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Awareness, Perception, Pattern and Perceived Risk Factors of Attacks on Healthcare Workers in Okada, Edo State

1.Dr. Hendrith Esene, 2.Dr. Bodeno Ehis, 3.Dr. Zekeri Sule, 4.Dr. Godwill Agbon-ojeme, 5.Dr. Felix Otuomagie, 6.Prof. Vincent Adam

1.Department of Community Medicine, Igbinedion University, Edo State, Nigeria
2.Department of Community Medicine, Igbinedion University, Edo State, Nigeria
3.Department of Obstetrics and Gynaecology, Igbinedion University, Edo State, Nigeria
4.Department of Obstetrics and Gynaecology, Igbinedion University, Edo State, Nigeria
5.Department of Obstetrics and Gynaecology, Igbinedion University, Edo State, Nigeria
6.Department of Community Health, University of Benin, Edo State, Nigeria

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ABSTRACT

Background: Violence against healthcare workers is a growing global concern, posing significant threats to the safety of medical personnel and disrupting healthcare delivery. Reports indicate that between March 2015 and November 2024, at least 7,693 attacks on healthcare workers and facilities were recorded worldwide, with 1,234 incidents reported in 2024 alone. The impact of such violence is especially severe in conflict zones and politically unstable regions. However, incidents of aggression are increasingly reported even in civilian healthcare settings, exacerbating challenges related to healthcare delivery and workforce retention. In Africa, including Nigeria, healthcare workers are frequently exposed to violent episodes, underscoring the urgent need for local evidence and context-specific interventions.

Objective: This study aims to assess the awareness, perception, patterns, and perceived determinants of attacks on healthcare workers in Okada, Edo State, Nigeria.

Materials and Methods: A cross-sectional survey design was employed to collect data from healthcare professionals working in various healthcare facilities in Okada. Structured questionnaires were used to gather information regarding participants' awareness of violence, personal experiences and perceived risk factors. Data analysis included descriptive and inferential statistics to identify patterns and determinants of workplace violence.

Results: The study revealed a high level of awareness of violence among healthcare workers, with verbal abuse and physical assault being the most commonly reported forms of aggression. Key determinants identified included inadequate security measures, poor communication between patients and staff, and widespread misconceptions about healthcare practices. The findings also highlighted a lack of standardized safety protocols in most healthcare settings.

Conclusion: Healthcare workers in Okada, Edo State, are significantly affected by violence, impacting their safety and professional performance. Addressing this issue requires comprehensive policy interventions, enhanced security measures, and training programs focused on conflict management and communication skills. Strengthening protective protocols will help reduce violence and improve healthcare service delivery in the region.

Keywords: Healthcare workers, Nigeria, Okada, Perception, Violence, Workplace Safety.

I. BACKGROUND

Violence against healthcare workers is a growing global concern, threatening the safety of medical personnel and disrupting healthcare delivery. Reports indicate that between March 2015 and November 2024, at least 7,693 attacks on healthcare workers and facilities were recorded worldwide, with 1,234 incidents reported in 2024 alone[1]. The impact of such violence is particularly severe in conflict zones and politically unstable regions, where targeted killings, abductions, and physical assaults are prevalent[2,3]. Beyond these high-risk areas, incidents of aggression against healthcare workers are also increasingly reported in civilian healthcare settings, aggravating challenges in medical service delivery and workforce retention[4–6].

In Africa, the issue is no less critical, with numerous violent episodes targeting healthcare workers across the continent, with recent reports highlighting the significant risks faced by medical professionals and aid workers in conflict-affected areas, where local healthcare personnel frequently

become victims of attacks. In 2024, violence against healthcare workers in Sudan and South Sudan accentuated the persistent dangers in these regions, contributing to disruptions in essential medical services[6–8]. Such incidents have far-reaching consequences, as they not only compromise the safety of medical personnel but also undermine healthcare access for vulnerable populations.

Nigeria has witnessed an alarming rise in attacks on healthcare workers, reflecting a broader trend of increasing violence within the healthcare sector. In 2023 alone, 37 healthcare workers were kidnapped, while 7 lost their lives to violent attacks[9]. The motivations behind these assaults are many-sided, with contributing factors including patient dissatisfaction, political instability, inadequate security measures in healthcare facilities, and broader systemic healthcare challenges[10,11]. The increasing frequency of these incidents poses a significant threat to healthcare professionals, leading to decreased morale, heightened job dissatisfaction, and potential workforce shortages[10].

Despite the rising prevalence of violence against healthcare workers, public awareness of the seriousness and consequences of such attacks is often low, with some members of the community perceiving aggression toward healthcare workers as justified in response to perceived negligence or poor service delivery[12]. A lack of structured training on workplace violence prevention further exacerbates the problem, leaving healthcare workers vulnerable and unprepared to handle violent encounters[13]. Additionally, reporting mechanisms for such incidents are often inadequate, leading to underreporting and a lack of reliable data on the true extent of the problem[14,15].

The consequences of violence against healthcare workers extend beyond individual safety concerns, influencing the overall quality of healthcare delivery. Frequent attacks create a climate of fear and insecurity within medical institutions, potentially deterring professionals from working in high-risk areas[10]. In Nigeria, the challenges posed by violence against healthcare personnel are further compounded by broader issues within the healthcare system, including inadequate infrastructure, resource constraints, and healthcare-associated infections[16]. Addressing these challenges requires comprehensive strategies that not only enhance the security of healthcare workers but also improve public trust in the healthcare system, reduce patient dissatisfaction, and mitigate the systemic factors that contribute to violence.

This study aims to assess the awareness, perception, pattern, and perceived determinants of attacks on healthcare workers within a tertiary facility in Southern Nigeria. The findings will support the development of targeted policies and programs to enhance awareness, improve security measures, and foster a zero-tolerance culture toward violence against healthcare personnel, ultimately promoting a safer healthcare environment and better patient care.

II. MATERIALS AND METHODS

Study Area

This study was conducted in Okada community, the headquarters of Ovia North-East Local Government Area (LGA) in Edo State, Nigeria. Okada is situated in the South-South geopolitical zone of Nigeria, lying between latitude 6°44′N and longitude 5°23′E. It covers an approximate land area of 2,301 square kilometres and shares boundaries with Usen Junction (Okha village) to the southwest and Iguomo village to the northeast. The community has a tropical climate characterized by distinct dry and rainy seasons, with temperatures ranging from 27°C to 44°C and an average annual rainfall of 150 cm.

Okada comprises two political wards, Okada East and Okada West, which are among the thirteen wards that make up Ovia North-East LGA. The population is predominantly of the Bini ethnic group, although other ethnic groups such as Yoruba, Urhobo, Isoko, Hausa, Igbo, Ijaw, and Fulani are also present. The main economic activities in the community include farming and trading, with a significant number of residents employed as civil servants, healthcare workers, bankers, lecturers, and students. The predominant religion is Christianity, followed by Islam and traditional beliefs.

As of the 2006 National Census, Okada had an estimated population of 153,849 people. Major landmarks within the community include Igbinedion University campuses, Igbinedion University Teaching Hospital, Okada Market, the Local Government Secretariat, the National Youth Service Corps (NYSC) Orientation Camp, and several commercial banks. The presence of a tertiary healthcare facility in the area made it a suitable location for studying awareness and perception of attacks on healthcare workers.

Study Population

The study population comprised indigenes and non-indigenes, students, lecturers, and healthcare workers aged 18 years and above residing in Okada community. These groups were

included to provide a broad perspective on the awareness and perception of attacks on healthcare workers.

Participants were eligible for inclusion if they had lived in Okada community for at least six months before the study commenced. This ensured adequate exposure to the healthcare system and relevant experiences regarding violence against healthcare workers. Individuals who declined participation or were too ill to complete the questionnaire were excluded from the study.

Sampling Technique

A multistage sampling technique was employed to select study participants, ensuring a representative sample of the Okada community.

In the first stage, Okada community was divided into two clusters—Area A and Area B—using simple random sampling by balloting. Crown Estate served as the central landmark for this division, with the region from Usen Junction to Crown Estate designated as Area A, and the region from Crown Estate to the NYSC Orientation Camp designated as Area B.

In the second stage, one of the two areas was selected for the study using simple random sampling by balloting, and Area A was chosen.

In the final stage, individuals within Area A who met the inclusion criteria were selected using simple random sampling by balloting, ensuring that eligible respondents had an equal chance of being included in the study, minimizing selection bias.

Data Collection

Data were collected using a structured, interviewer-administered questionnaire designed to assess awareness, perception, and experiences of attacks on healthcare workers. The questionnaire was organized into five sections: socio-demographic characteristics, awareness of attacks, perceptions of the impact of attacks, patterns of attack, and determinants of violence.

Prior to data collection, the questionnaire was pre-tested in Usen, Ovia South-West LGA, Edo State, to ensure clarity, validity, and reliability. Feedback from the pre-test informed necessary adjustments to enhance the quality of data collection.

Trained interviewers administered the questionnaires to eligible respondents following verbal consent. To maintain confidentiality, identifying information was not recorded, and interviews were conducted in a private setting. Completed questionnaires were reviewed for completeness and accuracy.

Ethical Considerations

Ethical approval was obtained from the Department of Community Medicine, Igbinedion University, Okada, Edo State. All respondents were provided with detailed information about the study's purpose, procedures, and potential risks or benefits. Participation was voluntary, and verbal informed consent was obtained before data collection.

Confidentiality and anonymity were maintained throughout the study. No personal identifiers were recorded, and all responses were securely stored. Privacy was ensured by allowing respondents to complete the interview in a setting of their choice. Participants were informed of their right to withdraw from the study at any time without penalty. Data were used solely for research purposes and were accessible only to members of the research team.

Data Analysis

Collected data were checked for completeness, coded, and entered into IBM SPSS Statistics version 27 for analysis.Descriptive statistics were used to summarize socio-demographic characteristics, awareness, perception, patterns and perceived risk factors of attacks on healthcare workers. Frequencies and percentages were calculated for categorical variables, while mean and standard deviation were applied to continuous variables.Data were presented in frequency tables and pie charts, with narrative explanations to provide context for findings.

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Conflicts of interest: There are no conflicts of interest.

III. RESULTS

Socio-demographic Profile of Respondents

A total of 323 participants were included in the study, with a mean age of 30.1 years (± 9.9). The most common age groups were 18-25 years and 31-35 years, each comprising 65 (20.1%) of the sample, while 41-45 years accounted for 81 (25.1%). Males represented 194 (60.1%) of the participants, while females constituted 129 (39.9%).

The majority of participants were married (177, 54.8%), while 129 (39.9%) were single, and 17 (5.3%) were separated. Most participants identified as Christians (307, 95.0%), with 16 (5.0%) identifying as Muslims.

Regarding ethnicity, 113 (35.0%) were Benin, 48 (14.9%) were Yoruba, 32 (9.9%) were Igbo, and 16 (5.0%) were Hausa, while 114 (35.3%) belonged to other ethnic groups. Most

participants had tertiary education (307, 95.0%), while 16 (5.0%) had secondary education.

Occupationally, nurses and those in other jobs each made up 81 (25.1%) of the sample, while doctors and lab scientists each comprised 65 (20.1%). Students and lecturers accounted for 16 (5.0%) and 15 (4.6%), respectively.

Awareness Level of Attacks on Healthcare Workers

Among the 323 participants, 280 (86.7%) were aware of attacks on healthcare workers, while 43 (13.3%) were not. The main sources of information for those aware were family and friends (159, 56.8%), followed by media outlets (67, 23.9%), personal experience (33, 11.8%), and eyewitness accounts (21, 7.5%).

The most commonly reported form of attack was bullying and intimidation (185, 66.1%), followed by verbal attacks (63, 22.5%) and physical assault (32, 11.4%). The majority of attacks were orchestrated by patient relatives (191, 68.2%), followed by patients (62, 22.2%) and healthcare workers themselves (27, 9.6%).

Regarding the frequency of attacks, the majority of respondents reported that attacks occurred occasionally (180, 64.3%), while 45 (16.1%) indicated they occurred often, and 55 (19.6%) reported they occurred rarely.

Perception of Workplace Attacks

The majority of participants agreed that attacks disrupt the relationship between healthcare workers and their clients, with 162 (57.9%) responding "Yes," while 89 (31.8%) disagreed and 29 (10.4%) were not sure.

More than half of the respondents (159, 56.8%) believed that attacks compromise the quality of care provided, while 48 (17.1%) disagreed, and 73 (26.1%) were uncertain. Similarly, 154 (55.0%) felt that attacks have a detrimental effect on patients' overall healthcare outcomes, while 102 (36.4%) did not share this view, and 24 (8.6%) were unsure.

A significant proportion of participants (217, 77.5%) believed that experiencing an attack may influence clients' decisions to seek professional medical care, while 36 (12.9%) disagreed and 27 (9.6%) were uncertain.

The vast majority (226, 80.7%) agreed that perpetrators of attacks should face appropriate disciplinary measures, while 44 (15.7%) disagreed and 10 (3.6%) were unsure.

Pattern of Workplace Attacks

Among the 323 participants, 238 (73.7%) reported having experienced attacks on healthcare workers, while 85 (26.3%) had not. Among those who experienced attacks, the most common forms were bullying (109, 45.8%) and verbal abuse (83, 34.9%). Harassment was reported by 21 (8.8%) participants, threats of aggression by 13 (5.5%), and physical assault by 12 (5.0%).

Patient relatives were identified as the primary perpetrators, accounting for 145 (60.9%) of the incidents, while patients themselves were responsible for 93 (39.1%). Nurses were the most frequently affected victims, with 153 (64.3%) reporting being attacked, while doctors accounted for 85 (35.7%).

Most of the reported incidents (222, 93.3%) were communicated to relevant authorities. However, disciplinary action was taken in only 3 (1.3%) cases, while 147 (61.8%) reported no action taken, and 88 (37.0%) were unsure of any follow-up.

A majority of respondents (217, 91.2%) believed that the experience of attacks in Okada could be generalized nationwide, while 20 (8.4%) were unsure, and only 1 (0.4%) disagreed.

Perceived determinants of Workplace Attacks

Among the 280 participants, the most commonly perceived determinant of violence against healthcare workers was the lack of disciplinary action in previous occurrences, reported by 268 (95.7%) respondents. The burden of the cost of treatment on patients and relatives was also a significant factor, cited by 209 (74.6%) participants.

Underlying medical conditions or substance abuse among patients and relatives were perceived as contributing factors by 136 (48.6%) respondents. Additionally, very long waiting hours were noted as a determinant by 102 (36.4%) participants, while stress among healthcare workers due to long work hours was identified by 99 (35.4%).

Communication-related factors were also reported, with poor communication between clients and service providers and poor communication skills among health workers each noted by 98 (35.0%) participants. Poor conduct of healthcare workers was identified as a factor by 52 (18.6%) respondents.

International Journal Dental and Medical Sciences Research
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Table 1: Socio-demographic profile of respondents

Variables	Frequency (n=323)	Percentage (%)
Age group (years)		
18-25	65	20.1
26-30	48	14.9
31-35	65	20.1
36-40	32	9.9
41-45	81	25.1
>45	32	9.9
Mean age (± S.D)	**30.1 ± 9.9**	
Sex		
Female	129	39.9
Male	194	60.1
Marital Status		
Single	129	39.9
Married	177	54.8
Separated	17	5.3
Religion		
Christianity	307	95.0
Islam	16	5.0
Ethnicity		
Benin	113	35.0
Yoruba	48	14.9
Igbo	32	9.9
Hausa	16	5.0
Others	114	35.3
Level of Education		
Secondary	16	5.0
Tertiary	307	95.0
Occupation		
Nurse	81	25.1
Doctor	65	20.1
Lab Scientist	65	20.1
Student	16	5.0
Lecturer	15	4.6
Others	81	25.1

Table 2: Awareness of Attacks on healthcare workers

Variables	Frequency (n=323)	Percentage (%)
Aware of attack		
Yes	280	86.7
No	43	13.3
Main source of information (n=280)		
Family and friends	159	56.8
Media outlets	67	23.9
Personal experience	33	11.8
Eye witness	21	7.5

Most common form of attack (n=280)		
Verbal	63	22.5
Bullying and intimidation	185	66.1
Physical assault	32	11.4
Source of Attack (n=280)		
Health workers	27	9.6
Patients	62	22.2
Patient relatives	191	68.2
Frequency of attacks (n=280)		
Often	45	16.1
Occasionally	180	64.3
Rarely	55	19.6

Table 3: Perception of Attacks on Healthcare workers

Variables	Yes n (%)	No n (%)	Not Sure n (%)
Attacks disrupt the relationship between healthcare workers and their clients	162 (57.9)	89 (31.8)	29 (10.4)
Attacks compromise the quality of care provided	159 (56.8)	48 (17.1)	73 (26.1)
Attacks have a detrimental effect on patients' overall healthcare outcomes	154 (55.0)	102 (36.4)	24 (8.6)
Experiencing an attack may influence clients' decisions to seek professional medical care	217 (77.5)	36 (12.9)	27 (9.6)
Perpetrators of attacks should face appropriate disciplinary measures	226 (80.7)	44 (15.7)	10 (3.6)

Table 4: Pattern of Attacks on healthcare workers

Variables	Frequency (n=323)	Percentage (%)
Experienced attack on healthcare workers		
Yes	238	73.7
No	85	26.3
Form of attack experienced (n=238)		
Bullying	109	45.8
Verbal abuse	83	34.9
Harassment	21	8.8
Threats of aggression	13	5.5
Physical assault	12	5.0
Perpetrators of attack (n=238)		
Patient relatives	145	60.9
Patients	93	39.1
Victims of attacks (n=238)		
Nurses	153	64.3
Doctors	85	35.7
Event reported to relevant authorities (n=238)		
Yes	222	93.3
No	16	6.7
Disciplinary action taken (n=238)		

International Journal Dental and Medical Sciences Research
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Yes	3	1.3
No	147	61.8
Unsure	88	37.0
Experience in Okada can be generalized nationwide (n=238)		
Yes	217	91.2
No	1	0.4
Unsure	20	8.4

Table 5: Perceived determinants of violence against health workers

Variables	Frequency (n=280)	Percentage (%)
Lack of disciplinary action in previous occurrences	268	95.7
Burden of cost of treatment on patients and relatives	209	74.6
Underlying medical conditions/Substance abuse among patients and relatives	136	48.6
Very long waiting hours	**102**	**36.4**
Stress among health workers due to long work hours	99	35.4
Poor communication between clients and service providers	98	35.0
Poor communication skills among health workers	98	35.0
Poor conduct of health workers	52	18.6

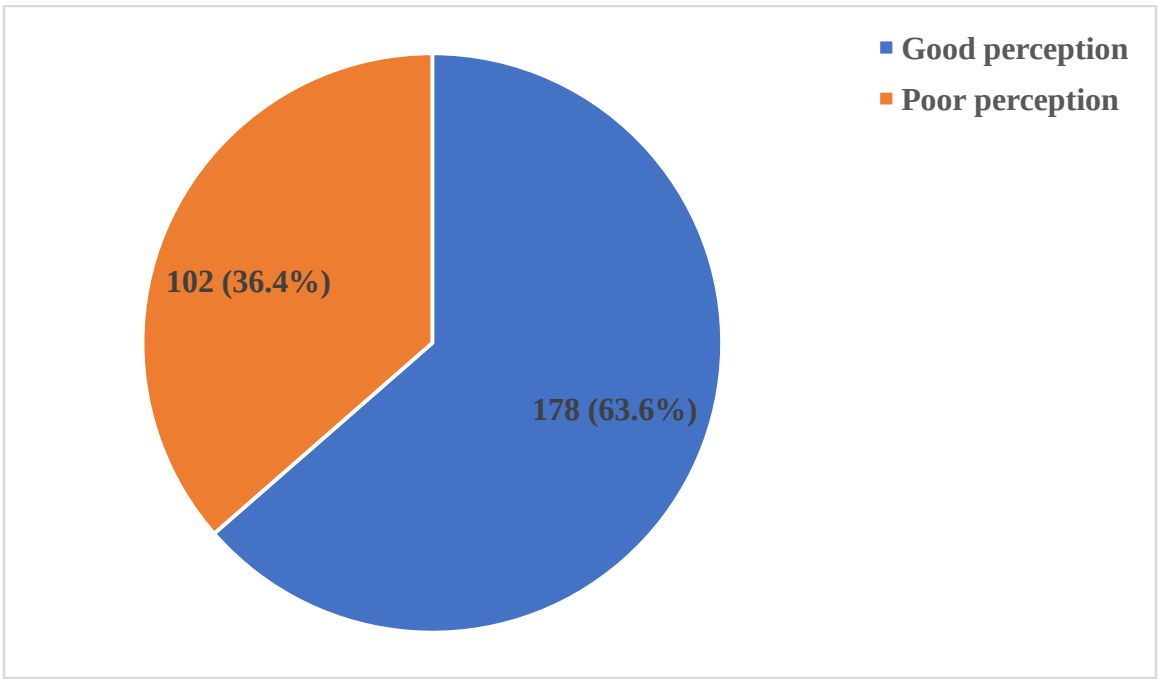

Figure 1: Distribution of perception regarding attack on healthcare workers

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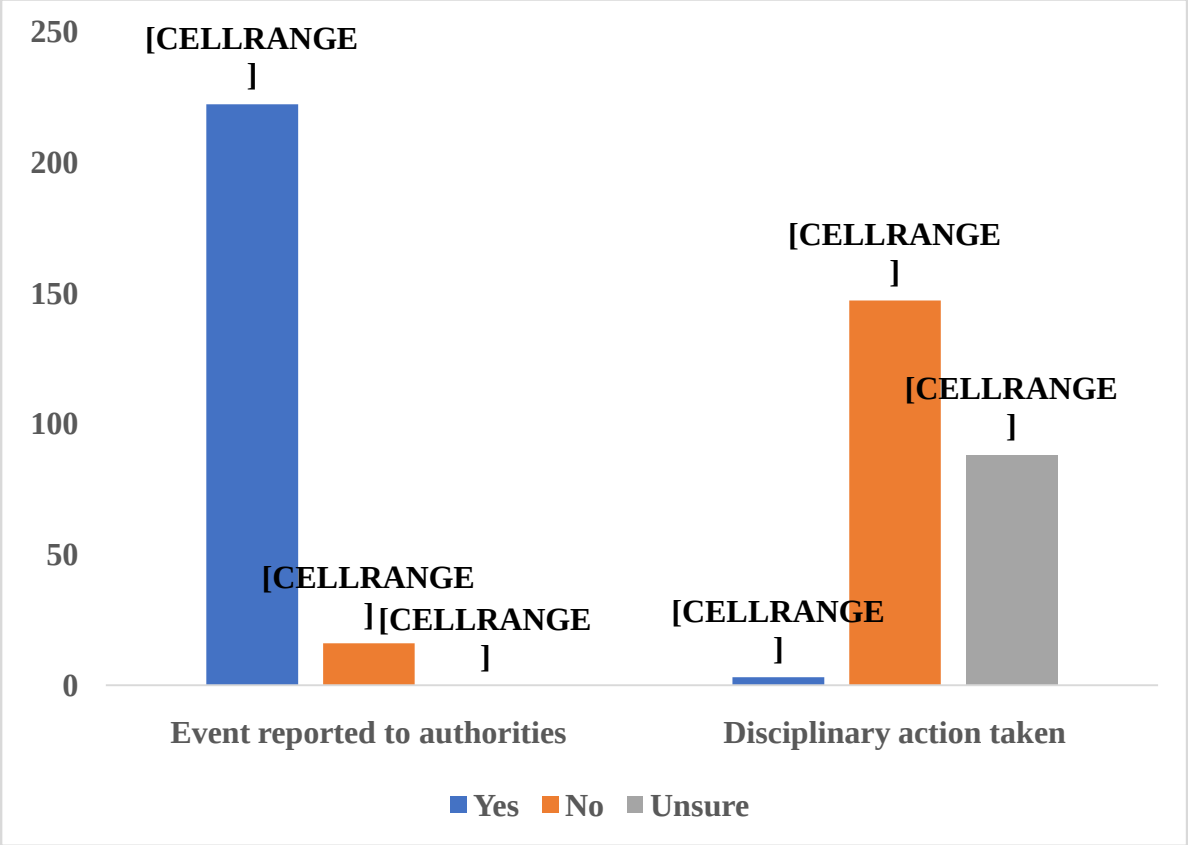

Figure 2: Image showing the responses to violence against health workers

IV. DISCUSSION

A total of 300 healthcare workers participated in the study, with a majority being female and aged between 25 and 45 years. Nurses made up the largest proportion of respondents, followed by doctors and other healthcare professionals. Most had more than five years of professional experience and worked in clinical settings.

Almost nine in ten respondents were aware of cases of attacks on healthcare workers, with the primary sources of information being family and friends, followed by media, personal experiences, and eyewitness accounts. This high level of awareness is similar to findings from Douglas and Enikanoselu[17] (2019), which reported a comparable awareness rate among healthcare workers in Osun State, with 89% of respondents being aware of cases of attacks on health workers. The high level of awareness in Okada may be linked to recent attacks as well as increased community dialogue around healthcare worker safety. This widespread recognition of workplace violence highlights the need for awareness programs to educate the public on the consequences of violence against healthcare personnel, fostering a safer and more supportive healthcare environment.

Over half of the respondents believed that such attacks disrupt the relationship between healthcare workers and clients, while others felt that the quality of care and patient outcomes were compromised. These perceptions align with findings from Usman et al.[18] (2022), who reported that workplace violence negatively affects healthcare quality and patient trust in northern Nigeria. The emotional toll of violence on healthcare workers can lead to burnout, low morale, and reluctance to work in high-risk settings, ultimately compromising patient care and increasing wait times. Support systems, including counseling and debriefing sessions, should be prioritized to mitigate these effects.

The most common form of violence reported was bullying and intimidation, followed by verbal abuse and physical assault. Patient relatives were the primary perpetrators in most cases, consistent with findings from Ikpae and Buowari[19](2023), who reported similar trends in Port Harcourt, with the main forms of workplace violence being verbal abuse and physical assault in over 85% of the study sample. The high prevalence of bullying may stem from power dynamics within

healthcare settings and poor communication between healthcare workers and patients' families. Addressing these issues requires improving communication skills and setting clear protocols for managing aggressive behavior.

One critical finding was the low rate of disciplinary action despite frequent reporting, with disciplinary measures taken in just over 1% of cases. This mirrors the results of a study by Ikpae and Buowari et al.[19] (2019), which highlighted similar gaps in institutional responses to workplace violence in southeastern Nigeria, with over 35% of attackers having no consequence for their actions, and in total, over 80% only being issued a verbal warning. However, reporting of incidences by health staff was also low, at 13.5%. The reluctance to address violent incidents may stem from fear of retaliation, bureaucratic challenges, or weak administrative commitment. Strengthening institutional policies, ensuring transparent reporting, and enforcing penalties for perpetrators are essential to breaking the cycle of impunity.

More than three-quarters of respondents believed that fear of violence could deter healthcare workers from providing care, similar to reports from Isara et al.[20] (2024), who found that safety concerns discouraged majority healthcare professionals from working in conflict-prone areas in three Northern Nigerian states, with many respondents reporting decline in productivity, loss of confidence and stress-related disorders from such encounters. Fear of violence affects both healthcare workers and community health outcomes by increasing wait times and reducing service availability. Safety policies and interventions should be prioritized to maintain consistent and reliable healthcare delivery.

Several determinants of workplace violence were identified, with the most frequently cited being the lack of disciplinary action following reported incidents. Other factors included the financial burden of treatment on patients and relatives, underlying medical conditions or substance abuse, long waiting times, and healthcare worker stress. These findings align with global studies that link workplace violence to inadequate healthcare funding and insufficient staffing, as seen in a systematic review conducted by Eshah et al.[21] (2024). Addressing these root causes requires comprehensive healthcare reforms that reduce financial strain on patients while enhancing workforce capacity and support.

To mitigate workplace violence, healthcare facilities should implement prevention programs that include conflict de-escalation training, patient communication improvement, and robust reporting mechanisms. Advocacy campaigns aimed at educating the public about the harmful effects of violence on healthcare services are essential. Strengthening collaborations between healthcare institutions, security agencies, and community leaders will also help create a safer working environment for healthcare professionals.

V. CONCLUSION

Workplace violence against healthcare workers in Okada, Edo State, is highly prevalent, with bullying, intimidation, and verbal abuse being the most common forms. Despite high awareness, institutional responses remain inadequate, with few perpetrators facing disciplinary action. Contributing factors include a lack of accountability and systemic challenges within healthcare settings.

Addressing this issue requires stronger policies, public awareness, and staff training to ensure the safety and well-being of healthcare workers, ultimately improving healthcare delivery and patient outcomes.

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