PREVALENCE OF WORKPLACE VIOLENCE AGAINST HEALTHCARE WORKERS IN THE UNIVERSITY OF BENIN HEALTH SERVICES DEPARTMENT

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DECLARATION

I hereby declare that this project titled "**Prevalence of workplace violence against Healthcare Workers in the University of Benin Health Services Department"** was conducted under supervision and has not been submitted in part or in full for any purpose.

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CERTIFICATION

This is to certify that this research titled "**Prevalence Of Workplace Violence Against Health care Workers in the University of Benin Health Services Department**" was conducted by **ROSABEL JOAN MUSA AND PRECIOUS ORUNCHUKWU NGWOKOR** with matriculation number **MED1807433 and MED1807434** under the supervision of **Prof. A. R. ISARA** in the Department of Public Health and Community Medicine, School of Medicine, University of Benin as part of the requirements for the award of Bachelor of Medicine, Bachelor of Surgery (MBBS) degree.

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LIST OF ABBREVIATIONS

ADMLS: Assistant Director of Medical Laboratory Services

AOR: Adjusted Odds Ratio

CMO: Chief Medical Officer

CMRO: Chief Medical Record Officer

DDNS: Deputy Director of Nursing Services

DDPS: Deputy Director of Pharmaceutical Services

ED: Emergency Department

HCW: Healthcare Worker

HCWs: Healthcare Workers

IBM SPSS: International Business Machines Statistical Package for the Social Sciences

ICN: International Council of Nurses

ILO: International Labour Organization

MBBS: Bachelor of Medicine, Bachelor of Surgery

PSI: Public Services International

PMO: Principal Medical Officer

PTSD:	Post-Traumatic Stress Disorder
PTS:	Public Transport Services
UBTH:	University of Benin Teaching Hospital
UNIBEN:	University of Benin
WHO:	World Health Organization
WPV:	Workplace Violence

DEFINITION OF TERMS

Workplace Violence (WPV): Workplace violence refers to incidents in which staff are abused, threatened, or assaulted in circumstances related to their work, including commuting to and from work, involving an explicit or implicit challenge to their safety, well-being, or health.

Healthcare Workers (HCWs): Healthcare workers are all people engaged in actions whose primary intent is to enhance health, including clinical and non-clinical personnel involved in health service delivery.

Physical Violence: Physical violence refers to the use of physical force against another person or group that results in physical, sexual, or psychological harm, including acts such as hitting, kicking, slapping, stabbing, pushing, biting, and pinching.

Psychological Violence: Psychological violence refers to the intentional use of power, including threat of physical force, against another person or group that can result in harm to physical, mental, spiritual, moral, or social development.

Verbal Abuse: Verbal abuse refers to behaviour that humiliates, degrades, or otherwise indicates a lack of respect for the dignity

	and worth of an individual through spoken or written communication.
Clinical Staff:	Clinical staff refer to healthcare workers directly involved in patient diagnosis, treatment, and care within the University of Benin Health Services Department.
Non-Clinical Staff:	Non-clinical staff refer to personnel who support healthcare service delivery through administrative, technical, transport, sanitation, and other supportive functions without direct clinical responsibilities.
Perpetrator:	Perpetrator refers to any person responsible for committing an act of workplace violence against a worker, including patients, relatives, co-workers, supervisors, or members of the public.
Post-Traumatic Stress Disorder (PTSD):	Post-traumatic stress disorder is a mental health condition that develops following exposure to an extremely threatening or horrific event or series of events and is characterized by persistent symptoms such as re-experiencing the event, avoidance, and perceptions of heightened threat.
Prevalence:	Prevalence refers to the proportion of individuals in a population who have a particular condition or characteristic at a specified point in time or over a defined period.

ABSTRACT

Introduction: Workplace violence (WPV) against healthcare workers is a major occupational and public health concern globally, with significant consequences on the safety, psychological well-being, job satisfaction, and productivity of healthcare personnel.

Objective: This study assessed the prevalence, causes, and effects of workplace violence against healthcare workers in the University of Benin Health Services department, Benin City, Edo State.

Methodology: A descriptive cross-sectional study design was adopted among healthcare workers in the University of Benin Health Services Department. A total population survey method was used, and data are collected using a structured questionnaire adapted from the International Labour Organization (ILO), International Council of Nurses (ICN), World Health Organization (WHO), and Public Services International (PSI) workplace violence research instrument, administered through both self-administered and interviewer-administered approaches. One hundred and sixty-five completed questionnaires are analyzed using IBM SPSS version 27.0, with descriptive and inferential statistics performed at a 95% confidence interval and a significance level of $p < 0.05$.

Results: The lifetime prevalence of workplace violence among respondents was 35.2%, while 21.2% and 33.3% report experiencing physical violence and verbal abuse respectively within the six months preceding the study. Patients or clients constitute the major perpetrators of both physical violence (72.7%) and verbal abuse (72.7%). Professional category shows a statistically significant association with workplace violence ($p = 0.003$), with clinical staff experiencing a

higher prevalence than non-clinical staff. The major perceived causes of workplace violence are the non-availability of doctors or nurses on call duty (72.7%) and the aggressive personality of perpetrators (70.9%). Post-traumatic stress disorder (63.1%) and loss of job satisfaction (53.3%) are the most commonly reported effects of workplace violence among respondents.

Conclusion: Workplace violence occurs among healthcare workers in the University of Benin Health Services Department, with verbal abuse being more commonly reported than physical violence. Non-availability of healthcare workers on call duty and aggressive behaviour of perpetrators emerge as the major perceived causes, while post-traumatic stress disorder and loss of job satisfaction constitute the major effects. Strengthened institutional policies, improved staffing, and supportive interventions are needed to reduce workplace violence and improve healthcare worker safety.

Keywords: Workplace violence, healthcare workers, prevalence, occupational health, University of Benin Health Services Department, Nigeria.

CHAPTER ONE

INTRODUCTION

1.1 BACKGROUND

Workplace violence (WPV) has increasingly been recognized as a pervasive occupational hazard within healthcare systems worldwide.[1,2] The World Health Organization (WHO) defines WPV as "incidents where staff are abused, threatened, or assaulted in circumstances related to their work, including commuting to and from work, and which challenge their safety, well-being, or health"[2] Within the healthcare context, WPV encompasses both physical acts such as hitting, kicking, or pushing, and non-physical forms including verbal abuse, threats, harassment, and intimidation.[1,3] These violent encounters may arise from patients, relatives, or even colleagues, and can occur in virtually all care settings.[1,4] Although some cases are documented, WPV is frequently underreported due to stigma, fear of reprisal, or a perception that such incidents are part of the job.[5]

Workplace violence is commonly classified into four broad categories: physical violence (such as slapping, hitting, and pushing), verbal abuse (including insults, threats, and shouting), sexual harassment, and psychological violence (such as intimidation, bullying, and humiliation).[3,6] Risk factors consistently associated with WPV include high patient volumes, overcrowded health facilities, prolonged waiting times, poor communication, inadequate staffing, and insufficient security presence.[7,8] Younger and less experienced staff, particularly nurses and junior doctors, are often at greater risk of exposure.[7,9] These factors highlight WPV as a complex occupational challenge in healthcare delivery.[9]

Research showed that workplace violence has an impact on medical personnel, hospitals, and society. Following instances in which doctors suffered workplace violence, this caused other issues such as reduced job performance, decreased job satisfaction, and negative effects in their own physical and mental health, which may increase turnover intention and influence their quality of life.[10] The ripple effects of workplace violence also extends to institutional

functioning as increased staff absenteeism, reduced morale and strained professional relationships may disrupt service delivery and organizational stability.[10] Furthermore, the normalization and underreporting of violent incidents in health care setting, make it difficult to implement effective preventive strategies and policy responses.[5,9] This realities underscore the importance of sustained attention to workplace violence within healthcare systems.

1.2 STATEMENT OF THE PROBLEM

In European countries, 4% of active health care workers (HCWs) have reported that they had been subjected to verbal or physical WPV from patients or visitors.[11] According to a national survey on WPV in Turkey conducted by Pinar et al, 6.8% of health workers have been exposed to physical violence, 43.2% to verbal violence, and 44.7% to both forms.[10] Beyond the immediate burden of workplace violence, many healthcare systems, particularly in Africa are further challenged by workforce shortages and migration. South Africa for example, has 0.818 physicians per 1000 population, reportedly the second highest density after Libya. Nigeria has 15 nurses per 10,000 people, Physicians 3.83 per 10,000 people yet nurses and other healthcare professionals emigrate the country in good numbers to western countries in search of greener pasture, healthy work environment, and positive career growth. An estimated 1/5 African healthcare workers migrate to the western world for employment purposes. About 10,684 African physicians left the continent in 2005, 13,584 in 2015 for greener pastures in the European countries. Violence against healthcare professionals is a severe cankerworm that has eaten deep into the fabrics of the African health system. It has robbed the continent and other continents of the world numerous experts untimely due to injury, job dissatisfaction and death.[11]

WPV has been documented in healthcare systems globally without a clear link to wealth, type of organization or cultural factors.[2] Workplace violence may occur most frequently in psychiatric wards, emergency rooms, waiting rooms, geriatric units, and areas that need to work directly with volatile people, especially when they are under the influence of drugs or

alcohol, have a history of violence or have certain psychotic diagnoses, are working in crowded and understaffed units, have long waits for service, have inadequate security, have unrestricted movement of the public, and are poorly designed environments.[12]

Healthcare workers (HCWs) are particularly affected by WPV, which has become a global social problem.[11] Many healthcare organizations and clinicians have observed increasing rates of violence over recent years with a concomitant rise in negative impacts on HCW.[2] Workplace violence has multiple negative physical and psychological consequences for healthcare workers, leading to reduced job motivation, burnout, depression and a desire to quit the job. These consequences in turn affect the quality of care and put health-care provision at risk, not to mention the rise in absenteeism in the workplace or increased costs, e.g. metal detectors and security guards.[14] The experience of WPV is linked to reduced quality of life and negative psychological implications, such as low self-esteem, increased anxiety, and stress.[15] Motivation to work, job security and job mobility have also been reported to be negatively impacted.[16,17] The exposure to stressful events at work is likely to increase cognitive activation that can be described as worrying or having repetitive thoughts, triggering autonomic arousal and emotional stress. Length of exposure has been referred as determinant to the severity of these effects. The impact of workplace violence on health is of greater concern when workers are permanently involved with other citizens which is the case of healthcare, where the risk of aggression is four times higher than in the general private sector. Additionally, it threatens the quality of the care provided to patients.[16,17] Nurses, who are primarily responsible for providing life-saving care to patients are victimized at a significantly higher rate than other health-care professionals, and it is estimated that workplace violence causes 17.2% of nurses to leave their job every year.[18] There is underreported WPV against healthcare workers because of the complex process of reporting and the fear that the manager will not support the victim.[13]

1.3 JUSTIFICATION OF THE STUDY

Workplace violence (WPV) targeting healthcare professionals (HCWs) constitutes a serious global occupational health concern.[15] This issue carries substantial consequences for employers, employees, and patients, impacting their safety, well-being, and the quality of patient care, underscoring the necessity of addressing it promptly.[6,13] The noticeable rise in WPV incidents has prompted researchers to dedicate greater attention to investigating its nature and occurrence, aiming to devise effective strategies for prevention and mitigation.[13,19]

While the severity of WPV within the healthcare sector is broadly recognized and has been extensively studied in high-acuity settings, there remains a significant knowledge gap regarding its manifestation in secondary care facilities.[15] Following the 1978 Alma-Ata Declaration, there has been an increased global focus on empirical studies examining WPV within the health care sector.[15] Despite this growing burden of evidence, comprehensive systematic reviews frequently encounter difficulties in formulating effective, generalizable policies due to the vast diversity found in study settings, the populations examined and the specific types of violence investigated across the literature.[6] While WPV is acknowledged and has been extensively studied in certain tertiary environments, it is essential to investigate this problem among personnel operating within other key healthcare settings, such as secondary care facilities. Ensuring that critical dimensions of WPV in these environments receive attention comparable to those in tertiary hospitals is crucial.[15]

Within the Nigerian healthcare context, workplace violence against health care workers remains a significant occupational concern. Although several studies have examined patient related issues within healthcare delivery, comparatively fewer investigations have provided comprehensive documentation on the safety and protection of healthcare workers in clinical settings.[19] Existing Nigerian studies have largely explored general patterns of violence or its effect on nurse productivity in specific institutions, such as hospitals in Ibadan, South-West

Nigeria,[20] or have focused primarily on tertiary facilities in selected geopolitical zones.[9] The limited breadth and contextual variation of available evidence indicate the need for broader empirical inquiry to better characterize workplace violence against healthcare workers and inform appropriate institutional responses.[19]

Given the serious implications for public and occupational health, this study is crucial for determining the prevalence of workplace violence against HCWs specifically at the University of Benin (UNIBEN) Health Center.[6] As a secondary healthcare facility connected to a major institution, this setting offers a focused environment for research. The findings will provide essential data to inform the creation of localized, targeted prevention strategies and support the implementation of long-term programs in the most affected areas.[6]

1.4 AIM AND OBJECTIVES

General Aim:

The aim of this study is to assess the prevalence, causes, and impact of WPV against HCW at the University of Benin (UNIBEN) Health Center.

Specific Objectives:

1. To assess the prevalence of workplace violence against health care workers in UNIBEN Health Center.
2. To investigate the causes of workplace violence against different health care workers in UNIBEN Health Center.
3. To assess the effects of workplace violence on health care workers in UNIBEN Health Center.

CHAPTER TWO

LITERATURE REVIEW

Workplace violence against healthcare workers has increasingly become a major occupational and public health concern globally. Healthcare settings are recognized as high risk environments due to frequent interactions with patients and their relatives, often under emotionally charged and stressful conditions. Workplace violence may occur in various forms, including physical assault, verbal abuse, and psychological intimidation, and has been widely reported across healthcare institutions in both developed and developing countries.[22,23,4] Evidence indicates that workplace violence is prevalent among different categories of healthcare workers and across multiple healthcare settings with significant implications for job satisfaction, productivity, psychological wellbeing, and staff retention.[23]

2.1 PREVALENCE OF WORKPLACE VIOLENCE AMONG HEALTHCARE WORKERS

A cross-sectional study conducted over four weeks in 2020 at a Teaching Hospital in Abakaliki, Ebonyi State, Nigeria, assessed the prevalence of workplace violence among 205 hospital employees. The hospital was stratified into Clinical, Nursing Services, Pharmacy, Laboratory, and Administrative divisions, and proportionate allocation with random sampling was used to select participants. Data were collected using a structured questionnaire. The study reported a high prevalence of workplace violence of 70% among healthcare workers.[21]

A cross-sectional study was conducted among 282 healthcare workers in the emergency department of a teaching hospital in Nigeria to determine the prevalence and forms of workplace violence. Data were collected using a standardized interviewer-administered questionnaire and analyzed using IBM SPSS version 25.0. The prevalence of physical violence was 22.3%, while psychological violence was reported by 87.6% of the respondents, indicating a high burden of non-physical violence among healthcare workers.[22]

Similarly, a multicenter cross-sectional study utilizing a mixed-methods approach was conducted among 1,218 healthcare workers across public healthcare facilities in Borno State, Plateau State, and the Federal Capital Territory, Nigeria. The study reported an overall prevalence of 16.7% for physical violence and 62.4% for psychological violence. The findings revealed that violent attacks against healthcare workers remain a significant public health concern in Nigeria.[23]

In East Africa, a descriptive cross-sectional study was carried out among emergency nurses in a tertiary hospital in Kenya using a structured questionnaire adapted from the "Workplace Violence in the Health Sector" research instrument. The overall lifetime prevalence of workplace violence was 81.7%, while the one-year prevalence was 73.2%, demonstrating a high occurrence of workplace violence among emergency nurses.[24]

In South Asia, a hospital-based cross-sectional study using a nationally representative sample of 1,081 healthcare workers across eight administrative divisions of Bangladesh found that 43% of participants experienced some form of workplace violence within the past year. Among those affected, 84% reported non-physical violence, while 16% experienced physical violence. Logistic regression analysis revealed that being married, working in the public sector, working in the emergency department, and understanding shift work were significant independent predictors of workplace violence.[25]

Globally, a systematic review and meta-analysis of 65 studies involving 61,800 healthcare professionals from 30 countries examined the one-year prevalence of workplace physical violence perpetrated by patients or visitors. The pooled one-year prevalence was 19.33% (95% CI: 16.49–22.53%), indicating that approximately one in five healthcare professionals worldwide experience physical workplace violence annually. The study also reported significant heterogeneity across geographic regions and healthcare settings.[4]

2.2 CAUSES OF WORKPLACE VOILENCE AMONG HEALTH CARE WORKERS

A cross-sectional descriptive study was conducted in 2023 among healthcare workers (HCW) at Enugu State University Teaching Hospital using a pre-tested semi-structured self-administered questionnaire on "workplace violence in the health sector", adapted from the International Labor Organization, International Council of Nurses, World Health Organization, and Public Services International (ILO/WHO/PSI). The study reported long patient wait time was reported as a cause by 50.3% of the respondents, unprofessional attitudes from healthcare professionals were reported by 37.9%, while relatives feeling that patients were in pain and not improving by 34.5%, and lack of security by 22.75%.[26]

An analytic cross-sectional study was conducted in the Greater Accra region from January 30 to May 31, 2023, involving selected health facilities. The participants for the study were selected using a simple random sampling technique based on probability proportional-to-size. The study was conducted among 607 healthcare providers and support personnel across 10 public and private hospitals. Factors significantly linked to experiencing any form of WPV in the previous 12 months were identified as follows: older age [AOR = 1.11 (1.06, 1.17)], working experience [AOR = 0.91 (0.86, 0.96)], having on-call responsibilities [AOR = 1.75 (1.17, 2.61)], and feeling adequately secure within health facility [AOR = 0.45 (0.26, 0.76)].[27]

A hospital-based cross-sectional study design used a nationally representative sample of 1,081 healthcare workers covering eight administrative divisions of Bangladesh. Logistic regression analysis was employed to estimate the adjusted effect of independent factors on WPV among healthcare workers. Four factors: being married (AOR = 1.63; CI: 1.12-2.39); public sector healthcare worker (AOR = 2.74; CI:1.99-3.76); working in an emergency department (AOR = 2.30; CI:1.03-5.12); and undertaking shift work (AOR = 1.52; CI: 1.10-2.11) were found to be significantly associated with WPV.[25]

A cross-sectional study was conducted in public, Ministry of Higher Education-affiliated teaching hospitals in Damascus, Aleppo, and Lattakia, Syria. A total of 832 healthcare

workers (68.1% physicians/residents, 31.9% nurses) completed a self-administered electronic questionnaire, distributed using a multi-stage, non-probability sampling strategy. Data were analyzed using logistic regression which reported significant risk factors for WPV included being a physician/resident (AOR = 2.72), working night shifts (AOR = 1.82), and having direct patient contact (AOR = 2.63).[28]

2.3 EFFECTS OF WORKPLACE VIOLENCE ON HEALTHCARE WORKERS

A descriptive cross-sectional study was carried out among 228 nurses in public and private healthcare facilities in Port Harcourt. The study showed the effects of workplace violence mostly experienced by nurses were repeated memories 81.3%, loss of self-esteem 66.6%, worrying of going back to work 65.8%, not doing job well 59.4% and requiring time off from work 44.7%.[30]

A cross-sectional study was conducted among 584 nurses working in public hospitals in the Volta Region to examine the incidence of workplace violence (WPV) and its effect on quality of care. Data were collected using a structured survey, the study reported that 12% of respondents experienced physical violence, with patients' relatives being the most frequent perpetrators; however, 17.1% of physical violence cases were perpetrated by supervisors and other staff members. A significant association was observed between physical violence and the rank of the nurse ($X^2 = 14.196$, df = 4, N = 584, p = 0.01). In terms of quality of care, WPV was significantly associated with declines in multiple facets, including nurses' relationships with patients ($X^2 = 26.862$, df = 1, N = 41, p = 0). The findings underscore the need for enhanced public awareness campaigns and increased support for victims of workplace violence.[31]

A cross-sectional study adopted a purposive sampling method to collect data from March 2017 through May 2017. A total of nine tertiary hospitals in four provinces, which provide healthcare from specialists in a large hospital after referral from primary and secondary care, were selected as research sites based on their geographical locations in the eastern, central

and western regions of China. Descriptive analyses, a univariate analysis, a Pearson correlation, and a mediation regression analysis were used to estimate the prevalence of WPV and impact of WPV on job satisfaction, job burnout, and turnover intention. WPV was positively correlated with turnover intention ($r = 0.238$, $P < 0.01$) and job burnout ($r = 0.150$, $P < 0.01$), and was negatively associated with job satisfaction ($r = -0.228$, $P < 0.01$) and social support ($r = -0.077$, $P < 0.01$). Social support was a partial mediator between WPV and job satisfaction, as well as burnout and turnover intention.[11]

A cross-sectional study was conducted in 14 emergency departments in the West Bank and 3 in Isparta Province in Türkiye. A convenience sample of 377 health workers (227 in Palestine and 150 in Türkiye), consisting of 97 physicians, 198 nurses, and 82 other workers, including administrative and support health personnel, participated in the study. A self-administered survey was used to collect data between June and November 2024. The participants were asked to indicate whether they intend to leave working in EDs (using a 5-point Likert scale), where 59.6% of them responded as likely or very likely: 62.5% in Palestine and 50.8% in Türkiye ($\chi2 = 18.684$, $p = 0.012$). Additionally, they were asked about the effect of exposure to violence, whereas 27.3% of them indicated that it led to feelings of hopelessness/disappointment (27.6% and 26.6% in Palestine and Türkiye, respectively), 24.9% minimized communication and contact with patients and their families/companions (24.3% and 26.6%, respectively), 10.4% minimized time of patient care (10.3% and 10.9%, respectively), 6.8% fear and anxiety (3.8% and 15.6%, respectively), 6.4% desired revenge (8.1% and 1.6%, respectively), 4.4% avoided taking decisions that might involve medical risks (3.8% and 6.3%, respectively), and 2.5% experienced guilt (2.1% and 3.1%, respectively). Notably, 20% of the participants in Palestine indicated that violence had no impact on them, whereas 9.4% of those in Türkiye did ($\chi2 = 17.016$, $p = 0.017$).[29]

CHAPTER THREE

METHODOLOGY

3.1 STUDY AREA

This study was conducted at the University of Benin Health Services Department, located at the University of Benin, Benin City, Edo State, Nigeria. The University of Benin is a federal university established in 1970 and is situated in Benin city, the capital of Edo state. The University operates two main campuses, Ugbowo and Ekehuan, with the Ugbowo campus serving as the main campus where most faculties and administrative units are located. The institution has a large population of students and staff drawn from different parts of the country. The University of Benin Health Services Department is dedicated to providing comprehensive medical services to its students, staff, and the university community. The department currently has a total staff strength of 179 personnel. These comprise of 41 medical doctors, 44 nurses, 10 pharmacists, 18 medical laboratory scientists, 12 medical records officers, 5 radiographers, 13 administrative staff, 9 public transport drivers, 18 laundry and sanitation staff, and 9 environmental staff. The department is headed by a Director, under whom are the Chief Medical Officers (CMO) of the Ugbowo and Ekehuan clinics, responsible for supervising medical doctors and administrative duties. Other key units include the Deputy Director of Pharmaceutical Services (DDPS) overseeing the pharmacy unit, the Deputy Director of Nursing Services (DDNS) supervising nurses and allied staff, the Assistant Director of Medical Laboratory Services (ADMLS) overseeing laboratory scientist and laboratory workers, and the Chief Medical Record Officer (CMRO) in charge of records staff. Additional support services include the Public Transport Services (PTS) responsible for ambulance drivers, the Registrar's representative overseeing centrally deployed staff, and the Principal Medical Officer (PMO) of Radiology supervising radiology and clinical staff. Located within the Ugbowo campus, the University of Benin Health Services Department

ensures accessible and quality healthcare for all.[33] The University of Benin lies on Latitude: 6°20' 1.32" N and Longitude: 5° 36' 0.53" E.[34]

3.2 STUDY DESIGN

A descriptive cross-sectional study design was adopted for this study.

3.3 STUDY POPULATION

This study was carried out amongst Healthcare Workers in the University of Benin Health Services Department, Benin City, Edo State.

3.4 SELECTION CRITERIA

3.4.1 INCLUSION CRITERIA

1. All healthcare workers who have worked at the University of Benin Health Services Department for at least 6 months.

3.5 SAMPLE SIZE DETERMINATION

The minimum sample size (n) was calculated using the Cochran's formula for descriptive studies.[37]

$$n = \frac{Z^2 pq}{d^2}$$

Where: n = Minimum Sample Size

Z = Standard normal deviation set at 95% confidence interval (1.96)

p = Prevalence rate of a particular characteristic of the target population.

q = 1 – p

d = Degree of precision set at 0.05 confidence interval

For this study, p was assumed to be 88.1% (0.881), which is based on a previous cross-sectional study done in Delta state which assessed the prevalence of violence against 194 healthcare workers in Federal Medical Centre, Asaba, and reported a prevalence of 88.1%.[10]

Thus, minimum sample size is calculated as;

$$n = \frac{1.96^2 \times 0.881 \times (1-0.881)}{0.05^2}$$

$$n = \frac{8416 \times 0{\cdot}104839}{0.0025}$$

n = 161.09 ≈ 161.

Therefore, the minimum sample size for this study is 161

To account for non-response, 10% non-response rate was added to the minimum sample size utilizing the formula for non-response rate.

$$n_{\text{adj}} = \frac{n}{1-n_r}$$

n = Minimum sample size = 161

n_{r} = Non response rate = 10% = 0.10

n_{adj} = Adjusted sample size

$$n_{\text{adj}} = \frac{161}{1-0.10}$$

$$n_{\text{adj}} = 178$$

A sample size of 180 was used for this study

3.6 SAMPLING TECHNIQUE

A total population survey was employed for this study since the total number of healthcare workers in the University of Benin Health Services Department was not large. The study

therefore included all eligible healthcare workers. Consecutive recruitment was used, whereby all healthcare workers who met the inclusion criteria to participate were recruited into the study until the entire population of eligible participants was captured.

3.7 DATA MANAGEMENT

3.7.1 DATA COLLECTION

Data for this study was collected using both self-administered and interviewer-administered questionnaires which was adapted from International Labor Office (ILO), International Council of Nurses (ICN), World Health Organization (WHO), and Public Services International (PSI) workplace violence in the health sector country case studies research instruments joint program to measure workplace violence.[35] The questionnaire was divided into four sections as follows:

Section 1: Sociodemographic Data; Age, sex, ethnicity, religion, marital status, job category, years of experience.

Section 2: Prevalence of workplace violence; physical violence and psychological violence.

Section 3: Causes of workplace violence; Non-availability of doctors/nurses on call duty, aggressive personality of the perpetrators, loss of patient, non-availability of bed space, talking with patient, unprovoked, attempting to calm patient, restraining aggressive patient, giving instruction to patient.

Section 4: Effects of workplace violence; Post-traumatic stress disorder, Loss of job satisfaction, Loss of confidence in themselves, Decline in productivity, Absence from work.

3.7.2 PRETESTING

The questionnaire was pre-tested at Benson Idahosa University Health Center to ensure its comprehensibility, sensitivity, validity and reliability**,** using 10% of the minimum sample size of this study**.**

3.7.3 DATA ANALYSIS

Data collected from the questionnaires was checked for completeness and consistency before being coded and entered into IBM SPSS version 27.0 for analysis. Descriptive statistics such as frequencies, percentages, means, and standard deviations were used to summarize the socio-demographic characteristics of respondents and to determine the prevalence of workplace violence against healthcare workers. Inferential statistics was employed to examine the association between workplace violence and selected independent variables such as age, sex, professional category, and years of work experience. Chi-square tests was used to determine associations between categorical variables. Variables found to be statistically significant at the bivariate level were entered into a multivariate logistic regression model to identify predictors of workplace violence among healthcare workers. Statistical significance will be set at $p < 0.05$ with a 95% confidence interval.

3.7.4 DATA PRESENTATION

Results obtained were presented using frequency distribution tables, contingency tables, charts and prose.

3.8 ETHICAL CONSIDERATIONS

Ethical approval for this study was obtained from the Health Research Ethics Committee of the University of Benin Teaching Hospital (UBTH) before the commencement of the study. In addition, institutional permission was obtained from the Director of the University of Benin Health Services Department to conduct the study within the facility. All participants were adequately informed about the purpose of the study, and informed consent will be obtained before participation. Participation will be entirely voluntary, and respondents will have the right to withdraw from the study at any stage without any consequences. Confidentiality and anonymity of all information obtained from participants was strictly maintained throughout the research process.

STUDY LIMITATIONS

1. Self-reported behaviors may be subjected to recall bias.

CHAPTER FOUR

RESULTS

A total of one hundred and seventy-nine (179) questionnaires were administered in this study. However, fourteen (14) respondents declined participation and returned uncompleted questionnaires. Consequently, one hundred and sixty-five (165) completed questionnaires were retrieved, giving a response rate of 92.2%. The results are presented as follows:

Section A: Socio-demographic characteristics of respondents

Section B: Prevalence of workplace violence among respondents

Section C: Causes of workplace violence among respondents

Section D: Effects of workplace violence among respondents

Table 1: Sociodemographic characteristics of respondents

Variables	Frequency (n=165)	Percent
Age (years)		
20-29	19	11.5
30-39	61	37.0
40-49	60	36.4
≥ 50	25	15.2
Mean ± SD = 39.5 ± 9.2		
Sex		
Male	85	51.5
Female	80	48.5
Marital status		
Single	32	19.4
Married	119	72.1
Divorced/Separated	12	7.2
Widowed	1	0.6
Cohabiting	1	0.6
Religion		
Christianity	157	95.2
Islam	3	1.8
Atheist	3	1.8
Jehovah witness	2	1.2
Ethnic group		
Bini	76	46.1
Esan	13	7.9
Etsako	13	7.9
Igbo	25	15.2
Yoruba	14	8.5
Urhobo	8	4.8
Hausa	4	2.4
Akoko Edo	5	3.0
Others	7	4.2
Profession		
Doctor	30	18.2
Nurse	31	18.8
Pharmacist	12	7.3
Laboratory Scientist	15	9.1
Administrative/Records	14	8.5
Technical/Clinical Support	31	18.8
Non Clinical Support	32	19.4
Years of work experience		
≤1	13	7.9
1–5	48	29.1
6–10	45	27.3
> 10	59	35.8

Others: Ika, Isoko, Itsekiri, Kwale, Tiv

The age group with the highest representation was 30–39 years, accounting for 61 (37.0%) of the sample, followed closely by the 40–49 age group with 60 (36.4%) respondents. Those aged 20–29 and ≥50 years constituted 19 (11.5%) and 25 (15.2%) of the population,

respectively. The mean age of the participants was 39.5 ±9.2 years. Males represented 85 (51.5%) of the sample, while females accounted for 80 (48.5%).

The majority of respondents were married 119 (72.1%), followed by those who were single 32 (19.4%). A smaller proportion of the population was divorced or separated 12 (7.2%), with widowed and cohabiting respondents each representing 1 (0.6%). Regarding religious affiliation, Christianity was predominant with 157 (95.2%) adherents, while Islam and Atheism were each practiced by 3 (1.8%) respondents. Two (1.2%) respondents identified as Jehovah's Witnesses. Bini was the primary ethnic group, representing 76 (46.1%) of the participants. Other ethnic representations included Igbo 25 (15.2%), Yoruba 14 (8.5%), and both Esan and Etsako at 13 (7.9%) each. Non-clinical support staff constituted the largest professional group with 32 (19.4%) respondents. This was followed closely by nurses and technical/clinical support staff, each representing 31 (18.8%) of the sample. Doctors accounted for 30 (18.2%) participants, while laboratory scientists, administrative/records staff, and pharmacists represented 15 (9.1%), 14 (8.5%), and 12 (7.3%) respectively.

Regarding years of work experience, the largest proportion of respondents had more than 10 years of experience 59 (35.8%). Participants with 1–5 years of experience accounted for 48 (29.1%), while those with 6–10 years of experience totaled 45 (27.3%). Respondents with one year or less of work experience represented the smallest group at 13 (7.9%).

Table 2: Prevalence of workplace violence among respondents

Variables	Frequency	Percent
Ever experienced workplace violence		
Yes	58	35.2
No	107	64.8
Physically attacked in last 6 months (n = 58)		
Yes	22	37.9
No	36	62.1
Nature of physical attack (n = 22)		
Without weapon	19	86.4
With weapon	3	13.6
Perpetrator of physical violence (n = 22)		
Patient/client	16	72.7
Relatives of patient/client	1	4.6
Staff member	4	18.1
Management/supervisor	1	4.6
Witnessed physical violence in last 6 months		
Yes	35	21.2
No	130	78.8
Frequency of witnessed violence (n = 35)		
Once	16	45.7
2–4 times	10	28.6
5–10 times	4	11.4
Several times a month	2	5.7
Once weekly	2	5.7
Daily	1	2.9
Verbally abused in last 6 months		
Yes	55	33.3
No	110	66.7
Frequency of verbal abuse (n = 55)		
Once	21	38.2
2–4 times	13	23.6
5–10 times	5	9.1
Several times a month	12	21.8
Once weekly	3	5.5
Daily	1	1.8
Nature of verbal abuse (n = 55)		
Insults	33	60.0
Bullying	12	21.8
Threats	9	16.4
Sexual harassment	1	1.8
Perpetrator of verbal abuse (n = 55)		
Patient/client	40	72.7
Relatives of patient/client	8	14.5
Staff member	3	5.5
Management/supervisor	1	1.8
General public	3	5.5

Fifty-eight (35.2%) participants reported ever experiencing workplace violence, while 107 (64.8%) had not. In the preceding six months, 22 (37.9%) respondents were physically

attacked, whereas 36 (62.1%) reported no such incident during that period. Among those physically attacked, the majority were assaulted without a weapon 19 (86.4%), while 3 (13.6%) were attacked with a weapon. Patients or clients were the primary perpetrators of physical violence 16 (72.7%), followed by staff members 4 (18.1%), management or supervisors 1(4.6%), and relatives of patients or clients 1 (4.6%).

Physical violence was witnessed by 35 (21.2%) respondents in the last six months. Of those who witnessed violence, 16 (45.7%) saw it once, 10 (28.6%) saw it two to four times, and 4 (11.4%) saw it five to 10 times. More frequent witnessing of violence was reported as several times a month by 2 (5.7%) respondents, once weekly by 2 (5.7%), and daily by 1 (2.9%).

Verbal abuse in the last six months was reported by 55 (33.3%) respondents, while 110 (66.7%) reported no verbal abuse. The frequency of verbal abuse varied, with 21 (38.2%) experiencing it once, 13 (23.6%) two to four times, and 12 (21.8%) several times a month. Insults were the most common nature of verbal abuse 33 (60.0%), followed by bullying 12 (21.8%), threats 9 (16.4%), and sexual harassment 1 (1.8%). Patients or clients were identified as the most frequent perpetrators of verbal abuse 40 (72.7%), while relatives of patients 8 (14.5%), staff members 3 (5.5%), the general public 3 (5.5%), and management or supervisors 1 (1.8%) were also cited.

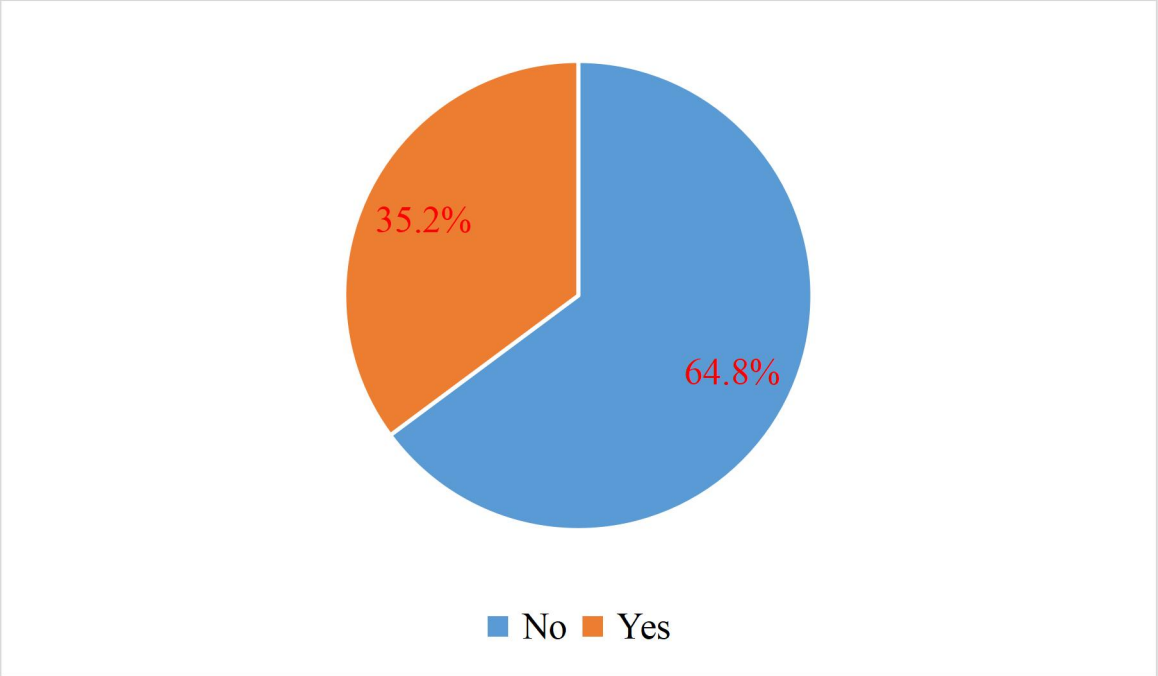

Figure 1: Life-time prevalence of workplace violence among respondents

Among the respondents, 107 (64.8%) had not experienced workplace violence, while 58 (35.2%) of respondents had experienced workplace violence, this is life-time prevalence since they have been working in the University of Benin Health Services Department.

Table 3: Sociodemographic characteristics and lifetime workplace violence among respondents

Variable	Ever experienced workplace violence		Test statistics	p-value
	Yes (n=58) Freq (%)	No (n=107) Freq (%)		
Age group				
20–29 years	7 (36.8)	12 (63.2)	1.503*	0.693
30–39 years	18 (29.5)	43 (70.5)		
40–49 years	24 (40.0)	36 (60.0)		
≥ 50 years	9 (36.0)	16 (64.0)		
Sex				
Male	32 (37.6)	53 (62.4)	0.479**	0.518
Female	26 (32.5)	54 (67.5)		
Marital status				
Not married	19 (41.3)	27 (58.7)	1.059**	0.364
Married	39 (32.8)	80 (67.2)		
Ethnicity				
Edo	36 (33.6)	71 (66.4)	0.047**	0.852
Non Edo	14 (31.8)	30 (68.2)		
Religion				
Christianity	56 (35.7)	101 (64.3)	0.526**	0.847
Islam	1 (33.3)	2 (66.7)		
Others	1 (20.0)	4 (80.0)		
Professional category				
Clinical staff	50 (42.0)	69 (58.0)	8.826**	0.003
Non clinical staff	8 (17.4)	38 (82.6)		

**Chi-square **Fishers exact test*

The prevalence of workplace violence was highest among respondents in the 40–49 years age group at 24 (40.0%), followed by those aged 20–29 years at 7 (36.8%) and those aged 50 years and older at 9 (36.0%). No statistically significant association was found between age group and the experience of workplace violence (p = 0.693). Male respondents reported a higher frequency of workplace violence at 32 (37.6%) compared to female respondents at 26 (32.5%), this difference was not statistically significant (p = 0.518).

Workplace violence was reported by 19 (41.3%) of respondents who were not married and 39 (32.8%) of those who were married. No statistically significant association was found between marital status and the occurrence of violence (p = 0.364). Edo indigenes experienced violence at a rate of 36 (33.6%), while non-Edo indigenes reported a rate of 14 (31.8%). Ethnicity was not significantly associated with workplace violence (p = 0.852). Religious

affiliation also showed no significant association ($p = 0.847$), with 56 (35.7%) of Christians, 1 (33.3%) of Muslims, and 1 (20.0%) of respondents from other religions reporting the outcome.

Professional category was the only variable significantly associated with the experience of workplace violence. Clinical staff reported a significantly higher prevalence of violence at 50 (42.0%) compared to non-clinical staff at 8 (17.4%). There is a statistically significant relationship between professional category and workplace violence ($p = 0.003$).

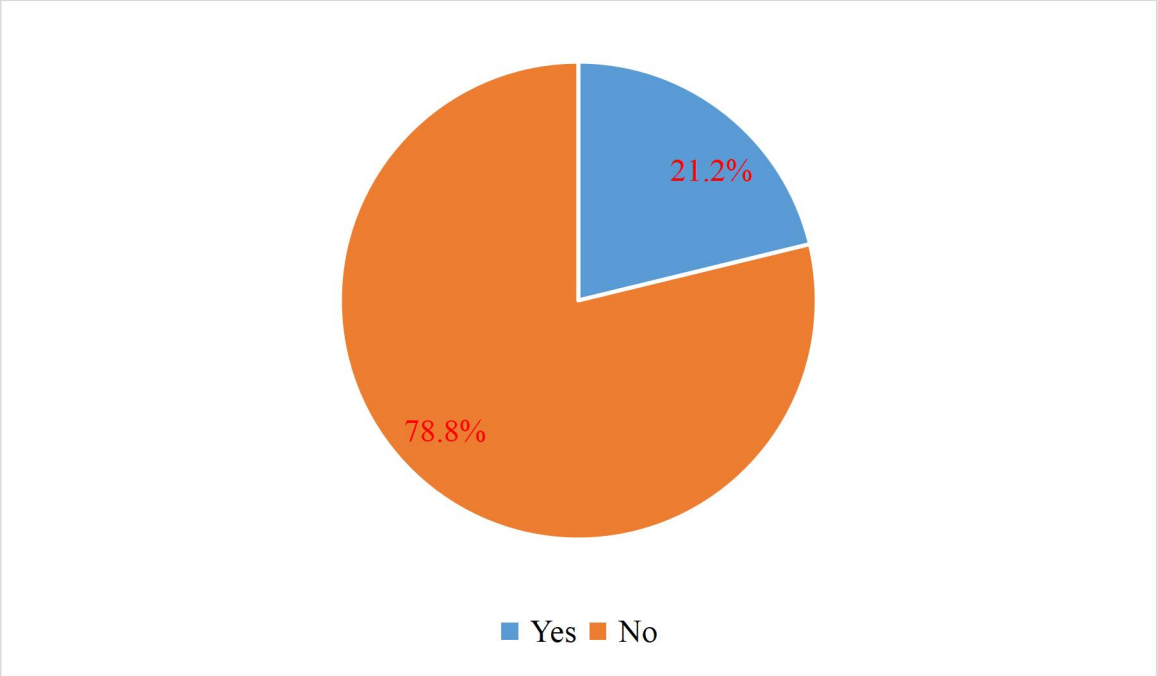

Figure 2: 6-month prevalence of physical violence in the workplace among respondents.

Among the 165 respondents assessed, 35 (21.2%) reported to have experienced physical violence in the workplace, while 130 (78.8%) reported not having experienced physical violence in the past six months preceding the study.

Table 4: Sociodemographic characteristics and 6-month prevalence of physical violence in the workplace among respondents

Variables	Experienced physical violence in the past 6 months		Test statistics	p-value
	Yes (n=35) Freq (%)	No (n=130) Freq (%)		
Age group				
20–29 years	6 (31.6)	13 (68.4)	2.811*	0.421
30–39 years	10 (16.4)	51 (83.6)		
40–49 years	12 (20.0)	48 (80.0)		
≥ 50 years	7 (28.0)	18 (72.0)		
Sex				
Male	19 (22.4)	66 (77.6)	0.137**	0.849
Female	16 (20.0)	64 (80.0)		
Marital status				
Not married	11 (23.9)	35 (76.1)	0.278**	0.672
Married	24 (20.2)	95 (79.8)		
Ethnicity				
Edo	20 (18.7)	87 (81.3)	0.062**	0.822
Non-Edo	9 (20.5)	35 (79.5)		
Religion				
Christianity	34 (21.7)	123 (78.3)	0.831**	0.834
Islam	0 (0.0)	3 (100.0)		
Others	1 (20.0)	4 (80.0)		
Professional category				
Clinical staff	28 (23.5)	91 (76.5)	1.371**	0.292
Non-clinical staff	7 (15.2)	39 (84.8)		

**Chi-square **Fisher's exact test*

The highest prevalence of physical violence in the last six months was observed in the 20–29-year age group at 6 (31.6%), followed by those aged ≥50 years at 7 (28.0%). The association between age group and physical violence was not statistically significant (p = 0.421). Male respondents reported experiencing violence at a rate of 19 (22.4%), while female respondents

reported a rate of 16 (20.0%). There was no significant association between sex and the experience of physical violence (p = 0.849).

Unmarried respondents reported a higher frequency of physical violence at 11 (23.9%) compared to married respondents at 24 (20.2%). Marital status was not significantly associated with the outcome (p = 0.672). Non-Edo indigenes experienced violence at a rate of 9 (20.5%), while Edo indigenes reported a rate of 20 (18.7%). No significant relationship was found between ethnicity and physical violence (p = 0.822).

Religious affiliation showed a prevalence of 34 (21.7%) among Christians, with no cases reported among Muslims and 1 (20.0%) case among respondents of other faiths. This association was not statistically significant (p = 0.834). Clinical staff reported a prevalence of physical violence at 28 (23.5%) compared with non-clinical staff at 7 (15.2%). Professional category was not significantly associated with physical violence in the preceding six months (p = 0.292).

Table 5: Perceived causes of workplace violence among respondents

Variables	Agree n (%)	Neutral n (%)	Disagree n (%)
Non availability of doctors/nurses on call duty	120 (72.7)	19 (11.5)	26 (15.8)
Aggressive personality of the perpetrators	117 (70.9)	24 (14.5)	24 (14.6)
Loss of a patient	80 (48.5)	31 (18.8)	54 (32.7)
Attempting to calm patient	82 (49.7)	41 (24.8)	42 (25.5)
Restraining aggressive patient	79 (47.9)	43 (26.1)	43 (26.0)
Giving instructions to patient	71 (43.0)	41 (24.8)	53 (32.2)
Unprovoked incidents	63 (38.2)	37 (22.4)	65 (39.4)

The highest levels of agreement were observed for the non-availability of doctors or nurses on call duty, reported by 120 (72.7%) participants, and the aggressive personality of perpetrators, reported by 117 (70.9%). Approximately half of the sample agreed that attempting to calm a patient 82 (49.7%), the loss of a patient 80 (48.5%), and restraining an aggressive patient 79 (47.9%) were contributory factors. Giving instructions to patients was cited as a cause by 71 (43.0%) respondents. Unprovoked incidents showed the least agreement and the highest level of contention, with 63 (38.2%) respondents agreeing and 65 (39.4%) disagreeing.

Table 6: Perceived effects of workplace violence among respondents

Variables	Agree n(%)	Neutral n (%)	Disagree n (%)
Post-traumatic stress disorder	104 (63.1)	18 (10.9)	43 (26.0)
Loss of job satisfaction	88 (53.3)	28 (17.0)	49 (29.7)
Loss of confidence	63 (38.2)	30 (18.2)	72 (43.6)
Decline in productivity	62 (37.6)	24 (14.5)	79 (47.9)
Absence from work	44 (26.7)	29 (17.6)	92 (55.7)

Post-traumatic stress disorder was the most significant consequence reported among the 165 participants, with 104 (63.1%) respondents in agreement. More than half of the sample, totaling 88 (53.3%), agreed that workplace violence resulted in a loss of job satisfaction. Impacts on professional efficacy and morale were less widely acknowledged; 72 (43.6%) participants disagreed that violence caused a loss of confidence, and 79 (47.9%) disagreed that it led to a decline in productivity. The lowest level of agreement was observed for absence from work, which was cited as an effect by 44 (26.7%) respondents, while 92 (55.7%) disagreed

CHAPTER FIVE

5.1 DISCUSSION

There was a low lifetime prevalence of workplace violence recorded among staffs of the University of Benin Health Services Department, with less than half reporting to have experienced workplace violence whether physical or psychological violence. This suggest that there was respectful communication between patients and healthcare workers leading to less violence against healthcare workers.

A likely reason for this finding may be due to the close-knit relationship between the healthcare workers in the health facility and the community it serves. Another probable reason may also be attributed to cultural and social beliefs that accord great respect to healthcare workers in Nigeria. Unfortunately, this cannot be said for all healthcare facilities as the health workforce in Nigeria is seriously fraught with the episodes of WPV in the healthcare setting.

The public heath implication of this finding was largely positive. Workplace violence against healthcare workers represented a significant public health concern with cascading effects across individual, organizational and systemic levels. When there is low prevalence of workplace violence it leads to lower burnout and emotional exhaustion, higher job satisfaction and retention and better quality of patient care.

However, although this finding was encouraging, it must also be known that low reported prevalence of WPV may mask several underlying problems. Low prevalence figures often reflect systemic underreporting rather than actual safety. In Nigeria where institutional accountability structure may be weak, the true burden of WPV likely exceeds documented cases.

To sustain and further strengthen this positive finding, continuous measures should be put in place to ensure the safety of healthcare workers. WPV should not be framed as an individual weakness but as a system failure. There should be normalization of reporting among healthcare workers. There should address cultural normalization of abuse as in many Nigerian healthcare settings, verbal abuse from patient is seen as part of the job consequently, there is pressing need to shift this prevailing mindset. The finding of this study was in contrast with a study done in a southern state in Nigeria where more than half of respondent reported having experienced workplace violence.[36]

A key finding from this study was the significant association between professional category and exposure to workplace violence. A more than half of the respondents who experienced WPV were clinical staff. A likely reason for this finding was that doctors and nurses were more frequently exposed to violence due to their direct and sustained interactions with patients, unlike non clinical staffs who have minimal patient contact, doctors and nurses cannot avoid or withdraw from clinical encounters. Additionally, Doctors and nurses have more authority than non-clinical staffs within the healthcare hierarchy making them symbolic targets for patients who feel disrespected by the system.

The public health implication is that frequent exposure of healthcare workers to WPV compromises the quality of patient care and discourages individuals from entering or remaining in the medical profession. It also leads to an increase in absenteeism because the victims of WPV may require sick leave, psychological recovery time which can disrupt service delivery in health facilities.

The negative findings can be mitigated through various measures like public education and health literacy because many violent incidents towards doctors and nurses stem from the unrealistic patient expectation, educating the public about the boundaries of clinical capabilities helps them have more reasonable expectations.

The findings of this study were in tandem with a study done in Edo State, Nigeria where there was a significant association between nursing profession and exposure to workplace violence.[37,38] The findings further suggested that a majority of respondents reported non-availability of doctors or nurses on call duty as a cause of workplace violence workplace of participants this suggests that there is a serious problem in the organizations management. In addition, aggressive personality of the perpetrator was also reported by the majority of respondents.

A likely reason for this was inadequate staffing levels, which creates gaps in service delivery. Perpetrators with aggressive tendencies may perceive healthcare workers as soft target because of their professional obligation to do no harm, this is then perceived as a lack of consequence, especially in institutions that don't follow up on WPV incidents.

The public health implication is that there will be delays in patient care due to non-availability of doctors or nurses on call duty will increase frustration among patients and their relatives making them more prone to respond with violence. The Aggressive personality of the perpetrator may also cause staff to avoid certain patients or units leading to unequal service distribution. To address these findings, there is a need for proper management of the healthcare worker services to avoid such delay. There is also a need for appropriate consequences to be given to the perpetrators to avoid repeated incidences and to settle the minds of the healthcare workers.

The findings of these study was in contrast with a study done in a southern state of Nigeria where finding showed a majority of the respondent reported improper manner of communication by healthcare workers as a cause of workplace.[39] The study revealed that a majority of respondent reported experiencing Post-traumatic stress disorder (PTSD) as an effect of exposure to workplace violence, this was followed closely by loss of job satisfaction.

A likely reason for this was that repeated exposure to workplace violence regardless of form, affect the emotional well-being of the victims, leading to emotional exhaustion and psychological drainage. In addition, when healthcare workers are psychologically drained, their capacity to experience positive engagement with their work diminishes, directly reducing satisfaction.

The public health implication is that it places an economic burden on the healthcare system with treatment cost for PTSD and indirect costs from absenteeism placing a strain on the already constrained healthcare budgets. Healthcare workers experiencing PTSD exhibit hypervigilance which reduces empathetic engagement with patients and increases the likelihood for medical errors.

The negative findings can be mitigated through measures such as provision of counselling services for victims exposed to workplace violence, continued advocation for healthcare worker safety through educational campaigns, facilitate forums for healthcare workers to share experiences and coping strategies amongst themselves.

The findings of this study was in tandem to a study done through Northwestern Academy of Quality and Safety Initiatives program, where an invitation to complete an online survey was sent to healthcare workers, a majority of participants reported experiencing loss of job satisfaction as an effect of WPV.[40]

5.2 CONCLUSION

This study revealed that workplace violence occurs among healthcare workers in the University of Benin Health Services department, with verbal abuse being more reported than physical violence.

The study identified non-availability of healthcare workers on duty and aggressive behavior of perpetrators as the major causes of workplace violence within the facility.

The study identified post-traumatic stress disorder and loss of job satisfaction as the major effects of workplace violence.

5.3 RECOMMENDATIONS

The management of the University of Benin Health Services department should develop and implement a clear workplace violence prevention policy that outlines reporting procedures, staff protection measures, and disciplinary actions against perpetrators of violence.

The management of the University of Benin Health Services department should ensure adequate staffing and proper scheduling of on-call duties in order to reduce delays in patient care and minimize patient frustration within the facility.

The management of the University of Benin Health Services department should establish a confidential and easily accessible reporting system that encourages healthcare workers to promptly report incidents of workplace violence without fear of victimization.

The management of the University of Benin Health Services department should strengthen security within the health facility through the deployment of trained security personnel and the installation of surveillance systems in high risk areas.

The management of the University of Benin Health Services department should provide psychological support and counselling services for healthcare workers who experience workplace violence in order to reduce its emotional and mental health effects.

The University of Benin should provide increased financial and administrative support to the health services department to improve staffing, infrastructure, and security within the facility.

The University of Benin should collaborate with the Health Services department to establish institutional policies that prioritize the safety, welfare, and occupational well-being of the healthcare workers.

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APPENDIX I

QUESTIONNAIRE

DEPARTMENT OF PUBLIC HEALTH AND COMMUNITY MEDICINE

UNIVERSITY OF BENIN, BENIN CITY

PREVALENCE OF WORKPLACE VIOLENCE AGAINST HEALTHCARE WORKERS IN UNIVERSITY OF BENIN HEALTH SERVICES DEPARTMENT

BENIN CITY

Dear respondent, I am a 600L medical student of the University of Benin, interested in studying

the **"Prevalence of Workplace Violence Against Healthcare Workers in the University Of Benin Health Services Department".** This questionnaire will aid as a tool of data collection in this research. Your sincere response will be helpful and the information given here will be appreciated and treated with utmost confidentiality.

Section 1: Sociodemographic Data

1. Age: _____ years (as at last birthday)
2. Sex: Male**[ ]** Female**[ ]**
3. Marital Status: Single**[ ]** Married**[ ]** Cohabiting**[ ]** Separated**[ ]** Divorced**[ ]** Widowed**[ ]**
4. Religion: Christianity**[ ]** Islam**[ ]** African Traditional Religion**[ ]** Others **[ ]** Pls Specify**:**_____
5. Ethnicity: Bini**[ ]** Igbo**[ ]** Hausa**[ ]** Yoruba**[ ]** Esan**[ ]** Etsako**[ ]** Urhobo[ ] Akoko-Edo[ ] Others**[ ]** Pls Specify:_____
6. Professional Category: Doctor**[ ]** Nurse**[ ]** Pharmacist**[ ]** Laboratory Scientist**[ ]** Paramedics**[ ]** Others**[ ]** Pls Specify**:**_____
7. Years of work experience: Less than 1yr**[ ]** 1-5yrs**[ ]** 6-10yrs**[ ]** more than 10yrs**[ ]**

Section 2: Prevalence of workplace violence

PLEASE NOTE: Physical violence refers to the use of physical force against another person or group, that results in physical harm, sexual or psychological harm. It can include beating, kicking, slapping, stabbing, shooting, pushing, biting, and/or pinching, among others

8. Have you ever experienced workplace violence in your workplace: Yes[ ] No[ ] if no

Skip to number 12

9. In the last 6 months, have you been physically attacked in your workplace: Yes[ ] No [ ]

10. If yes, please think of the last time that you were physically attacked in your place of work.

How would you describe this incident?

Physical violence without a weapon [ ] Physical violence with a weapon [ ]

11. Please think of the last time you were physically abused in your place of work. Who

physically abused you? Patient/client [ ] Relatives of patient/client [ ] Staff member [ ]

Management / supervisor [ ] General public [ ] other:_____

12. In the last 6 months, have you witnessed incidents of physical violence in your workplace?

Yes [ ] No[ ] if no skip to number 14

13. If YES, how often has this occurred in the last 6 months?

Once [ ] 2-4 times [ ] 5-10 times [ ] Several times a month [ ] About once a week [ ]

Daily [ ]

PLEASE NOTE: Psychological violence is defined as: Intentional use of power, including threat of physical force, against another person or group, that can result in harm to physical, mental, spiritual, moral or social development. Psychological violence includes verbal abuse, bullying/mobbing, harassment, and threats.

14. In the last 6 months, have you been verbally abused in your workplace: Yes [ ] No [ ]

15. If YES how often have you been verbally abused in the last 6 months? Once [ ]

2-4 times[ ] 5-10 times [ ] Several times a month [ ] About once a week [ ] Daily [ ]

16. When the incident occurred what exactly happened? Bullying [ ] Insults[ ] Sexual

Harassment [ ] Threats [ ]

17. Please think of the last time you were verbally abused in your place of work. Who

verbally abused you? Patient/client [ ] Relatives of patient/client [ ] Staff member [ ]

Management / supervisor [ ] General public [ ] other:_____

Section 3: Causes of workplace violence

The following statements relate to conditions in your workplace that may influence the occurrence of workplace violence. Please indicate the extent to which you agree with each statement based on your experience in your current workplace.

SA: Strongly agree, A: Agree, N: Neutral, D: Disagree, SD: Strongly disagree

	SA	A	N	D	SD
18. Non-availability of doctors/nurses on call duty					
19. Aggressive personality of the perpetrators					
20. Loss of a patient					
21. Attempting to calm patient					
22. Restraining aggressive patient					
23. Giving instruction to patient					
24. Unprovoked					

Section 4: Effects of workplace Violence

The following statements relate to effects that workplace violence may have on healthcare workers. Please indicate the extent to which you agree with each statement based on your experience in your current workplace.

SA: Strongly agree, A: Agree, N: Neutral, D: Disagree, SD: Strongly disagree

	SA	A	N	D	SD
25. Post-traumatic stress disorder					
26. Loss of job satisfaction					
27. Loss of confidence					
28. Decline in productivity					
29. Absence from work					

APPENDIX II

INSTITUTIONAL PERMISSION

Precious Orunchukwu Ngwokor,
Rosabel Joan Musa,
Department of Medicine,
Faculty of Medicine,
University of Benin,
Benin City,
Edo state.
12th March, 2026.

The Director,
University of Benin Health Services Department,
University of Benin,
Benin City,
Edo State.

Approved
DEPT. OF HEALTH SERVICES
UNIVERSITY OF BENIN CITY
12/3/2026

Dear Ma,

REQUEST FOR PERMISSION TO CONDUCT A RESEARCH STUDY

We are final year students of the department of Medicine, University of Benin, currently carrying out our final year research project titled "Prevalence of Workplace Violence Against Healthcare Workers in the University of Benin Health Services Department. The aim of this study is to assess the prevalence, causes, and impact of workplace violence against health care workers at the University of Benin Health Services Department. The findings of this study will be used strictly for academic and research purposes in partial fulfillment of the requirement for the award of our degree.

We hereby respectfully request your permission to conduct the study among healthcare workers in the University of Benin Health Services Department. Participation in the study will be entirely voluntary, and all information obtained will be treated with strict confidentiality and anonymity.

We would be grateful if approval is granted to enable us carry out this study within the department.

Thank you for your time and consideration.

Yours faithfully.

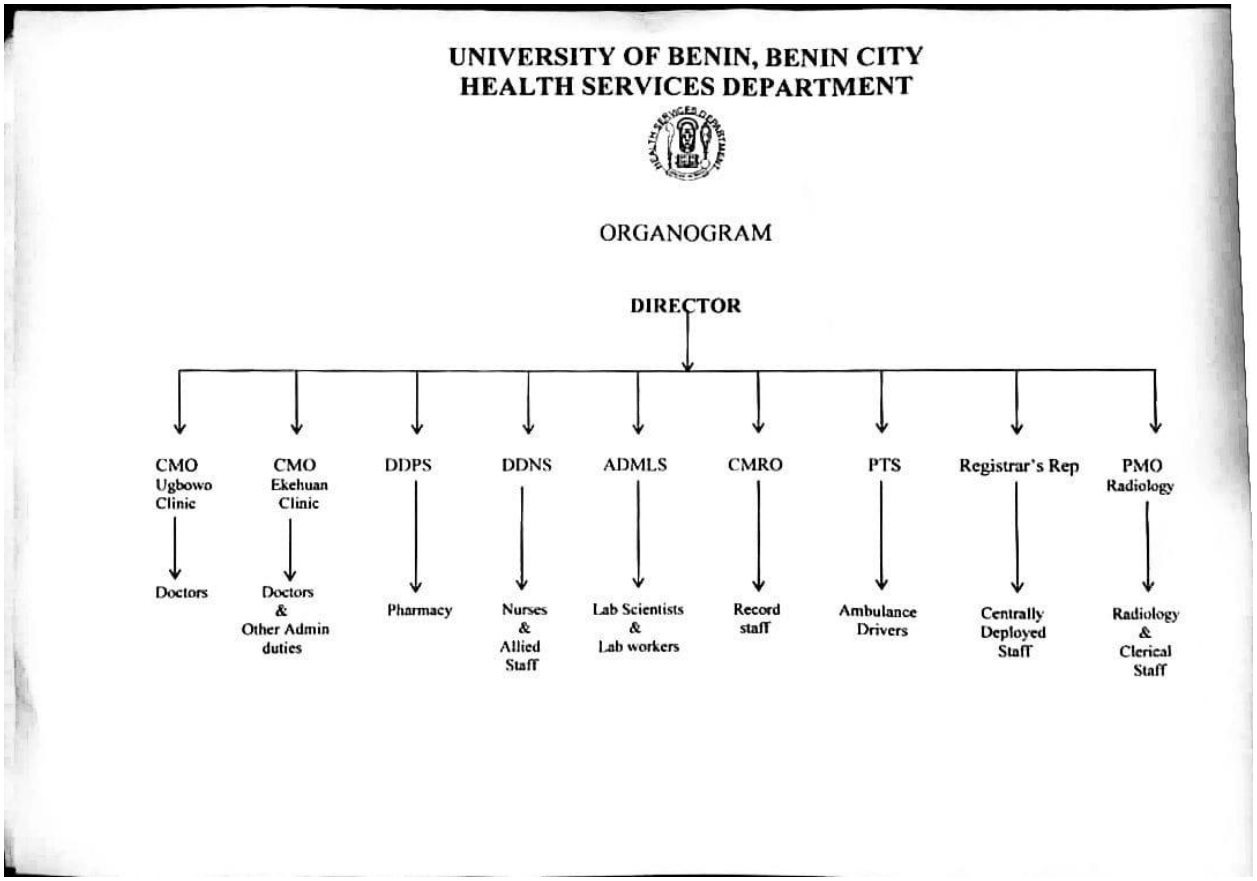
Precious Orunchukwu Ngwokor

Rosabel Joan Musa

The Director,
University of Benin Health Services Department.

APPENDIX III

ORGANOGRAM



APPENDIX IV

ETHICAL CLEARANCE FORM

HEALTH RESEARCH
ETHICS COMMITTEE (HREC)

UNIVERSITY OF BENIN TEACHING HOSPITAL

CHIEF MEDICAL DIRECTOR
Prof. (Mrs) LN Ize-Iyamu

DIRECTOR OF ADMINISTRATION
Jim Uwadia, Esq

CHAIRMAN
Prof. (Mrs.) Antoinette N. Ofili

HREC OFFICE:
Committee email: ubthresearchethics@gmail.com
Registration Number:
NHREC-UBTH-HREC/24/12/2022B

PROTOCOL NUMBER: ADM/E 22/A/VOL. VII/14865491272125

PROPOSAL TITLE: "PREVALENCE OF WORKPLACE VIOLENCE AGAINST HEALTHCARE WORKERS IN THE UNIVERSITY OF BENIN HEALTH SERVICES DEPARTMENT"

PRINCIPAL INVESTIGATOR(S): ROSABEL JOAN MUSA, PRECIOUS ORUNCHUKWU NGWOKOR

DEPARTMENT/INSTITUTION: DEPARTMENT OF PUBLIC HEALTH AND COMMUNITY MEDICINE, SCHOOL OF MEDICINE, UNIVERSITY OF BENIN, BENIN CITY, EDO STATE, NIGERIA

DATE CONSIDERED: MARCH 31ST, 2026

DECISION OF THE COMMITTEE: APPROVED

THIS APPROVAL DATES 31/03/2026 TO 19/03/2027. IF THERE IS DELAY IN STARTING THE RESEARCH, PLEASE INFORM THE HREC SO THAT THE DATES OF APPROVAL CAN BE ADJUSTED ACCORDINGLY

REMARK:

CHAIRMAN: PROF. (MRS) A.N. OFILI SIGNATURE & DATE: 31/3/2026

SUPERVISOR (S): PROF. A. R ISAAC

DECLARATION BY INVESTIGATOR(S):

PROTOCOL NUMBER (please quote in all enquiries)

Note that no participant accrual or activity related to this research may be conducted outside of these dates and **you are to furnish the committee with the research activities at the completion of the study**. All informed consent forms used in this study must carry the HREC assigned number and duration of HREC approval of the study. In multiyear research, endeavor to submit your annual report to the HREC early in order to obtain renewal of your approval and avoid disruption of your research. No changes are permitted in the research without prior approval by the HREC except in circumstances outlined in the Code. The HREC reserves the right to conduct compliance visit your research site without previous notification.

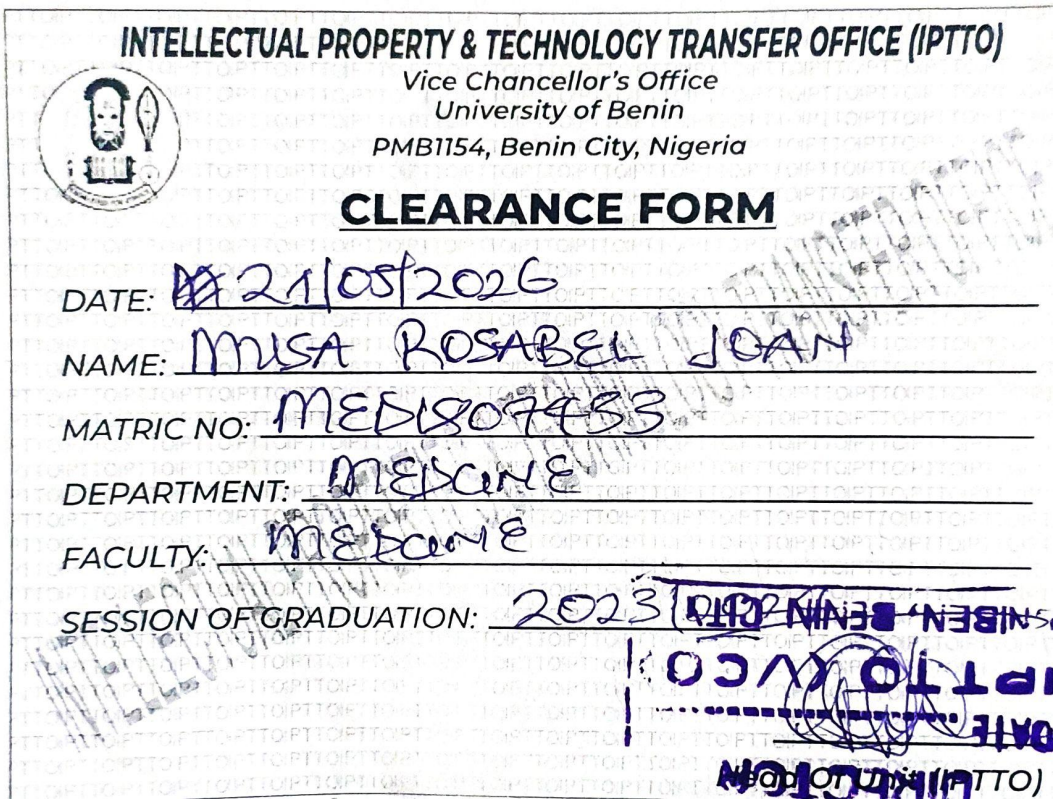
Signature & Date: 02/4/2026

ubthresearchethics@gmail.com

Registration Number: NHREC/24/01/2020

APPENDIX V

PLAGIARISM TEST FORM



INTELLECTUAL PROPERTY & TECHNOLOGY TRANSFER OFFICE (IPTTO)

Vice Chancellor's Office
University of Benin
PMB1154, Benin City, Nigeria

CLEARANCE FORM

DATE: 21/05/2026

NAME: MUSA ROSABEL JOAN

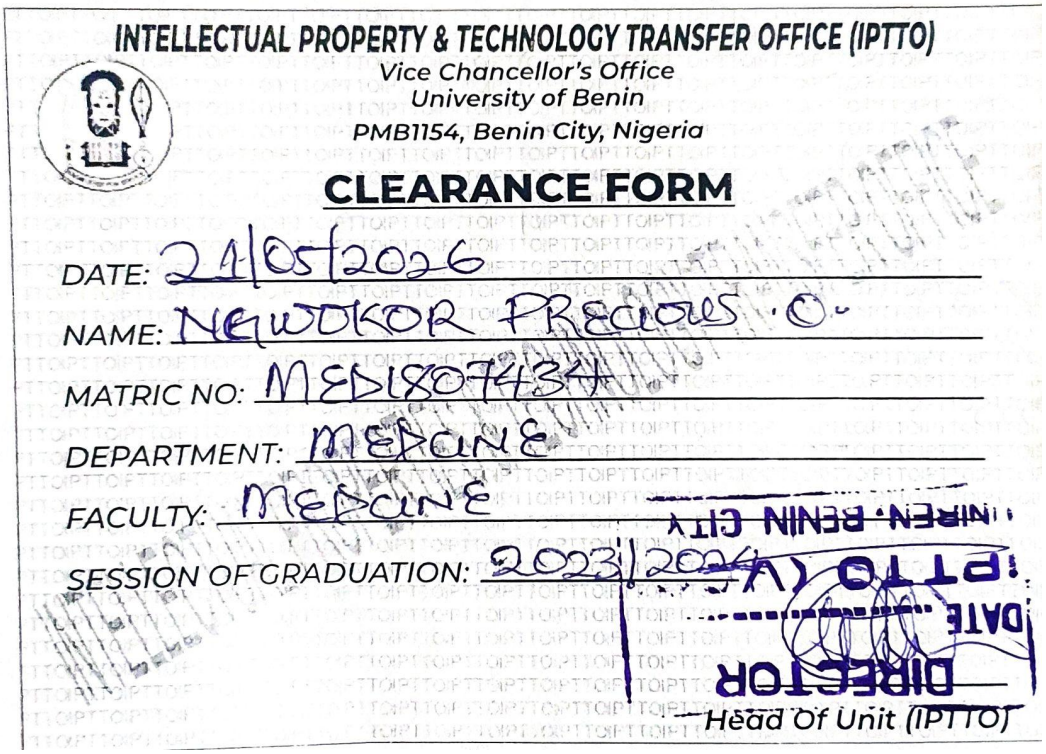
MATRIC NO: MED1807453

DEPARTMENT: MEDICINE

FACULTY: MEDICINE

SESSION OF GRADUATION: 2023

Head Of Unit (IPTTO)



INTELLECTUAL PROPERTY & TECHNOLOGY TRANSFER OFFICE (IPTTO)

Vice Chancellor's Office
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PMB1154, Benin City, Nigeria

CLEARANCE FORM

DATE: 21/05/2026

NAME: NEWDKOR PRECIOUS O.

MATRIC NO: MED1807434

DEPARTMENT: MEDICINE

FACULTY: MEDICINE

SESSION OF GRADUATION: 2023/2024

DIRECTOR

Head Of Unit (IPTTO)