)	12 (14.8)	45 (55.6)	21 (25.9)	81 (100)	3.04	0.749	0.561	21.946	9	0.009
Overall safety and security culture at the hospital	6 (7.4)	12 (14.8)	41 (50.6)	22 (27.2)	81 (100)	2.97	0.851	0.724	31.614	9	0.000

4.5.1.1 Analysis of the Relationship between Security Threat Levels and Contributing Security Factors

This section focuses on examining the relationship between security threat levels and the factors that influence these threats in relation to the response variable of security threat levels. To achieve this, an ordinal regression model was employed so as to identify the extent to which various drivers of security threats are associated with security threats.

The analysis indicates that the thresholds delineate the cut-off points among various security threat levels, specifically low, moderate, high and extremely high ones. The threshold for security threat level 1 (low) is estimated at -5.384, which is statistically significant (p=0.000). This finding suggests that the transition from low to moderate threat levels was considerably influenced by the variables within the model. The threshold for security threat level 2 (moderate) was estimated at -2.611, also statistically significant (p=0.000), indicating the cut-off point between moderate and high threat levels. Conversely, the threshold for security threat level 3 (high) was estimated at -0.189, which was not statistically significant (p=0.761). This implied that there was no meaningful difference between high and extremely high threat levels, as $p > 0.05$ significance threshold.

4.5.1.1.1 Lack of Security Personnel

For respondents who strongly disagreed with that there is inadequate security personnel, the estimate was 0.104, indicating no significant difference in threat levels. Similarly, those who disagreed had an estimate of -1.116, which was also not significant, suggesting that their disagreement did not have a meaningful effect on the threat level. Respondents who agreed that there is inadequate security personnel had an estimate of -0.793, which likewise was not significant. This analysis revealed that the perception of a “lack of security personnel,” regardless of whether respondents strongly disagreed or agreed, did not significantly influence the likelihood of experiencing elevated security threat levels.

4.5.1.1.2 Inadequate Staffing Level:

For those who strongly disagreed with the assertion that there were inadequate staffing levels, the estimate was -2.450, indicating no significant impact on threat levels. In contrast, respondents who disagreed had an estimate of -2.259, which was statistically less likely to perceive higher security threats. For respondents who agreed, the estimate was -1.186, which was not significant.

4.5.1.1.3 Inadequate Staffing Levels

Overall, the findings demonstrated that respondents who disagreed that there were inadequate staffing levels were associated with a significantly lower likelihood of perceiving elevated security threat levels.

4.5.1.1.4 High Crime in Surrounding Areas

For respondents who strongly disagreed with the statement on high crime rates, the estimate was -0.800, indicating no significant effect on perceived threat levels. In contrast, those who disagreed had an estimate of 1.592, which was marginally significant ($p=0.074$). This suggested that individuals who disagreed regarding the presence of high crime in surrounding areas were slightly more likely to perceive higher threat levels. For respondents who agreed, the estimate was -1.121, which was not significant overall. Those who disagreed with the notion of high crime in surrounding areas exhibited a slight, though not statistically strong, tendency to associate it with elevated security threats.

4.5.1.1.5 Inadequate Training

Respondents who strongly disagreed with the statement that staff members had inadequate training to handle security threats were an estimate of -1.787, indicating no significant effect. Those who disagreed had an estimate of -1.150, which was also not significant. However, respondents who agreed that there was inadequate training had an estimate of -1.443, which was also not statistically significant ($p=0.038$). This finding indicates that individuals acknowledging inadequate training were significantly less likely to be categorised within higher security threat levels. Thus, agreement regarding training deficiencies was significantly associated with lower perceived security risks, suggesting that recognising training inadequacies correlated with a reduced sense of threat.

4.5.1.1.6 Overall Safety and Security at Healthcare Facilities

For respondents who strongly disagreed with the notion that overall safety and security measures at healthcare facilities contribute to security threats. The estimate was -1.075 and this indicates no significant impact on threat levels. Those who disagreed had an estimate of 0.353, which was also not significant. Respondents who agreed had an estimate of 0.324, similarly not significant. Therefore, neither agreement nor disagreement regarding the overall safety and security culture within the healthcare facilities significantly affected perceived security threat levels.

4.5.1.1.7 Insufficient Safety Procedures and Protocols:

For those who strongly disagreed with the statement, the estimate was 1.341, indicating no significant effect. In contrast, respondents who disagreed had an estimate of -3.120, which was statistically significant ($p=0.030$). This finding suggested that individuals who disagreed with the notion of insufficient safety procedures were significantly less likely to perceive higher security threats. For those who agreed, the estimate was -1.239, which was marginally significant ($p=0.078$), indicating a potential, albeit weak, association with lower perceived threat levels.

The findings revealed that perceptions of security threat levels vary based on specific factors. Respondents who disagreed with the presence of high crime in surrounding hospital areas showed a marginally increased likelihood of perceiving higher threats, while those who acknowledged inadequate training of staff to handle security threats were significantly less likely to perceive elevated security risk. In contrast, views on overall safety and security within healthcare facilities did not significantly influence threat perceptions. Additionally, disagreement regarding insufficient safety procedures was significantly associated with lower threat levels, with agreement showing a marginally significant link to reduced threat perception. Overall, these results suggested that perceptions of security threats were notably influenced by factors like training inadequacies and safety protocols, while general safety culture appeared to have a minimal impact.

Table 10 Coefficients of Influencing Factors in the Security Threat Level Model

Category	Degree	Estimate	Std. Error	Wald	DF	P	Lower Bound	Upper Bound
Threshold	Low	-5.384	.894	36.306	1	.000	-7.135	-3.633
	Moderate	-2.611	.732	12.733	1	.000	-4.044	-1.177
	High	-0.189	.622	.092	1	.761	-1.408	1.030
Lack of security personnel	Strongly Disagree	-0.104	1.344	.006	1	.938	-2.737	2.530
	Disagree	-1.116	.952	1.376	1	.241	-2.982	.749
	Agree	-0.793	.723	1.203	1	.273	-2.209	.624
Inadequate staffing level	Strongly Disagree	-2.450	1.601	2.341	1	.126	-5.588	.688
	Disagree	-2.259	.883	6.537	1	.011	-3.990	-.527
	Agree	-1.186	.785	2.281	1	.131	-2.725	.353
High Crime in Surrounding	Strongly Disagree	-0.800	.896	.797	1	.372	-2.555	.955
	Disagree	1.592	.891	3.191	1	.074	-.155	3.338
	Agree	-1.121	.742	2.280	1	.131	-2.576	.334
Inadequate training on handling threats	Strongly Disagree	-1.787	2.379	.564	1	.453	-6.450	2.876
	Disagree	-1.150	1.063	1.171	1	.279	-3.234	.933
	Agree	-1.443	.697	4.288	1	.038	-2.808	-.077
Overall safety and security cultures at the hospital	Strongly Disagree	-1.075	1.650	.424	1	.515	-4.309	2.159

Category	Degree	Estimate	Std. Error	Wald	DF	P	Lower Bound	Upper Bound
	Disagree	0.353	1.249	.080	1	.777	-2.094	2.801
	Agree	0.324	.874	.138	1	.711	-1.388	2.036

4.5.2 Mean Results for Drivers of Security Threats

Figure 2 illustrates the average responses regarding threat drivers identified in the findings. It emphasises that insufficient safety protocols and procedures, in inadequate training for threat management, and the overall safety and culture within hospitals are significant threat drivers. Notably, the average responses indicated a tendency toward agreement with these assertions, highlighting the importance of addressing these areas to enhance security in healthcare settings.

The findings regarding the driver influencing security threats in healthcare facilities shed light on various factors contributing to the perceived threat among healthcare professionals. The mean score for insufficient safety protocols and procedures are 3.12, indicating that many workers feel that current measures employed to curb security threats were inadequate to ensure their safety and security. This perception led to heightened anxiety and stress among staff, as they feel unprotected in their work environment, which ultimately affected their ability to provide quality care to patients.

In combination with this, the scores for lack of security personnel and inadequate staffing levels (both at 2.94) highlighted critical gaps in the protective infrastructure within healthcare facilities. A lack of adequate security personnel resulted in insufficient monitoring of the premises, leaving workers feeling vulnerable to potential threats. Similarly, inadequate staffing levels is said to exacerbate the problem, as fewer healthcare personnel led to increased workloads and greater vulnerability to security incidents. These factors underscored the importance of ensuring that healthcare facilities are adequately staffed, not only in terms of medical personnel but also in terms of security staff who can effectively manage and respond to threats.

The mean score for inadequate training on handling threats was 3.04, which indicated a significant concern regarding the preparedness of healthcare workers to deal with potential security incidents. Without proper training, staff felt ill-equipped to respond effectively to threats, further contributing to their anxiety and sense of insecurity. This lack of preparedness had serious implications, as untrained personnel inadvertently escalated situations or failed to take necessary precautions, thereby putting themselves and their patients at risk.

Additionally, the score for high crime in the surrounding area, at 2.83, reflected external factors that contributed to the overall perception of insecurity within healthcare facilities. When healthcare workers were aware of elevated crime rates nearby, it created a pervasive sense of danger that affected their morale and willingness to work. Finally, the overall safety and security culture at Mohlomi Psychiatric Hospital, which made up 2.97%, indicated the need for a more robust framework that promotes a culture of safety among staff. A strong safety culture is essential for fostering an environment where workers feel valued and secure, ultimately resulting in better job satisfaction and patient care.

In summary, the analysis of the influencers of security threat reveals that insufficient safety protocols (mean: 3.12) and inadequate training (mean: 3.04) are the most significant influencers of security threats in the workplace, indicating a strong need for safety measures and enhanced training programs to be put in place. The overall safety and security culture (mean=2.97) also requires improvement to foster a proactive attitude towards security. Furthermore, the lack of security sufficient personnel (mean: 2.94) and inadequate staffing (mean: 2.94) are perceived as significant drivers, suggesting the need for increased hiring and resource allocation in order to ensure adequate staffing levels. While high crime rates in the surrounding area (mean: 2.83) are considered less significant, they still warrant attention and collaboration to mitigate external threats.

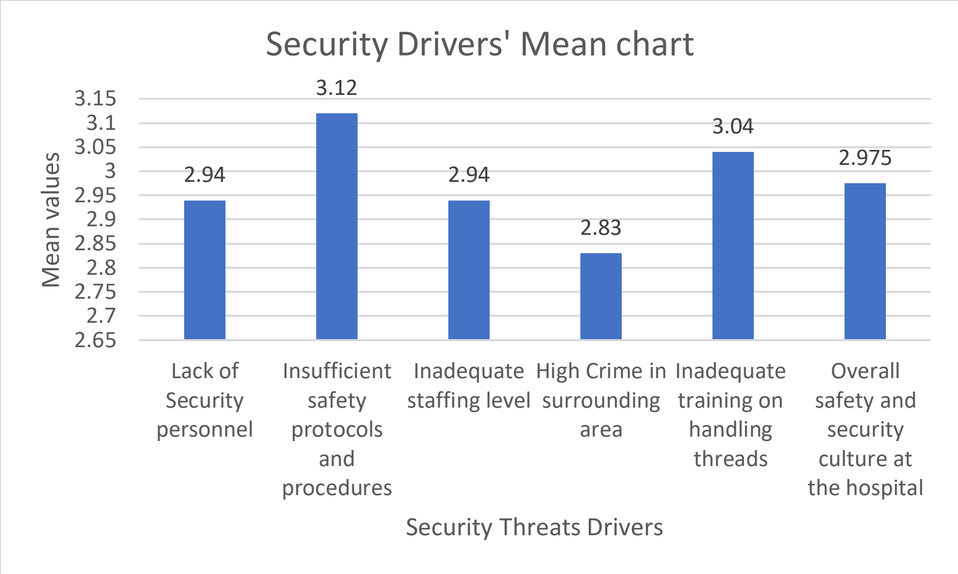

Figure 2: Average Responses on Predominant Threat Drivers in Healthcare Facilities

4.5.2 Qualitative Investigation into Factors Influencing Security Threats

Through qualitative analysis, a range of interconnected influencing factors emerged, underscoring the complexity of the environment in which healthcare professionals operate. Key findings highlighted that staffing issues, including insufficient workforce levels and high turnover rates, significantly exacerbated security concerns. Additionally, inadequate training for staff in managing potentially volatile situations has been identified as a critical gap that left workers ill-equipped to handle aggressive behaviours effectively. Furthermore, the physical environment of the facilities are said to play a crucial role in ensuring the safety and security of both staff and patients.

Poor infrastructure and inadequate lighting do not only compromise the safety of healthcare workers, but they also create an atmosphere conducive to violence. Socio-economic factors within the surrounding community, such as poverty and unemployment, have been linked to increased instances of unrest and aggression directed towards healthcare settings. The lack of essential resources, as well as funds and safety equipment, alongside out-dated technology, further hamper the ability of healthcare professionals to perform their duties safely.

Lastly, insufficient safety protocols and emergency response plans leave workers vulnerable during critical incidents. Collectively, these findings illustrate the urgent need for comprehensive strategies to address and mitigate security threats, ensuring a safer working environment for healthcare professionals and ultimately enhancing the quality of patient care.

Staffing issues represented one of the most significant drivers influencing security threats in healthcare settings, particularly within Mafeteng Hospital and Mohlomi Psychiatric Hospitals because all the 20 participant reported having experienced this concern. The qualitative findings indicate that inadequate staffing levels, characterised by a high patient-to-staff ratio, contribute to an environment where healthcare professionals felt overwhelmed and unable to provide the necessary attention and care to each patient. This situation did not only increased burnout among staff, but it also diminished their capacity to respond effectively to aggressive or violent behaviours exhibited by patients or visitors. For instance, participant MH-Q01 mentioned that *"the facility is constantly running short of doctors, which compromises both patient care and staff safety."*

Other participants from Mafeteng Hospital further reported that:

- MH-Q02 said that "*we are often overwhelmed due to the lack of sufficient medical staff, which creates a stressful environment. Re sebetsa re khathetse, 'me rele tlasa khatello (we work while in a tired state and very stressed)*."
- MH-Q03 highlighted that "*shortages of doctors lead to increased workloads for staff that is present, heightening the risk of security incidents. Bakuli ba hana ho re bona (we are in high demand from patients)*! "
- MH-Q04 noted that "*the absence of enough physicians puts both patients and staff at risk as we cannot attend to every patient adequately*."
- MH-Q05 purported that "*staffing shortages here are a major concern; we need more doctors to ensure safety for everyone*."
- MH-Q06 reported "*the lack of adequate medical staff makes it difficult to manage situations effectively when they rise. Rea imeloa* (we are overworked)."
- MHQ07 recounted that "*every shift feels understaffed, which raises anxiety among both staff and patients*."
- MH-Q08 proclaimed that "*the facility is in dire need of more doctors; this is a fundamental issue affecting our security*."

- MH-Q09 mentioned that "we often have to handle emergencies with a minimal number of doctors available."
- MH-Q10 acknowledged that "*I feel that the shortages of doctors and nurses here directly contribute to security threats. We get attacked quite often for delays in service delivery*."
- MH-Q02 stressed that "*yes, we need more male security guards in the facility and also the institution should buy proper cleaning materials to prevent nosocomial infections*." The participant further added that "*yes, [were have] one security guard while we expect more.*"

In contrast, Mohlomi Psychiatric Hospital interviewees emphasised the urgent need for more specialised mental health professionals in the facility, including psychiatrists, to manage complex needs of psychiatric patients effectively. This disparity in staffing does not only undermine the quality of care provided, but it also exacerbated the risk of security incidents, highlighting the pressing need for strategic interventions to enhance staffing levels and, consequently, safeguard both healthcare workers and patients alike. For instance, participant MPH-Q01 mentioned that *"here at our facility, we are facing a critical shortage of mental health doctors, including psychiatrists, which directly impacts our ability to provide comprehensive psychiatric work."*

Other participants further stated that:

- MPH-Q02 proclaimed that "*there aren't enough specialists here to handle the patient load, leading to unsafe conditions*."
- MPH-Q03 mentioned that "*The lack of psychiatrists is evident; it affects how we manage patient crises. Ha u fihla mona fela oa iponela hore rea fokola (upon arriving, you could also see that we are understaffed)*."
- MPH-Q04 declared that: "*without enough mental health professionals, it becomes challenging to maintain a secure environment. Batho ba ts'oeroe ke mafu a hlooho, ba bang re sitoa ho ba thusa (people have mental health issues, we cannot help others)*."
- MPH-Q05 revealed that "*we desperately need more psychiatric staff to ensure that we can safely care for our patients*."

- MPH-Q06 asserted that "*the shortage of qualified mental health professionals increased the likelihood of security threats. Enough staff could have solved so many problems in this facility*."
- MPH-Q07 indicated that "*staffing shortages in psychiatry are a major issue; we need more experts to help manage the patients effectively*."
- MPH-Q08 cited that "*everyday, we struggle with inadequate staffing, which puts us all at risk. We are being attacked even by outpatients due to long waiting periods*."
- MPH-Q09 professed that "*the absence of sufficient mental health doctors leads to heightened tension in the facility*."
- MPH-10 declared that "*we cannot provide the necessary level of care without adequate psychiatric staffing, which leads to security threats. The general condition of our facility has been taken for granted for a long time now.*"

The implications of the findings are profound, underscoring the urgent need for comprehensive staffing solutions to mitigate security threats within these facilities. Insufficient staffing deficiencies, healthcare administrators and policymakers can foster a safer work environment, improve the quality of care, and enhance the overall effectiveness of mental health services. As the healthcare landscape evolves, prioritising the recruitment and retention of qualified medical and mental health professionals will be essential in creating resilient healthcare systems that safeguard both staff and patients, ultimately leading to a more secure and supportive environment for all.

4.5.2.1 Inadequate Training:

Several participants highlighted the inadequate training related to security threats, indicating a significant concern that needs to be addressed. Participants from Mafeteng Hospital expressed their concerns as follows:

- MH-Q03 noted that "*without proper training, we are unsure how to respond to aggressive behaviour or emergencies*."
- MH-Q05 showed that "*inadequate training means we often feel unprepared to .manage potential security incidents effectively*."

- MH-Q01 suggested that *"we have received little to no training on how to handle security threats, which leaves us vulnerable. Sometime we fight back due to frustration and not knowing how to react.*"

From Mohlomi Psychiatric Hospital, participants also voiced similar concerns:

- MPH-Q02 highlighted that "*the lack of training on security protocols has made it difficult for us to ensure a safe environment."*
- MPH-Q04 expressed that "*We need training on security threats; without it, staff and patient safety are at ris*k."
- MPH-Q06 recounted that "*the absence of structured training programs leaves us ill-equipped to de-escalate tense situations*."

The lack of training experienced by healthcare workers at both facilities significantly undermined the safety and efficacy of care provided in these settings. Without adequate training in security protocols and crisis management, staff members are left ill-equipped to recognise and respond to potential threats, which can escalate into violent incidents, endangering both their safety and that of the patients. This deficiency does not only foster an environment of uncertainty and fear among healthcare workers, but it also deteriorated the overall quality of patient care, as untrained staff struggled to implement effective de-escalation techniques or manage challenging behaviours. Consequently, the absence of structured training programs creates a precarious situation that led to increased incidents of conflict and a breakdown in trust between staff and patients, ultimately compromising the therapeutic environment essential for effective mental health treatment.

4.5.2.2 Poor and Inadequate Infrastructure:

In addition to staffing shortages and lack of training, participants identified poor and inadequate infrastructure as a significant contributor to the security threats faced within these healthcare settings. This infrastructure-related issue encompasses a range of deficiencies, including insufficient physical barriers, inadequate lighting, and poorly designed spaces that do not support the safe management of patients, particularly those exhibiting aggressive or unpredictable behaviour. Participants expressed concerns that these infrastructural shortcomings do not only hinder their ability to maintain a secure environment, but they also exacerbate the risks associated with patient care, making it increasingly difficult to protect both staff and patients. The prevailing conditions create an atmosphere where security incidents were more likely to occur, highlighting the urgent need for investment in improved infrastructure to enhance safety and support the delivery of effective mental health services. For instance participant MPH-Q01 mentioned that *"the hospital is dilapidated beyond measure." Further explaining the difficulties of the hospital conditions. A patient committed suicide in a seclusion room due to poor seclusion room conditions."*

Participant MPH-Q04 added that "*glass windows without burglar-proof pose a hazard. Someday a patient was caught trying to jump through the window that had no security bars protection. That window is used to pass food and medication to patients. Yes, plugs in the wards may be dangerous to the patients and staff because patients might misuse the plugs, therefore, infrastructure is the major contributor of threats. We are not being attended to by the management. "*

Other participants continued to mention that:

- MH-Q01 said that "*outdated infrastructure and understaffing are our problem. The corridors and parking lots are not well-lit, making them unsafe at night. "Yes, there are areas with insufficient lighting, which increase the risk of incidents.*"
- Interviewee MH-Q03 shared that "*working in a small consultation room exposes us to many infections. Like I've said, being safe at work means we should work in a conducive environment and our BIN systems are not put in a proper way due to lack of space*."
- MH-Q04 indicated that "*inadequate lighting in the corridors creates blind spots, which leads to unsafe situations* "
- MH-Q06 highlighted that "*the layout of the facility is not conducive to managing patients effectively; narrow hallways and poorly placed furniture obstruct exits during emergencies. Maybe if it was back in the days*. *In the past, the layout could have been more functional, but today it poses significant challenges."*
- MPH-Q02 suggested that "*we often face challenges due to the lack of designated safe spaces for managing aggressive patients, which escalates situations. Other days really turn out bad. Our furniture, including beds, is not*

in good condition. The entire hospital needs some hands. The entire hospital needs additional help and resources. ”

- MPH-Q05 cited that: “*the absence of proper surveillance systems in hospitals limits our ability to monitor patient movements, making it difficult to prevent potential security threats.*”
- MPH-Q08 pronounced that “poorly designed common areas lead to overcrowding, which heightens tensions and increases conflicts among patients. The same applies to the room we keep patients collective in after being admitted. It is just not safe.”

The implications of the reported infrastructure deficiencies at both facilities were far-reaching as they directly compromise the safety and effectiveness of mental health care delivery. Inadequate physical barriers, poor lighting, and suboptimal facility layouts do not only create an environment that is ripe for security incidents, but they also hinder staff members’ ability to respond swiftly and effectively to crises. This led to increased violence and conflict, further exacerbating the already challenging dynamics of psychiatric and the general facility care. The lack of designated safe spaces and insufficient monitoring capabilities contributed to a persistent state of unease among staff, which diminished morale and increased turnover rates. Ultimately, these infrastructural shortcomings do not only jeopardise the safety of healthcare professionals and patients alike, but they also detract from the overall quality of care, highlighting the urgent need for targeted interventions in facility upgrades and redesigns to foster a more secure and supportive therapeutic environment.

4.5.2.3 Socioeconomic Factors:

Additionally, participants shared that there are external factors they believe influence security threats within healthcare facilities. These factors included economic difficulties and financial stress that led to increased theft and other criminal activities among patients and even staff members. The need for money is also one of the factors that drove individuals to engage in illicit behaviours within the hospital premises. High levels of unemployment reportedly also contributed to a sense of desperation among patients, potentially leading them to resort to stealing or other forms of misconduct as a means of coping with their financial struggles.

Participants from Mohlomi Psychiatric Hospital emphasised the socio-economic determinants of mental health, which in turn influenced security concerns. Participant MPH-03 remarked that *“the patients we see are often struggling with financial depression; it’s a direct result of their economic conditions.”* This insight underscored the correlation between mental health crises and socio-economic stressors, suggesting that the nature of security threats in Mohlomi Hospital are more closely tied to the mental states of patients rather than external community violence. Participant MPH-Q07 elaborated that *“substance abuse and gambling addictions are rampant among their patients. Many of our patients come from desperate situations, and their behaviours can sometimes pose a risk to staff.”* This statement indicated that the internal dynamics of mental health issues, exacerbated by financial despair, create unique challenges for security in the psychiatric setting.

Furthermore, unemployment rates in the country were reported as a significant socio-economic factor, particularly affecting the youth, who often turn to substance misuse and ultimately end up in psychiatric facilities, or at worst, in jail. Participants from Mohlomi Psychiatric Hospital provided several additional examples illustrating these issues:

- MPH-Q08 stated that “*we see a lot of young patients who are here because they’ve turned to drugs as an escape from their unemployment. It’s heart-breaking to see their potential being wasted*.”
- MPH-Q05 shared that “*many of our patients have been in and out of jail for petty crimes committed while under the influence of drugs. They often tell us they felt they had no other options due to their financial situation*.”
- MPH-Q10 noted that “*the economic situation is draining mme (madam). It is dire. Young people, in particular, feel hopeless and turn to the misuse of substances. This does not only affect their health, but it also affects their behaviour, which poses risks in a psychiatric setting.”*

In contrast, participants from Mafeteng Hospital highlighted the impact of community unrest on security threats within the facility. Participant MH-Q05 noted that *“the mob unrest in our communities often spills over into the hospital. It’s terrifying for us as healthcare workers.”* This statement reflected a common concern among staff members about the volatile nature of the hospital surrounding environment, particularly when it is linked to groups associated with *Famo* music culture. The phenomenon of mob violence was attributed to socioeconomic factors, with participant MH-Q02 stating that "*many of these individuals are unemployed and feel they have no choice but to join these* Famo *groups. They often seek validation and belonging in these communities."* This highlighted the connection between unemployment, social identity, and violent behaviour, therefore raising significant concerns about how these dynamics created a threatening atmosphere for healthcare workers and patients alike.

The findings illustrated a stark contrast between the security threats reported at Mafeteng Hospital and Mohlomi Psychiatric Hospital. At the Mafeteng Hospital, the primary concern revolved around external violence linked to community unrest and organised groups. In contrast, Mohlomi Psychiatric Hospital participants highlighted the internal struggles of patients as a significant factor influencing security dynamics. The predominant concerns reported by participants from Mohlomi Psychiatric Hospital suggested that socioeconomic factors critically shape patients' mental health landscape, which directly impacted security threats within the facility. As participant MH-Q01 succinctly noted, *"it's not just about the patients; it's about the environment they come from."*

In conclusion, the complex interplay between socio-economic factors and security threats in healthcare settings was revealed. While Mafeteng Hospital faced challenges primarily from external community violence, Mohlomi Psychiatric Hospital's security concerns stem from the internal struggles of its patients, exacerbated by high unemployment rates and substance abuse issues among patients. Addressing these issues will require a multifaceted approach that considers the socio-economic context of both healthcare workers and patients.

4.5.2.4 Lack of Resources:

Participants from both facilities reported a significant lack of resources as a contributing factor to their inability to provide quality care. This deficiency not only hampered patient care, but it also created an environment that escalated security threats. Participant MH-Q07 stated that *"we are understaffed and overworked. When there are not enough of us to manage the patients, it creates chaos and tension. Patients become agitated, and it put us at risk mme (madam)."* This comment highlighted how a lack of resources, specifically adequate staff, led to increased stress among healthcare workers and patients, escalating the chances of confrontations and security incidents. Participant MPH-Q04 noted that *“we often lack basic medical supplies, which means we can’t provide the care that patients expect. When patients feel neglected or that their needs are not being met, it leads to frustration and aggressive behaviour.”* This pointed out how the inability to provide adequate medical care led to feelings of dissatisfaction among patients, potentially resulting in confrontational situations that threaten the safety of staff.

Participants from Mohlomi Psychiatric Hospital specifically cited a lack of funding as a significant influencing factor aggravating the challenges faced by the facility. The inadequate financial resources have led to a deteriorating hospital environment, which did not only affect the quality of care provided, but also heightened security threats.

Participants further revealed the following:

- MPH-Q05 stated that “*our facility is falling apart. Some walls are cracked, and the ceilings leak. When patients see this neglect, it leads to feelings of anger and several escapes and frustration*.”
- MPH-Q08 remarked that “*Many of our beds are uncomfortable, and the mattresses are torn. This affects patient comfort. When patients are in discomfort, it leads to irritability and conflict*.”
- MPH-Q02 noted that “*the food provided in this facility is often insufficient and not satisfying. When patients are hungry or unsatisfied with their meals, it leads to unrest.”*
- MPH-Q10 expressed that “*we have broken furniture that we cannot fix due to lack of funds. This situation creates an unsafe environment for patients and they sometimes become frustrated with the conditions. They feel unwelcome*.”

In essence, the lack of resources, including funding, has resulted in a deteriorating environment that compromised patient care and increased the risk of confrontations. Addressing funding challenges is critical for improving the safety and well-being of healthcare workers and patients alike.

4.5.2.5 Community Unrest:

Community unrest was reported by the fewest participants, two from Mafeteng Hospital and one from Mohlomi Psychiatric Hospital, yet it still played a role in influencing security threats. The nature of unrest differed between the two facilities, with Mafeteng Hospital participants highlighting more incidents compared to Mohlomi Psychiatric Hospital participants. For instance, participant MH-Q02 highlighted that "*when there is shooting in the community, we know that the Famo men will come to the hospital in one large group demanding treatment for their injured men. It creates a tense environment. U tla fumana re ts'ohile* (this scares us)." Participant MH-Q09 also stated that "*these groups often expect to be prioritised for care, which puts us in a difficult position. We fear for our safety and the safety of other patients when they come in demanding medical services*."

A participant from Mohlomi shared specific incidents of community unrest:

- MPH-Q03 mentioned that "*occasionally, we hear of someone being accused of theft or assault and there would be a small gathering outside the hospital. It's not as intense though, it made us feel uneasy*."

The findings revealed that while community unrest was reported by fewer participants in both facilities, its implications differ significantly. Mafeteng Hospital faced more severe incidents of violence linked to organised groups, which created a climate of intimidation and fear for both staff and other patients. In contrast, Mohlomi Psychiatric Hospital staff experienced minor instances of unrest that still contributes to a sense of unease but do not reach the same level of intensity. The varying degrees of community unrest underscored the need for tailored security measures in each facility. This is because Mafeteng Psychiatric Hospital participants expressed a greater urgency for strategies to manage the risks associated with armed groups to be implemented, while Mohlomi Psychiatric Hospital staff indicated a need for protocols to handle minor disturbances and their impact on patient care.

4.5.2.6 Outdated Equipment:

Participants from both Mafeteng Hospital and Mohlomi Psychiatric Hospital reported outdated or insufficient equipment as a significant contributor to security threats. The lack of modern technology and resources does not only hinder the quality of care, but it also negatively impacts patient satisfaction and leads to increased tensions within the healthcare environment. For instance, participant MH-Q04 showed that "*we often have to tell patients that we can't provide the care they need because our equipment is out-dated or doesn't work at all. This makes them very impatient and sad."* This highlighted how the inability to meet patient needs due to frustration may escalate into confrontational situations. Participant MH-Q08 revealed that, "*when our patients are told they need to go to another hospital for treatment, they often react negatively. They feel neglected, and it creates a hostile atmosphere.*"

More participants reported specific instances of out-dated equipment:

- MH-Q06 expressed that "*working with out-dated equipment has demoralized for us. When we can't provide the care we want to, it affects our relationships with patients."*
- MPH-Q03 stated that "we don't have the technology to monitor our patients properly and it makes it difficult to provide the care they need, they sometimes become agitated."
- MPH-Q07 remarked that "*without modern diagnostic tools, we can't adequately assess our patients' needs. This often led to misunderstandings and frustration on their part, which escalated quickly. Re ba lisono (we become vulnerable).", even our patients eba lisono (become vulnerable)*
- MPH-Q10 noted that "*patients get anxious when they see that we lack the necessary tools to help them. Their anxiety is manifested in aggressive behaviour, especially when they feel their needs are not being met*."

In conclusion, the complex interplay between socio-economic factors and security threats in healthcare settings was revealed. While Mafeteng Hospital faced challenges primarily from external community violence, Mohlomi Psychiatric Hospital's security concerns stem from the internal struggles of its patients, exacerbated by high unemployment rates and substance abuse issues among patients. Addressing these issues will require a multifaceted approach that considers the socio-economic context of both healthcare workers and patients.

4.5.2.7 Insufficient Safety Protocols:

Interviewees from both facilities reported that insufficient safety protocols significantly contributed to security threats. The lack of comprehensive safety measures did not only endanger healthcare workers, but it also impacted patient care and created an environment ripe for conflict. For instance, interviewee MH-Q02 highlighted that "*we don't have a clear emergency response plan for when things get out of hand. If a violent situation arises, we are left scrambling for what to do.*" This comment highlighted the critical gap in safety protocols that leads to chaos during emergencies, increasing the risk of harm to staff and patients. MH-Q05 narrated that "we have very few security personnel on duty, especially during night shifts. This makes us feel vulnerable, and it's hard to manage aggressive patients without proper support. Our casualty turns horrible sometimes."

Some participants shared specific instances of insufficient safety protocols:

- MH-Q09 expressed that "*there are no clear protocols for managing aggressive patient interactions, especially when they have become agitated. We often don't know how to de-escalate a situation. Re ba boimeng bo sa tsejoeng (we are faced with unimaginable difficulty), as this leads to outbursts*."
- MH-Q03 illustrated that *"I am a member of Quality Improvement Committee, which ensures safety of clients and employees, but that is not even close to solving the problem.*"
- MPH-Q04 noted that "*we don't receive enough training on how to handle potentially dangerous situations. Without the right knowledge, we are at risk.*"
- MPH-06 remarked that "*we lack proper monitoring systems for patients. If someone is in crisis, we might not know until it's too late, which leads to dangerous situations.*"
- MPH-Q10 revealed that "*when incidents occur, we often don't know how to report them properly. Sometimes our reports are not being attended to, and for that, we feel neglected. This lack of clarity leads to unresolved issues and on-going tensions.*"

4.5.2.8 Work Cultures:

The environment in Mohlomi Psychiatric Hospital was described as a more supportive one, with the culture of understanding the mental health challenges faced by their patients. MPH-Q01 revealed that *"we understand that our patients are struggling, which helps create a more empathetic atmosphere among staff."*

Conversely, participants from Mafeteng Hospital reported a more stressful work environment, where the persistent verbal abuse leads to feelings of burnout and dissatisfaction. MH-Q04 noted that *"it feels like every day is a battle. The constant negativity can wear you down. It's hard to keep morale high."*

The qualitative data underscores a complex interplay of internal and external factors influencing security threats within the facilities. Internal challenges, including staffing issues, inadequate training, poor infrastructure, and a deficient work culture, are significant barriers to maintaining a secure hospital environment. These are compounded by external factors such as socio-economic conditions, community unrest, and resource limitations, which further strain the facility's security capabilities.

4.6 Effects of Security Threats on Workers' Disposition to Work

In today's rapidly evolving work environment, security threats have emerged as a significant concern that profoundly impacts employees' attitudes and behaviours. The presence of security threats; whether from external sources such as crime and violence; or internal issues like inadequate safety protocols; can create a pervasive sense of anxiety and vulnerability among workers (Spector, 2011). This heightened state of alertness does not only affect their emotional well-being, but it also influences their overall disposition toward work, leading to decreased motivation and job satisfaction (Hobfoll, 2001). Employees may exhibit increased absenteeism and reduced productivity, ultimately hindering organisational effectiveness (Kirk-Brown & Wallace, 2014). Understanding the complex relationship between security threats and workers' disposition is essential for developing robust strategies that foster a safe and supportive workplace, enabling employees to thrive amidst challenges (Hobfoll et al., 2018).

Table 11 Summary of Workers' Disposition in Relation to Security Threats

Disposition caused by security Threats level	S.Disagree	Disagree	Agree	S. Agree	Total	$\bar{x}$	σ	σ^2	X^2	DF	Sig
Negative motivation and willingness to work	7 (8.6)	7 (8.6)	34 (42.0)	33 (40.7)	81 (100)	3.15	0.910	0.828	40.639	9	0.000
Wanting to leave my current job	18 (22.2)	27 (33.3)	25 (30.9)	11 (13.6)	81 (100)	2.36	0.979	0.958	13.163	9	0.155
Anxiety and Stress	5 (6.2)	16 (19.8)	47 (58.0)	13 (16.0)	81 (100)	2.84	0.766	0.586	23.181	9	0.006
Feelings of insecurity and isolation	16 (19.8)	21 (25.9)	34 (42.)	10 (12.3)	81 (100)	2.47	0.950	0.902	26.265	9	0.005

The mean scores for the dispositions were recorded, where negative motivation and willingness to work appeared to have the highest mean score (mean: 3.15) collectively, indicating that security threats have the most significant impact on healthcare professionals' motivation and willingness to work. The high score suggests that security threats severely undermined the morale and motivation of healthcare workers, making it difficult for them to perform their duties effectively.

Anxiety and stress became the second significant effect, with the mean score of 2.84. This score indicates that security threats also have a substantial impact on the mental health of healthcare providers, leading to high levels of anxiety and stress. The close proximity to the highest mean score suggests that anxiety and stress are significant concerns that need to be addressed.

Feelings of insecurity and isolation (mean: 2.47) was another effect identified. This factor scores moderate perception of insecurity and isolation among healthcare workers and that security threats make healthcare workers feel insecure in their workplace, suggesting a notable level of perceived insecurity among the respondents. While not as high as negative motivation and anxiety, it still represents a significant concern. Furthermore, respondents reported wanting to leave their current jobs because of it. The mean score for this disposition is 2.36, reflecting the lowest perception and suggesting that while some healthcare professionals consider leaving their jobs due to security threats, it is not as prevalent as other dispositions. However, it still indicates a notable impact on job retention.

The findings highlight the significant impact of security threats on healthcare providers' dispositions, particularly in terms of negative motivation, anxiety, and stress.

4.6.1 Mean Disposition Scores across Worker Categories

The findings in Figure 3 are represented through a bar chart detailing various negative dispositions among healthcare workers in Lesotho, highlighting issues related to their motivation and mental well-being. The mean scores revealed that negative motivation and willingness to work are a total mean of 3.15, indicating that a substantial portion of healthcare workers experienced a lack of drive and engagement in their roles. This high level of negative motivation was attributed to various factors, including inadequate support, poor working conditions, and insufficient recognition of their efforts. Such sentiments led to diminished productivity and a lack of commitment to their responsibilities, which is concerning given the critical nature of healthcare services and the need for dedicated professionals to ensure quality patient care.

Additionally, the mean score for anxiety and stress was 2.84, reflecting a notable level of psychological strain among workers. The inherent stress of the healthcare environment, compounded by issues such as high patient loads, limited resources, and security threats, contributed significantly to feelings of anxiety and stress. These emotional states resulted in burnout, decreased job performance, and increased absenteeism; ultimately affecting the quality of care provided to patients. Addressing workplace stressors through implementing mental health support and stress management programs is essential for improving overall worker well-being, fostering a healthier work environment that can enhance productivity and employee retention.

Furthermore, insecurity and isolation were measured at a mean score of 2.47, indicating that healthcare workers perceived their working environment as unsafe and lacking in support. Such feelings were reported to have hindered teamwork and collaboration among staff, further impacting morale and mental health. As such, it is crucial for healthcare facilities to ensure that workers feel secure and integrated within a supportive work community since this can influence their job satisfaction and engagement.

The lowest mean score of 2.36 was attributed to wanting to leave their (participants) jobs. While comparatively smaller, it should not be overlooked. Even a minor percentage of turnover can have pronounced implications for resource allocation and continuity of care. Strategies aimed at improving retention, such as enhancing working conditions and providing career development opportunities, are vital to mitigate this sentiment and maintaining a stable workforce.

Overall, the findings from this study underscore critical issues regarding the motivation and mental health of healthcare workers in Lesotho. The negative scores across all dimensions indicated a troubling trend that warrants immediate attention, as these factors do not only impact the workforce, but they also affect the quality of care delivered to patients.

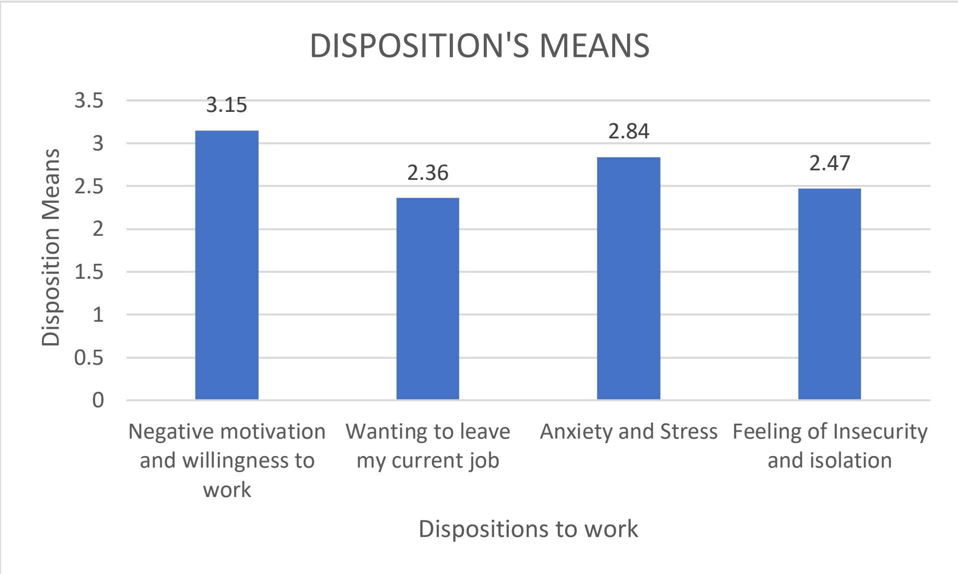

Figure 3: ***Average Worker Disposition to Work: Mean Scores by Category***

4.6.2 Qualitative Findings on the Impact of Security Threats on Healthcare Workers' Disposition to Work

The security threats faced by healthcare professionals in both facilities had profound effects on their overall disposition towards work. Participants reported experiencing a significant reduction on motivation, emotional stress, and decreased job satisfaction as a direct consequence of the unsafe working environment. These security concerns do not only diminish workers' commitment to their roles, but they also adversely affect their productivity and enthusiasm towards work. As healthcare workers grappled with anxiety associated with potential threats, their ability to focus on patient care becomes compromised, leading to a shift in priorities and a general decline in mental health. This sub-section explored these effects in greater detail, illuminating how the prevailing security issues undermined the well-being and effectiveness of healthcare professionals.

One of the most significant effects of security threats reported by participants is a marked reduction in motivation (towards work) among healthcare workers. The constant anxiety and fear associated with potential violence or unrest have left many feeling disheartened and disengaged from their work. Participants expressed that these security concerns created a daily struggle that diminished their enthusiasm for providing care. For instance, participant MH-Q03 specified that *"it's hard to feel motivated when you come to work every day wondering if something bad will happen. I find myself just going through the motions instead of being fully engaged."* This statement was echoed by participant MH-Q07, who remarked that *"I used to love my job, but now I dread coming in. The fear of violence has made me less motivated to do my best."*

Similarly, participant MPH-Q05 illustrated that *"I wake up feeling anxious about what might happen at work. It's hard to find the motivation to care for patients when I'm worried about my own safety."* These reflections highlighted a pervasive sense of unease that undermines the intrinsic motivation healthcare workers once felt, ultimately impacting their overall performance and the quality of care they provide.

Furthermore, participant MPH-Q09 added that *"when I see my colleagues stressed and fearful, it affects me too. We all feel less motivated when the environment is this unstable."* Participant MH-Q02 also made a contribution that "*it (the work environment) is demotivating. Constant worry about one's safety drains enthusiasm for work and yes, it has. Dealing with security threats is always stressful and it negatively impacts my well-being."* This collective sense of reduced motivation did not only affect individual healthcare workers, but it also contributed to a broader atmosphere of discontent and disengagement within the workplace.

Participants further provided incidents of reduced motivation:

- MH-Q01 detailed that *"I feel anxious and frustrated. It is difficult to be efficient when you are worried about your safety. It makes me feel demoralized.*"

- MH-Q08 expressed that "*when we constantly face verbal abuse, it's hard to stay positive. I feel demoralized knowing that my safety is often at risk while doing my job*."
- MH-Q06 specified that "*every time there is a security threat incident in this hospital, it drains my spirit. I used to be proud of my work but now I feel demotivated and just want to get through the day.*"
- Participant MPH-Q02 added that "*this fear has led to a sense of being emotionally drained and stressed out*," as another participant poignantly stated, "*I go home feeling like I've been through a battle every day."*
- *Participant MPH-Q02 illustrated that "I remember one day, a patient's family member came at me with such anger, shouting and threatening me because they were unhappy with the patient's condition. It was terrifying. Even after I reported it, the hospital didn't really do much to make me feel safe. It's not the first time something like this has happened, and it's taking a toll on me. I've started looking for jobs in South Africa because I just can't deal with this fear anymore. I need to work in a place where I feel secure, where I know my safety is a priority. I was so much demotivated working in this facility.*"
- MPH-Q07 declared that "*the physical setting of the facility is so dilapidated that it makes me sick. It is even hard to feel inspired to work here. It demotivates me every day when I see the conditions we work in."*
- Participant MPH-Q06 mentioned that "*when the environment is this unwelcoming, it affects my mood and motivation. On top of that, dealing with difficult behaviour from some patients makes it even harder to stay motivated and positive.*"

However, amidst these challenges, a few participants stood out with their resilience and unwavering commitment to their profession. Participant MH-Q10 remarked that *"despite everything, I still love my job. It's what I've dedicated my life to."* Participant MH-Q04 shared similar sentiments and said that "*In spite of all the challenges we face here, I've made a commitment to my profession and to the people of Lesotho. There have been times when I've felt unsafe, and yes, it's crossed my mind to leave. But I think about the patients who need me, the ones who have no one else to turn to. That's* *what keeps me going. I'm not going to let the threats and the fear drive me away from my duty. I'm here to help, and I'll continue to do so, no matter what."*

The demotivation and emotional stress experienced by healthcare workers at both facilities had several implications for both staff and patient care. Firstly, reduced motivation led to a decrease in job performance as workers lacked the energy necessary to deliver high-quality care. This resulted in a decline in patient outcomes, as demotivated staff became less attentive to patients' needs and less proactive in addressing health concerns. Additionally, the pervasive sense of demoralization contributed to higher turnover rates and absenteeism, as healthcare workers sought employment in more supportive environments. This turnover not only strains the remaining staff, but it also disrupts continuity of care for patients, further compromising the quality of healthcare services provided.

Moreover, the collective demotivation among healthcare workers created a negative work culture in both facilities, characterised by low morale and increased stress levels. This atmosphere fostered further disengagement, leading to a cycle of negativity that affected teamwork and collaboration. Ultimately, the implications of demotivation extended beyond individual workers, impacting the overall effectiveness and stability of healthcare facilities, and detracting from the essential mission of providing compassionate and effective care to patients.

4.6.2.1 Job Satisfaction:

Participants from both facilities reported that security threats substantially impacted their job satisfaction. The persistent fear and anxiety related to violence and unrest have created an environment where healthcare workers found it increasingly difficult to feel fulfilled in their roles. For instance, participant MH-Q04 shared that *"I used to take pride in my work, but now, with all these threats we face, I often feel dissatisfied and just want to leave at the end of my shift."* Participant MPH-Q01 declared that *"I am always looking over my shoulder, which makes it hard to focus on my work. It is time consuming."* This constant state of vigilance affects their mental well-being and their ability to perform their duties effectively.

Some participants further mentioned instances of their affected job satisfaction:

- MPH-Q03 said that "*the stress from security threats has really affected how I feel about my job. I don't enjoy it like I used to because I'm almost always on the edge.*"
- MPH-Q07 showed that "*when you can't feel safe at work, it changes everything. My job satisfaction has plummeted because I'm more focused on surviving my shifts than on caring for my patients*."

These reflections illustrated how the on-going security concerns diminished the love and fulfilment that healthcare workers derived from their roles and they also contributed to a broader sense of discontent within the healthcare environment.

4.6.2.2 Commitment and Work Focus:

Interviewees at both facilities reported that security threats have adversely affected their commitment to their work. The constant fear of violence and the emotional toll of navigating an unsafe work environment have led many healthcare workers to question their dedication to their roles. For instance, MH-Q01 indicated that *"I used to be fully committed to my job, I still try to maintain that but it is difficult. Now I find myself thinking about leaving. The security issues make it hard to stay dedicated when I feel unsafe."* This sentiment was also echoed by interviewee MH-Q06, who remarked that "*every time I hear about an incident (security threat), it makes me reconsider my commitment to this job. I'm always worried about safety, and that affects how much I care about my work."*

In Mohlomi Psychiatric Hospital, interviewee MPH-Q04 expressed that "*the threats we face have really shaken my commitment to work. I find it difficult to give my best when I'm constantly on edge."* MPH-Q09 added that *"when the environment feels hostile, it's hard to stay committed. Re se rea ka hlooho fela, pelo eona e ea hana (we are going to work but our hearts are no longer in it). My focus shifts from providing expected care to just getting through the day."* These reflections underscored how the prevalent atmosphere of insecurity not only diminished healthcare workers' commitment to their roles but also contributed to a broader culture of disconnection within the healthcare facilities, ultimately impacting the quality of patient care.

Despite the challenges posed by security threats, few participants reported an increased commitment to their work, choosing not to take these difficulties personally.

For instance, MH-Q10 declared that *“while the threats are concerning, I focus on my responsibilities and try not to let fear affect my commitment. I believe in the work we do, and I still manage to deliver on time.”* Similarly, participant MH-Q04 added that “*I understand that the environment is tough, but I remain dedicated to my patients. I make it a point to fulfil my duties, regardless of the challenges*.” MPH-Q10 expressed that *“the issues we face are real, but I don’t let them dictate my performance. I am committed to my role and ensure that I meet my responsibilities.”* Participant MPH-Q09 said that *“I refuse to let external factors sway my commitment. I still strive to do my job well and deliver what is needed on time.”* These responses highlighted that, for some healthcare workers, the challenges presented by security threats have reinforced their dedication, allowing them to maintain a strong sense of responsibility and professionalism in their work.

4.6.2.3 Productivity:

Many participants reported to maintaining productivity despite the daily challenges they encounter. For instance, MH-Q03 detailed that *“even with the on-going security challenges and difficult situations, I find ways to stay productive and focused on my tasks.”* MH-Q05 resonated with the, saying that *“I’ve learned to adapt and prioritise my work, ensuring that I complete my responsibilities no matter what obstacles arise.”* MPH-Q02 mentioned that “*the challenges are there, but I concentrate on my duties and make sure that I remain efficient and effective*.” Similarly, participant MPH-Q08 remarked that *“I believe that staying productive is crucial, so I focus on what I can control and continue to deliver high-quality care.”* These responses reflected a strong commitment to maintaining productivity, highlighting the resilience and adaptability of healthcare workers in the face of adversity.

4.6.2.4 Attitude and Enthusiasm:

Participants at both facilities expressed a range of attitudes and levels of enthusiasm in their work despite the security challenges they face. While some reported feeling demotivated, others displayed a remarkable resilience and dedication to their roles. As some participants conveyed a proactive attitude in confronting security threats, some took a totally opposite approach. MPH-Q03 mentioned that *“maintaining a positive outlook helps me tackle the day-to-day issues we encounter. At the same* *time, the fear of what might happen next makes it difficult to approach my job with the same enthusiasm I once had."* MPH-Q09 shared *that "facing these challenges has reinforced my commitment to my role, and I'm more enthusiastic about providing care."* Conversely, a few participants expressed frustration and fatigue regarding the security environment. Participant MH-Q02 stated that *"it's hard to stay enthusiastic when you're constantly worried about safety. It drains my energy and affects my attitude."* This was also mentioned by MPH-Q06, who admitted to feeling overwhelmed at times, which affects their overall enthusiasm for the job.

Participants shared specific incidents that illustrated their attitudes and enthusiasm in the context of on-going challenges:

- MH-Q08 recounted an incident where a violent altercation occurred inside the hospital premises. Despite the chaos, they chose to remain focused on their duties. "*When the incident happened, I quickly gathered my colleagues to ensure that we were prepared to assist our attacked staff who needed help*."
- MH-Q05 described a day when a patient became aggressive due to the stress of having to wait in a queue. This led to a tense situation. "*After the incident, I found myself drained and less enthusiastic about coming to work. It's hard to stay motivated when you're faced with such unpredictability*" they noted.
- MPH-Q10 shared their experience during a recent incident where a nearby protest escalated into violence. "*Even during the protest, I felt a strong sense of duty. I stayed late to ensure that all patients were safe and accounted for. It made me realize how much I care about my role*," they said.

In summary, participants exhibited a range of attitudes and enthusiasm levels in response to security challenges. While some faced emotional tolls and feelings of fatigue due to incidents like aggressive patient encounters and external violence, others demonstrated resilience by fostering teamwork and maintaining a strong sense of duty. Specific incidents highlighted commitment, showcasing how adversity can motivate healthcare workers to remain dedicated to their roles. Overall, their experiences reflected a commendable capacity to adapt and stay focused on patient care amidst challenging circumstances.

4.7 Quantitative Analysis of Security Responses and Interventions in Healthcare Facilities

Table 12 illustrated respondents' perceptions on whether "there has been collaboration between the hospital and community to address security threats." The data revealed that collaboration between the hospital and community (mean: 2.02) recorded the highest score. This score indicates that respondents perceive collaboration between the hospital and the community as the most possible effective intervention in addressing work security risks. This suggests that joint efforts between the hospital and the community could be seen as crucial for improving security. This mean score value also suggests that there had not been this kind of intervention in health setting. Overall 50.6% of the respondents disagreed with the effectiveness of this intervention, 27.2% strongly disagreed while only 18.5% agree and 3.5% strongly agreed.

The second highest mean score (1.99) is on the perception that there has to be community involvement handling in security improving initiatives or committees. This score suggests that respondents believed increased community involvement in security initiatives could be effective in addressing security concerns. Active participation from the community is believed to provide additional support and resources. This value also suggests that there had not been this kind of intervention in either of the healthcare settings. Overall 50.6% of the respondents disagreed with the effectiveness of this intervention, 27.2% strongly disagreed while only 18.5% agree and 3.5% strongly agreed. Thus, it can be realised that there should be improvement in this method, in trying to cub security threat levels.

Moreover, the assertion that "I have been involved in security improving initiatives or committees" scored a mean of 1.89, making this item the third from the table. This assumes that respondents believed their involvement in security-improving initiatives can lead to better security outcomes. Answers in this intervention were leaning towards disagreeing with the notion, which suggest that most of health care workers do not consider this an effect mechanism to mitigate security threat levels.

In forth position is the item "local authorities and community structure have been implementing security interventions" with the mean score of 1.88. This score indicates that respondents perceive the involvement of local authorities in implementing security interventions as moderately effective. Additionally, the chi-square value of 10.739 and a P-value of 0.294 implied that there is no statistically significant role in shaping perceptions of security threats.

It can therefore be concluded that these ideas pertaining to all the interventions need be improved in all departments since they are by far all not effective in solving the problem. This is because a notable number of respondents reported to have disagreements with almost all of them. It is, however, worth noting that "*there has been a collaboration between the hospital and the community to address the threats*," has the largest mean 2.02 compared to other interventions, suggesting a positive perception compared to others though it calls for immediate improvement.

Table 12 Statistics on Interventions in Healthcare Settings

Interventions	Strongly Disagree	Disagree	Agree	Strongly Agree	Total	$\bar{x}$	σ	σ^2	X^2	DF	Sig
The hospital addresses security threats in a satisfying manner	38 (46.9)	21 (25.9)	17 (21.0)	5 (6.2)	81 (100)	1.86	0.959	0.919	13.643	9	0.136
I have been involved in security improving initiatives or committees	18 (22.2)	57 (70.4)	4 (4.9)	2 (2.5)	81 (100)	1.89	0.600	0.360	10.739	9	0.294
Local authorities and community structure has been implementing security interventions	23 (28.4)	48 (59.3)	7 (8.6)	3 (3.7)	81 (100)	1.88	0.714	0.510	18.115	9	0.034
There has been improved community involvement of security threats	22 (27.2)	41 (50.6)	15 (18.5)	3 (3.7)	81 (100)	1.99	0.783	0.612	22.467	9	0.008
There has been collaboration between the hospital and community to address threats	22 (27.2)	40 (49.4)	14 (17.3)	5 (6.2)	81 (100)	2.02	0.836	0.699	13.396	9	0.145
Increase police patrol in the area	2 (2.5)	14 (17.3)	41 (50.6)	24 (29.6)	81 (100)	3.07	0.755	0.569	16.568	9	0.056
Community safety alarms and cameras	2 (2.5)	23 (28.4)	35 (43.2)	21 (25.9)	81 (100)	2.926	0.803	0.644	20.038	9	0.18
Organise community vigilance and watch programs and education about threats	1 (1.2)	6 (7.4)	43 (53.1)	31 (38.1)	81 (100)	3.284	0.656	0.431	7.041	9	0.633
Cameras at the Hospital	2 (2.5)	9 (11.1)	30 (37.0)	40 (48.4)	81 (100)	3.33	0.775	0.600	12.012	9	0.213

Interventions	Strongly Disagree	Disagree	Agree	Strongly Agree	Total	$\bar{x}$	σ	σ^2	X^2	DF	Sig
Collaboration of the Hospital with outside stake-holders	0 (0)	4 (4.9)	28 (34.6)	49 (60.5)	81 (100)	3.556	0.592	0.350	8.118	9	0.230
Support for initiative aimed at improving the environment and infrastructure for safer public spaces	0 (0)	1 (1.2)	28 (34.6)	52 (64.2)	81 (100)	3.630	0.511	0.261	7.337	9	0.291

4.7.1 Summary of Statistical Analysis of Responses on Interventions

Table 13 displays the results concerning the opinion on increasing police patrols in the hospital area. A majority of respondents, totalling 50.6%, agreed that a heightened police presence would effectively address security threats, with an additional 29.6% expressing strong agreement. In contrast, only 17.3% disagreed, and 2.5% strongly disagreed with this proposition. The average response, with a mean of 3.07, suggested a general consensus on the necessity of increased patrols, while the standard deviation (SD=0.755) indicated a moderate range of opinions among participants. The Chi-square value of 16.568, along with a P-value of 0.056, pointed to a marginal association between this intervention and the perceived level of security threats, though this association does not achieve statistical significance at the 0.05 level.

Regarding the suggested community safety alarms and cameras, the mean score of 2.926 was recorded, reflecting a general inclination towards disagreement regarding the value of alarms and cameras in enhancing community safety. 43.2% of respondents agreed, and 25.9% strongly agreed that this approach would be effective in tackling security threats. However, 28.4% disagreed. The standard deviation (SD=0.803) indicating moderate variability in the responses, coupled with a P-value of 0.18, suggested that there is no statistically significant relationship between this intervention and the perceived levels of security threats.

In the case of organising community vigilance activities and watch programmes along with education about security threats, more than half of the respondents (53.1%) agreed, and 38.1% strongly agreed on the importance of such initiatives. Only 7.4% disagreed; with 1.2% strongly opposing. The mean score of 3.284 is indicative of strong overall agreement and suggested that respondents believed that vigilance programmes could effectively mitigate security threats. The standard deviation of 0.656 reflected relatively low variability in opinions. However, this implied that this intervention may not be closely linked to the perceived levels of security threats within the hospital environment.

In relation to the installation of cameras at the hospital, nearly half of the respondents (48.4%) strongly supported this initiative, the mean score of 3.33 indicated a high level of agreement regarding the perceived effectiveness of this intervention. The standard deviation (SD=0.775) suggested a moderate degree of variability in the responses. However, the Chi-square result of 12.012 with a P-value of 0213 indicated that there is no statistically significant association, implying that the installation of cameras may not be strongly linked to the perceived level of security threats.

Regarding the collaboration of the facilities with external stakeholders, the mean score of 3.556 reflected strong overall agreement, demonstrating that respondents considered external collaboration to be highly relevant. A significant majority of respondents (60.5%) strongly agreed and 34.6% agreed that such collaboration is essential for effectively addressing security threats. However, only 4.9% expressed disagreement. The standard deviation of 0.592 indicated relatively low variability in the responses.

The opinions on support for initiatives designed to enhance the environment and infrastructure for safer public spaces, had a substantial 64.2% of respondents strongly agreeing with the effectiveness of this approach. On the contrary, 34.6% agreed. The mean score of 3.630 indicated a very high level of agreement on the importance of such environmental and infrastructural improvements for public safety. Furthermore, only 1.2% disagreed and no respondents expressed strong disagreement. The standard deviation of 0.511 suggested relatively low variability, reflecting consistent support for this intervention.

Respondents shared their thoughts on effective strategies to address security concerns, expressing a strong preference for actions that enhance physical safety. They highlighted the importance of supporting initiatives to improve the environment and infrastructure for safer public spaces (mean=3.630). This was followed by the collaboration of facilities with external stakeholders (mean=3.556), the installation of cameras at each facility (mean=3.333), organising community vigilance, watch programmes and educating about work-related risks (mean=3.284).

Table 13 Analysis of Suggested Measures against the Prevalent Threats

Interventions	Strongly Disagree	Disagree	Agree	Strongly Agree	Total	Mean	SD	V	Chi-Square	DF	Sig
Increase police patrol in the area	2 (2.5)	14 (17.3)	41 (50.6)	24 (29.6)	81 (100)	3.070	0.755	0.569	16.568	9	0.056
Community safety alarms and cameras	2 (2.5)	23 (28.4)	35 (43.2)	21 (25.9)	81 (100)	2.926	0.803	0.644	20.038	9	0.18
Organise community vigilance, watch program, and education about threats	1 (1.2)	6 (7.4)	43 (53.1)	31 (38.1)	81 (100)	3.284	0.656	0.431	7.041	9	0.633
Cameras at the Hospital	2 (2.5)	9 (11.1)	30 (37.0)	40 (48.4)	81 (100)	3.333	0.775	0.600	12.012	9	0.213
Collaboration of the Hospital with outside stake-holders	0 (0)	4 (4.9)	28 (34.6)	49 (60.5)	81 (100)	3.556	0.592	0.350	8.118	9	0.230
Support for initiatives aimed at improving the environment and infrastructure for safer public spaces	0 (0)	1 (1.2)	28 (34.6)	52 (64.2)	81 (100)	3.630	0.511	0.261	7.337	9	0.291

4.7.2 Comparative Analysis of Interventions across two Healthcare Facilities

From Table 14, it is evident that there is a notable difference in the mean scores of Mohlomi Psychiatric Hospital and Mafeteng Hospital regarding “the hospital’s response to security threats." The mean score for this intervention is higher at Mafeteng Hospital, indicating that Mafeteng Hospital may be more effective in implementing strategies to reduce threat levels. Additionally, there is a significant difference in the means for the variable "improved community involvement." This suggests that the intervention is more effectively practiced at Mafeteng Hospital, with a mean score of 2.17 compared to Mohlomi Psychiatric Hospital, which has a mean score of 1.80.

The variable "there has been collaboration between the hospital and community to address security concerns" also shows significantly different mean scores, with Mohlomi Psychiatric Hospital scoring 3.6250 and Mafeteng Hospital registering a mean score of 3.4878. The T-test statistics, with a P-value of 0.030, confirm a significant difference in the mean scores of this variable across the healthcare facilities, indicating that Mafeteng Hospital has made efforts to reduce high threat levels through this initiative.

Additionally, for the variable about local authorities and communities being involved in intervention, Mafeteng Hospital had a mean score of 2.0244, while Mohlomi Psychiatric Hospital scored 1.7250. The P-value is relatively close to 0.05, suggesting that while this intervention is not statistically significant, there is almost a perceptible difference in how the two facilities view this intervention.

According to the measures reported by respondents, there is a statistical difference in the mean scores for the intervention "installation of cameras at the hospital," with Mohlomi Psychiatric Hospital scoring 3.5500 and Mafeteng Hospital scoring 3.1220. This suggests that respondents from Mohlomi Psychiatric Hospital believe this intervention could be particularly beneficial, likely due to the types of threats they face and the specific characteristics of their facility.

Table 14 Comparative T-Test Statistical Analysis of Interventions across the two Health Facilities.

Threats	Variance	$\bar{x}$_Mohlomi	$\bar{x}$_Mafeteng	**T**	**Df**	Sig.(2-tailed)	Mean difference	Std.error difference
The hospital address to security threats is satisfactory	Equal variance assumed	1.5500	2.1707	-3.063	79	.003	-.62073	0.20268
	Equal variance			-3.068	77.994	.003	-.62073	0.20233

Threats	Variance	$\bar{x}$_Mohlomi	$\bar{x}$_Mafeteng	T	Df	Sig.(2-tailed)	Mean difference	Std.error difference
	not assumed							
I have been involved in security threat committees or initiative	Equal variance assumed	1.8250	1.9268	-.762	79	.448	.-.10183	.13361
	Equal variance not assumed			-.761	77.434	.449	.-.10183	.13381
Local authority and community involvement have been implementing security intervention	Equal variance assumed	1.7250	2.0244	-1.919	79	.059	-.29939	.15605
	Equal variance not assumed			-1.923	77.422	.058	-.29939	.15572
There has been improved community involvement	Equal variance assumed	1.8000	2.1707	-2.181	79	.032	.37073	.16996
	Equal variance not assumed			-2.182	78.996	.032	.37073	.16992
The has been collaboration between the hospital and community to address threats	Equal variance assumed	3.6250	3.4878	1.044	79	.300	.13720	.13140
	Equal variance not assumed			1.046	77.496	.299	.13720	.13114
Increase police patrol in the area	Equal variance assumed	3.000	3.2463	-.871	79	.386	-.14634	.16796
	Equal variance not assumed			-.868	69.734	.389	-.14634	.16868
Installation of community safety alarms	Equal variance assumed	2.9250	2.9268	-.010	79	.992	-.00183	.17953
	Equal variance not assumed			-.010	75.015	.992	-.00183	.18000
Organise community vigilance,	Equal variance assumed	3.1750	3.3902	-1.487	79	.141	-.21524	.14479

Threats	Variance	$\bar{x}$_Mohlomi	$\bar{x}$_Mafeteng	T	Df	Sig.(2-tailed)	Mean difference	Std.error difference
watch programs and education about threats	Equal variance not assumed			-1.483	75.470	.142	-.21524	.14513
Install Cameras in hospital	Equal variance assumed	3.5500	3.1220	2.572	79	.012	.42805	.16640
	Equal variance not assumed			2.581	74.485	.012	.42805	.16584
Collaboration of hospital with outside stake holders	Equal variance assumed	3.6250	3.4878	1.044	79	.300	.13720	.13140
	Equal variance not assumed			-1.046	77.496	.299	.13720	.13114
Support initiatives aimed at improving the environment and infrastructure for safer public space	Equal variance assumed	3.6750	3.5854	.787	79	.433	.08963	.11383
	Equal variance not assumed			.789	77.949	.433	..08963	.11363

4.7.2 Addressing Security Threats in Healthcare Centres: Responses and Interventions

The rising incidents of security threats within healthcare facilities necessitated a thorough exploration of the responses and interventions implemented by facility management and healthcare staff. The study identified critical areas such as safety protocols, security measures, staff training, community involvement, funding challenges, and partnerships as pivotal components of a comprehensive security strategy. This section delved into themes that emerged from the qualitative data, highlighting not only the interventions put in place, but also on-going struggles and successes in creating a safer environment for healthcare delivery. Ultimately, this analysis sought to contribute to the broader discourse on healthcare safety and inform future initiatives aimed at enhancing security within medical settings.

4.7.2.1 Safety Protocols:

Participants from the healthcare facilities highlighted significant concerns regarding the inadequacy and faults in existing safety protocols within their healthcare facilities. Many respondents reported that these protocols often fell short of addressing the real-time security threats faced by healthcare workers, leading to a sense of vulnerability among staff. For example, several participants noted that while there were established procedures for safety threads put in place, they were either out-dated or not effectively communicated, resulting in confusion during critical situations. This lack of robust safety measures did not only jeopardise the well-being of healthcare workers, but it also impacted the overall safety of patients and visitors, underscoring an urgent need for comprehensive revisions and enhancements to the protocols currently put into practice. For instance, MH-Q03 reported that *"he hospital staff seems unprepared to deal with aggressive patients, and there's no apparent protocol for such situations. It's like they have made their minds that we are simply here to work. They forgot the how part."* MH-Q05 also mentioned that *"I've noticed that there's no clear policy put in place to handle security threats, which makes me feel unsafe during my shifts."*

More participants reported other specific incidents where safety protocols failed:

- MH-Q07 highlighted that "*during a recent incident where a patient became aggressive, I found myself relying on out-dated protocols. The emergency response guidelines we had were not in line with the current risks we face, leading to confusion among the staff about the proper course of action*."
- MPH-Q04 revealed that "*I participated in a once-off training session, but it wasn't enough to prepare us for the unique challenges we face. When a security threat incident occurred, we were unsure about the steps to take*."
- MH-Q02 declared that "*we've had incidents of aggression, but the response protocols seem inadequate. We are not being attended to as workers. After a recent aggression encounter, I reported it, but no follow up was made and I felt neglected.*"
- MPH-Q09 cited that "*when we raised concerns about safety protocols not being enforced, management promised us changes, but failed to follow through. This has left us feeling unsupported and vulnerable*."

These incidents revealed a troubling picture of safety protocols that ware not only inadequate, but also poorly communicated and enforced within both facilities. Participants' experiences underscored the urgent need for a comprehensive review and overhaul of safety measures to ensure secure working environments for healthcare professionals.

4.7.2.2 Security Measures:

Security measures are essential components of a healthcare facility's strategy to protect staff, patients, and visitors from potential threats. In the context of these facilities, participants reported significant concerns regarding the effectiveness and adequacy of current security measures put in place. Participants highlighted issues such as insufficient security personnel, inadequate surveillance systems, and poorly enforced access controls. These shortcomings did not only compromise the safety of healthcare workers, but they simultaneously created an environment of uncertainty and vulnerability. For instance, participant MH-Q06 expressed that *"we often feel that there are not enough security personnel on-site, especially during night shifts when security threat incidents are more likely to occur. It leaves us feeling exposed."* Participant MH-Q03 reported that *"they (management) established a Quality Improvement Committee, which ensures safety of clients and healthcare professionals."* MH-Q04 mentioned that *"we really need more security personnel, particularly male guards at the casualty and the general hospital premise. We need more male security personnel."* Participant MPH-Q03 recounted *that "in the event of a security threat, the procedures for lockdown or evacuation are unclear. During a recent incident, we were unsure how to respond as one of our staff got her face injured from the attack."*

On the other hand, Mafeteng Hospital has established the Quality Improvement Committee, which plays a crucial role in ensuring the safety of both patients and healthcare professionals. The committee is responsible for identifying potential safety issues, developing protocols to address these threats, and implementing measures to mitigate risks amongst other things. MH-03 stated that *"being a member of the Quality Improvement Committee, which ensures safety of clients and employees is the one things that currently help me not to take security incidents personally. I now* *understand that sometimes we are actually the cause of threats as we tend not to be efficient."*

Furthermore, still on the established committee, participant MH-Q05 shared that *"I am a member of the Quality Improvement Committee. So far, it has taught us or let me say addressed common issues that we face here at work, but we still have a challenge of putting certain things to practice due to limited or absolute lack of resources."* Participant MH-Q08 indicated that *"measures taken to address safety concerns could be to raise awareness to the Ministry of Health on the lack of safety for staff, then improve commitment and dedication to lives of patients despite lack of resources."* In addition to measures, a participant (MPH-Q07) lamented that as healthcare professionals, there is lack of support by the Ministry of Health in addressing their problems, highlighting that there is *"lack of commitment and lack of support from the Ministry."*

Participants further shared incidents of inadequacy of safety measures:

- MH-Q09 shared that "*some areas of the hospital, especially parking lots and some entrances, are poorly lit. It makes it difficult to feel safe when coming to and from work, particularly after dark*."
- MPH-H-Q10 expressed that "*while security personnel receive training, many of us do not know how to handle a security threat. We need more training that includes all staff.*"
- MPH-Q08 conveyed that "*sometimes we fight back, I don't want to lie. That is because our feelings were hurt and the reflex you know… Ideally, that should not happen and it is not expected of us, but what can we do? We are trying to keep ourselves safe*."

In essence, the inadequacies of the lack of security measures reported by participants in both facilities have profound implications for the safety and well-being of healthcare professionals. Many staff members expressed feelings of vulnerability, leading to instinctive reactions during high-stress situations that can even escalate into deeper confrontations. Such responses increase the risk of injury for both staff and patients and can erode trust among colleagues, ultimately weakening teamwork, which is essential in healthcare settings. Additionally, unintended physical altercations may result in legal and ethical consequences for healthcare professionals and their facilities, complicating the dynamics of patient care. These issues underscored the urgent need for improved security measures, comprehensive training and a supportive environment that empowers healthcare workers to manage threats effectively, without resorting to physical confrontation, thereby fostering a safer workplace for all.

4.7.2.3 Staff Training:

Participants at Mafeteng Hospital and Mohlomi Psychiatric Hospital overwhelmingly reported that staff training is a crucial necessity in addressing the challenges they face in their daily roles. Many healthcare professionals expressed feelings of being untrained or unprepared, vulnerable, and unprotected, particularly in the face of security threats and unpredictable incidents of attacks or assaults that occur almost daily. The consensus among participants was clear: a one-time training session or lack of on-going education is insufficient for equipping staff with the skills and confidence needed to effectively manage such high-stress situations. As participant MH-Q10 stated, *"we encounter unpredictable circumstances regularly, and without proper training, we feel like we are navigating these challenges blindfolded."* This sentiment highlighted the urgent need for regular, comprehensive training programmes that prepare staff not only to respond to incidents of aggression, but also to foster a culture of safety and support within the healthcare environment.

Still on this point, other participants *made the following contributions:*

- *MPH-Q03 mentioned that "there is a clear need for training on security techniques and how to protect ourselves during patient outbursts, but unfortunately, we haven't been offered anything like that since I got here mme (madam).*"
- MPH-Q01 said that "*the lack of training for healthcare professionals on how to handle security threats is evident, and it affects the overall safety of the hospital environment."*
- MPH-Q07 revealed that "*everyday, we face situations that require quick thinking and the right response; without on-going training, we're left feeling helpless and unsure of how to act when confronted with aggression*."

The inadequacies in staff training reported by participants at these facilities carried significant implications for both the safety of healthcare workers and the quality of patient care. Many participants expressed concerns that one-time training sessions or none at all were insufficient to prepare them for the realities of their roles, particularly in managing crises and security threats.

4.7.2.4 Community Involvement:

In examining the perspectives of healthcare professionals regarding community engagement, a clear dichotomy emerged between participants from both facilities. Participants at Mohlomi Psychiatric Hospital expressed the view that involving community members in internal matters of the facility is unnecessary, emphasising the importance of maintaining professional autonomy in healthcare decision-making. For instance, MPH-Q-10 noted that *"involving the community in our internal matters feels unnecessary. We have our protocols and procedures that need to be followed without external influence."* MPH-Q03 indicated that "*I think the community should only be involved in specific outreach programmes. Our internal decisions should be handled by professionals who understand the complexities of mental health."*

In contrast, participants from Mafeteng Hospital highlighted the significance of community involvement, particularly during outreach and fieldwork; noting that such engagement enhances understanding of community needs and that it fosters trust, making daily work duties much easy to handle. This divergence in views underscored the varying approaches to community engagement in healthcare settings, reflecting differing priorities and philosophies among the professionals involved. For instance, MH-Q02 stated that *"community engagement is crucial during our outreach efforts. It helps us understand their needs and it fosters trust between us and the community."* MH-Q05 added that *"when we conduct fieldwork, the community input is invaluable. They often provide insights that we wouldn't have otherwise considered."*

In addition to the primary views expressed by participants regarding community involvement, there were also diverse opinions shared that reflected the complexity of the issue. Some participants acknowledged the potential benefits of community engagement while still emphasising the importance of professional autonomy in certain contexts.

More insights were provided by participants as follows:

- Participant MH-Q03 mentioned that "*during recent an outbreak, we had expected more community involvement, but it was disheartening to see so few people taking an active role in prevention efforts. Batho ba bang (0ther people) never understood the pressure we were facing, especially when they realised that we did not understand when we experienced COVID-19 at the time. They thought we were not helping quickly enough. Ka naka eno (that time) we feared for our lives too."* Participant MH-Q04 further affirmed that "*health education sessions are organised but the turnout is usually extremely low. It seems like there is a lack of interest or awareness about these issues, especially among the youth*."

Conversely, participants from Mohlomi Psychiatric Hospital noted that the community was not significantly involved in the internal matters of the facility. Instead, they observed that the community itself was grappling with mental health issues. Participant MPH-Q03 stated that "*addressing security concerns is challenging, especially when dealing with issues of mental illness"* and participant MPH-02 opined that *"after a scary incident at the hospital, we hoped the community will be made aware, unfortunately there was no such."* Participant MPH-Q05 also mentioned that *"we tried to establish a support group for families of patients, but that turned to only be an idea. It did not go through."*

Having revealed varying opinions, some participants believed that the lack of engagement stemmed from a lack of awareness or understanding of the importance of community involvement in healthcare settings. Others suggested that cultural barriers and stigma associated with mental health might be hindering active participation. Additionally, there was a perspective that the community's own challenges such as economic hardships and high rates of unemployment, limited their capacity to engage meaningfully with healthcare facilities.

Other participants added on this, sharing the following lived experiences:

MPH-Q05 shared that "*many community members are dealing with their own mental health issues and challenges, which makes it difficult for them to engage with our initiatives*."

MH-Q04 added that *"many people in our community are struggling to make ends meet. They're dealing with unemployment and financial difficulties, which makes it hard for* *them to prioritise healthcare. When you're worried about where your next meal is coming from, it's tough to focus on preventive care or even seek treatment when you're sick. So mme (madam), the economic hardship affects how the community interacts with healthcare facilities."*

MPH-Q03 explained that "*unemployment is rampant in our country, let alone what our communities look like… and it creates a lot of tension and desperation. People are frustrated and sometimes that frustration spills over into the healthcare setting. They can't afford medical bills, and there's a sense of hopelessness. It's challenging for us as healthcare providers because we want to help, but the community's economic challenges limit their ability to engage with us effectively*."

Other points revealed include:

- MH-Q05 shared that *"I've noticed that there's no clear policy put in place to handle security threats, which makes me feel unsafe during my shifts.*"
- MPH-03 highlighted that "*the hospital staff seems unprepared to deal with aggressive patients, and there's no apparent protocol for such situations. It's like they have made their minds that we are simply here to work. They forgot the how part."*
- MH-Q04 added that "*I experienced delays in addressing security concerns that I've reported, which is really concerning. To me, justice delayed is justice denied."*
- MPH-Q01 opined that "*the lack of training for healthcare professionals on how to handle security threats is evident, and it affects the overall safety of the hospital environment*."

The discussion on community involvement among healthcare professionals at both facilities revealed a complex landscape of opinions. Participants at Mohlomi Psychiatric Hospital expressed scepticism opinions about the necessity of involving community members in internal matters, emphasising the importance of maintaining professional autonomy and suggested that engagement should be limited to specific outreach programmes only. In contrast, participants from Mafeteng Hospital highlighted the significance of community engagement, particularly during outreach and fieldwork, arguing that it enhances understanding of community needs and fosters trust. Despite these contrasting views, some participants from both facilities shared more nuanced opinions, acknowledging the potential benefits of community input with professional expertise. Overall, the perspectives reflected a spectrum of beliefs, ranging from scepticism about community involvement in internal matters to strong advocacy for underscoring the importance of finding a balance that respects professional autonomy while valuing community insights.

4.7.2.5 Funding Challenges:

In the context of healthcare delivery, participants across these facilities reported that funding challenges posed significant obstacles to the execution of effective service provision. These financial constraints hindered the ability of healthcare professionals to deliver optimal care and they also limit the resources available for patient support and facility improvements. Participants emphasised that if these funding issues were addressed and facilities were supported in a manner that meets their needs halfway, it could lead to enhanced outcomes for both staff and patients. By alleviating financial pressures, healthcare providers would be better equipped to implement innovative practices and improve the overall quality of care, ultimately fostering a more productive and supportive environment for all stakeholders. For instance, participant MPH-Q03 mentioned, that "*there is shortage of necessary resources, like security personnel and equipment in the hospital, which makes it difficult to address security threats effectively."* MPH-Q01 stated that *"the funding challenges we face significantly limit our ability to provide the level of care our patients deserve. If we could receive more support, I believe we could achieve much better results."* MPH-Q04 revealed that *"without adequate funding, we struggle to implement new programmes that could benefit our patients. Meeting us halfway in terms of financial resources would make a huge difference."*

Other participants shared the following:

- MH-Q02 showed that "*lack of funding is a constant issue for us. If the facilities were better funded, we could focus more on patient care rather than worrying about budget limitation."*
- MH-Q09 highlighted that "*I truly believe that if we had the financial backing we need, it would lead to better outcomes for our patients and a more satisfying work environment for us as healthcare providers."*

4.7.2.6 Partnerships:

Participants expressed significant concerns regarding security threats within their facilities, indicating that there are currently no known partnerships in place to address these issues effectively. They emphasised that collaboration among healthcare professionals and relevant stakeholders would be beneficial in combating security threats. Many participants highlighted the difficulties they face in addressing security concerns through formal policies, citing delays in managements' responses to reported issues as a major barrier. This lack of timely action contributes to a sense of vulnerability among staff, who often feel unsafe due to the risk of assault, especially given the challenging state of patients in Mohlomi Psychiatric Hospital. Additionally, participants noted the stigma associated with verbal abuse in their roles, describing it as overwhelming and detrimental to their well-being. They conveyed a strong desire for more supportive work environments where security concerns are taken seriously, and where they can receive the help they need to ensure their safety and the safety of their patients.

Other points revealed are discussed below:

- MPH-Q02 mentioned that "*as far as I know, there are no partnerships in place to deal with security issues. It would be much better if we could work together with local authorities and community organisations to combat these threats.*"
- MPH-Q05 showed that "*we really need to establish partnerships with law enforcement agencies and other healthcare facilities. Alone, we are not equipped to handle the security challenges we face every day."*
- MPH-Q04 said that *"it's alarming that we're not collaborating with any external agencies. Teaming up would help us develop better strategies to ensure our safety and that of our patients."*
- MPH-Q01 cited that *"I want to work with administration or anybody in charge to resolve the problem. I feel like management compromises the safety of staff in the work environment and that we still have a relatively high number of security threats here. We are told to only inform our guards about the threats or incidents."*

- MPH-Q03 shared that "*when we report security issues, management often delays to respond. This lack of urgency leaves us feeling vulnerable, neglected and unsupported."*
- MH-Q06 reported that "*it's incredibly frustrating. We identify problems and report them, but it takes so long for management to act. In the meantime, we're left to deal with potential threats on our own*."
- MH-Q08 recounted that "*addressing security concerns through policy feels almost impossible when there's such a delay in management responses. We need quicker action to feel safer at work*."
- MH-Q01 testified that "*we often feel at risk because of the patients' conditions. There have been times when staff members have been assaulted, and it's alarming to think we have no immediate help available*."
- MPH-Q07 stated that "*the fear of being attacked while doing my job is always at the back of my mind. It's hard to focus on patient care when you feel so unsafe."*
- MPH-Q09 shared that "*the stigma that comes with verbal abuse is insane. We're expected to handle everything without acknowledgement of the toll it takes on us*."
- MPH-Q05 mentioned that "*it's not just physical threats; the verbal abuse we endure is also damaging. There's a stigma that makes it hard on us. I feel like we're not taken seriously when we discuss verbal abuse. It's a part of our job that people don't understand, and it adds to our stress levels*."

In general, the existing measures taken, whether visible or not, do not effectively benefit both patients and healthcare professionals. This is largely due to the absence of a clear and direct policy that addresses the security threats faced in the workplace. The lack of such a policies result in a fragmented approach to security, with inconsistent responses and inadequate protection for those who are most vulnerable to these threats. Consequently, both patients and healthcare professionals continue to experience a range of security issues that could be mitigated with a more structured and comprehensive security policy.

4.8 Chapter Summary

This chapter presented an overview of the findings regarding security threats in healthcare facilities, integrating both quantitative and qualitative data to provide an understanding of the challenges faced by healthcare workers.

Quantitative data was collected from 81 respondents, with 41 participants from Mafeteng Hospital and 40 from Mohlomi Psychiatric Hospital. The demographic distribution of the respondents was as follows: 63.0% were females, 35.8% males, and 1.2% identified as non-binary. The age range of the respondents spanned from 18 to 64 years old. The respondents worked in various departments, with 36 individuals from the mental health department at Mohlomi Psychiatric Hospital and 45 from other departments typically found in a general hospital setup at Mafeteng Hospital.

Furthermore, qualitative data was also collected. The study included 20 healthcare workers, with a gender distribution of 12 females and 8 males. The participants' ages ranged from 29 to 35 years old, providing a diverse sample of healthcare professionals.

A systematic coding was implemented to ensure confidentiality and facilitate data analysis. Participants from Mafeteng Hospital were assigned codes prefixed with "MH-Q" followed by sequential numbers from 01 to 10, while those from Mohlomi Psychiatric Hospital were given codes prefixed with "MPH-Q" also followed by sequential numbers from 01 to 10.

The study identified several security threats prevalent in the selected healthcare facilities. Under security threats, aggressive behaviour, intimidation, physical assault, and verbal abuse were identified as the top four prevalent issues in both facilities. However, Mafeteng Hospital fared better compared to Mohlomi Psychiatric Hospital, which experienced these threats more severely. Qualitative data further corroborated these findings, with participants recounting specific incidents of such threats.

Key factors contributing to these security threats included insufficient safety protocols and procedures, inadequate training on handling threats, and an overall safety and security culture within the facilities. Participants reported that these issues led to reduced motivation, emotional stress, and decreased job satisfaction. Consequently, their commitment to their roles diminished, and their productivity was negatively impacted.

Respondents suggested that supporting initiatives to improve the environment and infrastructure for safer public spaces, collaborating with external stakeholders, installing cameras, organising community vigilance activities and watch programmes, and getting education about threats were effective strategies to address these security concerns.

CHAPTER FIVE

DISCUSSION OF FINDINGS, CONCLUSION AND STUDY IMPLICATIONS

5.1 Introduction

This chapter deals with a discussion of the key findings of the study. It draws conclusions based on these findings, and outlines implication of the study.

5.1.1 Summary of the Study

The study aimed to identify and analyse the security threats faced by healthcare workers in selected hospitals. The research was conducted in two healthcare facilities: Mafeteng Hospital and Mohlomi Psychiatric Hospital. Data was collected through survey questionnaires and interviews. The objectives of the study were to explore workers' security concerns within the healthcare facilities through the four research questions as listed as follows:

RQ1: What are specific security threats faced by healthcare professionals in selected hospitals in Lesotho?

RQ2: What are the key factors contributing to safety concerns among healthcare professionals in Lesotho, and how do these factors interact to influence their overall sense of safety?

RQ3: How do the existing security threats affect workers' disposition to work?

RQ4: What institutional measures are put in place to protect employees from harm at the health facilities?

Research objective 1 investigated security threats that were prevalent among 81 respondents and 20 interviewees during the surveys and interviews. Research objective 2 assessed the multifaceted factors influencing work risks among healthcare workers. Research objective 3 assessed the impact of existing safety concerns on workers' disposition to work. Finally, Research objective 4 evaluated the institutional measures put in place to protect employees from harm at healthcare facilities.

5.2 Discussion of Findings

The study revealed a distinct tendency to perceive various security threats faced by healthcare workers among respondents and participants, including vandalism, physical violence, verbal abuse, intimidation and other risks. However, there were risks that were pervasive within the two facilities. For research objective1, the findings were as follows:

5.2.1 Prevalence and Types of Security Threats

In terms of general perceptions of security threats, all respondents and participants demonstrated the ability to recognise, understand, and report the various security threats they faced. These include awareness and perception of risk in the workplace.

The identified security concerns in the study were categorised into three main types: physical security threats, psychological threats and digital security threats. Physical security threats involved direct harm or damage to individuals or property within the healthcare facilities. The threats include physical assault, theft of personal belongings, aggressive behaviour, vandalism, and work-related injuries. Psychological security threats involve threats that affect the mental health and emotional well-being of healthcare workers, creating a hostile and stressful environment (Mauss, John, Zerwas & Ford, 2024). These threats encompass intimidation, seductive behaviour, drug-seeking behaviour, workplace violence, and verbal abuse. Digital security threats primarily involve cybersecurity issues, which pertain to the protection of digital systems and data from unauthorised access and cyber-attacks (The Joined Commission, 2020; Healthcare IT News, 2022).

Eleven specific work risks that were identified and examined within two selected hospitals corresponded to Occupational Safety and Health Administration (OSHA) and World Health Organisation (WHO)'s threatening disruptive behaviour that occurs at work. The findings revealed that all these concerns are external in nature, originating primarily from patients or their visitors (OSHA, 2015; WHO, 2002). The identified threats include physical assault by patients or visitors, intimidation by patients, visitors or co-workers, theft of personal belongings, vandalism and aggressive behaviour by patients or visitors. Others include seductive behaviour by patients, visitors or co-workers, verbal abuse by patients and visitors, drug seeking behaviour, cybersecurity, workplace violence, and lastly, work-related injuries.

These reported threats exhibited a tendency to reflect values of interpersonal relationships, humility, social security and caring, which are based on the motivations of those involved. This aligns with the principles outlined by Abraham Maslow's Theory of Human Motivation, particularly the hierarchy of needs, which emphasises the importance of safety, belonging, and esteem in human behaviour (Maslow, 1943). The manner and reason behind respondents' and participants' expressions in communication reflect various values based on their intentions. Therefore, there is a clear link between the deliberate act of speaking and moral considerations, which is pragmatic rather than semantic. This supports the views of Jürgen Habermas (1990) and Brown & Gale (2018), who argue that communication is inherently linked to moral considerations, emphasising the importance of the pragmatic aspects of speech acts in reflecting and shaping social and ethical values.

The findings further revealed that among the identified security threats, aggressive behaviour, intimidation, verbal abuse, and physical assault were the most prevalent work risks, which were bearing the highest mean scores. These threats, which fall under the categories of physical and psychological security threats, were consistently reported by healthcare workers across both Mafeteng Hospital and Mohlomi Psychiatric Hospital.

However, the identified security concerns do not manifest in isolation; they emerge within the context of human communication between the service provider (healthcare professionals) and the client (patient). This interdependence is inherently linked to the dynamics of interpersonal interaction. Supporting this perspective, Habermas' (1990) Theory of Communicative Action argues that language and communication are not merely tools for information exchange, but they are also fundamental to the negotiation of social norms and ethical standards. Habermas further emphasises that through communicative action, individuals engage in a process of mutual understanding and consensus, which can either mitigate or exacerbate conflicts and threats.

Comparatively, Mohlomi Psychiatric Hospital was found to be the worse facility in terms of the prevalence and severity of security threats. This was primarily due to the complex nature of mental health patients and the lack of adequate security measures. According to Björkenstam, & Ekselius (2020), this finding is typical for a psychiatric facility as this is inherent vulnerability of the patient population. Individuals with mental health disorders usually exhibit unpredictable behaviours due to their conditions, which sometimes lead to heightened tensions and conflicts (Fazel & Wolf, 2020). This unpredictability often creates an environment where staff and other patients are at risk of aggressive incidents (Cohen, 2019).

Majority of these risks are frustration-induced, where patients feel entitled to aggressively demand healthcare professionals' attention and services. This sense of entitlement further heightens tensions and conflict, ultimately compromising the safety and well-being of both staff and patients within the facility. This supports the views of Dobro's (2020) view, who highlights the difference between entitlement and advocacy, emphasising that while patients should advocate for themselves, some patients exhibit entitlement behaviour by harassing healthcare workers. This sense of entitlement can lead to demanding excessive attention and creating a hostile environment for healthcare providers.

At Mohlomi Psychiatric Hospital, the severe mistreatment of patients' illnesses and inhumane conditions of the facility indicate a failure in interpreting risk knowledge accurately. The hospital's management and staff are not adequately assessing the risks posed to patients' well-being and rights. On the other hand, the risk of infections and contamination is high at Mafeteng Hospital due to inadequate hygiene practices. In both ways, this factor highlights a gap in interpreting risk knowledge related to infection control and prevention. This aligns with Springer (2023) and GiveCase (2023), who provide an overview of the status, challenges, achievements, and recommendations related to healthcare quality in developing countries. These highlight the crucial role of healthcare infrastructure in providing access to quality healthcare services and improving healthcare outcomes. According to these articles, the severe mistreatment and inhumane conditions in these settings indicate a failure in interpreting and managing healthcare risks accurately.

As per the study's findings, there is a tension between the need for accurate and comprehensive risk assessments and the practical challenges of implementing these assessments in complex healthcare environments. Misinterpretation of risk knowledge leads to severe consequences for patient safety and well-being, concurring to the works of Brown & Gale (2018), who discuss the complexities and challenges of work risk in various settings, including healthcare. They argue that while accurate and comprehensive risk assessments are essential for effective risk management, the practical implementation of these assessments is often hindered by the complex and dynamic nature of different healthcare environments.

There is a tension between the need for effective risk interventions and the feasibility of implementing these interventions, especially given existing resource constraints. Healthcare facilities must balance the need for high-quality care with limited resources, which can lead to compromises in patient safety (Brown & Gale, 2018). Additionally, there is also a tension between managing social dynamics and power relations within both facilities. Healthcare workers must navigate complex social interactions while ensuring patient safety and maintaining professional boundaries (NurseMagic, 2024; ACLNYS, 2019). This tension is heightened by the increasing incidents of workplace violence and security threats.

These findings imply that specific threats exhibit considerable variation between the facilities, suggesting the need for customised security strategies to effectively address the unique risks associated with each location. This can be linked to Brown & Taylor (2019), who argue that security in healthcare settings should shift from a focus on violence reduction to a more integrated approach that combines safety with clinical care. They emphasise the importance of recognising the unique security needs of different healthcare environments and tailoring security measure to address these specific needs.

5.2.2 Key Factors Contributing to Safety Concerns among Healthcare Professionals, and how these Factors Interact to Influence their overall Sense of Safety

The findings reveal that there are numerous factors influencing these threats, each playing a significant role in shaping the safety perceptions of healthcare providers. This study identified six key influencers or drivers contributing to the security threats faced by healthcare professionals. These include: lack of security personnel (which hampers effective response to incidents); insufficient safety protocols (which leave staff and patients vulnerable); inadequate staffing (which escalates stress and diminishes the capacity to manage crises) and high crime rates in surrounding areas (which creates an environment of fear). Other influencers include inadequate training for staff in handling potentially volatile situations; and an overarching safety and security culture (which fails to prioritise the protection of healthcare workers). Collectively, these factors exacerbate the challenges of maintaining a secure and supportive healthcare environment.

In examining the drivers of security threats, it became evident that these factors are multifaceted and deeply rooted in the operational and environmental contexts of the facilities. One of the primary drivers is lack of adequate security personnel. This issue is particularly pronounced in mental health facilities, where the need for higher level of security is paramount due to uncertainty of incidents and the potential for volatile behaviour from patients. The lack of adequate security staff in these settings led to increased risks of incidents involving patients, staff, and visitors, thereby compromising the overall safety of the facility. This contradicts the arguments of Huckshorn (2016), Lanza, Zeiss and Rierdan (2006), Gillispie, Gates and Berry (2010), who mention that it is not typical for psychiatric facilities to have fewer security personnel. In fact, according to them, psychiatric facilities often require a significant number of security personnel due to the high risk of violent and aggressive behaviours among inpatients.

The findings revealed that perceptions of security threat levels vary based on specific factors. For instance, respondents who disagreed with the presence of high crime rate in surrounding areas influencing security threats in the hospital showed a marginally increased likelihood of perceiving higher threats, while those who acknowledged inadequate training as a source of security threats were significantly less likely to perceive elevated security risks. This finding corroborates the argument of Johnston et al. (2017), where they say that dispositional and situational factors influence perceptions of threat in information system security.

The words and phrases used to describe the drivers of risk work in healthcare facilities reflected the respondents' and participants' values, with some being socially focused, such as "high crime in surrounding areas," which encompasses interpersonal and social security values. These values highlight the participants' concern for the broader societal context and its impact on the safety of healthcare facilities. Other drivers, however, were more organisationally driven and they include lack of security personnel, insufficient safety protocols, inadequate staffing, and inadequate training. These phrases reflect the participants' focus on internal organisational structures and processes, emphasising the importance of resource allocation, policy implementation, workforce management, and staff development. All these validate Johnson (2019), who discusses how the language used to describe security threats in healthcare settings often encompasses interpersonal and security values, highlighting the importance of considering these factors in security planning and risk assessment.

Additionally, the overall safety and security culture within healthcare facilities is seen as a blend of both social and personal values. While it reflected broader societal concerns, it also incorporated individual perceptions and priorities within the organisation. This dual focus highlights the complexity of security threats and the need for a multifaceted approach to address them effectively.

The most pervasive influencers of security concerns - insufficient safety protocols, inadequate training, overall safety and security culture, and lack of security personnel - are not only deeply interconnected, but they are also foundational to the overall security framework of any healthcare setting (Gillespie, Gates & Succop, 2010; Whittington & Wykes, 2010). Each of these factors, when inadequately addressed, lead independently, and collectively undermine the safety and security of patients, staff, and visitors.

According to the findings, insufficient safety protocols represented a critical failure point in these security architecture of healthcare facilities. Protocols are the operational backbone that dictate how security threats are identified, managed, and mitigated. When these protocols are either absent, poorly designed, or inconsistently enforced, the facilities became vulnerable to a range of security breaches. For instance, without clear procedures for access control, emergency response, and incident reporting, the facilities were at a heightened risk of unauthorised access, verbal abuse, and physical violence. This insufficiency is particularly dangerous in mental health facilities, where the potential for volatile behaviour necessitates stringent and well-defined safety measures. The absence and ineffective measures led to chaotic and ineffective responses to security incidents, thereby endangering all individuals within both facilities.

This substantiates the argument of Gates, Fitzwater & Succop (2003), where they argues that this inconsistency can result in staff being unprepared to handle emergencies, leading to confusion and potentially harmful delays in response times.

On the other hand, this finding opposes Whittington & Wykes (2010), who state that the absence of effective safety measures can pose significant challenges. However, some argue that healthcare facilities can still maintain a level of safety through alternative means such as strong leadership, community support, and the implementation of basic safety practices, in which these factors can help mitigate the risks associated with inadequate safety measures and ensure a more effective response to security incidents.

Security threat training is the mechanism through which staff acquires the knowledge and skills necessary to respond effectively to security concerns. When training is inadequate, staff are ill-prepared to handle crises, manage patient behaviour, and implement safety protocols. The overall safety and security culture permeates all aspects of the facility's operations. A strong security culture emphasises the importance of security, encourages the reporting of suspicious activities, and fosters a sense of responsibility among staff.

These factors can be conceptualised as a complex web of interactions that collectively undermine the security framework of healthcare facilities. Each threat does not only contribute independently towards security vulnerabilities, but also amplifies the effects of the others, creating a feedback loop that perpetuates and exacerbates security risks. Additionally, agreement regarding training deficiencies was associated with training deficiencies that was significantly associated with lower perceived security risks, suggesting that recognising training inadequacies correlated with a reduced sense of threat. Phillips & Smith (2012) argue that individual security threats can be address independently without necessarily exacerbating other threats.

Another argument challenges the idea of a feedback loop by suggesting that security measures have a linear impact on reducing threats. This perspective posits that implementing effective safety protocols and training can directly reduce specific security vulnerabilities without necessarily amplifying other threats (Johnson & Brown, 2015). Furthermore, critics of the Complex Web Model argue that healthcare facilities have limited resources and must prioritise addressing the most significant security threats first. This approach suggests that focusing on high-impact, independent factors can lead to more effective and efficient security improvements without needing to consider the entire web of interactions (Smith & Jones, 2018).

The findings also revealed that socioeconomic factors play a significant role in exacerbating work risks in both Mafeteng Hospital and Mohlomi Psychiatric Hospital. These factors contribute to the myriad of admitted patients and they create additional challenges for healthcare providers. For instance, many patients admitted into both hospitals are said to come from impoverished backgrounds with limited access to healthcare, and this often results in delayed treatment, leading to more severe health conditions that require hospitalisation. Furthermore, it was also revealed that high rates of unemployment and homelessness contribute to the influx of patients with mental health issues and general health problems. These socioeconomic conditions often lead to increased stress, substance abuse, and lack of proper nutrition, all of which reportedly exacerbate of existing health conditions.

In addition to the more common issues, the study uncovered some rare anomalies that complicate the security landscape in both facilities. These are occurrences that deviate significantly from the norm and are not easily classified within standard patterns or expectations. These anomalies are uncommon and often stand out due to their unusual nature, making them difficult to explain or integrate into existing frameworks of understanding (Bernard & Stryker, 2024). For instance, while aggression among patients is not uncommon, there were several instances of highly unusual and extreme aggression that were not typical of the patient's known behaviour patterns. These incidents required immediate and intensive intervention, which strains the already limited security resources.

The interaction between socioeconomic factors and security concerns creates a vicious cycle. Socioeconomic stressors have led to more severe patient conditions and increased hospital admissions, which in turn strain healthcare facilities and increase security risks. This environment makes healthcare professionals feel unsafe, unsupported and neglected, leading to burnout and reduced work morale. This inherently supports Heponiemi (2012), who purports that workplace violence in healthcare settings is strongly associated with increased stress and burnout among healthcare professionals.

Rare anomalies, though infrequent, have a disproportionate impact on healthcare workers' sense of safety. These incidents create a sense of unpredictability and heightened risk, making healthcare professionals feel more vulnerable and less secure in their work environments (Ravies et al. 2018). This lends credence to the argument of Magnavita & Heponiemi, (2012), where they state that rare anomalies like unexpected violent incidents or rare medical emergencies can have a significant psychological impact on healthcare workers, as these events are often highly stressful and can lead to increased anxiety, fear, and a heightened sense of vulnerability; even if they occur infrequently.

The cumulative effect of these challenges leads to a strong desire for healthcare workers to leave their jobs. The constant exposure to security threats and the resulting emotional and psychological strain make it difficult for them to envision a long-term career in their current workplaces. This turnover intention does not only affect the individual workers, but it also has broader implications for the healthcare system, including increased recruitment and training costs and potential gaps in service delivery. This reinforces the argument of Lambert, Hogan & Barton (2002) and Leiter, & Maslach (2009), who indicate that pervasive threats in the workplace can have a significant impact on the mental health of healthcare providers. They further stress that the constant stress and anxiety associated with working in a threatening environment can lead to conditions such as depression, anxiety disorders and post-traumatic stress disorders, which make it challenging for healthcare workers to envision a long-term career in such settings.

The cumulative effect of multiple threat factors - socioeconomic stressors, security concerns, and rare anomalies - creates a highly stressful and unsafe work environment for healthcare workers. The constant exposure to these threats leads to chronic stress, anxiety, and burnout, which in turn affects their overall sense of safety and well-being. A study by Wu et al., (2020) demonstrate that healthcare workers exposed to multiple threat factors, including socioeconomic stressors and security concerns, experience higher levels of burnout and reduced job satisfaction. The cumulative effect of these risks significantly diminishes their sense of safety and well-being.

Overall, these findings suggest that perceptions of security concerns were notably influenced by factors like insufficient safety protocols, training inadequacies, general safety and security culture and lack of security personnel. Conversely, high crime rate in surrounding areas appeared to have a minimal impact.

5.2.3 Assessing the Effects of Existing Security Threats on Workers' Disposition to Work

Respondents shared their views, highlighting several significant issues that have emerged as a result of these threats. Many healthcare professionals reported experiencing less motivation as a results of security threats, which they say attributed to the constant stress and anxiety associated with their work environment. The pervasive sense of insecurity and isolation further compounds these feelings, making it difficult for them to maintain a positive outlook and commitment to their roles.

The dispositions reported by respondents and participants - negative motivation and willingness to work, wanting to leave my job, anxiety and stress, feelings of insecurity and isolation - paint a vivid picture of the psychological and emotional challenges faced by healthcare providers in environments fraught with work risks and socioeconomic stressors. These dispositions are not isolated experiences, but they are interconnected and influenced by various factors within the healthcare setting.

The phenomena of reduced motivation; anxiety and stress; and feelings of insecurity and isolation are pervasive across both psychiatric and general hospital settings, albeit with nuanced differences in their manifestation and intensity. According to McVicar (2003), both psychiatric and general hospital settings share common stressors that contribute to feelings of insecurity and isolation. These include high patient acuity, long working hours, and the emotional demands of caring for patients. These stressors can lead to a pervasive sense of insecurity and isolation among healthcare workers in both settings. A critical examination of these dispositions reveals a consistent trend: healthcare professionals in both settings experience significant psychological and emotional challenges that impact their overall well-being and job performance.

In psychiatric settings, reduced motivation is often linked to the chronic stress associated with managing patients with complex mental health issues. The demanding nature of psychiatric care, coupled with the emotional toll of dealing with distressed patients, lead to burnout and diminished sense of purpose among healthcare workers (Happell & Gaskin, 2013). The lack of tangible outcomes and the slow progress in patient recovery further contribute to a sense of futility, thereby reducing motivation levels.

Similarly, in general hospital settings, reduced motivation is a common response to high workloads, long hours, and the pressure to provide high-quality healthcare. The constant exposure to patient suffering and the responsibility of making critical decisions led to emotional exhaustion and a decline in work related motivation. The bureaucratic nature of healthcare systems and the perceived lack of recognition for their efforts also play a role in diminishing the intrinsic motivation of healthcare providers. Therefore, across both settings, reduced motivation is a prevalent issue which is driven by chronic stress, emotional exhaustion, and a perceived lack of progress or recognition. This aligns with West et al., (2018) who found that healthcare professionals experience high levels of stress and anxiety due to their work environments.

Anxiety and stress are particularly pronounced in psychiatric settings due to the unpredictable nature of patient behaviour. Healthcare workers in these settings are constantly on edge, anticipating potential outbursts or violent incidents. The high-stakes environment, where the safety of both patients and staff is at risk, contributes to heightened anxiety levels. The emotional intensity of working with mentally ill patients further exacerbates stress, as health professionals often form deep connections with their patients and are affected by patients' struggles. In a general hospital, however, anxiety and stress are primarily driven by the high-pressure environment and the responsibility of managing acute medical conditions. The fear of making errors, the pressure to meet performance metrics, and the constant demand for efficiency contribute to elevated stress levels (Jackson, Peters, Andrews, Edenborough, Halcomb, Luck & Wilkes, 2010).

Feelings of insecurity and isolation are common in both psychiatric and general hospital settings and they are driven by different factors. In psychiatric settings, the stigma associated with mental health care and the physical risks of the work are major contributors. In general hospital setting, the hierarchical nature of the organisation and the fast-paced environment are the primary sources of these feelings (McVicar, 2003; Happell & Gaskin, 2013; Gates, Fitzwater & Succop, 2003; Jackson, Peters, Andrew, Edenborough, Halcomb, Luck & Wilkes, 2010).

The fear of job loss or instability, exacerbated by socioeconomic factors such as high unemployment rate, led to negative motivation because professionals felt that their jobs are not secure. Similarly, when healthcare workers do not receive adequate recognition or rewards for their hard work, it led to a sense of disillusionment and reduced motivation. According to Maslach & Leiter (2016), burnout and negative motivation are closely linked to a work environment; a toxic workplace characterised by high stress and low support significantly reduces employees' willingness to work.

The desire to leave one's job is a strong indicator of job dissatisfaction and a lack of commitment to the organisation. This disposition led to high turnover rates, which are detrimental to the stability and community of care in healthcare settings. This inherently supports Shanafelt et al., (2012) who found that burnout and the desire to leave one's job are prevalent among healthcare providers, particularly those who work in high-stress environments.

The pressure to provide high quality care under these conditions was overwhelming. Additionally, the fear of being harmed or witnessing harm on others was identified as a significant source of stress. Furthermore, a lack of support from colleagues and management, coupled with the constant presence of security threats, make healthcare providers feel isolated and unsupported. Ribeiro et al., (2017) note that feelings of insecurity and isolation are prevalent among healthcare providers, particularly in high-stress environments.

Respondents and participants of this study perceived a discrepancy between demands of a situation and their resources to cope with it. This finding is consistent with the argument by Demerouti, Bakker, Nachreiner & Schaufeli (2001) on the Job Demand-Resources (JD-R) Model, which suggests that job demands (e.g., workload, emotional demands) and job resources (e.g., support, autonomy) play a crucial role in employees' well-being. When job demands exceed available resources, it can lead to stress, burnout and a sense of inadequacy among employees.

The findings revealed that individuals' (healthcare workers') ability to predict and control their work environments was challenged due to lack of clear information and constant potential for new threats, making it difficult for workers to develop effective coping strategies. This aligns with the concept of risk knowledge as discussed by with Brown & Gale (2018), who emphasise the importance of having accurate and comprehensive information to effectively manage and mitigate risks. Brown & Gale (2018) further highlight that without solid understanding of the risks involved, individuals are more likely to feel overwhelmed and less capable of maintaining a sense of control over their environments.

This dichotomy in responses highlights the variability in how individuals perceive and react to security concerns. While some are able to maintain a sense of professional detachment and resilience, others are more susceptible to the negative impacts of these threats. This validates the concept of Social Exchange Theory, which says that the variability of responses can be attributed to the perceived balance of benefits and costs associated with their roles. On the other hand, others are more susceptible to the negative impacts of these roles because they perceive the costs to outweigh the benefits. For these individuals, the security concerns and associated stress may be overwhelming, leading to feelings of insecurity, burnout and a diminished sense of professional identity (Blau, 1964; Homans, 1961).

5.2.4 Evaluating the Institutional Measures in Place to Protect Employees from Harm at Healthcare Facilities

This study revealed the institutional measures that are put in place to protect employees from harm at healthcare facilities.

It further revealed that the current interventions, while proposed and perceived to improve the situation upon implementation and execution, have not yet proven to be effective. This gap between proposal and efficacy suggests that the theoretical benefits of these interventions have not fully translated into practical outcomes.

An underlying assumption is that these initiatives are more thoughtfully conceived and potentially impactful at Mohlomi Psychiatric Hospital than at Mafeteng Hospital. This assumption is predicted on the nature of the healthcare services provided by each facility. Mohlomi Psychiatric Hospital, as a specialised psychiatric facility, deals exclusively with mental and psychological illnesses and disorders. In contrast, Mafeteng Hospital, as a general healthcare facility, addresses a broad spectrum of medical conditions.

The apparent contradiction- where Mohlomi Psychiatric Hospital, despite having thoughtful initiatives, remains more severely affected by threats - can be justified by the inherent nature of the threats present in psychiatric settings. The threats found in Mohlomi Psychiatric Hospital are, to a significant extent, inevitable due to the complex unpredictable nature of mental and psychological disorders. The very nature of these conditions often involves heightened risks of aggression, self-harm, and other unpredictable behaviours that are challenging to mitigate fully, even with well-conceived interventions.

This finding is in consonance with Gates, Fitzwater & Succop (2003); Happell & Gaskin (2013), and Magnavita & Heponiemi (2012), who argue that the nature of psychiatric disorders means that patients may have impaired judgement, heightened aggression, or other behavioural issues that can lead to violent outbursts. Secondly, the close and often prolonged interactions between healthcare workers and psychiatric patients increase the likelihood of exposure to threatening situations. Unlike in general hospital settings, where interactions may be more episodic and focused on specific medical issues, psychiatric care requires continuous monitoring and engagement, which can escalate the risk of confrontational encounters. Thirdly, the stigma and misunderstanding surrounding mental health can exacerbate the severity of threats. Healthcare workers in psychiatric settings may face not only physical threats, but also emotional and psychological stress due to the challenging nature of their work. This dual burden can make it particularly difficult to maintain a safe and secure environment, despite the presence of thoughtful initiatives.

Respondents' perceived collaboration between the hospital and the community was perceived as the most possible effective intervention in addressing work risks. Participants also believed that increased community involvement could be effective in addressing security concerns. This refutes the argument by Magnavita & Heponiemi (2012), who state that community collaboration relies on external factors that may be beyond the control of the hospital administration. These factors include community engagement, resource availability, and the willingness of community partners to participate in the implementation of security measures. Dependence on these variables can introduce uncertainty and inconsistency in the effectiveness of the intervention.

The findings indicate a low level of perceived effectiveness regarding collaborative efforts aimed at enhancing work security and safety within healthcare facilities. This perceived ineffectiveness suggests that the current approaches to collaborate may be fully addressing the complex challenges faced by healthcare providers (Tang, 2004). Additionally, there is also a notable lack of confidence in the perceived improvements resulting from community improvement initiatives and engagement efforts. This lack of confidence underscores the gap between the theoretical benefits of community involvement and the practical outcomes observed by healthcare professionals (Blau, 1964; Homans, 1961). The disconnect between community-based initiatives and the on-the-ground realities with healthcare facilities may contribute to this scepticism.

Interestingly, some participants reported that collaboration with the community was deemed irrelevant, as the majority of security threats and incidents occur within the facilities rather than in the surrounding community (McVicar, 2003). This perspective highlights a critical nuance in the understanding of security concerns. That is, while community engagement is often seen as a vital component of safety strategies, the immediate and pressing threats are internal to the healthcare environments (Gates, Fitzwater, & Succop, 2003; Happell & Gaskin, 2013). This internal focus suggests that efforts to mitigate security risks may need to prioritise internal measures and facility-specific interventions over external community engagement.

5.3 Conclusion

This dissertation has examined the multifaceted security threats faced by healthcare workers, categorising them into three primary types: physical security threats, psychological security threats, and digital security threats. Within the two selected healthcare facilities, a comprehensive analysis identified eleven specific work risks, which include physical assault, intimidation, theft of personal belongings, vandalism, aggressive behaviour, seductive behaviour, verbal abuse, drug-seeking behaviour, cybersecurity issues, and work-related injuries. Among these identified risks, aggressive behaviour, intimidation, verbal abuse, and physical assault emerged as the most prevalent work risks, exhibiting the highest prevalence rates. These threats are categorised under the domains of physical and psychological security threats. Conversely, the category of digital security threats, although reported by respondents and participants in the study, was found to be less significant in comparison to physical security threats.

The implication of these threats are profound, significantly impacting the mental and physical well-being of healthcare workers and potentially compromising the quality of patient care. By elucidating the nature and extent of these threats, this research underscores the critical need of the development and implementation of more effective mitigation strategies. The strategies developed should encompass the establishment of robust security measures, comprehensive training programmes for healthcare staff, and the cultivation of a supportive work environment.

With the above said, this study therefore concludes that the following key points highlight the main findings and implications of the research:

i. The current interventions aimed at mitigating work risks in healthcare facilities are perceived to be largely ineffective. Despite being well-conceived, and theoretically sound, these interventions have not yet translated into practical improvements in the safety and well-being of healthcare professionals. The gap between intention and outcome highlights the need for re-evaluation of existing security threat strategies and the development of more targeted, context-specific interventions.

ii. There is a notable lack of confidence in the perceived improvements of security threats resulting from community improvement initiatives and community engagement efforts. Healthcare professionals express scepticism about the relevance and impact of these initiatives, particularly when the majority of work risks occur within the facilities themselves rather than in the surrounding community. These insights suggest that the internal, facility-specific measures may be more effective in addressing the immediate security concerns of healthcare workers.

iii. The study reveals that the impact of security threats vary significantly between psychiatric and general hospital settings. Healthcare professionals in psychiatric facilities, such as Mohlomi Psychiatric Hospital, face inherently higher and more unpredictable threats due to the nature of mental and psychological illnesses of patients. In contrast, while general hospital settings (like Mafeteng Hospital) workers also experience security threats, they are often more manageable and less severe. This distinction underscores the need for tailored security strategies that address the unique challenges of each setting.

iv. The psychological and emotional toll of working in high-risk environments is profound. Healthcare workers across both settings report reduced motivation; heightened anxiety and stress; feelings of insecurity and isolation; and unease in their working environments. These dispositions are exacerbated by the chronic stress and emotional exhaustion associated with managing security concerns.

v. The findings emphasise the urgent need for comprehensive support systems that address the multifaceted challenges faced by healthcare workers. This includes the implementation of effective stress management programmes, robust security measures, and fostering a supportive and inclusive work environment. By addressing both internal and external factors that contribute to security concerns, healthcare organisations can better support their staff and improve overall organisational effectiveness.

vi. The study underscores the pivotal role of risk knowledge in shaping the perceptions and responses of healthcare professionals to security threats. Professionals who possess a comprehensive understanding of potential risks are better equipped to anticipate and mitigate risks, thereby enhancing their sense of safety and control. However, the findings reveal a gap in the dissemination and application of risk knowledge within healthcare facilities. This gap highlights the need for robust training programmes and continuous education initiatives that empower health professionals to effectively manage risk work.

vii. Social relations within healthcare settings play a crucial role in mediating the impact of security concerns because strong, supportive social networks among colleagues foster a sense of camaraderie and mutual support, which can buffer the adverse effects of risk at work. Conversely, strained or hierarchical social relations can exacerbate feelings of insecurity and isolation. The study emphasises the importance of cultivating positive social relations at work through team-building activities, open communication channels, and inclusive organisational cultures. These measures can enhance the overall resilience of healthcare workers in the face of risk.

viii. The presence of work related risks introduces significant tensions within healthcare environments. These tensions manifest as conflicts between the need to provide high-quality care and the necessity to ensure safety. Healthcare professionals often find themselves navigating a delicate balance between these competing demands, which can lead to heightened stress and burnout.

ix. Uncertainty is a pervasive feature of security concerns in healthcare settings. The unpredictable nature of these threats, such as sudden outbursts of violence, creates a climate of constant vigilance and anxiety among healthcare workers. This chronic uncertainty can erode their sense of safety and well-being, leading to reduced efforts healthcare workers.

The subjective construction of reality significantly influences how healthcare professionals perceive and respond to security threats. Individuals' perception of threat severity, their sense of control, and their beliefs about the effectiveness of safety measures all shape their responses to risk work. The study reveals that professionals who perceive threats as manageable; who also believe in the efficacy of safety measures, are more likely to maintain a positive disposition and perform their duties effectively. Conversely, those who perceive threats as overwhelming and feel powerless to address them are more likely to experience negative outcomes such as anxiety, stress, and burnout.

x. The deliberate act of speaking, particularly in the context of reporting security threats or voicing concerns about safety protocols, has a dual benefit in healthcare settings. On one hand, open communication is essential for identifying and addressing potential threats, thereby enhancing the overall safety of the environment. Healthcare workers who feel empowered to speak up about security concerns contribute to a culture of transparency and proactive risk management. On the other hand, the act of openly communicating can also expose individuals to retaliation, stigmatisation, or dismissal, particularly if the concerns challenge established norms or authority structures within the organisation. This paradox highlights the need for robust whistle-blower protections and supportive communication channels that encourage professionals to report security threats without fear of negative repercussions.

xi. Moral considerations play a pivotal role in shaping the responses of healthcare professionals to security threats. The ethical imperative to provide a safe and effective care often conflicts with the practical challenges of managing risk work, leading to moral distress among professionals. This distress arises when individuals are unable to act in accordance with their moral values due to organisational constraints or systemic barriers. The study underscores the importance of aligning security protocols with ethical principles aimed at reducing moral distress and to enhance the well-being of workers. This alignment requires a commitment to ethical decision-making, transparent communication and the provision of adequate resources and support.

5.4 Implications of the Study

The findings of this study carry profound implications for the understanding and management of security threats in healthcare settings. By elucidating the intricate relationship between communication dynamics and the emergence of security threats, this research underscores the necessity of adopting a holistic approach to workplace safety. The identification of these threats as not isolated incidents, but rather as products of communicative interactions between healthcare professionals and patients, aligns with Habermas' (1990) Theory of Communicative Action, which posits that language and communication are pivotal in the negotiation of social norms and ethical standards.

This study's insights suggest that addressing security concerns requires more than mere implementation of physical safety measures, it necessitates a deeper engagement with the communicative processes that underpin healthcare interactions. By fostering an environment of open, transparent, and respectful communication, healthcare facilities can mitigate the risks associated with workplace violence and other security issues. This approach does not only enhance the physical safety of healthcare workers, but it also promotes a culture of mutual understanding and ethical practice, which is essential for the delivery of high-quality patient care.

Furthermore, the study's findings highlight the importance of training healthcare professionals in effective communication strategies, conflict resolution, and de-escalation techniques (Gould, Kelly, White & Chudleigh, 2004). Such training can empower healthcare workers to navigate potentially volatile situations with greater confidence and competence, thereby reducing the incidence and severity of security threats (Dejoy, Schaffer, Wilson, Vandenberg & Butts, 2004).

The findings of this study, when interpreted through the lens of Shiping Tang's (2004) Systemic Theory, reveal profound implications for the management of security concerns in healthcare facilities. By figuratively perceiving healthcare facilities as states within a broader systemic framework, we can draw compelling parallels between the dynamics of international relations and the interactions within healthcare settings.

The Systemic Theory posits that the behaviour of actors within a system is shaped by the structural characteristics of the system itself, as well as the interaction among the actors (Tang, 2004). In the context of healthcare settings, this theory suggests that security threats do not arise in isolation, but they are the result of complex interactions between various actors, including healthcare workers, patients, and their families. These in the tractions are influenced by the structural attributes of the healthcare environment (such as organisational culture, policies, and power dynamics). Therefore, the systemic nature of healthcare facilities means that the structural environment significantly influences the behaviour of actors within it. Security threats, such as physical assaults and verbal abuse are not merely individual acts of aggression, but they are often symptoms of deeper systemic issues. For instance, a hierarchical organisational culture that prioritises efficiency over empathy may inadvertently foster an environment where tensions escalate into violence (Brown & Gale, 2018).

The interdependence of healthcare providers and patients within the healthcare system mirrors the interdependence of states in the intentional system. The actions of one actor can have cascading effects on others (Habermas, 1990). For example, a single incident of violence against healthcare workers can create a climate of fear and mistrust, thereby affecting the morale and performance of the entire healthcare team. This interdependence underscores the need for a collective approach to security management, where all actors are engaged in fostering a safe and supportive environment.

Tang's theory also highlights the role of feedback loops in reinforcing certain behaviours within a system. Negative feedback loops, such as repeated incidents of violence, can perpetuate a cycle of insecurity and fear. Conversely, positive feedback loops, such as effective communication and conflict resolution strategies, can enhance the overall feelings of safety and well-being of the healthcare environment.

The threat-identifying approach, as observed in political contexts, often relies on reactive measures rather than proactive strategies. This reactive stance is mirrored in healthcare settings where security threats are typically addressed after they have materialised rather than being pre-emptively mitigated. The study's findings suggest that healthcare facilities must shift towards a more proactive approach, incorporating predictive analytics, early warning systems, and comprehensive risk assessments to identify and address potential threats before they escalate (Tang, 2004).

Just as political entities may suffer from systemic blind spots that hinder their ability to accurately identify and respond to threats, healthcare facilities are similarly prone to overlooking critical indicators of potential work risks (Polkinghorne, 1997). These blind spots can arise from a lack of comprehensive data collection, inadequate communication channels, and insufficient training of healthcare workers to recognise early warning signs. The study underscores the need for healthcare facilities to implement robust monitoring systems and to foster a culture of vigilance and continuous improvement to address these blind spots effectively.

Political counterparts often face challenges in allocating resources effectively to address identified risks, a dilemma that healthcare facilities similarly encounter (Safer & Tang, 2009). The study highlights the importance of strategic resource allocation, ensuring that adequate funding, personnel, and technological support are directed towards security management initiatives (Tang, 2004). By prioritising security measures and investing in preventive strategies, healthcare facilities can enhance their capacity to manage and mitigate security threats.

The threat-identifying approach in political contexts often necessitates interagency coordination and collaboration to comprehensively address multifaceted threats (Madigan, Johnson & Linton, 1995). Similarly, healthcare facilities must foster collaboration with various stakeholders, including healthcare professionals, security personnel, administrative staff, and external, privately law enforcement agencies. The study's findings emphasise the need for a cohesive, multidisciplinary approach to security management, where diverse expertise and resources are leveraged to develop and implement effective security protocols (Simmon, 2004).

The ethical and moral dimensions of threat identification and management are critical in both political and healthcare contexts. This is because healthcare settings have a moral obligation to ensure the safety and well-being of their workers and patients (Walsh & Shapiro, 2006). The study's findings underscore the importance of aligning security management practices with ethical principles such as transparency, accountability, and respect for human dignity. By adopting an ethical framework, healthcare settings can enhance a culture of safety and mutual respect.

In essence, the implications of this study, when viewed through the lens of the threat-identifying approach employed by political counterparts, highlight the need for a paradigm shift in the management of security threats in healthcare facilities. By recognising the systemic deficiencies associated with reactive threat identification and addressing the underlying causes of work risks, healthcare settings can develop more effective, proactive strategies to ensure the safety and well-being of their workers and patients. The study’s findings emphasise the importance of adopting a holistic, multidisciplinary approach that integrates ethical considerations, strategic resource allocation, and interagency collaboration in order to create a safer and more supportive healthcare environment.

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APPENDIX A: Consent Form

Title of the Study: Workers' Security Threats in Healthcare Facilities: A Study of Selected Hospitals in Lesotho

Introduction

My name is 'Makhetheng Mary Khetheng and I am inviting you to participate in a research study aimed at exploring and addressing workers' safety concerns within the healthcare sector in Lesotho. Before deciding whether to participate or not, it is important for you to understand the nature, purpose, and potential risks and benefits of the study. Please take the time to read the information provided below and feel free to ask any questions you may have.

The primary purpose of this research is to gain insight into the drivers, patterns and responses to safety concerns among healthcare professionals in selected hospitals in Lesotho. It is important to note that this study is conducted as part of pursuing a Master of Science (MSc) in Sociology qualification. The information gathered will contribute to the development of the researcher and may inform future interventions and policies to enhance workers' safety and well-being.

Study Procedures

If you agree to participate in the study, you will be asked to:

- Participate in an interview where you can share your experiences and perspectives on security threats experienced in your capacity as a healthcare worker.
- Complete a brief survey to gather quantitative data on perceptions of safety in healthcare facilities.

Confidentiality

Your participation in this study is entirely voluntary and your responses will be kept confidential. Furthermore, personal identifiers will be removed from any data shared or published. Only the principal investigator and the research team will have access to the collected data.

Voluntary Participation

Your participation in this study is entirely voluntary. You have the right to withdraw from the study at any time and there will be no consequences suffered. If you choose not to participate or withdraw, it will not affect any current or future relationship with the healthcare facility or any associated organizations.

Contact information

If you have questions before, during, or after the study, please feel free to contact the principal investigator, at 62500296/58835259 or on email at marykhetheng@gmail.com or the research supervisor, at emekaobioha@gmail.com .

Consent

By agreeing to participate, you acknowledge that you have read and understood the information provided in this consent form. You voluntarily agree to take part in the study.

Participant's Name:

……………………………………

Participant's Signature:

…………………………………....

Date: …………..

Researcher's Signature:

……………………………………..

Date: …………..

APPENDIX B: Questionnaire

INTERVIWEE No…………

Workers' Security Threats in Healthcare Facilities: A study of Selected Hospitals in Lesotho

DISCLAIMER:

As part of my academic study, I would like to gather some information which will help me in an exploratory mixed-methods study from you. I would be obliged if you cooperate with me in filling the following questionnaire. Since the questionnaire is being used for academic purposes, the information gathered will be strictly confidential.

A. Demographic Information

1.0 What is your gender?	**1.** Male	**2.** Female	**3.** Non-Binary	**4.** other
2.0 What is the Name of Health Facility you are employed at?	**1.** Mohlomi Psychiatric Hospital		**2.** Mafeteng Hospital	
3.0 What is your Age group?	**1.** 18-35	**2.** 36-50	**3.** 51-64	

4.0 Which Department do you work in?												
4.1. Out patient	**4.2.** Men's Clinic	**4.3.** Mother and Child Health	**4.4.** Adolescent Health	**4.5.** ARV Centre	**4.6.** Mental Health	**4.7.** Male Medical	**4.8.** Female Medical	**4.9.** Maternity	**4.10.** Paediatric	**4.11.** Laboratory	**4.12** ICU	**4.13.** Emergency

5.0 How long have you worked at this Hospital?	**1.** 0-5 years	**2.** 6-9 years	**3.** 10-20 years

B. Security Threats in Healthcare Facilities

6.0 Which security threats are common or have been experienced in the workplace?

"Since working at this facility, I have experienced the following security threats…"

Security Threat	**Strongly Disagree**	**Disagree**	**Agree**	**Strongly Agree**
6.1 Physical assault by patients or their visitors	1	2	3	4
6.2 Intimidation or bullying by patients, their visitors, or co-workers	1	2	3	4
6.3 Theft or robbery of personal belongings	1	2	3	4
6.4 Vandalism	1	2	3	4
6.5 Aggressive behaviour or confrontations with patients or their families	1	2	3	4
6.6 Seductive or sexual behaviour by patients, their visitors or co-workers	1	2	3	4
6.7 Verbal abuse from patients, their visitors or management	1	2	3	4

6.8 Drug-seeking behaviour leading to conflicts or violence	1	2	3	4
6.9 Cybersecurity threats targeting patient data or hospital systems	1	2	3	4
6.10 Workplace violence stemming from disputes among staff members	1	2	3	4
6.11 Work related injury	1	2	3	4
6.12 others	1	2	3	4

7.0 What it the degree of the threats?

"In the past 6-12 months, I have experienced threats which are…"

7.1 Low	4
7.2 Moderate	3
7.3 High	2
7.4 Extremely high	1

C. Multifaceted Drivers Influencing Security Threats among Healthcare Professionals in Lesotho

8.0 Which factors influence security threats?

Causative Factor	Strongly Disagree	Disagree	Agree	Strongly Agree
8.1 Lack of Security Personnel	1	2	3	4
8.2 Insufficient safety protocols and procedures	1	2	3	4
8.3 Inadequate staffing levels	1	2	3	4
8.4 High crime rate in surrounding area	1	2	3	4
8.5 Inadequate training on handling security threats	1	2	3	4
8.6 Overall safety and security culture at the Hospital	1	2	3	4

D. Effects of Existing Security Threats on Workers' Disposition to Work

9.0 What is the attitude of workers who are affected by security threats?

"Threats at the hospital have led to…"

Effects	Strongly Disagree	Disagree	Agree	Strongly Agree
9.1 Negative motivation and unwillingness to work	1	2	3	4

9.2 No effect on motivation and willingness to work	1	2	3	4
9.3 Wanting to leave my current Job	1	2	3	4
9.4 Anxiety and stress	1	2	3	4
9.5 Inadequate support by management on security threats	1	2	3	4
9.6 Feeling of insecurity and isolation	1	2	3	4

E. Responses and Interventions Implemented by Key Role Players in Addressing Security Concerns among Healthcare Professionals

10.0 Which interventions and responses were employed?

Factors	**Strongly Disagree**	**Disagree**	**Agree**	**Strongly Agree**
10.1 The Hospital's address of the security threats has been satisfactory	1	2	3	4
10.2 I have been involved in security improving initiatives or committees	1	2	3	4
10.3 Local authority and community structures have been implementing security threats intervention	1	2	3	4
10.4 There has been improved community involvement of security threats	1	2	3	4
10.5 There has been collaboration between the hospital and community to address threats	1	2	3	4

F. Measures that can be Explored to Reduce Security Threats

11.0 What measures do you believe can be implemented to effectively reduce security threats in healthcare facilities?

Measures	**Strongly Disagree**	**Disagree**	**Agree**	**Strongly Agree**
11.1 Increased police patrol in the area	1	2	3	4
11.2 Community safety alarms and cameras	1	2	3	4
11.3 Organised community vigilance and watch programs and education about threats	1	2	3	4
11.4 Cameras at the Hospital	1	2	3	4
11.5 Collaboration of the Hospital with outside stake-holders	1	2	3	4

11.6 Support for initiatives aimed at improving the environment and infrastructure for safer public spaces	1	2	3	4

APPENDIX C: Interview Guide

In-depth Interview Guide

Workers' Security Threats in Healthcare Facilities: A Study of Selected Hospitals in Lesotho

Section 1: Demographic Information

1. Name of Facility…………………………………………

a) Age: ……

b) Gender: …………

c) Number of years of experience in the healthcare sector: ………..

d) Job role: Nurse/ Doctor/ Administrative staff/ other (please specify)…………………

Section 2: Security Threats or Concerns

2. From your experience, which safety challenges or threats have you encountered in your day-to-day work related activities in this healthcare facility?

3. Have you noticed any safety issues that could potentially pose risks to employees, patients, or visitors?

4. What are the most common security threats that you have encountered or heard about in this healthcare facility?

5. Can you describe any incident(s) or situations that have raised safety concerns within the healthcare facility?

Section 3: Drivers of Safety Concerns

6. In your experience, what are the most notable safety issues that healthcare professionals, like yourself, encounter in this facility?

7. What specific features of the work environment do you think contribute to security threats?

8. Would you say there are external factors that influence security threats within this healthcare setting?

9. Do you think resource availability or unavailability impact safety practices and perceptions?

Section 4: Effects on Workers' Disposition to Work

10. Can you describe any specific instances where safety concerns have influenced your work disposition or attitude towards your job?

11. How do security concerns in the workplace affect your motivation and enthusiasm for work?

12. Have safety concerns or threats ever affected your emotional well-being and or job satisfaction?

13. How do you feel when faced with unresolved safety issues or on-going security threats in the workplace?

14. Do you believe that the facility addressing safety issues would enhance your commitment to this facility?

15. How does the presence of safety threats influence your productivity and ability to perform job tasks effectively?

Section 4: Interventions

16. What specific responsibilities related to implementing interventions or responses to improve safety in this healthcare facility do you have?

17. What measures has your facility implemented to address safety concerns suffered by healthcare professionals?

18. What challenges or barriers in implementing safety interventions within this healthcare facility have you encountered?

19. Can you provide any examples of recent initiatives or programs aimed at improving workplace safety in this facility?

20. Are there any partnerships or joint efforts linked to this healthcare facility to enhance safety practices and response capabilities?

21. How does the local community contribute to efforts aimed at addressing safety concerns for healthcare professionals?

22. What impact have community interventions had on enhancing safety awareness and practices among healthcare professionals?

APPENDIX D: Ethic Clearance

LESOTHO

Ministry of Health
PO Box 514
Maseru 100

Category of Review:
[X] Initial Review
[ ] Continuing Annual Review
[ ] Amendment/Modification
[ ] Reactivation
[ ] Serious Adverse Event
[ ] Other ________________

REF: ID12-2024

Date: February 22, 2024

To
Mrs. Makhetheng Mary Khetheng
National University of Lesotho

Dear Mrs. Khetheng

RE: **Worker's Safety Concerns in the Health Care Sector: A study of Selected Hospitals in Lesotho**

This is to inform you that the Ministry of Health Research and Ethics Committee reviewed and **APPROVED** the above named protocol and hereby authorizes you to conduct the study according to the activities and population specified in the protocol. Departure from the approved protocol will constitute a breach of this permission.

This approval includes review of the following attachments:
[x] Study protocol
[ ] English & Sesotho informed consent form
[x] Data collection tools (English and Sesotho)
[ ] Participant materials *[insert types, versions]*
[x] Other materials: Letter of request for approval dated 22th January 2024, CV of Makhetheng Mary Khetheng

This approval is **VALID** until February 28, 2025.
Please note that an annual report and request for renewal, if applicable, must be submitted at least 6 weeks before the expiry date.

All serious adverse events associated with this study must be reported promptly to the MOH Research and Ethics Committee. Any modifications to the approved protocol or consent forms must be submitted to the committee prior to implementation of any changes.

We look forward to receiving your progress reports and a final report at the end of the study. If you have any questions, please contact the Research and Ethics Committee at rcumoh@gmail.com (or) 59037919.

Sincerely,

DR. NYANE LETSIE
Director General Health Services

DR. Llang Bridget Maama-Maime
Member, National Health Research Ethics Committee (NH-REC)

APPENDIX E: Certificate of Language Editor

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Faculty of Humanities

30th January 2024

Dear Sir/Madam

Re: Certification of Language Editing

This is to certify that **'Makhetheng Mary Khetheng's** MSc thesis entitled **Workers' Security threats in Healthcare Facilities: A Study of Selected Hospitals in Lesotho** has been language edited by Sebolelo Lesenyeho, a professional editor in the Department of English, Faculty of Humanities, National University of Lesotho.

Thank you.

Sebolelo Lesenyeho
(A facilitator of Communication and Study Skills)