Sci. Technol. Arts Res. J., Jan.-March 2018, 7(1), 01-14
DOI: https://doi.org/10.20372/star.v7i1.01
ISSN: 2226-7522 (Print) and 2305-3372 (Online)
Science, Technology and Arts Research Journal
Sci. Technol. Arts Res. J., Jan.-March 2018, 7(1), 01-14
Journal Homepage: https://journals.wgu.edu.et

Original Research

Workplace Violence among Health Care Workers and Associated factors in Public Hospitals of East Shoa Zone, Oromia Region, Ethiopia

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Abstract

Workplace violence in the health sector is a worldwide concern with healthcare workers being at high risk of being victims. Workplace violence appears to be an unrecognized issue in many developing countries including Ethiopia. This study aimed to assess the prevalence and associated factors of workplace violence against healthcare workers in public hospitals of East Shoa Zone of Oromia Region, Ethiopia. A hospital based cross-sectional study was from March to August, 2018. About 261 healthcare workers were selected from four Public hospitals. Data was collected using self-administered questionnaire. The collected data was double-entered into EPI-INFO version 3.3.1 and exported into SPSS version 21 for analysis. It was principally analysed using logistic regression models. The prevalence of workplace violence among healthcare workers was 70.2%. Physical violence accounted for 22.5%, verbal abuse for 65.1% and sexual abuse for 4.1%. Types of health institutions (AOR, 6.79; 95% CI: 2.98, 15.45), less than five years' work experience (AOR, 2.76; 95% CI: 1.31, 5.89), professional category (AOR, 0.32; 95% CI: 0.10, 0.98), frequent interaction with patients (AOR, 3.13; 95% CI: 1.08, 9.04), and worried about violence (AOR, 2.65; 95% CI: 1.02, 7.08) were predictors of workplace violence among healthcare workers.A significant proportion of healthcare workers faced workplace violence. Types of health institutions, work experience, professional category, having frequent interaction, and worried about violence were factors significantly associated with workplace violence among healthcare workers in the study area. Policy makers and stakeholders should focus on workplace violence prevention strategies.

Article Information

Article History:
Received : 04-01-2018
Revised : 27-0-2018
Accepted : 28-03-2018

Keywords:
Workplace, Violence, Hospitals, Oromia, Ethiopia

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INTRODUCTION

Workplace violence (WPV) is a serious problem globally (Cooper and Swanson, 2002; OSHA, 2015). Different organizations have defined workplace violence in various ways. However, the National Institute for Occupational Safety and Health defines workplace violence as violent acts, including physical assaults and threats of assault, directed toward persons at work or on duty (Cooper and Swanson, 2002; OSHA, 2015). In these aspects, violence includes any physical assault, verbal abuse or threatening

behaviour and sexual harassment occurring in a workplace setting (Cooper and Swanson, 2002).

Workplace violence in the health sector is a worldwide concern with health care workers being at high risk of being victims (Cooper and Swanson, 2002). According to the World Health Organization (WHO), workplace violence where staffs are abused, threatened, or assaulted in circumstances related to their work involved explicit or implicit challenges to their safety, well-being, or health (Khoshknab, 2012). Indeed, the consequences of workplace violence in the health sector have a significant impact on the effectiveness of health systems and care provisions (Kitaneh and Hamdan, 2012).

The possible sources of violence in health institutions or hospitals include patients, visitors, relatives, and even co-workers (OSHA, 2015). However, the most violent perpetrators are typically patients or emotionally disturbed family members. Physicians and Nurses are often at higher risk because they are typically the first and most frequent medical personnel at the bedside of ill and sometimes angry or frustrated patients (Abou-ElWafa, 2015).In 2013, for example, 80% of serious violent incidents reported in healthcare settings were caused by frequent interactions with patients (OSHA, 2015).

Violence in the health sector is a unique challenge as healthcare has some unique cultural factors that may contribute to the underreporting or acceptance of workplace violence (American Nurses Association, 2014). Caregivers, for example, feel a professional and ethical duty to do no harm to patients. Some will put their own safety and health at risk to help a patient, and many in healthcare professions consider violence to be part of the job (Needham*et al*. 2012). Healthcare workers also recognize that many injuries caused by patients are unintentional, and are therefore likely to accept them as routine or unavoidable (OSHA, 2015). Another consideration is unwillingness among healthcare workers to stigmatize the perpetrators due to their illness or impairment (Needham *et al*, 2012; OSHA, 2015).

Violence affects all work categories and takes place at various settings (Needham *et al*, 2012). It is becoming a fundamental human rights issue with its negative effect on the achievement of organizations and affects all sectors (OSHA, 2015). The impact of violence at work is not only for the employees, but also it affects the workplaces, colleagues, employers, families and society as a whole. It also exhibits a dramatic impact on the health, safety and welfare of workers (Gates *et al*, 2006). Different factors were identified in operating at the individual, organizational, and societal level to be associated with WPV among health workers (American Nurses Association, 2014; Beugre *et al*, 2014; Abou-ElWafa *et al*,2015; Tiruneh, 2016).

Although interest in WPV in the health sector has grown considerably within the developed world, it still appears to be an unrecognized issue in many developing countries (Kamchuchat *et al*, 2008). Even, the real size of the problem of violence and the associated factors in the health sector is largely unknown and recent information shows that the current knowledge is only the tip of the iceberg (Hoel *et al*, 1999). In the eyes of many commentators, the problem of workplace violence has risen to the point where, in many countries, it represents an international epidemic and an occupational health problem of significant proportion (Abbas *et al*, 2010).

As to the best knowledge of the investigators there is no handful information

regarding the magnitude and associated factors of workplace violence among healthcare workers in Ethiopia in general and the study area in particular. The objective of this study was to assess the prevalence of workplace violence against healthcare workers and associated factors in the public hospitals of the East Shoa Zone, Oromia Region, Ethiopia from March to August, 2018.

MATERIALS AND METHODS

Study setting and Period

The study was conducted in the Hospitals of East Shoa Zone of Oromia region. The Oromia Regional State is the largest and most populous region in Ethiopia. This region shares common boundary with all regions of the country except Tigray. The two city administrations, Addis Ababa and Dire Dawa, are also surrounded by administrative zones of the Oromia region (Federal Democratic Republic of Ethiopia (FDRE, 2016; ORHB, 2013/14). The Oromia Regional state has currently four specialized referral hospitals, 19 Zonal hospitals, 32 district hospitals (ORHB, 2013/14). However, the study was collected in East Shoa Zone having four hospitals (one referral, one zone and two districts). The study took five months and carried out during the months of March and August, 2018.

Study Design

Institution based cross sectional study design was employed using quantitative data collection method.

Population

Source Population: all categories of health workers working in public hospitals in East Shoa zone in Oromia region.

Study Population: all health workers who have direct communication with patients/clients or attendants/relatives working in the selected hospitals in East Shoa zone in Oromia region

Study Unit: Randomly Selected health workers working in the selected service delivery unit in all public hospitals in East Shoa zone.

Inclusion/Exclusion Criteria

All health workers involved in service provision (Physicians, all categories of nurses and others) were included in the study. However, a hospital worker who has no access to patients/clients was excluded from the study.

Sample Size Determination

The sample size was calculated based on the single population proportion formula using the following assumptions. The proportion of Workplace violence in the hospitals of 30% (Fute M et al, 2015), within the margin of error of 5% and 95% confidence level, the sample size was determined and given by:

$$\underline{n = Z^2\, p\,(1\text{-}p)}, \quad \underline{n = (1.96)^{2*}\,(0.3)*(0.70)} = 323 + 32 = 355$$
$$d^2 \qquad\qquad (0.05)^2$$

- ✓ The N = number of clients to be interviewed,
- ✓ P = proportion of Workplace violence
- ✓ d = margin of error for the study
- ✓ Z = the standard normal distribution z value of 1. 96 (at 95% level of confidence).

However, the total number of all categories of health worker in public hospitals of the East Shoa zone was 997 and assumed to be less than 10,000. So, the sample size was corrected using finite population correction formula.

Actual minimum sample size = n/1+ (n/N)

=355/1+ (355/997)

=261

Sampling Technique

All public hospitals found in the East Shoa Zone of Oromia Region were included. Accordingly, study participants from each of the hospitals were proportionally selected using simple random sampling. The lists of all health workers working in the selected service delivery points of the selected hospitals were prepared from the respective hospital profile. The sample size was determined for each hospital proportional to the size of their study population.

At the selected health service delivery points of the hospitals, all categories of health workers were consecutively included in the study once they gave consent until the required number was obtained. If one declined to consent, then the next health worker was included so that there was no any none response rate to be considered in the sample size.

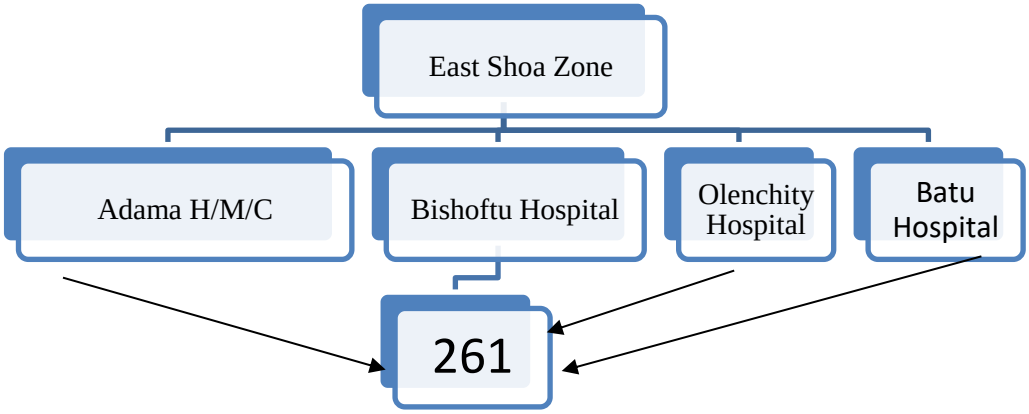

Figure 1: Sampling procedure for the assessment of workplace violence in Public Hospitals of East Shoa Zone, Oromia Region, Ethiopia, 2018

Data collection procedures

Data was collected using standard and structured self-administered questionnaire (*ILO/ICN/WHO/PSI,*2003). This tool was reviewed and adapted to the local context. The stated objectives and expected results were strictly taken into account while reviewing and adopting the data collection tool. Experienced male and female data collectors were selected and trained for two consecutive days. Pre-testing was done to see the functionality of the developed questionnaires and reviewed as per the feedbacks or findings.

Data analysis

Data was entered, cleaned and processed using EPI-INFO version 3.3.1 statistical packages and exported to SPSS version 21. 95% confidence interval was calculated to assess the association between the study variables. Binary logistic regression was performed to see the effect of each explanatory variable towards dependent variable. Those variables having *P*-value of

0.29 or less at bi-variable analysis was included for multi-variable analysis. In the final model *P*-value of 0.05 or less were used as cut off points to declare the significant association between the study variables. Proportions, tables and graphs were used for a description of the data as appropriate. All the assumptions like normality of continuous variables and multi-colinearity between independent variables were checked to be satisfied with the appropriate methods.

Data quality assurance

To ensure data quality, supervisors and data collectors were trained on the data collection tool and supervisors were assigned to the field to properly coach and mentor data collectors. Pre-testing of the developed tool was done to see the feasibility of the developed quantitative data collection tool or questionnaire. Participants were briefly explained about the objective of the study and questions one by one. Data entry and cleaning was done properly by the investigators.

Ethical consideration

Letter to conduct the assessment was collected from Adama Hospital Medical College and was distributed to the concerned organizations. These organizations informed the selected study Hospitals to practically conduct the study. Regarding the study participants, consent form was prepared and participants were informed to make the decision to participate in the study. Those who were willing to participate signed the consent form before proceeding to answer the questionnaires. They were informed that they had the right to discontinue or refuse to participate in the study and confidentiality of the information was assured and privacy was maintained.

Operational definitions

Workplace Violence: Incidents where 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 (*ILO/ICN/WHO/PSI,* 2003).

Physical Violence: The use of physical force against another person or group that results in, physical, sexual or psychological harm. These include beating, kicking, slapping, stabbing, shooting, pushing, biting, and pinching, among others (*ILO/ICN/WHO/PSI,*2003).

Psychological Violence *(*Emotional abuse)*:* Intentional use of power, including the threat of physical force, which can result in harm to mental, spiritual or moral. Includes verbal abuse, bullying/mobbing, harassment, and threats (*ILO/ICN/WHO/PSI,*2003).

RESULTS

A total of 261health professionals was planned to participate in the study, out of which 258 study subjects were enrolled making a response rate of 98.9%. The questionnaire for three respondents was incomplete or partially filled and excluded from the analysis.

Socio-Demographic Characteristics

From the study participants, half (49.2%) were from the specialized hospital and more than half (55.8%) were female. The majority were in the age range of 26-35 years with the median (± IQR) of 28 (±6) years. Of all respondents, 55.0% were nurses of all categories. About one in three, 61.6% and 63.6% were married and had five more years of experiences at the time of data collection.

Table 1: Socio-demographic Characteristics of the respondents, East Shoa Zone of Oromia Region, March to August, 2018

Variables	Frequency	Percent
Status of Health Institution		
Specialized	127	49.2
General	68	26.4
Primary	63	24.4
Sex of the respondent		
Male	114	44.2
Female	144	55.8
Age Category		
<25 yrs	33	12.8
26-35 yrs.	144	55.6
> 36 yrs.	35	13.6
Median (± IQR)age 28 (±6)years		
Profession Category		
Physicians	42	16.3
Nurses	142	55.0
Others	74	28.7
Marital Status		
Single	87	33.7
Married	159	61.6
Others	12	4.7
Work Experience		
<5 years	94	36.4
≥5 years	164	63.6

Workplace Violence experiences

Of those respondents who reported to have workplace violence, the majority (65.1%) reported to have ever verbal abuse and more than one in five (22.5%) ever had physical violence. A significant number (4.1%) of the respondents ever had workplace sexual violence. Moreover, about one in three, (70.2%) of the respondents reported to have ever workplace violence's.

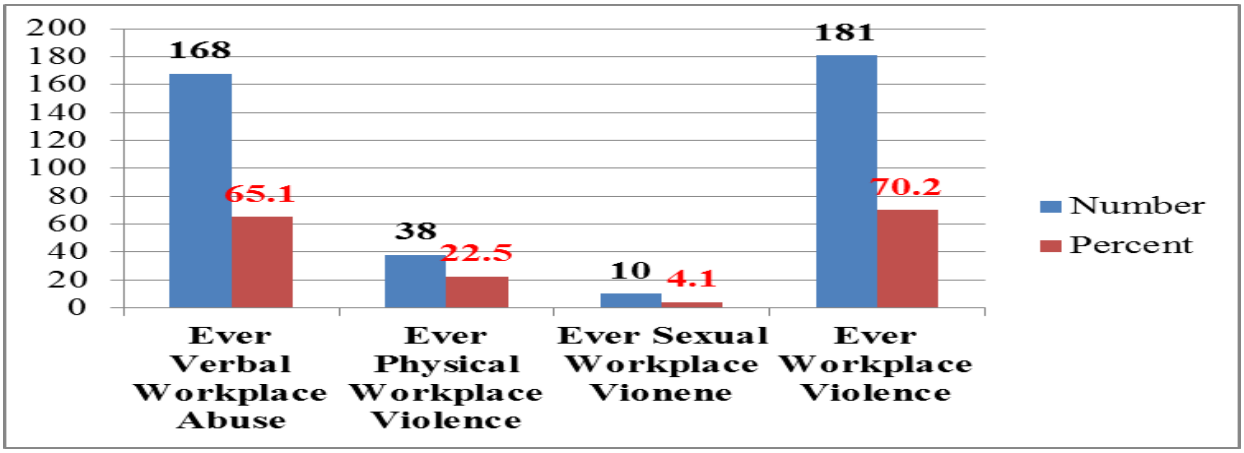

Figure 2: Workplace Violence experiences of the respondents, East Shoa Zone of Oromia Region, March to August, 2018

Actions on Workplace violence

Form all respondents reported to have ever workplace physical violence about one in four (24.3%) were injured due to the incident and 10 (62.5%) required formal treatment. Eventually, 14 (35.9%) took time off from their regular work due to the incident happened to them. From all the respondents reported to have ever workplace violence's, only 24.6% reported for the actions taken to investigate the incident by the concerned bodies like the management of the institutions and legal bodies. Of those reported cases, 58.3% had either verbal warning from the management, reported to the police or the aggressors were prosecuted. Nearly one third (34.2%) of those reported to have ever workplace violence had counselling and 29.6% had other supports from their supervisors, even if, the majority (74.2%) was not satisfied with the way the incidents were handled. Moreover, when asked about their perception towards workplace violence, nearly one third thought that the incident is preventable.

Table 2: Perception of the respondents about Workplace violence, East Shoa Zone of Oromia Region, March to August, 2018

Variables	Frequency	Percent
Injured due to workplace violence		
Yes	17	24.3
No	53	75.7
Require formal treatment		
Yes	10	62.5
No	6	37.5
Took time off from work		
Yes	14	35.9
No	25	64.1
Action taken to investigate the incident		
Yes	17	24.6
No	47	68.1
don't know	5	7.2
Consequence of the attacker		
None	15	41.7
Yes (either verbal warning, reported to police, aggressor prosecuted	21	58.3
Counseling from supervisor		
Yes	25	34.2
No	48	65.8
Support from supervisor		
Yes	21	29.6
No	50	70.4
Satisfaction level of handling the incident		
Not satisfied	46	74.2
Satisfied	16	25.8
Think incident prevented		
Yes	43	58.9
No	30	41.1

Measures to deal with workplace violence

Respondents were asked about the measures that exist in the workplace to prevent violence. Accordingly, security measures exist in the majority (74.9%) of the cases. For 53.8% of the respondent, efforts are being made to improve their working surroundings. More than two in three, (46.2%) of the respondents reported having a reduced time of working alone at the workplaces. For 43.3% of cases especial trainings were given to deal with workplace violence. Moreover, measures like increasing the number of staffs at different service delivery points, use of special clothing by health professionals, and improving patient protocol reported to be in place for improving workplace violence

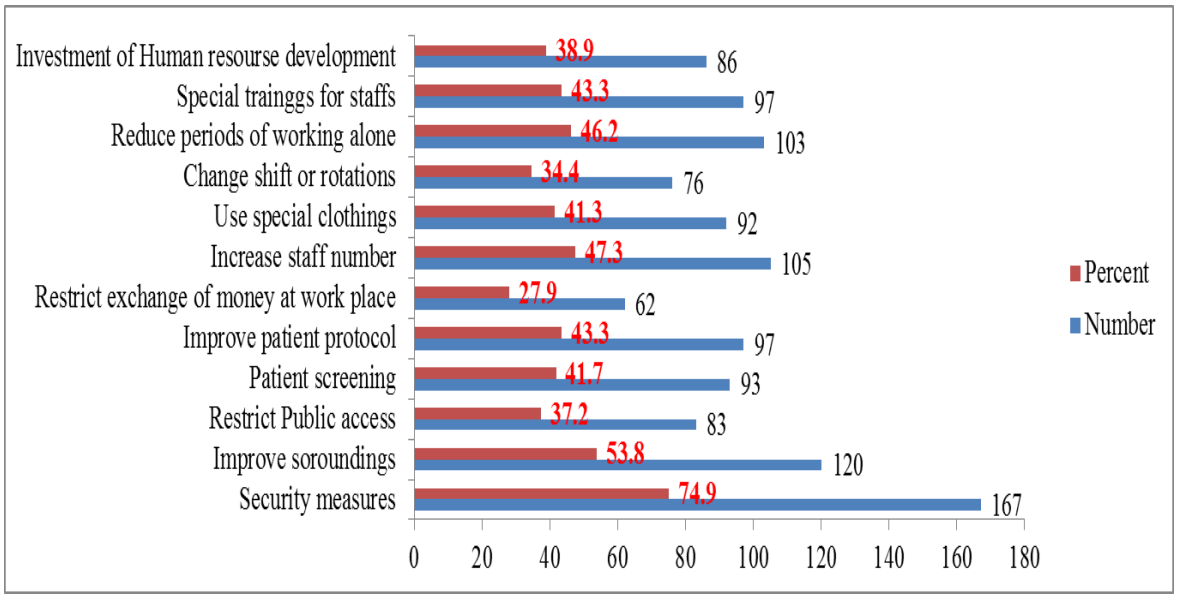

Figure 3: Measures to deal with workplace violence exist in workplace, East Shoa Zone of Oromia Region, March to August, 2018

Factors associated with Workplace violence

Multivariate logistic regression was used to identify the characteristics that differentiated health professional who had experienced workplace violence from those who had not hence ever experiences of workplace violence variable is a dichotomous and defined as 1= ever experienced workplace violence: 0= never experienced workplace violence. Coefficients were expressed as crude and adjusted OR relative to the referent category.

A number of factors emerged as significant predictors of workplace violence (Table 3). Types of health institutions in which they are working, their work experience, professional category, Frequent Interact with patients/clients and they are worried about violence was significant (P<0.05) predictors affecting workplace violence among health professionals. However, no statistically significant relationships were observed

between Age Category, sex of respondents they are working with, work shift and knowledge about the procedure of reporting violence (P>0.05).

Respondents not having procedures of reporting workplace violence reported more likelihood of workplace violence than their counterparts that was significant before adjustment (COR, 2.29; 95%CI: 1.21, 4.32). But, it was no more significant after being adjusted for variables in the model.

Those respondents working in specialized hospital were nearly seven times (AOR, 6.79; 95%CI: 2.98, 15.45) more likely to have a workplace violence compared to those working in primary hospital. Moreover, respondents having five years' work experience were nearly three times (AOR, 2.76; 95%CI: 1.31, 5.89) more likely to have a workplace violence compared to those who have six years work experiences. However, professional like Pharmacist, Laboratory workers, Radiologist, dental therapistwere less (AOR, 0.32; 95%CI: 0.10, 0.98) likely to report workplace violence compared to Physicians. Also, those respondents having frequent interaction with patients/clients were more (AOR, 3.13; 95%CI: 1.08, 9.04) likely to have a workplace violence than their counterparts. Consequently, those respondents who were worried about violence were more (AOR, 2.65; 95%CI: 1.02, 7.08) likely to experience workplace violence compared to those who do not have intention about it.

Table 3: Factors associated with Workplace violence, East Shoa Zone of Oromia Region, March to August, 2018

Variables		**Workplace violence**		**COR (95%CI)**	**AOR (95%CI)**
		No (%)	**Yes (%)**		
Health Institution	Specialized	15 (12.1)	109 (87.9)	**4.78 (2.25, 10.15)*** **	**6.79 (2.98, 15.45)*** **
	General	21 (36.2)	37 (63.8)	1.16 (0.55, 2.45)	1.66 (0.73, 3.76)
	Primary	23 (39.7)	35 (60.3)	1:00 (Reference)	1.00 (Reference)
Work Experience	<5 years	15 (17.6)	70 (82.4)	1.85 (0.96, 3.57)	**2.76 (1.31, 5.89)** **
	>6 years	44 (28.4)	111 (71.6)	1:00 (Reference)	1:00 (Reference)
Profession Category	Physicians	5 (12.8)	34 (82.7)	1:00 (Reference)	1:00 (Reference)
	Nurses	33 (24.1)	104 (75.9)	0.46 (0.17, 1.28)	0.50 (0.18, 1.45)
	Others§	21 (32.8)	43 (67.2)	**0.30 (0.10, 0.88)***	**0.32 (0.10, 0.98)***
Age Category	<25 yrs.	9 (29.0)	22 (71.0)	1.10 (0.38, 3.26)	2.21 (0.64, 7.67)
	26-35 yrs.	28 (19.9)	113 (80.1)	1.83 (0.78, 4.31)	2.37 (0.91, 6.19)
	> 36 yrs.	10 (31.2)	22 (68.8)	1:00 (Reference)	1:00 (Reference)
Work in shift	No	33 (30.6)	75 (69.4)	0.56 (0.31, 1.01)	0.74 (0.36, 1.53)
	Yes	26 (19.7)	106 (80.3)	1:00 (Reference)	1:00 (Reference)

Table 3 *Continued.*

The Sex of the patients works with	Female	15 (23.1)	50 (76.9)	1:00 (Reference)	1:00 (Reference)
	Male	8 (47.1)	9 (52.9)	0.34 (0.11, 1.03)	0.32 (0.09, 1.15)
	Male and female	32 (22.9)	108 (77.1)	1.01 (0.50, 2.04)	0.81 (0.36, 1.83)
Procedures for reporting of violence	No	33 (19.3)	138 (80.7)	**2.29 (1.21, 4.32)***	2.38 (0.81, 6.93)
	Yes	23 (35.4)	42 (64.6)	1:00 (Reference)	1:00 (Reference)
Know how to report WP Violence	No	43 (22.3)	150 (77.7)	1.80 (0.90, 3.60)	0.80 (0.25, 2.54)
	Yes	16 (34.0)	31 (66.0)	1:00 (Reference)	1:00 (Reference)
Frequent Interact with patients/clients	No	11 (47.8)	12 (52.2)	1:00 (Reference)	1:00 (Reference)
	Yes	43 (21.8)	154 (78.2)	**3.28 (1.36, 7.96)***	**3.13 (1.08, 9.04)***
Worried about violence	Not worried	13 (52.0)	12 (48.0)	1:00 (Reference)	1:00 (Reference)
	Worried	43 (20.9)	163 (79.1)	**4.11 (1.75, 9.64)***	**2.65 (1.02, 7.08)***

NB: §Others- pharmacist, Laboratory workers, radiologist, dental therapist * P< 0.05 ** P< 0.01 *** P< 0.001

DISCUSSION

Understanding workplace violence in the health sector and identifying factors that protect or put them at risk are crucial. Workplace violence in the health sector is one of the many forms of violence against health professionals that crosses the boundaries of social classes and across the world.

This study used a representative sample of health care workers in the health institutions of Oromia Regional State to estimate the prevalence and factors contributing to it. The study presents findings from institution based cross-sectional survey among health professional of different category. The prevalence of workplace violence in the health sector is found to be 70.2%. Types of health institutions, work experience, professional category, interaction, and worried were significant predictors of workplace violence's among health professionals.

In this study the lifetime prevalence of workplace violence in the health sector among health professional is found to be 70.2% of which physical violence accounted for 22.5%, verbal abuse for 65.1% and sexual abuse for 4.1%. This is consistent with the findings from Hong Kong (China) in which 76 % of nurses reported abuse of any kind (Kwok *et al*, 2006) and study from Palestinian public hospitals showed 80.4% of health professionals exposed to WPV in the past 12 months (Kitaneh and Hamdan, 2012). However, it is higher than the findings from Egypt found that, 28.1% of nurses working in emergency unit reported exposure workplace violence in the health sector (Abou-ElWafa *et al*, 2015). Also, in southern and Northern part of Ethiopia the prevalence of WPV among health workers was 29.9% and 26.7%, respectively (Fute *et al,* 2015; Tiruneh *et al*, 2016).These differences could be attributed to the study period, categories of health care workers and types of health institutions in which the research was conducted. In southern and Northern Ethiopia, for example,

the studies were conducted in the referral Hospitals, while the present study was conducted among the three levels of the health system (Referral, Zonal and district Hospitals). Moreover, the differences might be due to the types of health professionals involved in the study for which all the available health professional was included in the present study, while, only nurses and physicians were involved in the other studies.

In this study, the majority, 65.1% reported to have ever verbal abuse supports the results of studies conducted elsewhere, in which verbal abuse among health care workers is the highest which accounted for 76%, 73% (Kwok *et al*, 2006). Also, 22.5% and 4.1% of the study participants reported of having physical and sexual violence at workplace in the health sectors supports the findings from southern Ethiopia found the prevalence of physical violence for 18.2% and sexual harassment of 13.02% (Futee*t al*, 2015).

In the current study, 24.3% of the respondents were injured due to workplace physical violence and even about 10 (62.5%) required formal treatment. This supports the notion as Violence is the third leading cause of injury and death in the workplace (Azodo *et al*, 2011) and health care and social service workers are almost four times as likely to be injured as a result of violence as the average private sector worker (OSHA, 2015). Consequently, 14 (35.9%) took time off from their regular work due to the incident happened to them. This supports the findings from previous studies in which health care workers accounted for 45% of all reported non-fatal assaults resulting in lost work (OSHA, 2015).The negative consequences of such violence impact on the delivery of health care services, which could include a deterioration in the quality of care provided and the decision by health workers to leave the health care professions (*ILO/ICN/WHO/PSI,*2003).

Regarding the actions at work place security measures exists for the majority (74.9%) of the cases. This goes with findings from other study investigated the management of patient and visitor violence in a general hospital using security measures. Obviously, if the workplace had an official, organizational anti- violence strategy, healthcare staff felt more confident. However, only 43.3% of cases reported for having especial trainings to deal with workplace violence. This is in contrast to the findings from previous studies in which 42% of healthcare workers in general hospitals had not received instructions and training in dealing with workplace violence. This indicates the importance of an adequate organizational strategy and appropriate training measures for specific working groups.

In this study, respondents working in specialized hospital were more likely to have workplace violence compared to those working in primary hospital. This is corroborated the results from the United States, in which 85% of all non-fatal assaults in the workplace occur in specialized service industries including hospitals (Gates DM et al, 2006). This could be due to the higher caseload in the specialized hospital causes chaos for the patients and attendants on the need of urgent care.

Also, having less work experience are more likely to have workplace violence. This goes with the results of another study in which young and less experienced health professionals had higher odds of experiencing workplace violence (Futee*t al*, 2015). This might be due to the fact that less experienced

health worker's lack ability or experience in dealing with violence and use inadequate safety measures. In addition, this might partly be explained by the fact that older and more experienced health care providers receive due respect in the Ethiopian culture and perhaps elsewhere (Fute *et al*, 2015).Moreover, the higher odds of workplace violence among less experienced groups could possibly be attributed to lower threshold for insult and pain and less maturity compared to the more experienced groups.

The current study revealed for allied health professional like a pharmacist, Laboratory workers, radiologist, dental therapist are less likely to report workplace violence compared to physicians. As physicians are frequently having contact with patients or clients and if they had experienced violence at the workplace this might have a negative impact on quality of care that they are providing (Azodo*et al*, 2011). However, in the health care sector, all categories of healthcare workers are at risk of violence, though at different degrees with the nurses having up to three times higher than others (Abbas *et al*, 2010).

Respondents having frequent interaction with patients/clients were more likely to have work place violence than their counter parts. In 2013, for example, 80% of serious violent incidents reported in healthcare settings were caused by interactions with patients (OSHA, 2015).These is because of workplace in the health sector is characterized by inefficient organization and bad working conditions, including a 12-hour working day, work intensification due to insufficient personnel, understaffed night work teams which necessitates the need to work alone at night, and excessive paperwork (Martino, 2002; Abou-ElWafa*et al*, 2015). Also, this is supported by the study from other parts of Ethiopia shows working in the emergency ward (AOR, 4.28; 95% CI: 1.39, 4.34) and working in the Inpatient Department (AOR, 2.11; 95% CI: 1.98, 2.64) were factors positively associated with workplace violence (Fute*et al*, 2015). These are the workplace that is continued interaction between healthcare workers, patients and attendants are taking place.

Those respondents who were worried about violence as a whole were also more likely to experience workplace violence compared to those who do not have intention about it. This could be attributed for the current thinking in which sometime patients and clients stand on the belief that customers (patients) are always right (Abbas, 2010). On the other ways, stress and violence are widespread in the health sector and their negative effects cumulate in an exponential way, activating experience workplace violence (Khoshknab, 2012).

As to the limitation of the study, it was a cross-sectional study attempted to determine the prevalence and associated factors of workplace violence within a certain past period of time. Healthcare workers were asked about their memory of being abused in their lifetime, thus the estimated prevalence would have been subjected to recall bias. In addition, the feeling of being abused is very subjective. Despite the inclusion of a range of definitions for different types of workplace violence that attempts to be objective, subjective interpretation cannot be avoided. It is also possible that Health care workers who returned the questionnaires were more likely to have been victims of workplace violence.

CONCLUSION

The prevalence of workplace violence among healthcare workers was significantly higher (70.2%). The prevalence of physical violence accounted for 22.5%, verbal abuse for 65.1% and sexual abuse for 4.1%. Types of health institutions, work experience, professional category, frequent interaction, and worried about violence were significant predictors of workplace violence among healthcare workers.

Based on these findings, it is possible to recommend that policy makers and other stakeholders should focus on the provision of appropriate strategies for workplace violence prevention in the health sectors. The healthcare facilities should also establish health and safety programs for the prevention and management of workplace violence.This study also suggests the need for improved and specific prevention measures, as well as the effective implementation of aftercare to deal with the violence experienced by employees in the Oromia Region healthcare systems.

Conflict of Interest

The present author declares that there is no competing of interests.

Acknowledgements

I am very much grateful to the Adama Hospital Medical College for funding the study. My thanks also go to the study participants for their willingness to participate in this research.

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