Workplace Conflicts and their Effects on Healthcare Organizational Performance in Ghana: A Desk Review

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ABSTRACT

This desk review aims to examine the impact of workplace conflict on the quality of healthcare delivery in Ghana, with a particular focus on the clinical care profession. It examined existing literature, documents, and reports to gather information, identify patterns, the causes, consequences, and potential solutions to workplace conflict in Ghana's healthcare sector, and conclude.

The major findings of the review are that workplace conflicts in Ghana's health sector are caused by inadequate staffing, poor resource allocation, and communication breakdowns, amidst workforce shortages and limited resources, and can lead to reduced patient care and staff turnover. The findings imply significant consequences for Ghana's healthcare delivery, including compromised patient care, healthcare professional burnout, inefficient resource use, regional disparities, and staff retention challenges.

The review concludes that implementing conflict management training, early detection, collaborative problem-solving, effective communication, addressing systemic issues, and leadership support can reduce workplace conflicts in Ghana's health sector.

INTRODUCTION

Studies have shown that across the world, about two-thirds of all healthcare workers experience some form of workplace violence, such as verbal abuse, threats, physical abuse, and sexual harassment, which are fertile ground for workplace conflicts (Liu J, Gan Y, Jiang H, Li L, Dwyer R, Lu K, et al, 2019). In Africa, South Africa and Egypt topped the list of workplace violence and conflicts between patients, patient relatives, coworkers, or supervisors (Njaka S, Edeogu OC, Oko CC, Goni MD, Nkadi N., 2020). Although Abdellah RF, Salama KM. (2017) and Gates DM. (2004) admitted that workplace violence and conflicts in the healthcare sector pose significant challenges globally; they noted that developing countries experience higher rates.

Boafo IM, Hancock P. (2017) also noted that the health sector accounts for nearly one-third of all workplace violence incidents worldwide, and Abodunrin O et al (2014) found close to 90% of health workers in third-world countries facing various forms of violence, including abuse, bullying, and physical attacks. Azodo CC, Ezeja E, Ehikhamenor E (2011) found that such a situation has led to the healthcare industry being labeled as the most violent globally.

The impact of workplace violence is profound, affecting healthcare providers' and staff's dignity, safety, health, and well-being (Magnavita N, Heponiemi T., 2012; Blanchar Y., 2011). Healthcare facilities also suffer consequences, such as absenteeism, loss of skilled professionals, compensation claims, psychological effects, and increased employee turnover (Abdellah RF, Salama KM, 2017). Workplace violence affects all healthcare professionals, but nurses are particularly vulnerable (Nelson R., 2014; Gillespie GL, Gates D, Berry P., 2013). Tawiah, P. A. et al (2024) in their study found that more than 50% of healthcare workers suffered verbal abuses on account of old age, work experience, feuds over on-call duties from managers and colleagues, which made them apprehensive about the system, and most often resulted in workplace conflicts.

Workplace conflict is a pervasive issue in the healthcare sector, affecting the quality of care delivered to patients. Conflicts among healthcare professionals can arise from various factors, including poor communication,

differing opinions, and inadequate leadership. Healthcare systems face numerous challenges, and workplace conflict can exacerbate the problems, leading to decreased patient satisfaction, increased morbidity, and mortality. Research has shown that conflicts in the workplace can negatively impact the healthcare work environment and patient recuperation. When conflicts arise, communication breaks down, and patient care suffers (Valentine & Lavizzo-Mourey., 2007; Rosenstein & O'Daniel., 2008) Generally, healthcare professionals play a vital role in the healthcare system; conflicts can compromise their ability to provide quality care (Rosenstein, A. H., & O'Daniel, M., 2008). Studies have also highlighted the importance of effective leadership and management in resolving conflicts and promoting a positive work environment (Weberg, D., 2010).

Background

According to Piryani, Rano Mal & Piryani, Suneel. (2019), conflict arises from internal discord or interpersonal differences that can potentially cause harm. As an inherent aspect of human interaction, conflict can emerge in any profession, including healthcare. It may manifest within healthcare teams, between different professional groups, or between patients and healthcare providers. Piryani, Rano Mal & Piryani, Suneel. (2019) alluded that effective management of these conflicts is crucial to maintaining a positive and productive work environment. Conflict arises when individuals or groups with differing interests, beliefs, or experiences clash due to incompatible agendas or perspectives. This discord can manifest as disagreements or disputes, highlighting the need for effective management and resolution strategies (Hanifa et al., 2020).

Mohseni et al. (2022) espoused that conflict is an inherent aspect of healthcare teams, potentially compromising patient care and provider satisfaction, highlighting that effective conflict management involves identifying and addressing issues, fostering a positive approach to problem-solving, and promoting a harmonious work environment, which healthcare teams can do to enhance collaboration, job satisfaction, and professional performance, ultimately leading to improved patient care. Other scholars also noted that workplace conflict arises when individual perspectives, goals, or interests clash with those of the team or organization. While often viewed negatively, conflict can be beneficial if managed effectively. Properly handled, conflict can foster critical thinking, creativity, and innovative solutions. Effective conflict management enables leaders to harness diverse perspectives, build stronger teams, and drive success. With the implementation of a constructive approach to conflict resolution, organizations can transform potential drawbacks into opportunities for growth and improvement. Leaders who master conflict management can unlock the full potential of their teams and achieve better outcomes (Bernburg et al., 2019; Low et al., 2019; Malla et al., 2019; Veenema et al., 2019).

Workplace conflicts are double-edged swords that can both harm and benefit the workplace environment, especially within the healthcare sector. Larasati and Raharja (2020) and Abunemeh, S. (2024) maintained that the presence of conflict can compromise the quality and efficiency of patient care. When healthcare professionals experience conflict, communication and teamwork suffer, increasing the risk of medical errors and compromising patient safety. They further explained that unresolved conflicts can hinder an organization's ability to implement strategic plans, ultimately affecting its overall performance. They advised that finding constructive ways to manage and resolve conflicts is essential to maintaining optimal organizational functioning in healthcare settings.

Overview of the Ghanaian healthcare system and its challenges

Ghana's healthcare system and structure were initially organized around its traditional values and beliefs.

The Pre-Colonial Era

During the Pre-Colonial Era in Ghana, conventional healthcare practices were prevalent, particularly in rural areas. Traditional priests, clerics, and herbalists played a significant role in providing primary healthcare to the population. These traditional healthcare providers used herbal remedies, spiritual practices, and other forms of conventional medicine to treat various ailments (Addo, J., 2019; Twumasi, P. A., 2005). The key aspects of the colonial (traditional) healthcare system focused mainly on herbal medicine, where traditional healers used local plants and herbs to create remedies for various health conditions. These remedies were often passed down through generations and were tailored to the specific needs of the community (Twumasi, P. A., 2005). It also incorporated spiritual practices, with the traditional healthcare providers often combining spiritual practices,

such as prayer and ritual ceremonies, into their healing practices. These practices were believed to have a profound impact on the physical and mental well-being of individuals (Addo, J., 2019; Twumasi, P. A., 2005; WHO, 2008). In addition, the colonial healthcare system of Ghana functioned on Community-Based Care, where the traditional healthcare providers were often deeply rooted in the community and provided care that was tailored to the specific needs of the population. This community-based approach to healthcare allowed for a more personalized and culturally sensitive form of care (WHO, 2002). The traditional healthcare system of Ghana (then the Gold Coast) was challenged due to its lack of standardization. Traditional healthcare practices were often unregulated, and the quality of care varied depending on the individual practitioner (Antwi-Baffour et al., 2014). Patrons also have limited access to modern medical facilities and equipment, including medicines, inhibiting the system's ability to provide comprehensive care (Ampomah, I.G. et al., 2020; Agyei-Baffour, P. et al., 2020; Boateng, M.A. et al., 2016).

The Colonial Era

During the Colonial Era (1874-1957), the British established a formal medical system in Ghana, focusing on hospital-based clinical care. This system primarily served expatriates and merchants in urban areas, with limited access to healthcare for the indigenous population (Twumasi, P. A., 2005). The main elements of the Colonial Medical System include Hospital-Based Care (HBC), where the British built hospitals in urban areas that were often well-equipped and staffed by European doctors and nurses, which provided westernized medical care and facilities for expatriates and merchants (Addae, S., 1997). The colonial medical system introduced Western-style medicine to Ghana, which emphasized scientific approaches to healthcare that led to the development of modern medical practices and the training of local healthcare professionals (Kilson, M.,1971). However, the colonial medical system was largely inaccessible to the indigenous population, particularly in rural areas, because the provision of healthcare services was concentrated in urban centers, leaving rural communities without adequate medical care (Patterson, K. D., 1981). The colonial healthcare system impacted Ghana in two main ways: The introduction of Western-style medicine disrupted traditional healthcare practices in Ghana. Many Ghanaians were encouraged to abandon their traditional healing practices in favor of modern medicine (Feierman, S., & Janzen, J. M., 1992). It also exacerbated healthcare disparities in Ghana. The system allowed only expatriates and merchants to have access to high-quality medical care, while the indigenous population was often left with limited or no access to healthcare services (Addo, J., 2019).

Post-Independence Healthcare in Ghana (1957-1980s)

After gaining independence in 1957, the Ghanaian government made efforts to expand healthcare services to improve access and quality of care for its citizens. However, the country faced significant challenges, including economic decline and political instability, which impacted the healthcare system. To expand healthcare services aimed to improve healthcare access, particularly in rural areas aimed to improve healthcare access, particularly in rural areas, the government invested in healthcare infrastructure, increasing the number of hospitals, clinics, and healthcare professionals (Agyepong, I. A., & Adjei, S., 2008). However, during the 1970s and 1980s, Ghana experienced a series of coups and political instability, which further exacerbated the challenges facing the healthcare system and led to a severe economic decline, resulting in reduced resources for healthcare (Arhinful, D.K., 2003).

Consequently, in the 1980s, the government introduced the "cash and carry" system, which required patients to pay out-of-pocket fees for healthcare services. This system limited access to healthcare for many Ghanaians, particularly those from low-income backgrounds (Nyonator & Kutzin, 1999). The "cash and carry" system had a devastating impact on healthcare access in Ghana, as many people were unable to afford healthcare services, leading to reduced healthcare utilization, increased morbidity and mortality, and widening health disparities (Blanchet, N. J., Fink, G., & Osei-Akoto, I., 2012).

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Health Sector Reforms in Ghana (1990s-2000s)

Ghana introduced significant health sector reforms in the 1990s and 2000s, aimed at improving the healthcare system's effectiveness, efficiency, and accessibility. Some of these key reforms included the decentralization of healthcare management, which delegated greater responsibility for healthcare delivery to the regions and districts, focusing on increasing community participation and enhancing responsiveness to local needs (Agyepong, I. A., & Adjei, S., 2008). The reform saw the establishment of Regional and District Health Management Teams (RHMTs and DHMTs) to oversee healthcare delivery, manage resources, and implement national health policies at the district level (Nyonator, F., & Kutzin, J., 1999). To ensure the effective and efficient execution of national health policies, the Ghana Health Service (GHS) was established in 1996 through an Act of Parliament (Act 525), as an autonomous body to implement national health policies. The GHS has been mandated inter alia to improve healthcare delivery by enhancing the quality and accessibility of healthcare services, promoting health research, supporting research and innovation in healthcare, and developing health human resources by strengthening the capacity of healthcare professionals (Blanchet, N. J., Fink, G., & Osei-Akoto, I., 2012).

To ensure the financial accessibility of healthcare and the achievement of Universal Health Coverage (UHC), Ghana in 2003 launched the National Health Insurance Scheme (NHIS) to provide universal healthcare coverage and eliminate out-of-pocket fees. The NHIS is grounded on Risk Pooling, a system of spreading healthcare costs across a large population to reduce financial burden on individuals. It also operates on Premium Exemptions by exempting the vulnerable populations, such as the elderly and children, from premium payments. The NHIS has a Comprehensive Benefits Package that provides a wide range of healthcare services, covering about 95% of all hospital-reported conditions, including outpatient and inpatient care, maternity services, and emergency care (Saleh, K., 2012). The health sector reforms in Ghana had a significant impact on Ghana's healthcare system, including increased healthcare utilization, particularly among previously underserved populations. It has also improved health outcomes, including reduced maternal and child mortality rates (Sodzi-Tettey, S., Aikins, M., Agyepong, I. A., & Nonvignon, J., 2012).

Ghana's Current Healthcare System

Ghana's current healthcare system operates under a mixed model, combining public and private providers to deliver healthcare services. The National Health Insurance Scheme (NHIS) is a healthcare financial arrangement that aims to provide equitable access to healthcare. According to information from Ghana's NHIS website, the NHIS is funded by the National Health Insurance Levy (NHIL), where a 2.5% value-added tax (VAT) on goods and services is dedicated to funding the NHIS. The levy was increased by 1% in 2021 to support the COVID-19 Health Recovery Levy. The NHIS is also funded through a 2.5% Social Security and National Insurance Trust (SSNIT) contribution from formal sector workers. The scheme is additionally supported by a portion of vehicle insurance paid by vehicle owners that is ceded to cover road accident victims, although this amount is relatively small. Internally Generated Funds (IGF) generated by the National Health Insurance Authority (NHIA) through premiums, registration fees, credentialing fees from healthcare providers, and investment income are also used to fund the NHIS. In 2019, IGF accounted for 7.5% of the NHIA's total revenue. The National Health Investment Fund (NHIF) also generates revenue through returns on investments made by the Fund to support the NHIS.

Despite these sources of funding to ensure uninterrupted healthcare, the NHIS in Ghana faces challenges. The NHIS faces sustainability issues due to inadequate funding, which affects its ability to provide comprehensive healthcare coverage. The scheme relies on funding sources like the National Health Insurance Levy, Social Security, and National Insurance Trust (SSNIT) contributions, and internally generated funds. However, delayed fund releases and inadequate expenditure controls exacerbate the funding challenges. Rural areas often lack access to modern healthcare facilities, forcing residents to rely on traditional medicine or travel long distances for care. Geographic disparities in healthcare access and workforce distribution are significant, with urban centers having a higher concentration of health professionals. Ghana's healthcare delivery also faces a shortage of healthcare workers, particularly in rural areas. The doctor-to-patient ratio is lower than the global average, leading to excessive workloads for existing staff and negatively impacting patient care and outcomes (Adin-Darko, D.A., 2021).

Ghana's NHIS is associated with high out-of-pocket costs can deter families from seeking timely medical help, aggravating existing health issues. This disproportionately affects low-income families, who may have to make difficult choices between seeking medical care and affording necessities. Public healthcare facilities often face infrastructure and resource constraints, including inadequate facilities, equipment, and essential medicines, leading to reduced quality of care and increased morbidity and mortality rates. There are also significant disparities in health outcomes based on geographical location, with urban areas often experiencing better health services compared to rural areas (Sellassie Sokpe, 2024).

To overcome these challenges, it is important that there should be increased funding, calling on the government to allocate a higher percentage of GDP to healthcare and explore innovative financing mechanisms. The government should also improve healthcare infrastructure, where the state should work with Public Private Partnerships (PPPs) to expand health infrastructure, especially in rural areas, and implement community-based healthcare programs. There must be a strong political and administrative commitment to strengthen the NHIS, increasing its coverage and benefits, and improving the quality of care. Healthcare must be improved through rigorous training and retraining with a focus on bridging the equity gap of healthcare workers, especially in rural areas. Preventive care must be taken seriously, with a huge investment in disease surveillance, prevention, and control, and promotion of public health campaigns and education.

Types and Causes of Workplace Conflict

The existing literature is replete with information on the causes and types of workplace conflicts. Riaz, Muhammad & Junaid, Fatima (2011) identified cultural differences, lack of employees' social intelligence, and pre-existing mindsets as the primary causes of workplace conflicts. Scholars provided two dimensions of workplace conflicts: Affective Conflict and Substantive Conflict.

Workplace Affective Conflict

Workplace affective conflict arises when the feelings and emotions of parties connected to the workplace conflict when involved in resolving a problem (Guetzkow & Gyr, 1954; & Amason, 1996; Rahim, 2010). Others described it as *relational conflict* (Jehn, 1997a) and as *emotional conflict* (Pelled, Eisenhardt, & Xin, 1999; & Schermerhorn, Hung, & Obsborn, 2002). Affective conflict has also been explained as conflict based on interpersonal clashes, such as anger, frustration, and other negative feelings, suspicion, dislike, anxiety, and bitterness (Pelled et al.,1999; Schermerhorn et al., 2002). Research suggests that this type of conflict can have detrimental effects on employees' emotional well-being and job satisfaction, ultimately leading to increased turnover intentions (Medina et al., 2005).

Workplace Substantive Conflict

Substantive workplace conflict arises when organizational members have differing opinions on task-related issues, such as goals, procedures, or decision-making processes (Guetzkow & Gyr, 1954). It is often referred to as task conflict (Jehn, 1997a; Pelled et al., 1999) or cognitive conflict (Amason, 1996). Task conflict involves disagreements about task-specific issues, including the appropriate course of action (Jehn, 1997a; Pelled et al., 1999).

Aside from affective and substantive conflicts, there are other workplace conflicts that have been identified. They include conflicts of interest where people seeking to solve the same problem prefer to address it differently (Rahim, 2001). There may also arise differences in values and ideologies among parties in addressing the same issue, which (Druckman, Broome & Korper, 1998) referred to as *'conflict of values'*. We also have *'role conflicts',* where the performance of two or more tasks by the same person results in some apathy between the person and colleagues of the same organization (Rahim, 2010).

Sources of Workplace Conflicts

Research has identified four main sources of workplace conflicts: intrapersonal, interpersonal, intragroup, intergroup, interprofessional, and organizational (Rahim, 2010; Elmagri & Eaton, 2011).

Intrapersonal and Interpersonal Conflicts

According to Nistorescu (2006), while intrapersonal conflicts arise out of differences in values or properties between parties executing a project, interpersonal conflicts, also known as social conflicts, erupt as a result of group interest differentials between parties to a project, where one party frustrates the other and prevents it from achieving a desired outcome. As Elsayed-Elkhouly (1996) explained, interpersonal conflicts in the workplace most often come as a result of personal differences, including personality, philosophy, insolence, principles, and discernment between people in the workplace. Ilies et al. (2011) noted that interpersonal differences are the most common sources of workplace conflicts, and Williams (2011) said they can be caused by workplace misattributions about perspectives and sentiments. Perusing literature, there is no ambiguity saying that workplace intrapersonal conflicts can occur within an individual, often due to conflicting values, goals, or loyalties, manifesting in several ways, such as role ambiguity coming from uncertainty about job responsibilities or expectations can lead to internal conflict, value conflict, resulting from personal values may clash with organizational values or policies, causing discomfort or guilt, and goal conflict emanating from competing goals or priorities can create tension and stress. Intrapersonal conflict can affect an individual's well-being, job satisfaction, and performance. If left unaddressed, it can lead to decreased motivation, absenteeism, or turnover. Conversely, workplace interpersonal or social conflicts arise between two or more individuals, often due to differences in personalities, values, or communication styles, which can be evident via communication breakdowns consequent to misunderstandings or miscommunications, or personality clashes, from differences in personality traits or work styles can create tension, and power struggles due to conflicts over authority, control, or resources can arise. Interpersonal conflict can impact team dynamics, productivity, and overall work environment. Effective conflict resolution strategies, such as active listening and empathy, can help manage interpersonal conflicts and improve relationships.

Intragroup and Intergroup Conflicts

Intragroup workplace conflicts occur when individuals within the same group or team have differing perspectives, values, or goals. Such conflicts can affect team cohesion, dynamics, and productivity. Intragroup conflicts come in three forms: Task Conflict, which comes from disagreements about task-related issues, such as goals, procedures, or decision-making processes; Relationship Conflict, arising out of interpersonal incompatibilities or disagreements that affect relationships within the group; and Process Conflict, manifesting from disagreements about how tasks should be accomplished or resources allocated (Jehn, 1997; Pelled et al., 1999). Intragroup conflicts are mainly caused by diversity within groups, where differences in perspectives, values, or work styles can lead to conflicts. They can also arise from role ambiguity, where uncertainty about job responsibilities or expectations can create tension, and communication breakdowns, with misunderstandings or miscommunications within groups escalating into conflicts (De Dreu & Weingart, 2003).

Intragroup conflicts can result in decreased job satisfaction by creating reduced employee or team morale and motivation among group members, negatively impact productivity and overall performance, and ultimately lead to increased turnover rates (Pelled, L. H., Eisenhardt, K. M., & Xin, K. R., 1999). Conversely, intergroup conflicts arise from disagreement or antagonism between two or more social groups, resulting from perceived incompatibility in goals, values, or resources, such as power and economic wealth. Intergroup conflicts are fueled by factors such as negative emotions, stereotypes, prejudice, and a competitive desire for scarce resources, leading to behaviors ranging from social exclusion to physical violence (Robert Böhm, Hannes Rusch, &

Jonathan Baron, 2020). Several scholars have made specific analyses of the causes of intergroup conflicts. Sherif (1966) described it as arising from competition for resources and suggested that limited organizational resources can lead to competition and tension between groups. Tajfel and Turner (1979) linked the causes to differences in goals or values, and stated that because groups deal with people with different objectives or values, the likelihood of experiencing conflict may be high. They again noted that intergroup conflicts are associated with social identity theory since group members may favor their own group and discriminate against other groups, leading to conflicts. It is also possible that intergroup conflicts can be exacerbated by poor communication or misunderstandings between groups, and power imbalances resulting from unequal power distribution between groups (Robert Böhm, Hannes Rusch, & Jonathan Baron, 2020; Tajfel and Turner, 1979; Sherif, 1966).

Interprofessional and Organizational Workplace Conflicts

Hall (2005) noted that interprofessional workplace conflicts pose a significant concern in many organizations and arise from actual or perceived contradictions of needs, values, or interests between two or more individuals from different professions. Hall (2005) maintained that interprofessional conflicts can lead to stress, tension, and negative emotions among team members, ultimately affecting patient care and team effectiveness. Scholars agreed that the causes of interprofessional conflicts are multifaceted. According to Suter et al. (2009), individual factors, such as differences in personalities, values, and communication styles, can contribute to such conflicts. Reeves et al. (2010) listed interpersonal factors, including poor communication, lack of trust, and inadequate collaboration, as causes of interprofessional workplace conflicts. Hall (2005) stated that organizational factors, such as power imbalances, inadequate resources, and unclear roles, can exacerbate interprofessional conflicts.

Thomas (1992) explained that organizational workplace conflicts emanate from disagreements or incompatibilities that arise within an organization, often resulting from differences in goals, values, or interests, noting that they can occur at various levels, including between individuals, teams, or departments, and can have significant consequences for organizational performance and employee well-being. The causes of organizational workplace conflicts are diverse. Structural factors, such as role ambiguity, overlapping responsibilities, and inadequate communication channels, can contribute to conflicts (Rahim, 2002). Additionally, interpersonal factors, including differences in personality, values, and communication styles, can also lead to conflicts (Thomas, 1992). Furthermore, organizational changes, such as restructuring or downsizing, can create an environment conducive to conflict (Jehn & Mannix, 2001).

Organizational conflicts can have far-reaching consequences, affecting various aspects of an organization. One of the primary areas impacted is productivity and performance. Research has shown that conflicts can lead to decreased productivity, efficiency, and overall performance (Rahim, 2002). When conflicts arise, employees may become distracted, demotivated, or disengaged, ultimately affecting the organization's ability to achieve its goals. Employee morale and job satisfaction are also significantly affected by organizational conflicts. Unresolved conflicts can result in decreased job satisfaction, increased stress, and lower employee morale, leading to increased absenteeism, turnover rates, and recruitment costs, ultimately affecting the organization's bottom line (Jehn & Mannix, 2001).

Communication and collaboration can break down when organizational conflicts occur. Research has shown that such conflicts can disrupt communication channels, leading to misunderstandings, miscommunications, and a breakdown in collaboration among team members, departments, or levels of management, and ultimately impede decision-making processes, leading to delays or poor decisions (Thomas, 1992). Organizational conflicts can damage the organizational culture, leading to a toxic work environment. An organizational culture with conflict can stifle innovation and creativity, as employees may become less willing to share ideas or collaborate, and may ultimately impact customer satisfaction, particularly if conflicts affect service delivery or product quality (Rahim, 2002).

Workplace Conflict in the Ghanaian Context

Workplace conflict in the Ghanaian context arises from various sources, including cultural, organizational, and individual factors. One of the primary causes of workplace conflict in Ghana is the cultural dynamics that shape employee behavior and interactions. According to a study by Boachie-Mensah and Seidu (2012), Ghanaian employees place a high value on respect and hierarchy, which can lead to conflicts when these values are not

adhered to. Additionally, organizational factors, such as poor communication, inadequate resources, and unclear roles and responsibilities, including the lack of effective conflict management strategies and training, can also contribute to and exacerbate workplace conflicts, leading to decreased productivity and employee dissatisfaction (Mensah & Agyemang, 2017). Furthermore, individual factors, like personality differences, work style, disregard for traditional Ghanaian values, such as respect for authority and communalism, can adversely influence employee behavior and interactions, potentially leading to conflicts (Amponsah & Adams, 2016). Understanding these general causes of workplace conflict is crucial for developing effective conflict management strategies in the Ghanaian context. Organizational leadership needs to acknowledge the cultural, organizational, and individual factors that contribute to conflict, and take pragmatic steps to prevent and resolve them to improve employee relationships and overall performance.

Cultural Drivers of Workplace Conflicts in Ghana vis-à-vis other African or global contexts.

With respect to the African Continent, experts revealed that Ghana's unique cultural drivers of workplace conflicts are deeply rooted in its collectivist culture, which emphasizes communal responsibility and harmony within the community. This cultural context influences how conflicts are perceived and addressed in the workplace. They talked of Communal Values vs. Individualism and maintained that Ghanaians tend to prioritize communal, societal, or shared values over individual interests, and this sometimes leads to conflicts when personal goals clash with collective expectations, Respect for Authority and Elders, where traditional Ghanaian culture places significant emphasis on respect for authority and elders, which affects workplace dynamics, particularly in conflicts involving senior staff or authority figures, High-Context Communication, where they alluded that Ghanaian communication styles often rely on implicit cues, shared knowledge, and context, which provide fertile grounds for misunderstandings or miscommunications in the workplace, especially in multicultural settings, and Cultural Diversity and Ethnicity, where Ghana a home to many ethnic groups, each with its own distinct culture and language, often sloganeered 'diversity can be a strength' often leads to conflicts stemming from historical grievances, cultural differences, or competition for resources (Justice Reuben Aduse, 2024; Abbey Francis, 2004; Martha Anyimiah Ackah, 2014). Compared to other African contexts, Ghana's cultural drivers of workplace conflicts differ in terms of the level of cultural homogeneity. They maintained that while some African countries have more homogeneous cultures, Ghana has a more diverse cultural heritage, which makes cultural integration difficult (Justice Reuben Aduse, 2024; Abbey Francis, 2004; Martha Anyimiah Ackah, 2014).

Experts say that despite having a complex clan system, Somalia has a relatively homogeneous cultural identity shaped by its shared language (Somali), religion (Islam), and geographic location. Although Lesotho is a small mountainous country, it is predominantly Sesotho-speaking and has a distinct cultural identity. According to them, despite Mauritania's cultural diversity, Mauritania has a strong Arab-Berber influence and a dominant Islamic faith, contributing to its relatively homogeneous cultural identity. In Rwanda, after the 1994 genocide, the country has made efforts to promote national unity and a shared cultural identity, although ethnic tensions still exist. In Burundi, similar to Rwanda, the country has a complex history, but it's working towards a more unified cultural identity. Other contributors to Ghana's unique cultural identity include its Traditional Authority Structures, where the role of traditional authority figures, such as chiefs and elders, varies significantly across African cultures, providing a distinct cultural identity and heritage to Ghanaians in contrast to other African nations. For example, the Asantes, Akans, Ewes, Fantes, Dagombas, Gonjas, and others have varied cultural norms that do not align with each other. Ghana's Colonial Legacy, the British colonization of the country also had a lasting impact on its cultural and institutional landscape, influencing workplace dynamics and conflict resolution (UNICEF, 1995; Rashmi Jawalkar, 2014; Shaan Roy, 2024)

In global contexts, Ghana's cultural drivers of workplace conflicts differ in terms of Individualism vs. Collectivism. Generally, Ghana's cultural drivers of workplace conflicts differ significantly from those in more individualistic cultures, such as those found in many Western countries. Ghana's collectivist culture and emphasis on group harmony dominate individual interests, a situation that has led to different workplace conflicts and extended resolution approaches and expectations in the workplace beyond its normal borders (Abbey Francis, 2004; University of Ghana, 2014).

Research has shown that in Ghana's premium on power distance and respect for authority and elders most often led to different conflict resolution approaches as compared to cultures with lower power distance. Also, Ghana's

high-context communication style requires different approaches to conflict resolution compared to other global low-context cultures. It is a common practice in Ghana that most workplace conflicts have to be finally resolved by community elders and traditional authorities instead of the normal organizational conflict resolution structures (Abbey Francis, 2004; University of Ghana, 2014). Abbey Francis (2004) further confirmed that workplace conflicts in Ghana most often arise from multiple sources, including interpersonal conflicts, structural conflicts, and cultural differences, and this requires a deeper understanding of the cultural nuances and context-specific approaches for their effective resolution.

Workplace conflicts in Ghana that could be mediated through cultural and traditional domains include land disputes between companies and local communities. Unlike other global contexts, in Ghana, land disputes often arise between companies and local communities, particularly in rural areas where traditional leaders hold significant authority. Traditional leaders could mediate these disputes, leveraging their knowledge of local customs and land ownership norms to find mutually beneficial solutions. Also, workplace conflicts between employees from different ethnic backgrounds are commonly resolved through cultural and traditional domains. Ghana's diverse ethnic landscape can sometimes lead to workplace conflicts between employees from different backgrounds. Traditional leaders or respected community elders could facilitate dialogue and mediation to resolve these conflicts and promote a harmonious work environment. Furthermore, the Ghanaian workplace experiences disputes over employment practices and cultural norms. Conflicts arise when companies adopt employment practices that clash with local cultural norms. For instance, disagreements over working hours during traditional festivals or respect for authority. In these instances, traditional leaders help mediate these disputes, finding solutions that balance business needs with cultural sensitivities (Senyo, M. Agyabeng, 2007; Feyisaso Ajayi, 2025; Alhaji Khuzaima Mohammed Osman, 2025). Senyo, M. Agyabeng (2007) stated that in Ghana, traditional conflict resolution mechanisms often emphasize restorative justice, focusing on restoring harmony and balance within the community rather than punishing wrongdoers. Alternative Dispute Resolution (ADR) mechanisms, such as mediation and arbitration, are also being increasingly used to resolve workplace conflicts.

Conceptual Model: Workplace Conflicts and Healthcare Performance
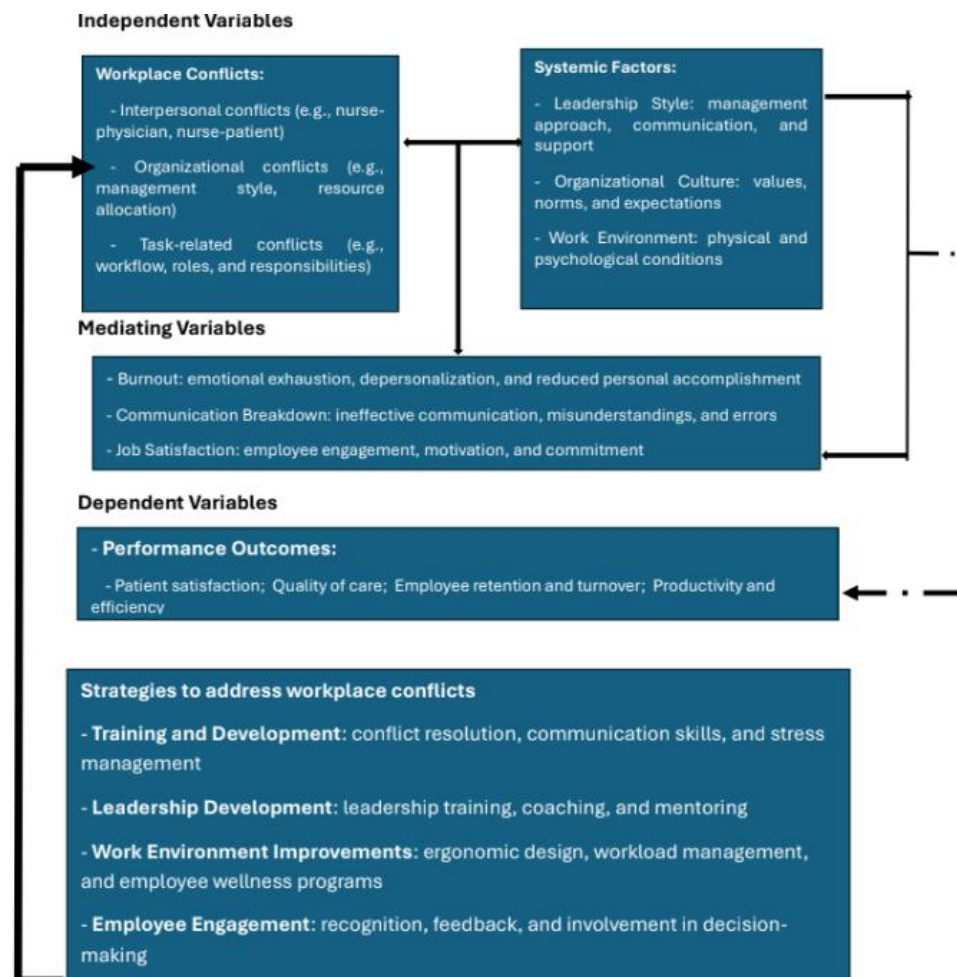
This model is informed by existing frameworks, such as the Job Demands-Resources (JD-R) model and the Maslach Burnout Inventory (MBI). By understanding the relationships between these variables, healthcare organizations can develop targeted interventions to mitigate the negative effects of workplace conflicts and improve performance outcomes (Nagle, E., Griskevica, I., Rajevska, O. *et al., 2024).* The conceptual framework proposes that systemic factors, such as leadership style, organizational culture, and work environment, influence the occurrence and impact of workplace conflicts in healthcare settings. These conflicts, in turn, affect performance outcomes, such as patient satisfaction, quality of care, employee retention, and productivity. The framework suggests that workplace conflicts can lead to burnout and communication breakdowns among healthcare professionals, which can further exacerbate the negative impact on performance outcomes. The framework proposes that addressing systemic factors and implementing various strategies under Training and Development, Leadership Development, Work Environment Improvements, and Employee Engagement can help mitigate conflicts and support healthcare professionals. Organizations can potentially improve performance outcomes. The framework implies that effective leadership, a positive organizational culture, and a supportive work environment can help reduce the occurrence and impact of workplace conflicts, leading to improved performance outcomes. To ensure high performance, organizations must understand the relationships between these variables and develop targeted interventions to improve performance and provide high-quality patient care.

Unique challenges and stressors of workplace conflicts in the Ghanaian healthcare system

The Ghanaian healthcare system faces unique challenges and stressors that contribute to workplace conflicts. One of the primary concerns is the shortage of healthcare workers, particularly in rural areas, which has led to excessive workloads and burnout among staff, which has resulted in role ambiguity and overlapping responsibilities, further exacerbating conflicts (Agyei-Baffour et al., 2017). In addition, workplace violence is a significant issue in the Ghanaian healthcare setting, with clinical staff and other health professionals experiencing physical and verbal abuse from their managers, patients, and their relatives. This phenomenon has exacerbated stress, anxiety, burnout, disillusionment, depression, and turnover among healthcare workers (Aziato & Omenyo, 2018). Perhaps, complicating the issue is the challenge of resource limitations and inadequacy. Healthcare facilities in Ghana generally lack infrastructure, including inadequate equipment, medicines, and non-drug consumables, general supplies, and other medical facilities, which have contributed immensely to frustration and conflict among healthcare workers, since they are unable to provide the best quality of care that patrons of healthcare deserve (Gilson et al., 2017). Furthermore, cultural and socio-economic factors have adversely impacted workplace dynamics and conflict in the Ghanaian healthcare context. For example, the lack of mutual respect between the rank and file within the health sector in Ghana is a cause for worry. It is also true that conflicts within the Ghanaian healthcare environment are rife, as most often, the system experiences conspicuous communication breakdowns and conflict between senior and junior staff members (Boachie-Mensah & Seidu, 2012).

The Ghanaian healthcare system is also plagued by various HR-related issues that contribute to workplace conflict. One of the primary concerns is inadequate staffing and workload imbalance, which has led to burnout and decreased job satisfaction among healthcare professionals. The significant shortage of healthcare workers, particularly in rural areas, exacerbates this issue, resulting in excessive workloads and stress (Agyei-Baffour et al., 2017). The system is also challenged by the lack of clear job descriptions and roles, which has resulted in task-related confusion, overlapping work, and role conflicts among team members (Gilson et al., 2017). Limited career development opportunities, workplace violence, welfare, and safety concerns also contribute to workplace conflict in Ghana's healthcare system. In many cases, healthcare professionals feel undervalued and unsupported, leading to demotivation and dissatisfaction, resulting in conflicts (Aziato & Omenyo, 2018).

Highlights of Industrial Actions from Unresolved Workplace Conflicts in the Health Sector in Ghana

One common effect of workplace conflicts within the Ghanaian health context is industrial (strike actions) by aggrieved parties, especially the caregivers, with patients being the most affected. Statistics from the Ghana Labour Commission in 2008 indicated that out of 28 major strikes that occurred in Ghana stemming from workplace-related conflicts, Korle Bu Teaching Hospital (KBTH) alone recorded 13 of them (46%) (Awori, S. N., & Tettey-Enyo, A., 2015). A conflict between junior nurses and midwives in 2016 resulted in an industrial action involving more than 7,000 of them, which adversely impacted healthcare delivery (Peacefmonline, 2016). In August 2015, the Government and Hospital Pharmacists Association (GHOSPA) initiated a nationwide strike

due to dissatisfaction with their placement on the Single Spine Salary Structure (SSSS). Approximately 600 pharmacists across Ghana participated, significantly impacting outpatient services in regional hospitals. The strike was sparked by GHOSPA's frustration with the Finance Ministry's failure to implement a directive from the Chief of Staff regarding salary adjustments. Despite assurances from government officials, the pharmacists' concerns remained unaddressed, leading to the industrial action (Graphic Online, 2016). Between 2011 and 2017, consequent to unresolved workplace conflicts, the Ghana Association of Biomedical Laboratory Scientists (GABMLS) on two occasions laid down their tool. First, over the discrepancies and distortions in their placement on the Single Spine Salary Structure (SSSS), and second, over the government's delayed implementation of the National Health Laboratory Policy (NHLP). In both cases, clinical care came to a halt since clinicians were unable to arrive at diagnoses without the appropriate investigation results (Joyonline, 2011; CitiFMonline, 2016). The Ghana Registered Nurses and Midwives Association (GRNMA) in 2020, following a breakdown in negotiations with the Fair Wages and Salary Commission on their conditions of service, again embarked on an industrial action (Ampofo, P.O. et al., 2022). Very recently, in June 2025, the Ghana Registered Nurses and Midwives Association (GRNMA) laid down their tools, resulting from unsettled conflicts prompted by the delay in implementing some conditions of service, the government's failure to address members' key welfare concerns, and the annulment of public sector appointments made after December 7, 2024, which affected many newly qualified nurses (Joshua Bediako Koomson & Joyce Awuni, 2025; Peju Aderogba, 2025).

Effects of Workplace Conflict on Healthcare Delivery in Ghana

In their study, which evaluated the impact of conflicts among clinical care professionals on patient care in the Tamale Teaching Hospital (TTH) in Ghana, Konlan, K. D. et al. (2023) found that conflicts within the health sector have both positive and negative ramifications. Konlan, K. D. et al. (2023) discovered that workplace conflicts can be a catalyst for positive change, driving individuals to think critically and approach problems with creativity. They also found that workplace conflicts can be an avenue for fostering open discussion and debate to ensure that ideas are thoroughly vetted and that the most effective solutions are implemented. Their findings further revealed that conflict can serve as a checks-and-balances mechanism, promoting accountability and adherence to institutional policies and laws. Konlan, K. D. et al. (2023) noted that the emotional toll of conflict in healthcare institutions is significant, leading to frustration, burnout, and decreased job satisfaction among healthcare professionals. Also, the time and resources spent on resolving conflicts detract from patient care, compromising the quality of services provided, and increasing the risk of medical errors (negligence), delayed or inadequate treatment, decreased patient satisfaction, increased morbidity, and mortality, leading to generally poor health outcomes.

Ampofo, P.O. et al (2022) found that a nationwide industrial action declared by the Ghana Registered Nurses and Midwives Association (GRNMA) in 2020, following a breakdown in negotiations with the Fair Wages and Salary Commission on their conditions of service, had a significant impact on healthcare service utilization, as service delivery in over 70% of the country was severely disrupted. The study further discovered that there was more than a 100% post-strike surge in service use, suggesting a substantial backlog of patients and unmet healthcare needs.

The June 2025 Ghana Registered Nurses and Midwives Association (GRNMA) was again occasioned by grievances, including delayed conditions of service negotiations, the government's failure to address key welfare concerns, and the annulment of public sector appointments made after December 7, 2024, which affected many newly qualified nurses. Especially in the nation's capital, Accra, there was evidence of major disruption of service delivery in major healthcare facilities, including the Korle Bu Teaching Hospital, the Greater Accra Regional Hospital (Ridge), and the Adabraka Polyclinic, as nurses and midwives deserted their posts (the wards and consulting rooms) to the detriment of patients (Joshua Bediako Koomson & Joyce Awuni, 2025; Peju Aderogba, 2025). These findings highlight the consequences of workplace conflicts in the health sector and the need for effective conflict resolution strategies to minimize disruptions to patient care.

Managing Workplace Conflicts

Research has shown that workplace conflicts of any form can collapse the organization if not properly managed (De Dreu C.K.W. et al., 2003; Jehn K.A., 1993; Pelled, L. H., 1999). According to Katz (2013), effective conflict management requires a multifaceted approach, tailored to the specific type of conflict. Intrapersonal conflicts,

which arise from internal contradictions or ambiguities, can be managed through self-reflection, journaling, or seeking guidance from a mentor or coach, and individuals can also engage in stress management techniques, such as meditation or deep breathing, to reduce emotional turmoil. Interpersonal conflicts, which occur between individuals, can be managed through effective communication, active listening, and empathy. Conflict resolution strategies, such as mediation or negotiation, can also be employed to resolve disputes. Building strong relationships, based on trust and respect, can help prevent interpersonal conflicts from arising (Beebe & Masterson, 2012). (Beebe & Masterson, 2012).

Intragroup conflicts can be controlled through team-building activities, open communication, and clear goal-setting. Leadership of organizations can also foster a positive team culture, encouraging collaboration and respect among team members. Intragroup conflicts can also be managed by establishing clear roles and responsibilities, reducing role ambiguity and conflict (Wheelan, 2005). Organizations can reduce intergroup conflicts through intergroup dialogue, collaboration, and shared goal-setting. Leaders can also encourage communication and cooperation between groups, reducing stereotypes and biases. Intergroup conflicts can also be managed by establishing clear policies and procedures, reducing ambiguity and conflict (Sherif, 1966).

Reeves et al. (2010) advised that interprofessional conflicts can be managed through interprofessional education, training, and collaboration. Healthcare professionals can learn to appreciate the perspectives and expertise of other professions, reducing conflicts and improving patient care. Organizational conflicts, which occur at the organizational level, can be managed through effective leadership, communication, and conflict resolution strategies. It is also important for organizations to establish clear policies and procedures, as well as foster a positive organizational culture, encouraging collaboration and respect among employees to reduce ambiguity and conflict (Rahim, 2002).

CONCLUSION AND FUTURE DIRECTIONS

In conclusion, effective conflict management requires a tailored approach, addressing the specific needs and circumstances of each type of conflict. By understanding the causes and consequences of conflict, individuals and organizations can develop strategies to manage and resolve conflicts, improving relationships, productivity, and overall well-being.

Summary of key findings and implications for healthcare delivery in Ghana

From this review, it is evident that workplace conflicts in Ghana's health sector are a pressing concern, impacting both healthcare professionals and patients. The major findings are that:

1. Workplace conflicts in the health sector can lead to reduced patient care, increased absenteeism, and turnover among healthcare professionals.

2. Common causes of conflicts include inadequate staffing, poor resource allocation, remuneration, and conditions-of-service-related issues, lack of clear job descriptions, and communication breakdowns.

3. The healthcare system in Ghana faces significant challenges, including workforce shortages, regional disparities, and limited resources.

4. Workplace conflicts within the health sector in Ghana arise mainly from differences in values, priorities, and personalities among healthcare professionals.

These findings have significant implications for healthcare delivery in Ghana, including:

1. **Compromised Patient Care:** Workplace conflicts can lead to reduced patient care, compromising health outcomes and patient safety.

2. **Healthcare Professional Burnout:** Increased absenteeism and turnover among healthcare professionals can exacerbate workforce shortages, further straining the healthcare system.

3. **Inefficient Resource Utilization:** Poor resource allocation and communication breakdowns can lead to inefficient use of limited resources, hindering healthcare delivery.

4. **Regional Disparities:** Workplace conflicts and systemic challenges can exacerbate existing regional disparities in healthcare access and outcomes.

5. **Staff Retention and Recruitment:** Unaddressed conflicts and poor working conditions can make it challenging to retain and recruit healthcare professionals, perpetuating workforce shortages.

Suggestions for Reducing Workplace Conflicts in the Health Sector

In truth, conflicts are as natural as the human race and may be extremely difficult to completely avoid. However, they can be minimized to ensure a harmonious work environment and high organizational performance. Some of the steps that can help reduce workplace conflicts within the health sector, especially in Ghana, inter alia, are:

1. **Conflict Management Training:** There must be the provision of regular training for healthcare professionals and managers on conflict management, effective communication, and emotional intelligence.

2. **Early Detection and Intervention:** Mechanisms that encourage early detection of conflicts and intervene should be implemented promptly to prevent escalation.

3. **Collaborative Problem-Solving:** Leadership should foster a culture of collaboration and teamwork that encourages open communication and mutual respect among healthcare professionals.

4. **Improved Communication:** Across the board, the implementation of effective communication strategies, including active listening, clear expectations, and regular feedback, must be vigorously pursued.

5. **Addressing Systemic Issues:** Leadership must at all times address underlying systemic issues, such as workforce shortages and resource constraints, to reduce the likelihood of conflicts.

6. **Leadership Support:** Leaders and managers must be supported and equipped to manage conflicts effectively and promote a positive work environment.

It is important to know that when managing workplace conflicts, these approaches can be employed; however, each of them has its own strengths and limitations. Avoidance involves sidestepping conflicts or postponing resolution, which may be suitable for minor issues but can lead to unresolved problems and growing frustration if not addressed properly. Leaders and managers must know that in conflict management, adopting a competing approach, characterized by assertiveness and directness, can be effective in crises where swift action is necessary. However, this method may damage relationships if not handled carefully. Accommodation prioritizes cooperation over assertiveness, which can be beneficial for building relationships. Nevertheless, it may result in feelings of resentment if one party consistently sacrifices their needs. Compromise involves finding a middle ground, which can facilitate quick resolutions. Yet, this approach might not fully satisfy all parties' needs, potentially leaving some concerns unaddressed. Collaboration, which involves working together to find a mutually beneficial solution, is often considered the most effective approach for managing workplace conflicts. When open communication and cooperative problem-solving are used, collaboration can lead to outcomes that meet the needs of all parties involved, strengthening relationships and promoting a positive work environment.

Future research directions and potential areas for improvement

Future research should focus on the following:

1. **Context-specific conflict management models**: Developing context-specific conflict management models tailored to the Ghanaian health sector, taking into account its unique challenges and cultural nuances.

2. **Impact of conflict on patient outcomes:** Investigating the relationship between workplace conflict and patient outcomes, including morbidity, mortality, and patient satisfaction.

3. **Conflict management training:** Evaluating the effectiveness of conflict management training programs for healthcare professionals in Ghana and identifying areas for improvement.

4. **Workplace culture and conflict:** Examining the role of workplace culture in shaping conflict dynamics and identifying strategies to promote a positive work environment.

5. **Healthcare professional well-being:** Investigating the impact of workplace conflict on healthcare professionals' well-being, including burnout, job satisfaction, and mental health.

6. **Technology-based conflict resolution:** Exploring the potential of technology-based conflict resolution tools, such as online mediation platforms, to improve conflict management in the health sector.

7. **Stakeholder engagement:** Engaging with stakeholders, including healthcare professionals, patients, and policymakers, to identify priorities and develop effective conflict management strategies.

8. **Longitudinal studies:** Conducting longitudinal studies to examine the long-term impact of workplace conflict on healthcare professionals and patient outcomes.

It is anticipated that exploring these areas would assist future research to contribute to the development of effective conflict management strategies, improving the work environment and patient care in Ghana's health sector.

Funding:

Conflict of Interest:

The author declares no conflict of interest.

REFERENCES

1. Abunemeh, S. (2024). Investigating the Impact of Conflict Management Approaches on Organizational Productivity in Healthcare Settings: A Qualitative Exploration. Open Journal of Social Sciences, **12**, 322-335. doi: 10.4236/jss.2024.1211023.
2. Bernburg, M., Groneberg, D. A., & Mache, S. (2019). Mental health promotion intervention for nurses working in German psychiatric hospital departments: A pilot study. Issues in Mental Health Nursing, 40(8), 706-711.
3. Larasati, R., & Raharja, S. (2020). Conflict Management in Improving Schools' Effectiveness. In Proceedings of the 3rd International Conference on Learning Innovation and Quality Education (pp. 191-197). Atlantis Press. https://doi.org/10.2991/assehr.k.200129.025
4. Daniel Asare Adin-Darko (2021, September 20). Earmarking in Ghana: Impacts on the Financial Sustainability of the National Health Insurance Scheme. JLN Network Manager. https://jointlearningnetwork.org/earmarking-in-ghana-impacts-on-the-financial-sustainability-of-national-health-insurance
5. Hanifa, S. M., Ismail, Z., Ahmad, S., & Arsat, Z. (2020). Work-Family Conflict and Psychological Health Among Nurses: A Preliminary Observation. https://scite.ai/reports/10.47405/mjssh.v5i7.449
6. Veenema, T. G., Burkle, F. M., & Dallas, C. E. (2019). The nursing profession: A critical component of the growing need for a nuclear global health workforce. Conflict and Health, 13, 9.
7. Low, B. K. L., Man, S. S., Chan, A. H. S., & Alabdulkarim, S. (2019). Construction worker risk-taking behavior model with individual and organizational factors. International Journal of Environmental Research and Public Health, 16(8).

8. Malla, A., Margoob, M., Iyer, S., Majid, A., Lal, S., Joober, R., & Issaoui Mansouri, B. (2019). Testing the effectiveness of implementing a model of mental healthcare involving trained lay health workers in treating major mental disorders among youth in a conflict-ridden, low-middle income environment: Part II results. The Canadian Journal of Psychiatry, 64(9), 630-637.

9. Mohseni, F., Mohammadi, A., Mafinejad, M. K., Gruppen, L. D., & Khajavirad, N. (2022). Development and Validation of Conflict Management Attitude Questionnaire for Medical Students. BMC Medical Education, 22, Article No. 860. https://doi.org/10.1186/s12909-022-03928-0

10. Piryani, Rano Mal & Piryani, Suneel. (2019). Conflict Management in Healthcare. Journal of Nepal Health Research Council. 16. 481-482. 10.33314/jnhrc.v16i41.1703.

11. Addo, J. (2019). Traditional medicine in Ghana: A review of the current state of knowledge. Journal of Ethnopharmacology, 231, 145-155.

12. Twumasi, P. A. (2005). Medical systems in Ghana: A healing process. Ghana Universities Press.

13. WHO. (2008). Traditional medicine. World Health Organization.

14. Ampomah, I.G., Malau-Aduli, B.S., Malau-Aduli, A.E.O., & Emeto, T.I. (2020). Effectiveness of Integrated Health Systems in Africa: A Systematic Review. Medicina, 56(6), 271. https://doi.org/10.3390/medicina56060271

15. Agyei-Baffour, P., Kudolo, A., Quansah, D., & Boateng, D. (2017). Integrating herbal medicine into mainstream healthcare in Ghana: Clients' acceptability, perceptions, and disclosure of use. BMC Complementary and Alternative Medicine, 17, 513.

16. Boateng, M.A., Danso-Appiah, T., Turkson, B.K., & Tersbøl, B.P. (2016). Integrating biomedical and herbal medicine in Ghana—experiences from the Kumasi South Hospital: A qualitative study. BMC Complementary and Alternative Medicine, 16, 189.

17. Twumasi, P. A. (2005). Medical systems in Ghana: A healing process. Ghana Universities Press.

18. Addae, S. (1997). The evolution of modern medicine in Ghana: A historical perspective. Ghana Medical Journal, 31(2), 547-554.

19. Kilson, M. (1971). African urban kinsmen: The Ga of central Accra. C. Hurst & Co.

20. Patterson, K. D. (1981). Health in colonial Ghana, 1860-1914. Crossroads Press.

21. Feierman, S., & Janzen, J. M. (1992). The social basis of health and healing in Africa. University of California Press.

22. Nistorescu, T., 2006, Patterns And Strategies of Interpersonal Conflicts Mediation During The Projects, University of Craiova

23. Elsayed-Elkhouly, S. M. (1996), Styles of Handling Personal Conflict in Egypt. United States, Africa, and the Gulf States, Cross-Cultural Management: An International Journal, Vol. 3, No. 1, pp. 20-32

24. Williams, F. (2011), Interpersonal Conflict: The Importance of Clarifying Manifest Conflict Behavior, International Journal of Business, Humanities and Technology Vol. 1 No. 3; P. 149

25. Ilies, R., Johnson, MD., Judge, T.A. & Keeney, J. (2011), A within-individual study of interpersonal conflict as a work stressor: Dispositional and situational moderators, Journal of Organizational Behavior, 32, 44–64

26. Elmagri, M.I. and Eaton, D. (2011), Identifying the Factors Causing Interpersonal Conflict in Organizations (Through Analyzing Secondary Data), The Built & Human Environment Review, Volume 4, Special Issue 1, P. 60

27. Beheshtifar, Malikeh & Zare, Elham. (2013). Interpersonal Conflict: A Substantial Factor to Organizational Failure. International Journal of Academic Research in Business and Social Sciences. 3. 2222-6990.

28. Rahim, M.A. (2010), Managing Conflict in Organizations (3rd ed). London: Quorum Books.

29. Druckman, D., Broome, B.J. & Korper, S. H., (1988), Value differences and conflict resolution: Facilitation or delinking? Journal of Conflict Resolution, 32, pp 489-510.

30. Pelled, L. H., Eisenhardt, K. M., & Xin, K. R. (1999). Exploring the black box: An analysis of work group diversity, conflict, and performance. Administrative Sciences Quarterly, 44, pp 1-28.

31. Jehn, K. (1997a), A Qualitative Analysis of Conflict Types and Dimensions in Organizational Groups. Administrative Science Quarterly, 42, pp 530-557

32. Medina, J. F., Munduate, L., Dorado, A. M., Martinez, I., & Guerra, M. J. (2005). Types of Intragroup conflict and affective reactions. Journal of Managerial Psychology, 20, pp 219-230.

33. Schermerhorn, R. J(Jr), Hunt, G.,& Osborn, (2002), Organizational Behavior", (7th ed.), Wiley.

34. Amason, A. C. (1996), Distinguishing the effects of functional and dysfunctional conflict on strategic decision making: Resolving a paradox for top management teams. Academy of Management Journal, 39, pp 123-148.

35. Guetzkow, H, & Gyr, J. (1954). An analysis of conflict in decision-making groups. Human Relations, 7, pp 367-382.

36. Riaz, Muhammad & Junaid, Fatima. (2011). Types, Sources, Costs & Consequences of Workplace Conflict(Link). Asian Journal of Management Research. , Volume 2. Pp. 600-611. https://www.researchgate.net/publication/236120015_Types_Sources_Costs_Consequences_of_Workplace_ConflictLink

37. Agyepong, I. A., & Adjei, S. (2008). Public social policy development and implementation: A case study of the Ghana National Health Insurance scheme. Health Policy and Planning, 23(2), 79-89.

38. Arhinful, D. K. (2003). The solidarity of self-interest: Social and cultural feasibility of rural health insurance in Ghana. Koninklijke Brill NV.

39. Nyonator, F., & Kutzin, J. (1999). Health for some? The effects of user fees in the Volta Region of Ghana. Health Policy and Planning, 14(4), 329-341.

40. Blanchet, N. J., Fink, G., & Osei-Akoto, I. (2012). The effect of Ghana's National Health Insurance Scheme on health care utilization. BMC Health Services Research, 12, 1472-6963.

41. Saleh, K. (2012). A health sector in transition: The case of Ghana. World Bank.

42. Sodzi-Tettey, S., Aikins, M., Agyepong, I. A., & Nonvignon, J. (2012). Challenges in provider payment under the Ghana National Health Insurance Scheme: A case study of claims management in two districts. Ghana Medical Journal, 46(2), 67-76.

43. Sellassie Sokpe (2024, June 29). Ghana's Healthcare System: Challenges & Solutions. Better Ghana Digest. https://betterghanadigest.com/2024/06/29/ghanas-healthcare-system-challenges-solutions-george-ocansey-writes

44. De Dreu, C. K. W., & Weingart, L. R. (2003). Task versus relationship conflict, team performance, and team member satisfaction: A meta-analysis. Journal of Applied Psychology, 88(4), 741-749.

45. Jehn, K. A. (1997). A qualitative analysis of conflict types and dimensions in organizational groups. Administrative Science Quarterly, 42(3), 530-557.

46. Pelled, L. H., Eisenhardt, K. M., & Xin, K. R. (1999). Conflict in multicultural teams: The effects of diversity, task, and relationship conflicts on outcomes. Academy of Management Journal, 42(4), 374-386.

47. Sherif, M. (1966). In common predicament: Social psychology of intergroup conflict and cooperation. Houghton Mifflin.

48. Tajfel, H., & Turner, J. C. (1979). An integrative theory of intergroup conflict. The Social Psychology of Intergroup Relations, 33, 47.

49. Robert Böhm, Hannes Rusch, Jonathan Baron (2020). The psychology of intergroup conflict: A review of theories and measures. Journal of Economic Behavior & Organization, Volume 178, Pages 947-962, ISSN 0167-2681, https://doi.org/10.1016/j.jebo.2018.01.020.

50. Sherif, M. (1966). In common predicament: Social psychology of intergroup conflict and cooperation. Houghton Mifflin.

51. Tajfel, H., & Turner, J. C. (1979). An integrative theory of intergroup conflict. The Social Psychology of Intergroup Relations, 33, 47.

52. Robert Böhm, Hannes Rusch, Jonathan Baron (2020). The psychology of intergroup conflict: A review of theories and measures. Journal of Economic Behavior & Organization, Volume 178, Pages 947-962, ISSN 0167-2681, https://doi.org/10.1016/j.jebo.2018.01.020.

53. Sherif, M. (1966). In common predicament: Social psychology of intergroup conflict and cooperation. Houghton Mifflin.

54. Tajfel, H., & Turner, J. C. (1979). An integrative theory of intergroup conflict. The Social Psychology of Intergroup Relations, 33, 47.

55. Robert Böhm, Hannes Rusch, Jonathan Baron (2020). The psychology of intergroup conflict: A review of theories and measures. Journal of Economic Behavior & Organization, Volume 178, Pages 947-962, ISSN 0167-2681, https://doi.org/10.1016/j.jebo.2018.01.020.

56. Hall, P. (2005). Interprofessional teamwork: Professional cultures as barriers. Journal of Interprofessional Care, 19(sup1), 188-196.

57. Reeves, S., Lewin, S., Espin, S., & Zwarenstein, M. (2010). Interprofessional teamwork for health and social care. Wiley-Blackwell.

58. Suter, E., Arndt, J., Arthur, N., Parboosingh, J., Taylor, E., & Deutschlander, S. (2009). Role understanding and effective communication as core competencies for collaborative practice. Journal of Interprofessional Care, 23(1), 41-51.

59. Jehn, K. A., & Mannix, E. A. (2001). The dynamic nature of conflict: A longitudinal study of intragroup conflict and group performance. Academy of Management Journal, 44(2), 238-251.

60. Rahim, M. A. (2002). Toward a theory of managing organizational conflict. International Journal of Conflict Management, 13(3), 206-235.

61. Thomas, K. W. (1992). Conflict and negotiation processes in organizations. In M. D. Dunnette & L. M. Hough (Eds.), Handbook of industrial and organizational psychology (Vol. 3, pp. 651-717). Consulting Psychologists Press.

62. Beebe, S. A., & Masterson, J. T. (2012). Communicating in small groups: Principles and practices. Pearson.

63. Rahim, M. A. (2002). Toward a theory of managing organizational conflict. International Journal of Conflict Management, 13(3), 206-235.

64. Wheelan, S. A. (2005). Group processes: A developmental perspective. Pearson.

65. Amponsah, K. D., & Adams, P. J. (2016). Workplace conflict and employee performance in Ghana: A study of the banking sector. Journal of Business and Management, 12(1), 1-11.

66. Boachie-Mensah, F. O., & Seidu, P. A. (2012). Employees' perception of workplace conflict in Ghanaian organizations. Journal of Management and Organization, 18(4), 534-548.

67. Mensah, A. O., & Agyemang, C. B. (2017). Conflict management strategies in Ghanaian organizations: A study of the public sector. Journal of Conflict Management, 20(1), 34-50.

68. Agyei-Baffour, P., Agyepong, I. A., & Ogbu, F. A. (2017). Health workforce challenges in Ghana: Perceptions of professionals. Human Resources for Health, 15(1), 1-11.

69. Aziato, L., & Omenyo, C. N. (2018). Workplace violence and coping strategies among nurses in Ghana. Journal of Nursing Education and Practice, 8(3), 1-9.

70. Boachie-Mensah, F. O., & Seidu, P. A. (2012). Employees' perception of workplace conflict in Ghanaian organizations. Journal of Management and Organization, 18(4), 534-548.

71. Gilson, L., Hanson, K., Sheikh, K., Agyepong, I. A., Ssengooba, F., & Bennett, S. (2017). Building the field of health policy and systems research: Framing the questions. PLoS Medicine, 14(11), e1002442.

72. Agyei-Baffour, P., Agyepong, I. A., & Ogbu, F. A. (2017). Health workforce challenges in Ghana: Perceptions of professionals. Human Resources for Health, 15(1), 1-11.

73. Aziato, L., & Omenyo, C. N. (2018). Workplace violence and coping strategies among nurses in Ghana. Journal of Nursing Education and Practice, 8(3), 1-9.

74. Boachie-Mensah, F. O., & Seidu, P. A. (2012). Employees' perception of workplace conflict in Ghanaian organizations. Journal of Management and Organization, 18(4), 534-548.

75. Gilson, L., Hanson, K., Sheikh, K., Agyepong, I. A., Ssengooba, F., & Bennett, S. (2017). Building the field of health policy and systems research: Framing the questions. PLoS Medicine, 14(11), e1002442.

76. Konlan, K. D., Abdulai, J. A., Saah, J. A., Doat, A. R., Amoah, R. M., Mohammed, I., & Konlan, K. D. (2023). The influence of conflicts among members of the clinical team on patient care: an explorative, descriptive study, Ghana. Journal of Global Health Science, 5(1), Article e1. https://doi.org/10.35500/jghs.2023.5.e1

77. Ampofo, P. O., Tenkorang-Twum, D., Adjorlolo, S., Chandi, M. G., Wuni, F. K., Asiedu, E., Kukula, V. A., & Opoku, S. (2022). The impact of strike action by Ghana registered nurses and midwives on the access to and utilization of healthcare services. PloS one, 17(10), e0275661. https://doi.org/10.1371/journal.pone.0275661

78. Joshua Bediako Koomson & Joyce Awuni (2025, Jun 05). Public sector nurses' strike cripples healthcare delivery. Graphic Online. https://www.graphic.com.gh/news/general-news/new-court-of-appeal-justices-including-dormaahene-sworn-into-office.html

79. Awori, S. N., & Tettey-Enyo, A. (2015). An evaluation of the effects of industrial unrest at the Korle-Bu Teaching Hospital (KBTH), Accra, Ghana. African Journal of Nursing and Midwifery, Vol. 2 (7), pp. 425-428.

80. Graphic Online (2016). http://www.graphic.com.gh/news/general-news/pharmacists-in-govt-hospitals-begin-indefinite-strike.html

81. Peacefmonline (2016). ttps://www.peacefmonline.com/pages/local/news/201602/268811 https://bit.ly/3ajKsoB

82. Joyonline (2011). https://www.myjoyonline.com/biomedical-laboratory-scientists-strike-over-single-spine

83. CitiFMonline (2016). https://www.modernghana.com/news/713653/biomedical-lab-scientist-begin-strike-today.html

84. Peju Aderogba (2025, June 12). Ghana Faces Healthcare Crisis as Nationwide Nurses and Midwives Strike Escalates. Empire Magazine, Africa. https://empiremagazineafrica.com/ghana-faces-healthcare-crisis-as-nationwide-nurses-and-midwives-strike-escalates

85. Valentine, N. M., & Lavizzo-Mourey, R. (2007). The relationship between staff perceptions of the work environment and patient satisfaction in a large academic medical center. Journal of Healthcare Management, 52(5), 332-344.

86. Rosenstein, A. H., & O'Daniel, M. (2008). A survey of the impact of disruptive behaviors and relationships with nurse outcomes in healthcare settings. Journal of Nursing Administration, 38(11), 468-474.

87. Weberg, D. (2010). Transformational leadership and the role of the nurse leader in healthcare. Nursing Administration Quarterly, 34(3), 246-254.

88. Tawiah, P. A., Appiah-Brempong, E., Okyere, P., Adu-Fosu, G., & Ashinyo, M. E. (2024). Prevalence, risk factors, and psychological consequences of workplace violence among health workers in the Greater Accra region, Ghana: A cross-sectional study. BMC Public Health, 24, 563. https://doi.org/10.1186/s12889-024-17962-8

89. Liu J, Gan Y, Jiang H, Li L, Dwyer R, Lu K, et al (2019). Prevalence of workplace violence against healthcare workers: a systematic review and meta-analysis. Occup Environ Med. 76(12):927–37. doi: 10.1136/oemed-2019-105849

90. Njaka S, Edeogu OC, Oko CC, Goni MD, Nkadi N., (2020). Workplace violence (WPV) against healthcare workers in Africa: a systematic review. Heliyon. 2020;6(9):e04800. https//doi: 10.1016/j.heliyon.2020.e04800.

91. Abdellah RF, Salama KM (2017). Prevalence and risk factors of workplace violence against health care workers in emergency department in Ismailia, Egypt. Pan Afr Med J. 26(1):1–8. doi: 10.11604/pamj.2017.26.21.10837.

92. Gates DM (2004). The epidemic of violence against healthcare workers. Vol. 61, Occupational and Environmental Medicine. BMJ Publishing Group Ltd; 2004. pp. 649–50.

93. Boafo IM, Hancock P. (2017). Workplace violence against nurses: a cross-sectional descriptive study of Ghanaian nurses. Sage open. 2017;(1):2158244017701187.

94. Abodunrin O, Adeoye O, Adeomi AA, Akande TM (2014). Prevalence and forms of violence against health care professionals in a South-Western city, Nigeria.

95. Azodo CC, Ezeja E, Ehikhamenor E (2011). Occupational violence against dental professionals in southern Nigeria. Afr Health Sci. 2011;11(3).

96. Magnavita N, Heponiemi T. (2012). Violence towards health care workers in a Public Health Care Facility in Italy: a repeated cross-sectional study. BMC Health Serv Res. 2012;12(1):1–9. doi: 10.1186/1472-6963-12-108.

97. Blanchar Y. (2011). Violence in the health care sector: a global issue. World Med J. 2011;57(3):87–9.

98. Nelson R.(2014). Tackling violence against health-care workers. Lancet. 2014;383(9926):1373–4. doi: 10.1016/s0140-6736(14)60658-9.

99. Gillespie GL, Gates D, Berry P. (2013). Stressful incidents of physical violence against emergency nurses. Online J Issues Nurs. 2013;18(1).

100. Senyo, M. Agyabeng (2007, August 13). **Alternative Dispute Resolution In Ghana.** **https://mediate.com/alternative-dispute-resolution-in-ghana**

101. Feyisaso Ajayi (2025, January 15). The Role of Traditional Chiefs in Modern Ghana's Politics. https://ghanasentinel.com/2025/01/15/the-role-of-traditional-leaders-in-modern-ghanaian-politics

102. ALHAJI KHUZAIMA MOHAMMED OSMAN (2025, March 27). Conflict resolution: a Ghanaian perspective in the context of Africa. Ghanaian Times. https://ghanaiantimes.com.gh/conflict-resolution-a-ghanaian-perspective-in-the-context-of-africa

103. Nagle, E., Griskevica, I., Rajevska, O., Ivanovs, A., Mihailova, S., & Skruzkalne, I. (2024). Factors affecting healthcare workers' burnout and their conceptual models: A scoping review. BMC Psychology, 12, 637. https://doi.org/10.1186/s40359-024-02130-9

104. Abbey Francis (2004). Conflicts in Workplaces – Definition, Causes, Impacts, and Handling. MBA Knowledge Base. https://www.mbaknol.com/human-resource-management/conflicts-in-workplaces

105. Justice Reuben Aduse (2024, July 10). Conflict and Reconciliation in the Workplace: A Case Study in Ghana. https://ghananewsonline.com.gh/conflict-and-reconciliation-in-the-workplace-a-case-study-in-ghana

106. Martha Anyimiah Ackah (2014). Socio-Cultural Values About Work and Work Attitudes: An Exploratory Study Among Ghanaian Workers (pdf). https://ugspace.ug.edu.gh/items/41806731-ce73-4aa8-b32c-61fcad6a09a9

107. United Nations Children's Fund (UNICEF). State of Burundi's Children, 1995, http://www.HORN/burundi/UNICEF/burundi

108. Shaan Roy (2024, March 15). Mauritania's Cultural Diversity: Exploring Ethnic Groups And Indigenous Languages. https://www.afrodiscovery.com/country/mauritania/mauritania-tribes-languages/mauritanias-cultural-diversity-exploring-ethnic-groups-and-indigenous-languages

109. Rashmi Jawalkar. (2014). Impact Of Colonial Languages on Indigenous Cultures and Traditions. International Journal of Engineering, Science and Humanities, 4(1), 08–14. Retrieved from https://www.ijesh.com/j/article/view/170

110. University of Ghana. (2014). Socio-Cultural Values about work and work Attitudes: An Exploratory study among Ghanaian Workers.