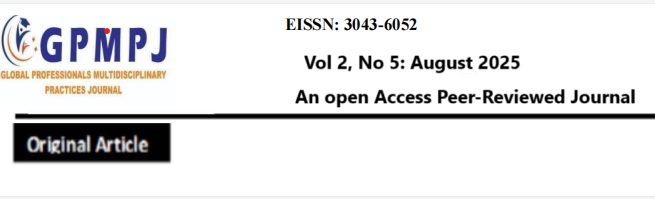
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**ASSESSMENT OF WORK PLACE VIOLENCE AMONG PRIMARY HEALTHCARE WORKERS IN OSHIMILLI SOUTH LOCAL GOVERNMENT AREA, DELTA STATE**

**Omenogor, J. N.,1\* Stanley, H.O.,1 Nwakili P.C1,** **Sawyer W.E1**

**Affiliation**

Department of Community Medicine, Niger Delta University Wilberforce Island,

Bayelsa State, Nigeria.

**Correspondence:** Omenogor, J. N

**Email address:** Jennyngozi90@gmail.com

**ABSTRACT**

Work place violence (WPV) a major occupational hazard in health-care facilities is continuously on the rise and in most cases is underreported. This study investigated the frequency rates and effects of workplace violence which PHC workers encountered in the course of their work in Oshimilli South Local Government Area, Delta State, Nigeria. The study gathered data from 111 PHC workers through structured questionnaires after participants were selected via multi-stage sampling. The researcher analysed data through frequency tables together with charts. The results showed that Work-Related Violence affected 71.2% of PHC workers resulting in diverse kinds of mistreatment like verbal assault, bullying, physical contact abuse, and sexual abuse. Most patients' relatives (58.6%) who interacted with workers reported WPV incidents the most while patients (22.2%) and co-workers (5.1%) were less frequent sources of violence and misunderstanding often served as the main cause of problems. The primary risk factors which contributed to WPV occurrence were worker age and gender along with their facility type and years of practice. Health centre workers among all staff types together with women and new medical employees showed higher rates of Work-Related Violence than their peers and victims stated fear of discrimination together with uncertainty about the management's response as their main barriers to reporting. Training received by some workers help them toward relating to their patient and patient relatives. Healthcare workers reported poor outcomes from WPV due to missing workplace policies and security measures and training programs related to workplace violence prevention. This lack of operational protection directly led to increased workplace violence occurrences. It is therefore recommended that WPV victims should speak out and the necessary measures put in place to eradicate the scourge of WPV.

**Keywords**: Workplace violence; primary health-care workers; private health-care facilities; public health-care facilities.

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**INTRODUCTION**

Workplace violence is a pressing issue that affects various industries worldwide, including the healthcare sector. It encompasses a range of aggressive and harmful behaviours that occur within the workplace, posing significant risks to the safety and well-being of employees. Primary healthcare workers in particular, face numerous challenges and hazards in their day-to-day responsibilities, making them vulnerable to workplace violence.1

Oshimilli South Local Government Area is located in Delta State Nigeria. It is home to a considerable number of primary healthcare facilities. These facilities play a crucial role in providing essential healthcare services to the community. However, there is a lack of comprehensive research on the prevalence, types, and contributing factors of workplace violence specifically among primary healthcare workers in the Local Government Area. Understanding the extent and nature of workplace violence in this context is vital for developing effective strategies to prevent and address such incidents. The World Health Organization (WHO) defined workplace violence (WPV) as the wilful use of physical force.

There is a substantial likelihood of causing injury, death, psychological harm, mal-development, or deprivation; or power, whether threatened or actual; against another person, oneself, or a group of people.2 It takes place when a worker is mistreated, threatened, or physically assaulted because of their employment, especially while traveling to and from work, posing an implicit or overt threat to their safety, wellbeing, or health. The National Institute for Occupational Safety and Health defines WPV as violent acts, including physical attacks, committed against someone while they are at work or performing their official duties. According to empirical data, 30% of all acts of violence, security, happiness, or health.3 The National Institute for Occupational Safety and Health defines WPV as violent acts, including physical attacks, committed against a person while they are at work or performing their official duties. According to empirical studies, 30% of societal violence may be associated to WPV. According to reports, WPV is the biggest global cause of workplace fatalities. Each year, WPV claims the lives of 1.5 million employees, while 8% and 33% experience physical assault.

WPV is most prevalent in the health sector globally4 because more than one-third of WPV is focused at Health care professionals (HCWs). Because of this, the Australian Institute of Criminology identified the medical field as having the worst workplace violence rates among all occupations. Due of its rising prevalence worldwide, it is a public health issue and a workplace hazard. Any HCW is susceptible to assault while at work, albeit some are more negatively impacted than others.5, 6 The majority of incidents of violence against HCWs go unreported and it is worst in nations or medical facilities without reporting or anti-violence measures.

The situation is severe in developing nations when the quality of healthcare service is appalling. While all employees are at risk of being assaulted at work, it is greater for those who are teachers, HCWs, bankers, and law enforcement personnel. HCWs are the group most negatively impacted by workplace violence.7 According to a comprehensive review, some HCWs had light violent experiences (verbal insults and abuse), 26% had moderate aggressive experiences (such as criminal property damage), and 8% had severe aggressive experiences (such as sexual assault and physical violence). In Germany, 23% of general practitioners experienced terrible antagonism. Between 2004 and 2015, a few American studies found that doctors and nurses frequently experience WPV during the course of their work. The majority of HCWs who experienced WPV in developing nations—about 88% of them—were bullied, verbally abused, or physically attacked. Throughout their professional lives, both doctors and nurses have experienced attack.8 In a Sudanese research, 92% of WPV was verbal and psychological, and 50% of doctors reported having experienced it. Younger ages (30 years or less) and feminine gender are risk factors. Men made up the majority of the offenders.9 A research at Egypt's emergency unit found that 59.7% of HCWs had experienced some form of violence. Verbal abuse made up 58.2% of the violence encountered by HCWs, while physical violence made up 15.7% of the time and verbal abuse 58.2% of the time. In Namibia, every single radiographer has dealt with WPV.10 WPV prevalence was observed to be 62.1% in Gambian nurses and 71% in Malawian nurses Despite the severity of the incident, the majority of WPV sufferers do not report the indents when they happen. In Namibia, every single radiographer has dealt with WPV.10 WPV prevalence was observed to be 62.1% in Gambian nurses and 71% in Malawian nurses.11 Despite the severity of the incident, the majority of WPV sufferers do not report the indents when they happen. At least one in two doctors suffer from WPV. The findings of numerous studies have demonstrated that the gender and age of the HCW have an impact on violence towards them. Additionally, shift workers, people who work in emergency rooms, and people who work in psychiatric units are more likely to experience workplace violence than other HCWs.12 Patients, escorts of patients who are their family members and caretakers, coworkers, superiors, and other clinical and nonclinical staff of the facility are the violent offenders. Patients, escorts of patients, who are also their family members and caretakers, as well as other members of the clinical and nonclinical personnel of the facility, are those that carry out this violence in hospital.13 WHO estimates that in order for low- and middle-income countries (LMICs) to achieve universal health coverage by 2030, there will need to be roughly 18 million HCWs. There are no workers in this number. The few available HCWs must deal with violence, subpar working conditions, and lack of health funding. Because the health-care infrastructure in LMICs is underdeveloped, WPV weakens it and makes Africa's already subpar health indicators even worse. Increased, protected, and retained manpower in the health sector is necessary to strengthen the healthcare system.14 The WHO divides WPV into racial, sexual, physical, and psychological categories. (WHO., 2020) Physical contact occurs during physical violence or physical conflict between the attacker and the victim. Health care institutions are reportedly four times more likely to experience physical abuse than any other industry. In nonphysical workplace violence, which includes verbal, emotional, and sexual harassment, there is no physical contact between the victim and the offenders. Shouting, ranting, and even issuing threats are all examples of verbal abuse, which is described as using offensive and disparaging words, tone, and manner of voice against a health worker. Although there are no physical signs of injury, the emotional toll can be severe, leaving the victim feeling attacked, humiliated, or undervalued on a personal or professional level. This research examines the impact of WPV on HCWs in Oshimilli South Local Government of Delta State Nigeria, including its causes, perpetrators, and effects.

**MATERIALS AND METHODS**

**Research Design**

The study design was descriptive cross sectional.

**Study Area**

The research was carried out in Oshimilli South Local Government in Delta State of Nigeria. Oshimilli South LGA. Is one of the 25 LGA in Delta State. Asaba serves as the Local Government's administrative centre. Other communities that make up the LGA are Okwe, Oko, Odifulu, Amakom, Oko Anala, and Oko Ogbele. The Council Area is bordered on the east by the state of Anambra, on the west and north by the local government of Oshimili North, and on the south by the local government of Ndokwa East. The native population of the region is Igbo, and they speak the Igbo dialect of the larger (Anioma) Igbo subculture west of the Niger, specifically the Aniocha/Oshimili subculture. The other communities that make up the Local Government, aside from Asaba, the LGA's administrative centre and Delta State's capital city, are rural communities where farming and fishing are the main sources of income.

**Population of the Study**

The study population comprised full-time, part-time, contract, and voluntary frontline health workers across the network of eight (8) primary healthcare facilities in Oshimilli South LGA. These include: (Umuagu PHC, Oko Amakom PHC, Cable point PHC, Oko Ogbele PHC, Anwai PHC, Okwe PHC, Model PHC and Anala PHC). These facilities employ a range of healthcare professionals, each with varying levels of exposure to workplace violence.

**Inclusion and Exclusion Criteria**

**Inclusion Criteria:**

These include workers in PHCs in Oshimili South Local Government of Delta State

The inclusion criteria for the study population are as follows:

i. Public Primary Healthcare facilities registered and operating in Oshimilli South Local Government of Delta State (Umuagu PHC, Oko Amakom PHC, Cable point PHC, Oko Ogbele PHC, Anwai PHC, Okwe PHC, Model PHC and Anala PHC).

ii. Facilities that provide primary healthcare services.

iii. Facilities that have been in operation for at least two years to ensure a sufficient level of experience and service delivery.

**Exclusion Criteria**

i. Non-permanent workers in the PHC

ii. Worker that were on leave

iii. Workers who have not worked for six months in service

**Sample Size**

Sample size determination formula for descriptive cross section were used. The sample size calculation used the Cochrane’s Finite Formulae

where n is the smallest sample size if the population is > 10, 000

**nf** represent the required sample size when population is < 10, 000

**z** represent the standard normal deviate at 95% confidence interval (1.96),

**N** represent the population size which is 380 health care workers

p is the proportion of health-care workers who had experienced at least an episode of work place violence from a previous similar study 88.1% (0.88) carried out in South East Nigeria

q represents the complementary probability (1 – p) = 1-0.88 = 0. 12,

d represent the precision of the study set at 0.05

Adjustment of minimum sample size for non-response was made thus;

A non-response rate of 10% of 114 was calculated by adding 10% of the sample size to the sample size:

**Sampling Technique**

A consecutive probability sampling method was utilized to recruit study participants. The sampling technique involved selecting available and willing subjects who met the inclusion criteria from the target study population to attain the required sample size. The study adopted a two-stage sampling technique which aimed to generate representative results.

**Methods of Data Collection**

A structured questionnaire used for similar study was adopted and used to collect data based on the research objectives and research questions. The questionnaire was adapted from International Labour Organization (ILO), World Health Organization (WHO) and Public Service International (PSI) joint programme on work place violence in the health sector template, and modified to suit this study (WHO, 2003). The questionnaire were divided into seven sections: A, B, C, D, E, F, G, according to the specific objectives.

**Validity of Instrument**

To establish the face and content validity of the data collection instrument, the instruments were presented to the researcher’s project supervisor. Corrections made were effected before its administration to respondents. Also, structured, self-administered questionnaires were used after a pre-test among primary health care workers not included in the study, to determine the clarity, quality and validity of the tools.

**Reliability of Instrument**

The instruments were tested for reliability using the Cronbach's alpha on SPSS before its administration to respondents; this was to ensure that the anticipated result were what it was supposed to be.

**Administration of Instrument**

The researcher administered the instruments. In order to capture respective respondents needed for the study, respondent on their own after much explanation and briefing answered questions.

**Method of Data Analysis**

The data was analysed using appropriate statistical software, such as version 23 of SPSS. Descriptive statistics, such as frequencies, percentages, means, and standard deviations, were computed to summarize the data. Qualitative data from interviews and observations were transcribed, coded, and thematically analysed using the force factor analysis template to identify patterns and themes related to service delivery factors.

**RESULTS**

About 111 primary health workers indicated their gender. Out of which 45 (56.7%) are female and 59(43.3%) are male. Most of the respondents were between 29 and 39 years of age (about 37.3%), followed by about 33.3% were less than 29 years, while about 29.4% were above 39 years of age. Furthermore, of the 111 respondents, 34 (45.9%) of the primary health workers who are less than 29 years, 38 (51.4%) primary health workers between 29 years and 39 years, and 2 (2.7%) primary health workers above 39 years, experienced work place violence; while 28 (100.0%) primary health workers above 39 years, and none of the primary health workers who are less than 29 years and between 29 years and 39 years never experienced work place violence.

The marital status of the respondents showed that among 100 primary health workers, 42 are Married, 40 are Single, 14 are Single/Divorced, and 4 are Widow/Widower. About 101 respondents had one form of education or another. Of these respondents, 7 had only primary school education, 30 had up to secondary education while 64 of them had up to tertiary education. Based on the occupations of the respondents, 30 of them were community health extension workers (CHEW), 12 of them where community health officers (CHO), 28 of them are Nurses, 12 of them are Medical Lab Scientist/Technicians, 3 of them are Nutritionist/Dieticians, while 19 of them had other forms of employment.

Furthermore, based on the employment status of the respondents, 58 of them were full-time workers, 28 of them were part-time workers, 10 of them were contract workers, while 8 of them were volunteer workers. Finally, based on the type of facilities the respondents work in, 92 of them were from a health centre, 4 of them were from a clinic, while 8 of them were from an outpost. Of these respondents who work in these facilities, 74 (100.0%) of them who work in a health centre, and none of them who work in a clinic or in an outpost have experienced work place violence.

**Table 1: Prevalence and Types of Workplace Violence**

|  |  |  |  |
| --- | --- | --- | --- |
| **Items on Prevalence** | **Responses** | **Frequency** | **Percentage** |
| **Experience of Workplace Experience** | Yes | 74 | 71.2 |
|  | No | 30 | 28.8 |
|  | Total | 104 | 100.0 |
| **Last Time of Abuse** | Last One Month | 18 | 17.6 |
|  | Six Months Ago | 38 | 37.3 |
|  | More Than Six Months Ago | 46 | 45.1 |
|  | Total | 102 | 100.0 |
| **Where did the WPV take place?** | Inside health facility | 82 | 83.7 |
|  | At patient's home | 1 | 1.0 |
|  | Outside (On way to work/health visit/home) | 5 | 5.1 |
|  | Other | 10 | 10.2 |
|  | Total | 98 | 100.0 |
| **What types of WPV do you know?** | Physical Violence | 25 | 22.5 |
|  | Bullying/Mobbing | 12 | 10.8 |
|  | Threats | 17 | 15.3 |
|  | Verbal abuse | 28 | 25.2 |
|  | Sexual harassment | 29 | 26.1 |
|  | Total | 111 | 100.0 |

**Table 2: Sources and Characteristics of Workplace Violence**

|  |  |  |  |
| --- | --- | --- | --- |
| **Items on sources** | **Responses** | **Frequency** | **Percentage** |
| **What is the source of the WPV?** | Patients | 22 | 22.2 |
|  | Patient's relatives | 58 | 58.6 |
|  | Managers/Supervisors | 5 | 5.1 |
|  | Co-workers | 2 | 2.0 |
|  | Others | 12 | 12.1 |
|  | Total | 99 | 100.0 |
| **How did you respond to the incident?** | Took no action | 2 | 1.7 |
|  | Told the person to stop | 62 | 53.0 |
|  | Tried to defend myself | 37 | 31.6 |
|  | Tried to pretend it never happened | 11 | 9.4 |
|  | Transferred to another position | 5 | 4.3 |
|  | Total | 89 | 100.0 |
| **Do you think the incident could have been prevented?** | Yes | 80 | 78.4 |
|  | No | 22 | 21.6 |
|  | Total | 102 | 100.0 |
| **Were you injured as a result of the violent incident?** | Yes | 11 | 11.1 |
|  | No | 88 | 88.9 |
|  | Total | 99 | 100.0 |
| **If YES, did you require formal treatment for the injuries?** | Yes | 2 | 18.2 |
|  | No | 9 | 81.8 |
|  | Total | 11 | 100.0 |
| **Did you have to take time off from work after being attacked?** | Yes | 60 | 63.2 |
|  | No | 35 | 36.8 |
|  | Total | 95 | 100.0 |
| **If YES, for how long?** | One day | 2 | 11.1 |
|  | 2 – 3 days | 1 | 5.6 |
|  | One week | 7 | 38.9 |
|  | Less than one month | 3 | 16.7 |
|  | Above one month | 5 | 27.8 |
|  | Total | 18 | 100.0 |

**Figure 1: Bar Chart Showing The Experiences of Health Workers in the Past One Year**

**DISCUSSION**

The result of our study indicates that WHV has become widespread at 71.2% of given institutions with a clear age distinction as younger workers aged 29-39 experienced WPV at 51.4% whereas workers older than 39 years faced WPV infrequently at 2.7%. This is similar to research carried out by Okechukwu and Agomoh15 in Nigeria, and Abdellah et al.16 in Egypt who discovered that newly trained workers encountered violence because patients suspected they lacked experience and became impatient with them. The study also corroborates global WPV patterns which show a minimal violence exposure among workers over 39 years (WHO, 2020). This patterns between younger versus older staff experiencing workplace violence in Oshimilli South could result from two factors: (1) cultural norms that honour older maintenance workers or (2) survivorship effects where long-serving personnel have learned avoidance strategies or moved to protected positions.

Our research also reveals that 30(100.0%) of the primary health workers who are females, and none of the health workers who are males have experienced work place violence. This shows that female healthcare workers make up 79.7% of WPV victims because women in healthcare consistently experience higher rates of verbal and sexual harassment (ILO, 2022). The lack of workplace violence reports among male workers in this study differs from findings in Lagos17 that revealed substantial abuse incidents among male nurses. Underreporting by male workers and the predominantly female sample (56.7%) in this study may explain why no WPV incidents were reported. Furthermore, 8(30.8%) of the primary health workers who are Married, none of the health workers who are Single, 14 (53.8%) of the primary health worker who are Single/Divorced, and 4 (15.4%) of the primary health worker who are Widow/Widower, never experienced work place violence. This indicates that unmarried workers faced more workplace violence incidents compared to their married colleagues (54.1% and 45.9% respectively), an observation which matches data from Ethiopia18. The study found unmarried staff lacked perception of authority. The low WPV reports from widowed/divorced workers can be explained by their small participant count of 4% or cultural beliefs about personal resiliency linked to their marital status.

According to their level of education, the 7 (9.5%) health workers with primary education, 30 (40.5%) of the health workers who completed secondary school, and 37 (50.0%) of the health workers who attained tertiary educational level, experienced work place violence. This also indicates that those working in frontline positions (CHEWs: 40.5% and nurses: 37.8%) along with workers with tertiary education (50.0%) experienced the greatest exposure since they directly interact with patients. In Ghana community health workers alongside nurses received the most violent patient encounters because of their active roles in direct patient care19 The absence of reported work-related violence among dietitians/nutritionists may stem from their minimal patient handling responsibilities which reduces their hazard exposure according to findings14

From this result also, workplace violence rates were higher among full-time employees (78.4% of victims) in comparison to part-time and contract staff in Oshimilli South but differed from WPV experiences reported by temporary workers in Malawi11. Full-time workforce in Oshimilli South cares for larger patient volumes and handles night shifts and this could explain their higher exposure to workplace violence20. This result showed that all WPV events happened at health centres matching findings from a Gambian research21 linked aggressive behaviour to overcrowded and under resourced primary care facilities. The absence of incidents reported by rural facilities demonstrates both patient population density and site size presenting as crucial risk elements.

**CONCLUSION**

This study has shown that health care practitioners are exposed to varying forms of violence but are mostly verbal and sexual assaults. The contributing factors to WPV include running shifts and working alone in shifts. The predictors of WPV are subject to the type of work the health worker does and the years of experience. Training received by some workers help them toward relating to their patient and patient relatives. Though when such incidence eventually occurs, they change position or tell the perpetrators to stop to avoid escalating. Most health workers who experience of WPV in their place of work were emotionally disturbed which lead to impaired work outcome, absence from work and can as well lead to resignation from work.

**LIMITATION OF STUDY**

This study is limited to Primary Care Health Centres and workers. It is also limited to Oshimilli South LGA of Delta State, Nigeria.

**AREAS OF FURTHER RESEARCH**

The incidence and prevalence in WPV in the educational Sector can equally be a very important area for further research for public health scholars, and also because of the fact that apart from the health sector, the education sector is also a very important yardstick in assessing the development of any nation.

**CONSENT AND ETHICAL APPROVAL**

Official authorization was obtained to make the study implementation legal. Approval for the study came from both the Delta State Ministry of Health and the Oshimilli South Local Government Health Department to demonstrate proper adherence to regional health protocols

**CONFLICT OF INTEREST**

The authors declare no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

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