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Research Article

Leadership Decision-Making amid Staff Turnover and Protest: A Phenomenological Study at a Regional Hospital in Central Ethiopia

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Abstract

Healthcare leaders in low-resource settings frequently confront severe workforce instability, yet little is known about how they experience and navigate decision-making during simultaneous staff turnover and protest. This study explored the lived experiences of healthcare leaders managing these intersecting crises at Saja General Hospital in Central Ethiopia. The purpose of the study was to understand how leaders made decisions, adapted leadership practices, and coped with institutional and emotional pressures during prolonged organizational instability. A hermeneutic phenomenological research design was employed to capture the meanings participants attached to their experiences. Six senior healthcare leaders, including hospital directors and department heads, were purposively selected based on their direct involvement in managing staff turnover and protest situations. Data were collected through in-depth semi-structured interviews conducted in Amharic and English. The interviews were audio-recorded, transcribed verbatim, and analyzed using Braun and Clarke's reflexive thematic analysis approach. Sensemaking Theory and Adaptive Leadership Theory guided the interpretation of findings. The study identified four major themes. First, leaders shifted between reactive and adaptive decision-making approaches in response to urgent operational pressures. Second, decisions were shaped by interconnected institutional, political, financial, and personal factors. Third, participants adopted flexible leadership styles depending on the severity and nature of the crisis. Finally, leaders experienced significant emotional and moral burdens, including stress, exhaustion, guilt, and professional isolation. Although participants implemented temporary coping mechanisms such as staff redistribution, dialogue facilitation, and limited incentive arrangements, they reported that structural and systemic constraints restricted sustainable solutions. The study concludes that healthcare leadership during prolonged crises in resource-constrained settings requires adaptive capacity, emotional resilience, and institutional support. Strengthening leadership development, workforce retention strategies, and health system governance is essential for improving organizational stability and healthcare delivery in Ethiopia and similar contexts.

Keywords

Healthcare Leadership, Decision-Making, Staff Turnover, Protest, Phenomenology, Adaptive Leadership, Ethiopia

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1. Introduction

Leadership in healthcare is fundamentally about guiding people through uncertainty, complexity, and life-or-death consequences. Effective leaders in this domain do not merely manage resources; they inspire trust, foster collaboration, enhance job satisfaction, improve staff retention, and ultimately safeguard patient safety and care quality [3, 6, 14, 20, 24, 32]. A substantial body of evidence demonstrates that leadership style, whether transformational, transactional, democratic, participative, autocratic, or laissez-faire, significantly influences employee performance and organisational outcomes, with growing consensus that no single style is universally superior. Instead, contextual flexibility and situational adaptation are key to success, particularly in high-pressure environments [5, 13, 15, 22, 28, 33].

In low- and middle-income countries, however, healthcare leadership operates under conditions of extreme structural constraint. Chronic underfunding, severe shortages of skilled personnel, weak governance systems, and recurrent socio-political instability create an environment in which leaders must constantly balance immediate clinical imperatives against long-term organisational survival [16, 23]. Sub-Saharan Africa bears a disproportionate burden of these challenges. Health systems across the region suffer from poor workplace culture, absenteeism, low motivation, and alarmingly high rates of staff turnover, often exceeding levels seen in high-income nations [7, 21, 29]. A systematic review found that more than 50% of nurses in Sub-Saharan Africa intend to leave their jobs [34], a statistic that translates into disrupted service delivery, increased workload on remaining staff, diminished morale, escalating recruitment and training costs, and compromised patient outcomes [8, 25, 26].

Ethiopia exemplifies and amplifies these regional trends. Despite impressive progress in expanding primary healthcare infrastructure over the past two decades, the country continues to grapple with one of the world's most severe health workforce crises. Recent studies reveal that 59% of Ethiopian health professionals express a clear intention to leave their current positions, with rates climbing to 78% among nurses in certain regions [19]. These intentions are driven by a constellation of interrelated factors: persistently low salaries that fail to keep pace with inflation and cost of living, inadequate benefits and risk allowances, lack of supervisory support, limited recognition and career progression opportunities, excessive workload, work–family conflict, and organisational commitment deficits [1, 4, 10, 18, 27]. Demographic patterns further complicate the picture; male professionals and older nurses exhibit significantly higher turnover intention than their female and younger counterparts [27].

When chronic dissatisfaction escalates into collective protest and industrial action as has occurred repeatedly in Ethiopian public hospitals since 2018, the consequences become catastrophic. Emergency and essential services are disrupted, patient referrals skyrocket, mortality risks rise, and hospital leaders find themselves thrust into the impossible role of simultaneously maintaining clinical operations, negotiating with protesting staff, responding to higher authorities, and protecting institutional reputation. In such moments, leadership ceases to be an administrative function and becomes an intensely embodied, morally charged, and emotionally exhausting practice of crisis navigation under conditions of extreme scarcity and ambiguity.

Despite the frequency and severity of these crises, empirical research on how Ethiopian healthcare leaders actually experience and enact decision-making during concurrent staff turnover and protest remains strikingly scarce [2]. The overwhelming majority of existing studies are quantitative, focusing on prevalence, predictors, and correlates of turnover intention [7, 19, 34]. Qualitative explorations of leadership during acute or prolonged industrial unrest are virtually absent, particularly at the regional hospital level where resources are thinnest and political pressures most intense. We know remarkably little about how leaders make sense of chaotic, rapidly evolving situations; what internal and external forces most powerfully shape their decisions; how they adapt (or fail to adapt) their leadership styles in real time; and what personal, professional, and moral costs they bear in the process.

This phenomenological study was therefore designed to address this critical gap by illuminating the lived experiences of senior healthcare leaders at Saja General Hospital a typical public referral facility in the rural Yem Zone of Central Ethiopia Regional State during periods of high staff turnover compounded by protest. By giving voice to leaders who have repeatedly managed these twin crises with minimal institutional support, the study seeks not only to document their struggles and strategies, but also to generate contextually grounded insights that can inform leadership development, health policy reform, and future research in Ethiopia and comparable low-resource settings across Sub-Saharan Africa.

Theoretical Framework and Literature Review

The study integrated Sensemaking Theory [31] and Adaptive Leadership framework [12]. Sensemaking explains how individuals retrospectively create plausible interpretations of ambiguous, disruptive events through identity, cues, and social interaction. Adaptive Leadership distinguishes technical problems (amenable to existing expertise) from adaptive challenges (requiring learning, innovation, and value shifts) and emphasizes regulating distress while mobilizing stakeholders.

Literature confirms that transformational, transactional, participative, and democratic styles all positively influence healthcare worker performance and retention when applied contextually [13, 33]. However, most evidence originates from high-income countries. In Sub-Saharan Africa, leadership is frequently reactive, undermined by inadequate training and systemic underfunding [11, 21, 23]. Crisis leadership research has largely focused on acute events rather than chronic,

compounded turbulence. This study fills a critical gap by illuminating leaders' phenomenological experiences in a fragile health system.

2. Methodology

A hermeneutic phenomenological design [30] was employed at Saja General Hospital, a public referral facility serving a rural catchment in Yem Zone. Purposive criterion sampling recruited six senior leaders (medical director, nursing director, clinical director, and department heads) who had managed turnover and protest episodes within the preceding two years. Data were collected through individual semi-structured interviews (60–90 minutes) conducted in Amharic or English, audio-recorded, and transcribed verbatim. Reflexive thematic analysis followed [9]'s six-phase process. Trustworthiness was established through member checking, thick description, peer debriefing, and a detailed audit trail. Ethical approval was granted by Leadstar Christian University; informed consent ensured confidentiality and voluntary participation.

3. Findings

Four major themes emerged from the lived experiences of the six leaders.

Theme 1: From Reactive Firefighting to Tentative Adaptive Responses

Initially, leaders resorted to directive, survival-oriented measures. The medical director explained: "When half the nurses did not report for duty and patients were waiting, I had no choice but to order the remaining staff to cover all wards, even if they were exhausted. It felt like commanding soldiers in battle."

Over time, however, most shifted toward adaptive strategies: facilitating open dialogue, negotiating temporary financial top-ups from limited hospital revenue, and redistributing non-clinical tasks to administrative staff. One department head reflected: "Ordering people only creates more resentment. Later I realised sitting with them, listening to their anger, and finding even small concessions like adjusting night shifts calmed the situation more than any directive."

Theme 2: Multilayered and Often Contradictory Influences

Decisions were shaped by interlocking constraints. Budgetary paralysis was universal: "We beg the zone health office for emergency funds, but the answer is always 'no budget until next fiscal year.' How can I promise salary increases when I cannot even buy gloves?" (Nursing Director)

National socio-political instability, fear of disciplinary action from higher authorities, and personal values of service to poor rural communities created moral tension. A senior surgeon stated: "I was born in this zone. My mother died because there was no hospital. I cannot let this hospital collapse—even if it means I pay staff allowances from my own pocket sometimes."

Theme 3: Fluid and Situational Leadership Styles

Participants consciously shifted styles according to context. During acute protest, directive leadership predominated; as tensions eased, participative and transformational approaches emerged. The clinical director summarised: "Sometimes you must be autocratic to protect patients. Other times, you must be a father, a counsellor, a negotiator. There is no single 'best' style here—only the style that fits the moment."

Theme 4: Profound Moral Responsibility and Emotional Toll

All leaders described intense feelings of duty toward patients and remaining staff, coupled with guilt, sleeplessness, and burnout: "I go home at midnight, but I cannot sleep. I keep thinking: Did I push the remaining nurses too hard? Will a patient die tomorrow because we are short-staffed? You carry everyone's lives on your shoulders." (Department Head)

Several reported physical symptoms hypertension, weight loss, family strain and a sense of isolation: "No one outside the hospital understands what we are going through."

4. Discussion

The findings strongly corroborate Sensemaking Theory [31]: leaders retrospectively constructed meaning from chaotic cues (empty duty rosters, protest banners, patient complaints) to enact plausible, if imperfect, responses. Their oscillation between reactive-technical and tentative-adaptive strategies mirrors [12] distinction: systemic issues such as salary inadequacy and bureaucratic inertia are adaptive challenges requiring regional or national solutions, yet resource scarcity forced leaders to treat them as technical problems solvable locally an ultimately unsustainable approach.

The contextual flexibility in leadership style aligns with recent African studies challenging the universal superiority of transformational leadership [33] and supports calls for situational and hybrid approaches in low-resource settings [17]. The intense emotional burden reported exceeds findings from high-income crisis leadership literature, suggesting that cultural expectations of self-sacrifice and weak institutional support amplify moral injury in African contexts.

Critically, leaders' pragmatic innovations occurred despite not because of the broader health system. Their efforts represent "productive disobedience" within a governance structure that punishes initiative while offering no viable alternatives, echoing broader critiques of bureaucratic paralysis in African public services.

5. Conclusion

This study illuminates the extraordinary resilience and moral commitment of healthcare leaders managing chronic crisis in one of Ethiopia's under-resourced regional hospitals. Faced with high staff turnover and protest, leaders at Saja General Hospital oscillated between directive survival tactics

and adaptive dialogue, constrained by budgetary paralysis, bureaucratic inertia, and national socio-economic pressures. Their lived experiences reveal leadership not as a set of abstract competencies but as an embodied, emotionally taxing practice of holding a collapsing system together through personal sacrifice and improvised solutions. While demonstrating remarkable situational flexibility and deep moral responsibility, these leaders operate at the limits of human endurance, highlighting the unsustainability of relying on individual heroism to compensate for systemic failure. Without structural reforms addressing remuneration, governance, and leadership support, turnover and unrest will persist, jeopardizing universal health coverage goals in Ethiopia and similar settings.

Limitation of the study

The study's principal limitations were its single-site scope at Saja General Hospital, which restricts generalization to other healthcare settings in Ethiopia, and its qualitative phenomenological design, limiting the ability to make statistical inferences. Challenges also arose from the use of self-reported data, risking social desirability bias in a public sector context, and the ongoing national instability, which restricted the assessment of long-term decision outcomes. To mitigate these issues, the researcher employed triangulation (using hospital records alongside interviews) and member checking to enhance credibility, ensured anonymity and utilized private interview settings to encourage honest disclosure, and maintained a reflective journal to minimize personal bias during analysis.

6. Recommendations

Practice and Policy

1) Implement mandatory adaptive leadership and crisis sensemaking training for all hospital directors and department heads in Ethiopia.
2) Establish regional "crisis leadership support networks" providing peer supervision and psychological support.
3) Revise public sector salary scales and create retention allowances for rural and referral hospitals.
4) Reform budgetary processes to allow rapid emergency disbursements during industrial action.

Research

1) Conduct longitudinal phenomenological studies tracking how leadership practices evolve during prolonged crises.
2) Undertake multi-site comparative studies across Ethiopian regions to identify transferable adaptive strategies.
3) Explore the perspectives of protesting staff to generate whole-system interventions.

Abbreviations

PhD	Doctor of Philosophy
LMICs	Low- and Middle-Income Countries
SSA	Sub-Saharan Africa

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Author Contributions

Kirubel Zerfu Worku: Conceptualization, Methodology, Data curation, Formal Analysis, Writing – original draft, Writing – review & editing

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Conflicts of Interest

The author declares that there are no conflicts of interest regarding the publication of this paper.

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Biography

Kirubel Zerfu Worku is a health professional and PhD candidate at LeadStar University, Ethiopia. He holds a BSc in Public Health from Haramaya University and an MSc in Surgery. He has 19 years of professional experience in the healthcare sector, including 9 years in public health and 10 years in surgical practice. Throughout his career, he has served in various health centers and hospitals across Ethiopia, contributing to healthcare service delivery, clinical practice, and health system strengthening. He currently works as a senior surgical professional at Saja General Hospital and also manages a private healthcare clinic. His research interests include public health, surgical care, healthcare management, and health systems development.