



Assessment of Workplace Violence among Primary Healthcare Workers in Enugu Metropolis

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Authors' contributions

This work was carried out in collaboration between both authors. Author HOS designed the study, performed the statistical analysis, wrote the protocol and wrote the first draft of the manuscript. Authors OPN and HOS managed the analyses of the study. Author OPN managed the literature searches. Both authors read and approved the final manuscript.

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ABSTRACT

Introduction: Work place violence in health-care facilities are on the rise and are routinely underreported.

Objective: This study investigated the prevalence of workplace violence among primary health-care workers in Enugu metropolis.

Materials and Methods: The participants were selected via multi-stage sampling method. A total of 117 out of 135 questionnaires from primary health-care workers in Enugu metropolis were collated and analyzed with the aid of frequency tables and charts.

Results: The results showed that the primary health-care workers are exposed to verbal and non-verbal harassment when working alone in shifts as a contributing factor to workplace violence, subjected to their type of work. This violence most times not reported owing to fear, stigmatization and mistrust of the workers that management will not take their cases serious, this, ultimately impinge on the overall job performance, revenue generation as well as job integrity. Based on the influence of workplace violence on work and life of primary health-care workers about 61.5% of

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primary health-care workers agrees that workplace violence experience leads to fear and impaired performance and majority agrees that workplace violence does not depends on tribe and religion. Based on predictors of workplace violence, about 69.4%, 69% and 69.1% of primary health-care workers agrees that level of education, work cadre and years of experience influences workplace violence respectively.

Conclusion: The study shows that primary health-care workers are exposed to different workplace violence: physical, threat, verbal and sexual harassment. Also, primary health-care workers agree that patient relatives (31.9%) and colleague (17.4%) are the main sources of workplace violence mostly due to misunderstanding. Out of 75 victims of workplace violence 66.7% reported their cases while about 53.6% did not report. Victims of workplace violence should be encouraged to speak up.

Keywords: Workplace violence; primary health-care workers; misunderstanding.

1. INTRODUCTION

Work plays a very important role in the development of every nation. It is an indubitable fact that workers are in the forefront of national growth and economic development of every country. Moreover, when the workplace becomes a security threat environment, work engagement becomes a complex problem such that workers will not be self-assured and secured to carry out his or her with duty commitment. This in return affects productivity in the workplace. Workplace violence (WPV) constitutes a serious safety and health hazards and has gained recognition in recent times. Estimates for the prevalence of WPV considerably vary from one study to another, the employment sector, the WPV type measured, and the country that was surveyed [1]. Violence ranked among the top causes of death in a workplace and as well as major cause loss of revenues that runs millions of dollars [2].

By definition, WPV is occurrences in which workers may be confronted with threat, ill-treatment or attack in a condition related to their work which exposed them inwardly or outwardly, their safety, health or wellbeing [3]. WPV is one of the recognized and complicated hazard against workers more than ever in the health sector, yet they found it uneasy to be regulated [4].

WPV is common in a health-care setting with serious increase in every departments of health facility, though with challenge of underreporting of incidence, this tends to impact adversely on the commitment and dedication of the workers towards their work and with a negative effects on patient's recovery and satisfaction. Despite the fact WPV happens at far greater rates in the health-care sector than it does in other private sector jobs as whole the problem, it enjoys less attention as just few people speak about it [5].

Patients, their relation and visitors exhibit violence to health workers and sometimes it occurs among co-workers [6]. Violence has become an increasing issue of general concern over the past 15 years, especially North America, Europe, and Australia. In Africa, underreporting is still an issue. In the USA, 85% of non-physical assault occurs in servicing and retailing industries, within the servicing industries, health-care sector faces a peculiar risk of violent behavior amongst workers. Poor working relationship, stressful condition like long wait times, patients feeling not listened to, being given a poor prognosis or bad news, work overload, individual and environmental factors, may increase the risk of aggressions in the health-care settings [7]. However, the real incidence of violence in the health-care sector is difficult to estimate.

Today, WPV as a professional hazardous factor is counted as warning of mental well-being globally. Nevertheless, workplace can create an eventful long-term outcome for survivor that can continue long after working period, manifesting in low quality of life, poor health/depression. The complications for WPV in the health sector are multiple, being absent from work, frequent hospital visit, anger, reduction of working spirit, loss of self-confidence, job changing and even death. It can as well have a grave behavioral manifestation on the victim [8]. Aggression against health-care workers is not limited to a particular continent, region or race. Many are exposed or threatened to verbal aggression. During conflict and disaster situation, health-care workers sometimes become the target of collective and political violence. Violence against health-care workers is totally unacceptable and must be averted in our society.

There have been reports on WPV against specific health-care professionals in tertiary

health-care institutions in Nigeria [2,9] which did not provide specific information on WPV among primary health-care (PHC) workers in Enugu metropolis. This study aims to unravel the causal factors, predictors and the effect of WPV against PHC workers in Enugu metropolis.

2. MATERIALS AND METHODS

2.1 Research Design

The study design was descriptive cross-sectional.

2.2 Study Area

The research was carried out in Enugu State in Eastern region of Nigeria. Enugu state shares boundaries with Abia, Anambra, Ebony, Benue and Kogi States [10]. The state has seventeen Local Government Areas (LGAs), has a high and humid temperature distinct dry and wet which enable the state to thrive in agricultures. Enugu state has a land mass covering about 7,526 sq. km area [10].

Enugu State operates the Ward health system where every local government area is operating at same capacity as others with control over the health centres under it. Hence, primary health station uses General Hospital as the centre for referral centres. Every ward has one or more primary health institution which will contain including health post, sub-health posts and health centre. They are strategically placed for easy accessibility by the people. As at January 2019 there are over eight hundred fifty health facilities in Enugu states [10]. Enugu Metropolis comprises of Enugu North, Enugu East and Enugu South LGAs. There are 49 primary health facilities in Enugu Metropolis distributed in the order Eighteen, Sixteen, and Fifteens for Enugu North, Enugu East and Enugu South LGAs respectively [10]. The facilities provide avenue for meeting point between the health-care workers and the patients. Heads of department health is appointed at Local Government Council to direct and handle primary health centres affairs.

2.3 Population of the Study

The population under study are workers of primary health-care in Enugu state that are currently working in the health centres in the three local government that make up Enugu metropolis. The population of the workers is about four hundred and eighty with female

almost the double number of male. Their maximum attained academic level ranges from secondary to higher education. These health facilities have the following cadres of workers: The nurses, CHEW (Community Health Extension workers), CHO (Community Health Officer), Ward orderlies, technicians [11], as well as security and cleaners.

2.4 Inclusion Criteria

These include workers in PHCs in the three Local Government Areas of Enugu state that make up Enugu metropolis who

- i. Had valid identity card.
- ii. Who have been working for the past 12 months.

2.5 Exclusion Criteria

- i. Non-permanent workers in the PHC.
- ii. Worker that were on leave.

2.6 Sample Size

Sample size determination formula for descriptive cross section were used [12].

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

$$nf = \frac{n}{1 + (\frac{n}{N})}$$

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 represents the standard normal deviate at 95% confidence interval (1.96),

N represents the population size which is 430 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 [9].

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

d represent the precision of the study set at 0.05
 $n = 1.96^2 (0.88) (0.12)/0.05^2$ (for population greater than 10000)

n = 162 respondents

nf = 162/1+ 162/430) = 117.39 (for population < 10,000)

nf = 117 + 10% of 117 (considering non-response rate of 10%)

nf = 117+ 12
nf = 129 respondents

Approximately 130 health-care workers were sampled (rounded up).

2.7 Sampling Technique

To obtain a true representative sample of the primary health-care practitioners in the Enugu Metropolis, a multistage sampling technique were employed.

First: The metropolis were divided into three LGAs with the following: 16, 18 and 15 clusters of Primary Health-care (PHC) facilities in Enugu East, North and South LGAs respectively from which five (5) PHC Institutions in each of the 3 were selected by systematic random sampling technique summing up to 15 health-care centres.

Second: There were proportionate sampling and selection of nine (9) PHC practitioners (by the use of table of random numbers) from each of the 5 selected PHC facilities in the LGA. This gave 45 respondents in each LGA with a sum total of 135 respondents.

Source of data for staffing and size of primary health-care facilities was issued from Enugu State Ministry of Health (ESMOH) office which also served as the frame for the sampling. The ESMOH also provided the staff list.

2.8 Methods of Data Collection

An arranged close-ended self-administered questionnaire was used for data collection which lasted for two weeks and it was conducted by two research assistants and the researcher. The research assistant went through series of training for four days to ensure they understood the content of the questionnaire. Pilot-test were conducted using twenty- two workers in a different health-care institution that were not included in my sample study health facility, to test suitability and compliance to the content of the questionnaire. Amendment and corrections were made for appropriate study organization and technicalities. The data collection instrument titled Questionnaire on Violence against Primary Health-care Workers in Enugu Metropolis (QVAPHWEM) has five sections A, B, C, D, E in accordance to specific objectives.

2.9 Validity of Instrument

To establish the face and content validity of the data collection instrument, samples of the QVAPHWEM were given to three experts at the Centre for Occupational Health, Safety and Environment, University of Port Harcourt and my project supervisors. The comments, suggestions and recommendations made by these experts were carefully studied and used to improve the quality of the instrument.

2.10 Reliability of Instrument

The test re-test method was used to determine the reliability. The questionnaire was administered to twenty (20) health-care workers in Enugu Metropolis. The questionnaire was collected and the same questionnaire re-administered to the same persons again within two weeks. The responses on the questionnaire from the first administration were correlated with the responses from the second administration using Pearson Product Moment Correlation and it yielded .87 co-efficient (r).

2.11 Methods of Data Analysis

The data were entered, coded and analysed with statistical software SPSS version 23. The data were summarised using chart, tables and frequencies. They are presented in tables and figures.

3. RESULTS

Out of the 135 questionnaires sent out, only 117 were returned. Table 1 shows the socio demographic characteristics of respondents.

Table 1 shows the social demography of the respondents. Most of the respondents were between 29 and 39 years of age (about 36%) while about (28%) the least, were above 39. Based on the gender, about 112 health workers indicated their gender, of which 89 (79.5%) are female and 23(20.5%) are male. The marital status of the respondents showed that majority of the health workers (44) are married and widow/widower 3 are the least. About 108 respondents had one form of education or another, of these 2 had only primary school education, which is the least while majority (94) of them had up to tertiary education. Based on the occupations of the respondents, majority are nurses and community health extension workers

(31 each) and 3 of them are orderlies, making them the least. Based on the respondents with different occupations, about 87 of them run shifts while only 13 doesn't run shifts.

Table 2 shows the exposure of PHC workers to diverse forms of WPV. Among the respondents, 15(25.4%) reported at least one abuse within the last one, 30(50.8%) more than six months ago and 14(23.7%) six months ago. Majority of the respondents 99(92.5%) agreed to the occurrence of WPV while 8 respondents did not give answers that conforms to what work place violence is all about. The WPV took the form of tribal harassment (22.8%), religious harassment (17.6%). Most of the abuse occurred inside the health facility (77.5%), with the majority as physical + sexual + threats + verbal (35%). Most of the health workers (75.2%) did not consider WPV to be a typical incident of tribal harassment and (82.4%) did not consider WPV to be a typical incident of religious harassment.

Fig. 1 show the number of times health workers experienced WPV in the last one year. Majority of respondents 74(59.1%) reported been abused at least once and only 5(0.045%) reported abuse of five or more times. Verbal abuse was more prevalent (34.9%) while sexual was the least (0.13%).

Table 3 shows the different factors contributing to WPV. The table highlights that 12(12.6%) of respondents acceded that working alone shift has effects on WPV experience, while 83(87.4%) respondents said that it has no influence on workplace violence experience. Misunderstanding was the major reason given for WPV from 100(34.6%) of respondents.

Table 4 shows the influence of WPV on the lives and works of the victims. Majority of the respondents affirmed that having a policy on WPV (63.1%) influences WPV as against the 36.9% who hold a contrary view. Majority (66.7%) reported the incidence of WPV and majority (56%) reported that action was taken. For the non-reported cases, majority (53.6%) were of the opinion that it was not important. Majority of the attackers (41.9%) received verbal warning and majority (64.3%) of the respondents were satisfied with the consequence. A preponderance of respondent (61.5%) reported fear and impairment of performance as the effects of WPV on their work while off duty and impairment of performance (1.7) was the least reported.

4. DISCUSSION

In the present study, the social demography of the respondent revealed that female employees were more than double number of male. Their maximum attained academic level was tertiary education. The health facilities have the nurses, CHEW (Community Health Extension workers), CHO (Community Health Officer), Ward orderlies, technicians, as well as security and cleaners, which were the category of workers reported in Obionu [11].

The WPV uncovered in this study took the form of tribal harassment (22.8%), religious harassment (17.6%). Most of the abuse occurred inside the health facility (77.5%), with the majority as physical + sexual + threats + verbal (35%). In agreement with this study, Ruiz-Hernández et al. [13] averred that WPV come in form of threat, ill treatment or attack which exposes workers inwardly or outwardly, their safety, health or wellbeing. This is also in congruence with the study carried out in the United States health sector which recorded 75% of verbal aggressions against health workers and 21% physical violence [14].

The contributing factors of work place violence was also investigated and shown in Table 3. From the table, there were 109 health workers who had reasons for experiencing work place violence and majority 100 (34.6%) of them were of the opinion that misunderstanding is the major reason for them experiencing WPV. In comparison to the study done in 2001 and 2004 at University of Southern Queensland Australia, the result showed consistent increase in WPV in health sector and they attributed the main causes WPV to misunderstanding between the health workers and patient/patient relatives and co-workers [15].

Table 3 also reveals that 12(12.6%) of respondents acceded that working alone in shift has effects on WPV experience, while 83(87.4%) respondents said that it has no influence on workplace violence experience. In the same light, Yenealem et al. [16] listed shift work among factors responsible for WPV in the health sector. Also, out of the 65 health workers who indicated the time of occurrence of WPV, most 17 (26.2%) health workers are of the opinion that they experienced WPV at 07:00h to before 13:00h. In as much as most of the respondents (about 43%) don't remember when they were abused, a good number (about 20%) reported that they experienced WPV on Wednesday.

The influence of work place violence on the lives and work of the victims of work place violence was also examined. Majority 65 (63%) of the respondents agreed that having a WPV policy influences WPV as against 38 (36.9%). A good number of healthcare workers that admitted that they have policy in their work place reported that

policies put in place to control WPV are ineffective and inadequate. Healthcare workers who do not have policy on WPV are more likely to experience workplace violence. Poor intelligent quotient, poor socioeconomic class or poor education background are predictive variables for workplace violence [17].

Table 1. The socio demographic characteristics of the respondents

Demographics	Frequency	% Frequency
Age		
Less than 29	40	35.1
29 TO 39	41	36.0
Above 39	33	28.9
Total	114	100.0
Sex		
Female	89	79.5
Male	23	20.5
Total	112	100.0
Marital status		
Single	52	47.3
Married	44	40.0
Single/Divorced	11	10.0
Widow/Widower	3	2.7
Total	110	100.0
Educational level		
Primary	2	1.9
Secondary	12	11.1
Tertiary	94	87.0
Total	108	100.0
Occupation		
CHEW	31	27.4
CHO	10	8.8
Nurse	22	19.5
Orderlies	3	2.7
Technicians	16	14.2
Others	31	27.4
Total	113	100.0
Run shifts		
Yes	87	87.0
No	13	13.0

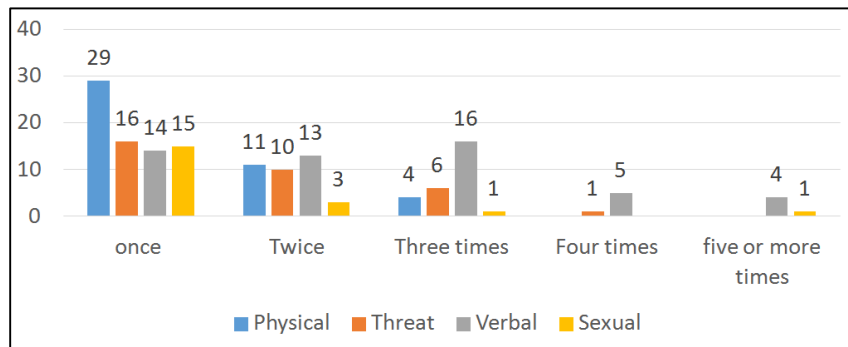


Fig. 1. Plot of times a PHC worker experienced WPV in the past one year

Table 2. Exposure to different forms of WPV

Variables	Frequency	% Frequency
Last time of abuse		
Last One Month	15	25.4
More Than Six Months Ago	30	50.8
Less than Six Months Ago	14	23.7
Total	59	100.0
Understanding of WPV		
Yes	99	92.5
No	8	7.5
Total	107	100.0
Tribal harassment		
Yes	27	24.8
No	82	75.2
Total	109	100.0
Religious harassment		
Yes	19	17.6
No	89	82.4
Total	108	100.0
Places WPV occurred		
At patients house	2	2.5
Inside health facility	62	77.5
Others	11	13.75
Outside	5	6.25
Total	80	100.0
Types of WPV		
Not Available	5	4.3
Physical	3	2.6
Physical, Sexual	1	.9
Physical, Threat	4	3.4
Physical, Threat, Sexual	4	3.4
Physical, Threat, Verbal	35	29.9
Physical, Threat, Verbal, Sexual	41	35.0
Physical, Verbal	4	3.4
Physical, Verbal, Sexual	2	1.7
Threat	3	2.6
Threat, Sexual	5	4.3
Threat, Verbal, Sexual	3	2.6
Verbal	7	6.0

Table 3. Contributing factors of WPV

Variables	Frequency	% Frequency
Working alone in shift		
Yes	12	12.6
No	83	87.4
Time of occurrence		
07:00H to before 13:00H	17	26.2
13:00H to before 18:00H	12	18.5
18:00H to before 24:00H	8	12.3
24:00H to before 7:00H	3	4.6
Don't know	25	38.5
Day of occurrence		
Don't remember	28	43.8
Monday	5	7.8
Tuesday	3	4.7
Wednesday	13	20.3

Variables	Frequency	% Frequency
Thursday	4	6.4
Friday	6	9.4
Saturday	4	6.4
Sunday	1	1.6
Reason for WPV		
Fault of oneself	43	14.9
Scapegoat	30	10.4
Drunk	26	9.0
Illness	40	13.8
Concern	46	15.9
Misunderstanding	100	34.6
Unknown	4	1.4

Table 4. The influence of WPV on work

Variables	Frequency	% Frequency
Policy on WPV		
Yes	65	63.1
No	38	36.9
Report of incidence		
Yes	50	66.7
No	25	33.3
Action taken		
Don't Know	7	14.0
Yes	28	56.0
No	15	30.0
Investigated by whom		
Management	39	81.3
Management and union	2	4.2
Others	1	2.1
Union	6	12.5
Non reporting		
Didn't know how to report	4	16
Not important	15	60
Will not be taken serious by management	6	24
Consequences of the attacker		
Aggressor prosecuted	1	1.6
Care discontinued	5	8.1
None	19	30.6
Others	2	3.2
Reported to the police	5	8.1
Verbal warning and care discontinued	1	1.6
Verbal warning	26	41.9
Verbal warning and aggressor prosecuted	1	1.6
Verbal warning and reported to police	2	3.2
Satisfaction of cases handled		
Yes	30	60
No	20	40
Effects of WPV on work		
Fear	4	3.4
Fear, Impaired performance	72	61.5
Fear, Impaired performance, Off duty	6	5.1
Fear, Off duty	1	.9
Impaired performance	14	12.0
Impaired performance, Off duty	2	1.7
Off duty	18	15.4

Majority of the respondents (66.7%) reported the incidence of WPV and majority (56%) opined that actions were taken. For the non-reported cases, majority (53.6%) were of the opinion that it was not important. Fear, impairment of performance and off duty was reported by the respondents as some of the effects of WPV. In developing countries, fear of stigmatization, management reluctance to apply disciplinary measures against perpetrators often discourage a healthcare worker from reporting any violence against them, while in developed countries, healthcare worker are bold and eager to report violence against them [18].

Table 4 also shows that that the management of that medical institution are mostly the bodies that carries out enquiry of reported WPV incidents finding out the root cause and also provides cogent solutions to the problem. The chart depicts the growth of investigated cases Furthermore, the table depicts that after the WPV incidents have been investigated, the consequences melted out on the attacker most of the times are just verbal warnings, sometimes, no action was taken (cases are being closed). Only on rare cases are attacks reported to the police. The majority of the respondents however expressed satisfaction on how WPV cases were handled.

5. CONCLUSION

This study has shown that health-care practitioners are exposed to varying forms of violence but are mostly physical, threats, verbal and sexual assault. The contributing factors to WPV include running shifts and working alone in shifts. Most health workers who experience WPV were emotionally disturbed which lead to impaired work outcome and absence from work.

CONSENT AND ETHICAL APPROVAL

Health Research Ethics Committee (HREC) of Enugu State Ministry of Health issued an ethical clearance. Written and verbal permission were granted by different heads of departments of the three local government areas that constitutes Enugu Metropolis. Informed consents were granted by the respondent by means of verbal and written approval following which questionnaire were administered.

COMPETING INTERESTS

Authors have declared that no competing interests exist.

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