



**ST. MARY UNIVERSITY
SCHOOL OF GRADUATE STUDIES
DEPARTMENT OF SOCIAL WORK**

**WORKPLACE VIOLENCE AGAINST HEALTHCARE WORKERS:THE
CASE OF URBAN HEALTH EXTENSION WORKER IN KOLFE KERANYO
SUB-CITY ,ADDIS ABABA**

**By
TIHITINA ABEBE**

**July ,2025
ADDIS ABABA, ETHIOPIA**

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**A THESIS SUBMITTED TO ST. MARY’S UNIVERSITY, SCHOOL OF
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ENDORSEMENT

This thesis has been submitted to St. Mary's University, School of Graduate Studies for examination with my approval as a university advisor.

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July, 2025 G.C

DECLARATION

I, Tihitina Abebe , here by declare that this research entitled, ‘workplace violence against healthcare workers;the case of urban health extension worker in kolfe keranyo sub-city Addis Ababa, Ethiopia’ is the outcome of my own effort and that all sources of materials used for the study have been duly acknowledged.

Tihitina Abebe
St. Mary’s University, Addis Ababa

Signature & Date

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List of Abbreviation and Acronyms

HEW- Health Extension Worker

CHW - Community Healthcare Worker

HEP- Health Extension Program

WPV - Workplace Violence

WHO - World Health Organization

HCW - Health Care Workers

AA - Adiss Ababa

LMICs - Low And Middle-Income Countries

HP- Health Post

UHC- Universal Health Coverage

ABSTRACT

Workplace violence is a significant yet under-addressed issue affecting healthcare professionals, particularly Health Extension Workers (HEWs) who operate within community settings. This study aimed to assess the forms of workplace violence, the effects of workplace violence and the availability of reporting mechanisms among urban health extension workers in Kolfe Keranyo Sub-City, Addis Ababa. Using a qualitative approach with phenomenological study design. Data was collected through in-depth interviews from five health extension workers which were selected through purposive sampling method then data was analyzed thematically. Findings revealed that verbal abuse, physical aggression, and psychological intimidation were the common forms of violence, frequently perpetrated by community members, leading to emotional exhaustion, job dissatisfaction, and fear. Despite of the finding of such incidents, participants reported an absence of formal reporting mechanisms, resulting in normalization of violence and reliance on peer support or silence. The study highlights the urgent need for institutional reforms and social work advocacy to establish protective policies, effective reporting systems, and psycho-social support structures for front line healthcare workers.

Key words: violence, workplace violence, health extension workers, urban, reporting violence

CHAPTER ONE

1.1 Background of The Study

Violence is a deeply rooted societal issue that transcends geographical, economic, and institutional boundaries. It can occur in nearly every context—homes, schools, streets, religious institutions, and workplaces. While traditionally viewed through the lens of criminal justice or personal conflict, the understanding of violence has gradually evolved to encompass structural and institutional dimensions. Today, scholars and practitioners recognize workplace violence as a multidimensional phenomenon influenced by systemic inequalities, social norms, and the power dynamics inherent in professional environments. (Mikołajczuk, 2020).

The World Health Organization (WHO) defines violence as the intentional use of physical force or power, whether real or threatened, against oneself, another individual, a group, or a community that has repercussions or a high likelihood of causing harm, death, or mental distress. (WHO,2020)

While violence impacts workers in numerous sectors, it is assumed to be more widespread in the health care industry because to professional features such as long hours, shift work, regular contact with mortality, and a shortage of human resources, materials, and equipment. Psychiatric, geriatric, and emergency departments are regarded to be the health care areas where staff are most vulnerable to assault. It is also crucial to highlight that working directly with persons who have a history of violence and drug or alcohol addiction, in poorly lighted locations with little to no safety, and in high crime-rate areas are all risk factors for patients and their families being exposed to workplace violence.(Bernardes,2021) Despite the critical role healthcare workers play in safeguarding community health, they remain disproportionately vulnerable to physical, verbal, and psychological violence from patients, patients' families, coworkers, and even the broader public. This vulnerability is often exacerbated by poor institutional responses, lack of protective policies, and inadequate reporting mechanisms, which collectively contribute to a culture of silence and normalization of abuse.

Workplace violence affects not only the victim, but the whole healthcare system. It may induce tension among employees, affecting their work and resulting in bad service. This also has an impact on recruiting, making it more difficult for health-care providers to attract appropriately trained individuals.(Al-Qadi,2021)

Healthy, fair, inclusive, and worker-protective working environments are necessary. Employees' safety, dignity, and human rights must be prioritized. Research conducted globally has identified WPV as a major deterrent to professional satisfaction and retention in the healthcare sector. In countries such as India, Brazil, and South Africa, similar patterns emerge: community-based health workers often encounter threats, physical aggression, sexual harassment, and emotional abuse from those they are tasked to serve (Closser et al., 2023; Gadapati & R, 2024).

Moreover, social stigma, cultural silence around abuse, and fear of retribution discourage HEWs from reporting violent incidents. Many are compelled to normalize abuse as “part of the job,” further entrenching a toxic work culture that prioritizes service delivery over worker safety. From a social work perspective, this normalization of violence is deeply problematic. Social work as a profession upholds values of dignity, social justice, and human rights. It therefore becomes imperative to challenge structures and systems that devalue front line healthcare workers and expose them to harm without institutional support or recourse. social workers are present in settings across the health care continuum, including prevention and public health, primary and acute care, specialty care, rehabilitation, home health, long-term care, and hospice. Professional social workers provide services to individuals and families throughout the life span, addressing the full range of bio-psycho-social & spiritual and environmental issues that affect well-being. Social work’s strengths-based, person-in- environment perspective provides the contextual focus necessary for client- and family-centered care and is unique among the health professions.(NASW,2016)

In our country, Health Extension Workers (HEWs) are responsible for implementing the 16 health extension program(HEP) packages in five categories. The five categories of HEP were Family health services, environmental sanitation and personal hygiene, major communicable and neglected tropical diseases, non-communicable

diseases, and health education and communication comprised the five HEP categories. Policymakers deemed the packages pertinent to rural populations, and they were distributed through home visits, outreach, and static tactics. In 2009, the program was extended to include more curative services in metropolitan areas. Furthermore, in 2016, Two extra service packages were added by the government, bringing the total number of packages with increased commodity requirements and HEW training to 18. Through a health post (HP) at the local level, it is intended to offer basic healthcare to about 5000 people.(Zufan, 2020)

Two health extension workers (HEWs) who have one year of training and are paid directly by the government work in each HP. In order to teach and demonstrate HEP packages to family households, the HEWs spend seventy-five percent of their time on home visits. The remaining portion of their time is spent in the health post, where they provide basic health services. (Tiruneh et al., 2024)

HEWs are expected to act not only as health educators and service providers but also as mediators between formal health institutions and informal community structures. Their duties, although indispensable, frequently place them at the receiving end of community frustrations, resistance to behavior change, and deeply ingrained gender norms. Despite their significant contributions, these workers are often undervalued, underpaid, and under protected. Their exposure to occupational violence is compounded by factors such as gender, cultural stigma, and the limited authority they possess within the healthcare system.(Gebrie,2021)

One of the key challenges in addressing workplace violence against HEWs in Ethiopia is the limited availability of research and data. Most existing studies tend to focus on institutional health settings, such as hospitals and clinics, with little attention given to community-based workers. As a result, there exists a critical gap in the literature regarding the unique vulnerabilities and experiences of urban HEWs, especially those operating in volatile neighborhoods or underserved populations. This gap not only hampers the development of targeted interventions but also marginalizes a segment of healthcare workers who are essential to Ethiopia's public health success.

The connection between social work and the healthcare system lies in their shared mission of improving human well-being. Social workers are uniquely positioned to support HEWs through counseling services, advocacy, policy reform, and community engagement. Understanding the extent and effects of workplace violence on HEWs provides a foundation for developing holistic interventions that address both immediate safety needs and long-term structural change.(Zheng et al., 2021)

Furthermore, workplace violence has far-reaching consequences beyond individual health workers. It affects the morale and cohesion of healthcare teams, reduces the quality and continuity of care, and ultimately erodes public trust in the health system. Patients in need of services may receive substandard care from demoralized or fearful workers, while communities lose access to critical health information and support. In contexts such as Ethiopia, where healthcare systems are already strained due to limited resources, losing skilled HEWs due to burnout, trauma, or resignation has a devastating impact on community health outcomes.

The finding of this study will not merely be an academic inquiry into the experiences of violence; it is a call to action for institutions, policymakers, and communities to acknowledge the silent suffering of HEWs and invest in their protection and empowerment. By documenting the lived experiences of urban HEWs in Kolfe Keranyo Sub-City, this research seeks to shed light on the scope of workplace violence, its psychological and professional toll, and the systemic barriers that hinder effective redress.

1.2. Statement of problem

Workplace violence(WPV) against healthcare workers is under-reported primarily because of the challenging reporting process and fear that the supervisor might refrain from helping the victim. (Al-Qadi,2021)According to statistics from the Bureau of Washington Labor Statistics, the rate of workplace violence increased by 17% in hospitals, 95% in mental and drug treatment centers, and 63% in home health agencies between 2006 and 2020.The rate jumped 25 percent in hospitals in 2020.(Courtney & Baldwin, 2023)

WPV rates rose highly across all types of health care institutions and workplace violence against medical professionals is a major issue in industrialized, developing, and transitional nations. (lombardi et al 2024) In addition to the immediate shock, adverse effects might include diminished team cohesion, low morale and productivity brought on by mistrust of management, and a perception of a hostile and hazardous work environment. Additionally, workplace violence may lead to higher levels of stress at work, absenteeism, family strife, and employee turnover.(Mukhtar et al., 2024)

Despite of the numerously available studies on the workplace violence against health care workers ranging from nurses to doctor at different department of a hospital setting, less emphasis is given to the extension workers. Health Extension Workers (HEWs) face various forms of violence, including attempted rape, verbal abuse, physical assault, and economic exclusion often by community members, officials, or supervisors (Gebrie, 2021). These abuses threaten their safety, dignity, and career development. Unlike facility-based staff, HEWs' door-to-door outreach exposes them to unpredictable risks. Despite their key role in achieving universal health coverage in low- and middle-income countries, they remain undervalued and understudied.

Current research and policy have focused predominantly on hospital-based staff, leaving a critical gap in understanding and addressing the risks community-based workers face. This systemic neglect not only jeopardizes the safety and mental health of HEWs but also threatens the quality and continuity of community health services. Without targeted interventions and effective reporting mechanisms, the cycle of silence and violence will persist undermining the goals of universal health coverage and the broader public health system.

1.3. Research question

1. What form of workplace violence do urban extension healthcare workers most frequently report?
2. What effects does workplace violence have on urban extension healthcare professionals' psychological health and job satisfaction?

3. How well do the current systems for reporting workplace violence address those problems raised by healthcare professionals in urban extension?

1.4. Objective

I.4.1. General Objective

- ✓ To assess the forms, the effects and the availability of reporting mechanism on workplace violence against urban extension health workers and at kolfe keraniyo sub-city, Addis Ababa

I.4.2. Specific Objective

1. To determine forms of workplace violence experienced by urban extension healthcare workers.
2. To identify psychological and professional effects of work place violence on Health Extension Workers.
3. To analyze existing reporting mechanisms and their effectiveness in addressing incidents of workplace violence.

1.5. Significance of the study

This study will have significance for it has the potential to fill a significant knowledge gap in workplace violence (WPV) that focuses on urban extension healthcare workers, a population that has not gotten much attention in the literature yet. By examining the forms and effects of WPV as well as the effectiveness of reporting systems in Kolfe Keraniyo sub-city, this study seeks to raise awareness and close the knowledge gap regarding WPV against extension workers. The results may serve as a guide for actions to improve worker safety and well-being. This would ultimately improve the standard of healthcare services offered by vulnerable groups. Additionally, the results will guide the creation of community awareness campaigns, creating a positive atmosphere that reduces violence against healthcare professionals and advances improved health outcomes for the populations they serve. From a social work perspective, this research underscores the importance of advocacy for vulnerable populations within the healthcare system. The findings can inform social work

practitioners about the unique challenges faced by urban extension healthcare workers and guide them in developing supportive interventions.

1.6. Scope Of The Study

This study focuses on workplace violence experienced by urban Health Extension Workers (HEWs) in Kolfe Keraniyo Sub-City, Addis Ababa. It specifically explores different forms of violence physical, verbal, psychological, and sexual encountered during their routine community based duties. Health extension workers with at least one year of experience were the participants. The research is qualitative in nature, aiming to understand the personal and professional impacts of violence as well as institutional responses.

1.7. Limitation of The Study

The limitation of this study is the limited number of participants, while it is rich in detail, may not fully capture the broader scale of workplace violence among all HEWs in Addis Ababa or other regions of Ethiopia. Second, the sensitivity of the topic may have led some participants to unreported or withhold experiences, due to fear, shame, or social stigma. Third, the study relies solely on the perspectives of HEWs, without including the viewpoints of supervisors, healthcare administrators, or community members, which could have provided a more holistic understanding of the workplace environment. Considering all these limitations to enhance reliability document analysis was used to support data gathered through interview.

1.8. Operational Definition

Urban- cities and towns with dense population

Health extension worker-A trained health professional who delivers essential health services at the community level.

Violence -The intentional use of physical force or power against another individual or group that results in injury, psychological harm, or deprivation.

Workplace violence-any act of violence that occurs in a work setting such as physical violence, verbal violence, sexual harassment...

Physical violence- violence that involves the use of physical force against an individual, resulting in bodily harm or injury. This can include hitting, pushing, slapping, or any other act that causes physical harm.

Verbal violence-violence characterized by the use of words or language to threaten, insult, or demean an individual. This includes shouting, swearing, derogatory remarks, and any form of communication intended to intimidate or belittle a person.

Reporting Mechanism- formal reporting protocols, support services for victims

1.9. Organization of the study

This research is composed of six parts. Chapter one provide introduction of the study and specifically address the following: background of the study and statement of the problem, research questions, objective, significance of the study, operational definition of terms. Where as Chapter two contains various local and international literature done on workplace violence against healthcare and chapter three is all about study setting, research design, sampling mechanism, data collection and analysis, trustworthiness and an ethical consideration, chapter four contains finding. On Chapter five conclusion and recommendations are presented finally list of reference is located at the end.

CHAPTER TWO

LITREATURE REVIEW

2.1 Overview Of Violence Against Healthcare Workers

Workplace violence (WPV) is significantly more prevalent in healthcare settings, with incidents occurring up to four times more frequently in hospitals compared to other work environments. This heightened risk is attributed to the high-pressure nature of medical settings and frequent interactions with patients in distress. Studies indicate that nearly twenty percent of healthcare workers have experienced physical violence while on the job. The risk is notably higher in urban areas and in tertiary hospital, where patient volume and diversity of cases are greater.(Ma PF, 2023)

A study conducted in southern Brazil found that colleagues and supervisors were the most frequent perpetrators of workplace violence against healthcare workers, surpassing patients and their families in the incidence of such behavior (Courtney & Baldwin, 2023). This finding highlights the significant role that internal organizational dynamics and hierarchical relationships play in contributing to workplace violence within healthcare settings. Furthermore, research carried out in 2021 confirmed that the majority of violent incidents occur directly within the workplace environment, emphasizing the urgent need for institutions to address internal factors that foster aggression and hostility (Bernardes, 2021).

These insights suggest that efforts to combat workplace violence must not only focus on patient interactions but also critically examine and improve staff relationships and supervisory practices to create a safer and more supportive working atmosphere. In a study conducted at a public hospital in northeastern part of Ethiopia, verbal abuse was found to be the most common type of WPV. (Bekalu&Wudu, 2023) Inappropriate remarks, unfounded rumors, and gossip all contribute to workplace harassment. In the healthcare industry, sexual harassment and gender-based harassment are prevalent, with women more likely than men to experience the it. Both sexes can be subjected to sexual harassment by direct physical approaches, remarks, and unpleasant rumors spread via social media, email, and the workplace.(Luong and Green, 2023)

As reported by the majority of health extension specialists, there was community opposition to taking part in the urban health extension program. According to a health extension expert, the public is not aware of the program's advantages. They did not volunteer for the service and sometimes attempted to chase us away from their home.(Adamu, 2012)

2.2 Workplace Violence Against HEW

Health Extension Workers (HEWs), also referred to as Community Health Workers (CHWs), play a vital role in extending basic healthcare services to underserved and marginalized populations, particularly in low- and middle-income countries. Their contributions are essential in bridging the gap between formal healthcare systems and the communities they serve, often providing care in remote and resource-constrained settings where medical infrastructure is weak or absent. (Zufan, 2020)

These frontline workers are instrumental in delivering preventative and promotive health services, conducting home visits, providing maternal and child health support, facilitating immunization campaigns, and raising awareness about hygiene and disease prevention. Recognizing their significance, global health frameworks such as the Sustainable Development Goals (SDGs) identify HEWs as critical to achieving universal health coverage (UHC) and addressing the global shortage of healthcare professionals. Despite their indispensable role, HEWs are frequently subjected to workplace violence, including verbal abuse, physical assault, sexual harassment, and psychological intimidation. Such violence not only endangers their safety and well-being but also severely disrupts the continuity and effectiveness of healthcare delivery at the community level (Gadapati & R, 2024).

Beside common anxiety about presenting themselves in a re-presentably manner, HEWs were subjected to severe, sporadic assault while at work. This included being shouted at, assaulted with household objects, and threatened with murder. Female HEWs were more vulnerable due to their gender and Community members often felt empowered to mistreat vulnerable individuals without fear of repercussions.(Closser et al., 2023)

A systemic review by Closser et al. (2023) and Gadapati & R. (2024) emphasized that gender plays a pivotal role in violence against HEWs. Female HEWs reported feeling especially vulnerable during field visits, particularly in low-income or densely populated neighborhoods. These findings reinforce that HEWs are doubly burdened by their occupational risks and by the gendered expectations placed upon them

The study done in Pawe Woreda, Benishangulgumuz discovered that female Health Extension Workers are subjected to numerous forms of gender-based violence, including psychological, sexual, physical, and financial abuse. The most common type of violence was psychological, which included threats, insults, humiliation, and ethnic prejudice. HEWs also claimed sexual assault, such as attempted rape and verbal abuse, which were frequently perpetrated by community members and municipal officials. Physical violence included beatings, slapping, and spitting, sometimes by supervisors or close partners. Economically, HEWs were denied training and advancements and faced theft. These obstacles endanger their safety, dignity, and professional advancement.(Gebrie,2021)

2.3 Types Of Workplace Violence Against Healthcare Workers

Workplace violence (WPV) in the healthcare sector is a multifaceted issue encompassing a wide spectrum of aggressive behaviors that can occur between patients, family members, coworkers, supervisors, or the broader public. According to the World Health Organization (WHO, 2002), workplace violence in healthcare refers to “incidents where staff are abused, threatened or assaulted in circumstances related to their work.” WPV can be broadly categorized into four major types: physical violence, verbal abuse, psychological or emotional violence, and sexual harassment. Each of these forms of violence has distinct characteristics, causes, and consequences, and their prevalence varies depending on the work setting, healthcare role, gender, and sociocultural context.

Physical Violence

Physical violence in healthcare settings refers to deliberate acts of aggression that result in bodily harm to healthcare workers. These acts can include hitting, pushing, slapping, or throwing objects, all of which pose serious threats to the safety and well-

being of staff. Research has consistently shown that physical violence is especially prevalent in high-risk areas such as psychiatric units and emergency departments, where patients may exhibit unpredictable or aggressive behaviors. Additionally, health extension workers (HEWs), who often operate in uncontrolled and challenging environments, face elevated risks of physical assault during their routine duties (Martinez, 2016).

HEWs frequently conduct their work in remote or forested locations, which lack the safety infrastructure commonly found in traditional healthcare facilities. Due to these conditions, they are vulnerable to a wide range of violent acts, including beatings, slaps, and even attacks involving weapons. Such violence is not only perpetrated by community members who may be hostile or distrustful but, alarmingly, in some cases, it has also been reported to come from supervisors or colleagues within the healthcare system itself (Gebrie, 2021).

Verbal Abuse

Research has consistently shown that verbal abuse is particularly prevalent among female healthcare workers. Women in healthcare settings are often disproportionately targeted by patients, visitors, and even colleagues, a trend closely linked to prevailing gender-based discrimination and societal biases . These attacks are not only expressions of individual hostility but also reflect deeper cultural and structural inequalities that place female workers at greater risk of verbal violence. Addressing this issue requires not only awareness and support mechanisms for affected individuals but also broader efforts to challenge and change discriminatory attitudes within healthcare environments.(Bekalu & Wudu, 2023)

Sexual Harassment

Sexual harassment in healthcare settings includes inappropriate physical contact, unwelcome sexual advances, suggestive comments, and coercion. Both male and female healthcare workers can be victims of sexual harassment, although women are disproportionately affected. Studies indicate that healthcare workers who engage in direct patient care, such as nurses and other front line HCW, are more likely to

experience sexual harassment from patients, colleagues, or superiors (Luong & Green, 2023).

sexual harassment remains one of the most pervasive forms of workplace violence against healthcare workers, particularly affecting female nurses and community health professionals. It encompasses a range of unwelcome sexual behaviors including verbal innuendos, non-verbal gestures, unsolicited touching, and coercive advances—often perpetrated by colleagues, supervisors, or even patients. A recent qualitative study conducted in Ghana found that nurses experienced verbal, non-verbal, and physical sexual harassment frequently in healthcare settings, with physicians, coworkers, and patients being the primary perpetrator. (Mohammed et al., 2023)

Psychological Intimidation

Psychological intimidation encompasses a range of non-physical forms of aggression aimed at instilling fear, asserting control, or compelling an individual to act against their will. It typically manifests through covert and indirect actions such as threats, manipulation, persistent bullying, and coercive pressure, all of which are designed to undermine the confidence and autonomy of the target. Within healthcare environments, psychological intimidation contributes significantly to the development of hostile work cultures, diminishing employee morale and impairing mental and emotional well-being. This type of aggression can lead to reduced job satisfaction, increased absenteeism, and compromised quality of patient care due to the emotional toll it places on affected healthcare workers (Adhikari et al., 2024).

psychological violence is particularly damaging because its consequences, though not physically visible, are deeply internalized and long-lasting. Victims may experience a host of mental health challenges such as chronic stress, anxiety, depression, burnout, and in severe cases, post-traumatic stress disorder (PTSD). These effects not only impair the well-being of healthcare professionals but also hinder their capacity to deliver compassionate and effective care, thereby impacting overall healthcare system performance. (Luo et al., 2024)

2.4 Effect Of Workplace Violence On Healthcare Workers

Regardless of the cause, workplace violence can have far-reaching emotional, professional, physical, and psychological ramifications (Al-Qadi, 2021). According to a literature review analysis of 15 prior studies, nurses' confidence and self-esteem are negatively impacted when they are verbally assaulted, especially when the attacker uses abusive language, and they express their fear, especially in the event of a physical assault. (Eshah Et al, 2024)

They could suffer from fatigue, despair, shame, and post-exposure trauma, all of which may harm their physical and mental health. In a qualitative study conducted on health care professionals after an incidence of a physical violence, respondents claimed that they went back to work a week after the violent incident, but that their trust in their own abilities and decision-making skills had decreased. They also reported having memory problems and being confused about how to treat patients. (Adhikari et al., 2024)

similarity in a literature review study done in Iraq Violence against nurses can have psychological consequences in hospital administration, such as fear, rage, distrust, and lower employee performance. Early career nurses are the most affected, as it can lead to professional dissatisfaction. Violence has an impact on caregivers' professional perspectives, hampers recruitment and retention efforts, and can ultimately jeopardize clinical outcomes, particularly during the health professional shortage. (Saad et al., 2023)

An article written in 2023 on WPV, absenteeism and quitting to find work elsewhere are two consequences of workplace violence on the company or employer. Workplace violence can have negative effects on patient care, such as an impairment in general medical outcome, a delay in non-violent patients' treatment, and mistakes in patient care. (Gillespie and Tamsukhin, 2023)

As expressed in a systemic review of literature, Following a violent incident at work, nurses frequently suffer serious physical and psychological effects. (Martinez, 2016)

Most of health professionals participated expressed being victim of either verbal or physical violence had an effect on their confidence, patient care performance, experience of feeling being disrespected, an injuries which are beyond just a buries.(Hsu et al.,2022)

Differences between individuals exist in the emotional, behavioral, and physical responses to every given circumstance. The severity could be substantial the next time if medical personnel reluctantly address a violent incident as a patient trait. This suggests that the violence is situational but not inevitable, as medical professionals had believed. Post-traumatic stress disorder (PTSD) is the result of a long-term psychological reaction to a brief exposure to a violent incident, which turns into a stressful experience.(Mukhtar et al., 2024)

In another study done in India, The participants acknowledged that their medical decision-making may be influenced by their fear of violence, leading them to treat patients in a way that is less likely to end in violence rather than following medical advice, and they reported a drop in morale as a result of violent incidents.(Davey et al, 2020)

Workplace psychological violence not only leads to psychological fatigue for victims but can also result in adverse outcomes such as depression and anxiety, thereby decreasing job satisfaction. According to resource conservation theory, workplace psychological violence may damage various resources of nursing staff, increase work pressure, and reduce job satisfaction, thus prompting them to take measures to protect their resources, resulting in a tendency to leave. (Al-Qadi, 2021)

Experiencing psychological violence at work can lead to decreased work efficiency, professional burnout, and even resignation due to an unbearable work environment. Ongoing stress and anxiety might also cause physical health problems, reduce employees' quality of life, further deplete their future resources, and ultimately increase the turnover intention among nursing staff. Additionally, lower job satisfaction among clinical nurses correlates with higher turnover intention, consistent with previous findings. Workplace psychological violence threatens the physical and mental health of nursing staff, particularly having significant psychological impacts.

Victims may feel uneasy and anxious, become dissatisfied with their work tasks, and may even make nursing errors or accidents, leading them to consider seeking new career paths.(Luo et al., 2024)

As a study done in pawe werda among HEW, underscore the psychological toll that workplace violence takes on health extension workers, especially when it comes from persons of authority who are supposed to support and protect them. The study also discovered that sexual assault, such as attempted rape and verbal sexual harassment, was a major issue (Gebrie,2021). The supply of health services available to the general public will be limited, resulting in higher healthcare expenses due to resource constraints. Furthermore, if healthcare workers abandon their jobs due to harassment and threats of violence, equal access to basic health care would be compromised, especially in developing countries where the number of healthcare workers is insufficient to meet the population's requirements and aspirations.(Lim M.et al,2022)

2.5 Reporting Workplace Violence In Health Care System

The Occupational Safety and Health Administration (OSHA) standards establish a fundamental requirement for employers to provide workers with a safe and hazard-free workplace environment. This mandate goes beyond merely minimizing physical dangers; it also guarantees employees the right to voice concerns or report injuries without fear of retaliation or discrimination. Ensuring that workers can raise safety issues freely is critical for fostering a culture of transparency and prevention within any organization. (OSHA,2015)

A study conducted in Saudi Arabia across urban and semi-urban tertiary hospitals underscores the urgent need to address workplace violence (WPV) through the implementation of rapid-response systems that facilitate real-time reporting and immediate intervention. Given the high-stress and fast-paced nature of healthcare environments, delayed responses to violent incidents not only endanger healthcare workers but also compromise patient care. To effectively mitigate these risks, healthcare facilities must develop and integrate comprehensive mechanisms that enable swift reporting and timely management of WPV cases. Key components of

such effective rapid-response systems include several practical and user-friendly measures. (.Elsharkawy et al.,2025).

1. 24/7 dedicated violence reporting hotline staffed by trained personnel is essential. This hotline would allow healthcare workers to report incidents at any time, with staff prepared to accurately document the event and promptly initiate institutional response protocols, including notifying security or management teams.
2. Mobile-based reporting applications can empower healthcare workers by providing an accessible and convenient platform to submit reports quickly and discreetly, minimizing disruptions to their clinical duties while ensuring critical information is captured in real time.
3. The appointment of unit-based “safety officers” plays a crucial role in bridging communication between frontline staff and hospital leadership. These officers would have direct access to security teams and administrative leaders, facilitating rapid escalation and resolution of incidents within their specific units.
4. The introduction of streamlined “urgent report” forms that require less than two minutes to complete addresses a common barrier—cumbersome paperwork. By simplifying the reporting process while still allowing options for detailed follow-up, healthcare workers are more likely to report incidents promptly.
5. Adopting a “no wrong door” policy ensures that all reports, regardless of where or how they are submitted—whether through the hotline, mobile app, or direct communication with staff—are consistently logged, reviewed, and acted upon. This policy fosters an inclusive and supportive reporting environment that eliminates confusion or misdirection, which often contribute to under-reporting. Collectively, these interventions respond directly to the frustrations expressed by healthcare workers regarding administrative burdens and slow institutional responses during critical incidents, as highlighted in the study by Elsharkawy et al. (2025).

Workplace violence (WPV) is a common and pervasive issue across healthcare settings worldwide, yet underreporting of such incidents remains a significant barrier to effectively addressing the problem. A cross-sectional study conducted in Saudi Arabia found that more than half of violent episodes experienced by healthcare workers were not reported. The primary reason for this widespread underreporting was the perception that reporting violence would not lead to any meaningful action or change, rendering the process seemingly pointless and discouraging victims from coming forward (Harthi et al., 2020).

In a similar , research carried out in Dire Dawa, Ethiopia, highlighted that over 50% of healthcare workers were unaware of the existence of formal mechanisms for reporting workplace violence. This lack of awareness not only hampers the reporting process but also increases vulnerability, as those unaware of reporting channels were found to be twice as likely to experience incidents of violence compared to their informed counterparts (Legesse et al., 2022). This points to a critical gap in communication and training within healthcare institutions, where staff need to be better informed and empowered to utilize available support systems.

However, normalizing the acceptance of violence within healthcare settings or among healthcare personnel should never be considered an inherent or acceptable aspect of the profession. Several interrelated factors contribute to under-reporting in this context. Healthcare workers often fear stigmatization on both personal and professional levels, worry about the lack of adequate administrative support, and are concerned about being perceived by colleagues as unprofessional or incompetent. Such concerns foster an environment where victims remain silent, despite experiencing violence, because speaking out might negatively impact their reputation or career progression. Mukhtar et al. (2024)

Addressing these barriers requires cultural change within healthcare institutions and stronger protective measures to empower staff to report without fear of judgment or reprisal.own well-being or their reluctance to report in order to prevent the stigmatization of the offender because of illness or disability is another issue that contributes to under-reporting. This issue is rooted in cultural, economic, and political dynamics. Accepting violence among healthcare personnel and in healthcare

institutions shouldn't be viewed as a requirement of employment. concern of being stigmatized both personally and professionally, lack of administrative assistance, and concern of being viewed by peers as unprofessional or as a sign of subpar work are linked factors that keep healthcare professionals from reporting.(Mukhtar et al., 2024)

2.6 Barriers To Reporting

One of the leading reasons emotional abuse remains largely unreported among healthcare workers is the belief that reporting such incidents will not lead to any meaningful change. Additionally, many employees are unaware of the existence of formal reporting mechanisms designed to address workplace violence (Lee et al., 2024).

Compounding this issue, a significant number of healthcare professionals hesitate to report violent incidents due to fear of retaliation from perpetrators—particularly when these individuals are supervisors or colleagues—and due to a lack of trust in the institutional reporting systems. Some also fear that taking action might result in hostility or damaged relationships within the communities they serve (Lim et al., 2022).

Despite the prevalence and severity of workplace violence (WPV) in healthcare settings, underreporting remains a pervasive problem. Several systemic and institutional barriers contribute to this issue, limiting the effectiveness of response mechanisms and allowing a culture of silence to persist. Common management-related barriers include a lack of visible changes following reports, non-supportive administrative environments, and the absence of concrete punitive measures for perpetrators. These factors often signal to healthcare workers that reporting will not lead to meaningful outcomes (Bhattacharjee, 2021).

The inadequacy of organizational support is further exacerbated by poor confidentiality protocols, which diminish trust in the system and discourage potential reporters. Minha and Sahiran (2024)

Observed that healthcare workers often refrain from reporting incidents out of fear that their identity will be exposed, leading to workplace retaliation.This fear is

heightened when perpetrators occupy supervisory or authoritative roles, leaving victims with limited recourse and support. Mohammed et al. (2023)

Cultural and social stigma play a critical role in the underreporting of workplace violence (WPV). In many societies, particularly those with traditional or patriarchal norms, healthcare workers—especially women—often fear that reporting incidents of violence could lead to social repercussions, including victim-blaming and reputational damage. Concerns that such reports may be perceived as a sign of personal weakness or professional incompetence further discourage victims from speaking out. Hsu et al. (2022)

Another study highlighted that these anxieties exert a paralyzing effect, leading many nurses to silently endure emotional abuse or intimidation rather than risk being labeled as unsuitable for high-pressure clinical environments. This fear is compounded by the widespread lack of institutional mechanisms that ensure protection or support for those who report violence. Elsharkawy et al. (2025)

The absence of formal guarantees and psychological safety discourages healthcare workers from pursuing justice, thereby perpetuating a culture of silence. In the healthcare sector, the perception of violence as part of employment norms contributes to underreporting of workplace violence. Incidents are not considered 'violence' if no physical hurt is sustained. (Minha & Sahiran, 2024)

Lengthy and complicated reporting systems, combined with bureaucratic hurdles, often discourage victims of workplace violence from coming forward. When the process to report an incident is unclear, time-consuming, or involves excessive paperwork, healthcare workers may feel overwhelmed or frustrated. This complexity can make reporting seem impractical or even futile, especially when victims fear that their complaints will get lost in administrative delays or ignored by management. Consequently, these cumbersome procedures contribute significantly to the persistent problem of underreporting, leaving many incidents unaddressed and allowing workplace violence to continue unchecked (Lombardi et al., 2024).

2.7. Conceptual framework of work

The categories that emerged from the integrative literature review phases of this study were emerged to develop the following conceptual framework. The assumption is based on health extension workers are exposed to a wide range of work place violence related to their working condition that has a negative effect on both professional and psychological effect on them which has an interfering effect on the performance of the HEWs.

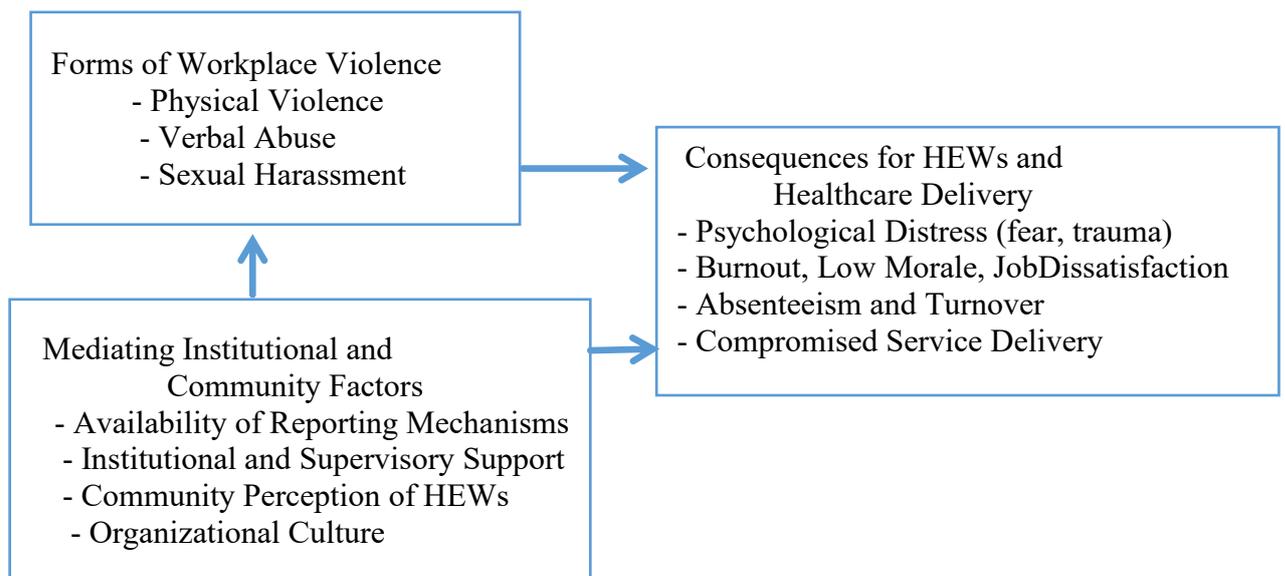


Figure 1 conceptual framework for workplace violence against HEW

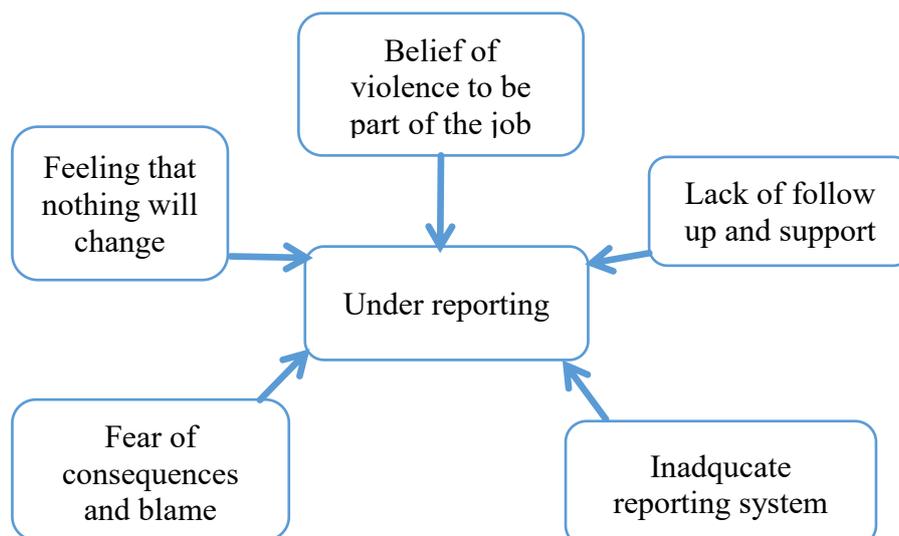


Figure 2- Adopted and modified conceptual From of barrier to reporting workplace violence (Schulz-Quach et al., 2025)

CHAPTER THREE

METHODOLOGY

3.1. Study Area

Kolfe keraniyo is a one of 11 sub-cities found in the capital city of Ethiopia, Addis Ababa. The subcity is located in the western suburb of the city. It borders the districts of Gullele, Addis Ketema, Lideta and Nifas Silk-Lafto. The specific study area was be at governmental health centers. There are 7 health centers under the governance of this sub-city and each health centers has there own health extension workers, that are assigned to each ketena. Each werda under this subscity has two HEW who are responsible in shaping the society to be model household by imparting health knowledge such as Hygiene and environmental sanitation; disease prevention and control; family health services; and health education and communication. However, due to the importance of preventive and promotive health services for pastoral and urban communities too, the HEW's fundamental tenet is to empower individual homes to take charge of and manage their own health. and abilities to homes. Seventy-five percent of health extension workers' time is spent conducting community outreach and visiting people in their homes. Finding households to act as role models is the first step in the house-to-house activity. Since their work environment fluctuate day to day as the move village in the process of transferring and teach the villagers vital knowledge due to the norm difference of the village and other different reason the may face a challenge or rejection.

3.2. Research Design

In studying violence against healthcare workers, phenomenological study designs was employed. This design is particularly valuable for gaining insights into people's motivations, actions, and for cutting through taken for granted assumptions and conventional wisdom. The aim of phenomenological research is to arrive at phenomenal understandings and insights into the meaning of lived experience. These insights should be "impressively unique" and "primordially meaningful", illuminating the specific experience being studied. Phenomenological research attempts to uncover the meaning in lived experiences that are often overlooked in daily life. In other words,

phenomenology asks the basic question “What is this (primal) experience is like?”. (McLeod, 2024)

Social scientists frequently use phenomenological research in an attempt to gain a deeper understanding of the individuals they are studying. This approach is very good at highlighting people's experiences and viewpoints from their own points of view. (Greening, 2019)

Moreover it contribute for the purpose of breaking assumptions. This approach is suitable for enabling the researcher to examine the phenomena through a professional lens with the goal of finding significant answers. There for it was found to be best suited for this study. It is also particularly valuable in social work research, as it highlights individual stories and provides a platform for marginalized voices. Data collected through phenomenological methods was analyzed to identify common themes, patterns, and insights that contribute to a deeper understanding of workplace violence in the healthcare sector. This design was suitable for a thorough examination of the unique circumstances of challenges the HEW may face.

In phenomenology, the researcher's goal is to achieve transcendental subjectivity, described as a state where ‘the impact of the researcher on the inquiry is constantly assessed and biases and preconceptions neutralized, so that they do not influence the object of study’. This state can be achieved through phenomenological reduction that is facilitated by epoche (the process of bracketing). Bracketing requires researchers to hold off one's ideas in abeyance or bracket off assumptions, past knowledge and understanding of a phenomenon Various types of bracketing such as ideal, descriptive, existential, analytic, reflexive and pragmatic bracketing. (Shorey,2022)

3.3. Research Approach

This study employed a qualitative research design, as it enables researchers to encompass the perspectives of the problems from the affected parties and enables researchers to develop a comprehensive and deep understanding of the issue under the study, moreover it gives chance to modify study participants or data collection site till an adequate data is collected. (Creswell, 2018) since it's flexible on participant

modification possibility of overcoming information gaps arising from a sudden drop out of participants.

3.4. Population Of The Study

The study was conducted at Kolfe keraniyo sub-cities there are 7 health centers under the governance of this sub-city and each health centers has there own health care workers. A total population of 34 HEW are currently working under the 7 health centers, which are included in the study.

3.5. Sampling Method

Purposive sampling was utilized to identify participants. This method is ideal for enrolling participants to get those who have specific knowledge and experiences relevant to the research topic workplace violence in the healthcare sector. The researcher deliberately enrolled 5 health extension workers who have relevant experience, ensuring that the study captures a wide range of perspectives on workplace violence.

3.5.1. Inclusion criteria

- Health extension workers found in the health center found in kolfe keraniyo sub-City
- HEW who are willing to be interviewed

3.5.2. Exclusion criteria

- HEW, that are unwilling to participate
- HEW,who are on annual leave

3.5.3. Sampling Size Determination

Determining the appropriate number of participants in qualitative research isn't a straightforward task. It depends on multiple factors, including practical limitations, research design. Experts in the field suggest that an ideal sample size allows for a deep and detailed exploration of the subject while remaining manageable enough for in-depth, case-specific analysis. When each participant provides meaningful, rich data, fewer individuals may be needed overall. Additionally, the order and format of questions used in interviews can influence the depth of responses, with later, more

open-ended questions often yielding more insightful data. One key concept used to guide sample size in qualitative studies is "saturation"—the point at which no new information is being discovered from additional participants. In practice, individuals are chosen based on their relevant experience, and once the information becomes repetitive and no new insights emerge, the data is considered saturated, indicating it is appropriate to conclude data collection. In this study participants were Health extension workers working in the health center of Kolfe Keraniyo sub-city. In order to gather enough data the researcher collected information through in-depth interviews and reached saturation on 5 of the HEW who work under the sub-city.

3.5.4. Sampling Techniques

The study used a Purposive sampling to identify participants. The selection process began by identifying health extension workers currently employed at the seven health centers in Kolfe Keraniyo Sub-City. The researcher collaborated with health center administrators to identify eligible workers and explain the purpose of the study to potential participants. Then the researcher ceased enrolling participants after 5th participant data saturation level was reached. Participants included based on their willingness and availability to share their experiences.

3.6. Data Collection Tool

Primary Data

An In-depth interview was conducted with a subset of participants who consent to share their experiences with workplace violence. The interviews follow an open-ended question format, allowing for flexibility in exploring specific themes such as personal experiences of violence, barriers to reporting incidents, and perceived support from management and peers. Interviews were audio-recorded with participants' consent and transcribed for analysis. According to Rutledge, & Jerri an in-depth interview is best suitable in gathering a qualitative information, due to its conversational style, which makes follow-up and clarification easier, it builds rapport. The conversational style gives the participant the flexibility to add whatever they think is significant. The interviewer can detect tonal characteristics and physical

symptoms during in-depth interviews, which are flexible and easily adjusted to the participant's responses.(Rutledge, & Jerri 2020)

Interviews are used to gain insights into a person's subjective experiences or opinions. Qualitative interviews have the benefit of being participatory, which enables the researcher to address unexpected issues as they arise. By nature, written surveys can only measure what is known or presumed to be relevant to the researcher; this can also assist overcome a provider- or researcher-centered bias.(Busetto,2020)

Secondary Data

Document analysis is a systematic procedure for reviewing or evaluating documents both printed and electronic (computer-based and Internet-transmitted) material. Like other analytic methods in qualitative research, document analysis requires that data be examined and interpreted in order to elicit meaning, gain understanding, and develop empirical knowledge. It covered research reports, articles, journals and other relevant literature to solidify the data gathered through interview.

3.7. Data Collection Procedure

This qualitative research study relied on primary and secondary source of data. All the data collection tools that were prepared in English were translated to Amharic. The primary data covered an in-depth interview to capture challenges or stories of obstetric fistula survivors. For primary data collection participants were selected purposely and informed consent was taken from each participant then upon the participants approval an interview done with each of the participants were recorded. Secondary data covered research reports, articles, journals and other relevant literature carefully reviewed for triangulation purpose.

3.8. Data Analysis

Thematic analysis was used to analyze the qualitative data collected from the interviews. This method involves identifying, analyzing, and reporting patterns (themes) within the data. The analysis process began after the interviews' notes and recordings were all verbatim transcribed then analysis proceed with data

familiarization, where the researcher will read and re-read the transcripts to gain a comprehensive understanding of the content. Initial codes were generated to categorize significant pieces of information.

Initially 20 codes were synthesized then they were grouped into six core themes, each representing a central aspect of the phenomenon under investigation. Within these main themes, reflecting more specific dimensions of the participants' experiences. The final thematic structure captures the nature of the violence faced by HEWs, its emotional and professional effects, and the institutional challenges surrounding response and reporting. This approach ensured that the findings remained grounded in the data while offering a structured interpretation aligned with the study objectives.

3.9. Trustworthiness

The researcher ensured that the participants' personal information does not get disclosed to a third party . A bias in the research was dealt by "bracketing out" said that researcher must bracket off their own preconceptions and experiences in order to accurately depict how participants see and feel the phenomena and refute early categorization. Further more to maximize the trustworthiness of the study and to avoid respondent biases the researcher developed a good rapport with the participants and explain the purpose of the study genuinely. Equal opportunities was also given to gather data with different views.

Ensuring trustworthiness in qualitative research is essential to establish the rigor, reliability, and authenticity of the findings. This study followed established criteria for trustworthiness: credibility, transferability, dependability, and confirmability—to ensure that the research accurately represents the lived experiences of Health Extension Workers and can be considered valid within the context of social work and public health.

Credibility

Credibility refers to the confidence in the truth of the data and the interpretations made from it. To ensure credibility, data were collected through in-depth interviews with HEWs who had firsthand experience with workplace violence. Participants were

selected purposively to capture a range of perspectives across different work units and neighborhoods in Kolfe Keraniyo Sub-City. Probing questions were used during interviews to obtain deeper insights.

Transferability

Transferability refers to the extent to which the findings can be applied to other settings or groups. While the study is context-specific, rich and detailed descriptions of the setting, participant characteristics, and research procedures have been provided to enable readers to assess the relevance of the findings to other contexts. By presenting direct quotes from participants and elaborating on the social and institutional environment in which the HEWs operate, the research allows others to judge the applicability of the findings to similar urban settings in Ethiopia or elsewhere.

Dependability

Dependability refers to the consistency and repeatability of the research process. To ensure dependability, a detailed explanation of the research design, data collection tools, and analysis procedures was documented. Additionally, an audit trail was maintained, outlining the steps followed during the study, decisions made during the coding process, and how emerging themes were developed. This transparency allows other researchers to follow the methodology and evaluate the stability of the findings over time.

Confirmability

Confirmability ensures that the findings are shaped by the participants' responses and not by researcher biases or motivations. To achieve this, the researcher practiced reflexivity by keeping field notes and reflecting on personal assumptions throughout the data collection and analysis phases. Triangulation was also used by comparing data across participants and checking the consistency of emerging patterns. Direct quotations from participants were included to support interpretations, ensuring that the voices of the HEWs were central in drawing conclusions.

3.10.Ethical consideration

Ethical approval was sought from the health institutional review board prior to data collection. Informed consent was obtained from all participants, ensuring they understand the purpose of the study, their right to withdraw at any time without penalty, and how their data would be used. Confidentiality was maintained by anonymizing responses and securely storing data.

CHAPTER FOUR

Data Presentation And Interpretation

4.1. Demographic Data Of Participants

This chapter presents a comprehensive account of the findings that were derived from the in depth interviews conducted with Health Extension Workers (HEWs) who work in Kolfe Keraniyo Sub-City. The goal was to explore their experience with various forms of workplace violence, the psychological as well as professional impacts such incidents had on them, and the institutional facility for reporting. The qualitative data gathered from open-ended interviews were analyzed thematically and the predominant themes were discussed thoroughly.

Table 1: Demographic information of participants

No	Participants	sex	Age	Work experience
1.	Participant 1	female	30	5 years
2.	Participant 2	female	25	3 years and 6 month
3.	Participant 3	female	27	4 years
4.	Participant 4	female	34	7 years
5.	Participant 5	female	22	2 years

Source: interview

The table above presents the demographic characteristics of the five participants involved in the study. All participants are female urban Health Extension Workers (HEWs), which reflects the gender composition commonly observed in this profession in Ethiopia. The ages of the participants range from 22 to 34 years, indicating a relatively young workforce. Participant 5 is the youngest at 22 years old, while Participant 4 is the oldest at 34. In terms of work experience, the participants have varying lengths of service, ranging from 2 years to 7 years. Participant 4, with 7 years of experience, is the most senior among the group, suggesting a deeper exposure to workplace realities, while Participant 5, with only 2 years of service, represents the relatively newer cadre of HEWs. These variations in age and professional experience offer a diverse range of insights and perspectives on workplace violence and its impact. The mix of younger and more experienced workers allows for a more comprehensive understanding of both the short-term and long-term effects of occupational challenges within urban health extension services.

4.2. Analysis of Qualitative Data

From the analysis of the in depth interview conducted on the experience of workplace violence at kolfe keranyo HEW, predominant themes emerged were verbal and physical violence, psychological intimidation, emotional impact, and reporting challenges. The other themes developed were job dissatisfaction and low morale under the interview conducted on effect of workplace violence on HEW and finally reporting mechanism and institutional response was also discussed. This chapter explores these themes and uses direct quotes from the participants as a means of retaining the originality of their accounts and answers the research question of this studies.

4.2.1. Experience Of Workplace Violence At Kolfe Keranyo HEW

Theme 1: Verbal violence

Verbal violence was the major form of workplace violence that the HEWs interviewed have experienced. The participants elicited that they are verbally abused by members of the communities they visit for outreach activities or when they are

stationed at health centers. The abuse primarily occurs in the form of insults, derogatory remarks, and abusive language even when the HEWs are just trying to provide assistance or deliver health services

Participant 3 stated demonstrated this:

“on one of afternoon on my duty in our health center, a man client approached me and asked for some information and I directed him to the right place to get the right information yet in return he said that I was useless.”

This reflects the type of hostility that most HEWs have to face on a daily basis. What was so painful about these experiences was that at times the verbal abuse came from individuals who were admired or respected. The respondents indicated that they were more emotionally upset and less inclined to perform their job to the same level by verbal abuse from individuals whom they previously held in high regard.

participant 2 stated:

"A man I recognized from a television show visited our health center. For reasons I couldn't understand, he suddenly insulted us, shouting 'You son of a bitch!' Although we're used to name-calling, hearing such harsh words from someone we admired really hurt."

As the participants said insulting was not uncommon for them as it has become apart of their duty to be insulted but when they hear such bad words from people they did not expect, sometime it cause them a discouragement.

HEWs also expressed that working in urban neighborhoods exposed them to adolescent groups or gangs who typically harass them verbally. Working in condominium compound or densely populated areas, the HEWs reported having frequent encounters with youth under the influence of drugs. For instance

Participant 1 stated:

“when work in a group housing compounds (condominium) most of the time we meet a group of gangs who are addicts, usually they attack us with many offensive words that I don`t want to mention it with my own mouth.”

These repeated verbal attacks not only inflict emotional damage but also degrade the professional integrity and purpose of the HEWs. They are vulnerable, unprotected, and demoralized by the lack of respect for their role by the community

Theme 2: Physical violence/ attack

The other kind listed was physical attack since the health extension workers are front line and in direct communication with the community they are at a high rate of exposure to harassment. Mostly the work of health extension worker is done house to house visit.

Working in a group makes the occurrence of violence less and gives a sense of confidence to perform freely with out feeling of uncertainty of violent incidence occurrence. Even if moving in a team gives sense of safety due to scarcity of the professional available to reach out all of the locations and community in their catchment area. Due to this kind of condition the community either feels powerful to practice violence against HEW/CHW or lack of awareness/ misconception of role of the HEW violet incidences are remarkably usual.

This was illustrated well by participant 5 who stated:

“ while I was out for our field work to collect data we decided to do the task separately thinking we would finish the task quickly, then as I approach one house to fill data the man who open the door instructed and forced me to hand him my engagement ring.”

Even if these HEW are working for the good of the society majority of the community either did not accept the fact or for some other reason they are not willing to welcome the HEW. The other form of physical aggression witnessed was that of violent behavior on the part of household members. A HEW remembered an incident where a

door was slammed in her face by a male resident who referred to her and her colleague as thieves;(participant 2)

“I remember on one of home to home visit, while my colleague and I were chatting with the house wife, the husband rushed us to the gate and he slammed the door on our face accusing us to be a thief.”

These kinds of confrontations not only present a physical threat but also breed fear and reluctance to engage deeply with households in the future. In other cases, violence came indirectly. Some part of the society consider as a joke or they act recklessly.

Participant 3 stated:

“I will never forget what happened at one of the catchment area after they let us in and we started explaining the aim of our visit. The client let their dog out to chased us away, after that day I prefer to work in area where dogs are not available.”

These incidents show that physical violence and threats are not random acts but structural dangers inherent in the day-to-day work of HEWs.

Theme 3: Psychological intimidation

The other type of WPV is psychological intimidation which is posed on the health extension workers while doing their field work/ visit. Such violence may encompass threats, coercion, and manipulation and can create an atmosphere of fear and anxiety. Some respondents conveyed feelings of emotional security and mental insecurity in the event of GBV incidences. One of the most compelling stories was that of an HEW who attempted to intervene in a domestic violence situation.

Participant 4 *“ I witnessed a gender based violence on one of my home visit in the neighbourhood of our health center and I tried to help yet the man warned me to keep quite and disappear. I tried to report to women and child affair but I was unable to proceed reporting after I received a warning assuring*

that he will harm my family then I chose silence since I got no help from no one. Even if I felt bad for the girl I was in no position to help her while putting my self and my family at risk. After this incidence I felt powerless for a longer period of time and I was anxious that it consumed my energy ”

She explained that the fear she felt went on for several months and impacted her private and public life. She explained a situation of constant anxiety, low energy, and an overall feeling of powerlessness that persisted well after the event.

Working as a health care professional, one has to be presented with confidence and make thousands of critical thinking and decision in order to provide or solve problem of the client, yet in a condition of compromised work space where the professionals are deprived of their freedom and right poor quality of service gets provided beside it force the professionals to question their worth. Some incidence force you to think that you are acting out of your way.

participant 1 stated:

"There was a family who refused vaccination yet claimed it was my fault. They accused me of being disrespectful and discriminatory in order to get out of the program. "I felt gaslighted."

These experiences illustrate how psychological bullying results in long-term emotional strain, creates self-doubt, and reduces a HEW's faith in undertaking tasks. The emotional effect contributes to creating work dissatisfaction and poor performance over time.

4.2.2. Effect Of Workplace Violence On HEW

The participants' feedback clearly showed the cumulative impact of frequent exposure to physical, verbal, and psychological abuse. Most HEWs reported experiencing feelings of emotional exhaustion, fear, burnout, job dissatisfaction and low morale, all of which have a direct negative impact on their motivation and productivity at work.

Theme 1: Job dissatisfaction

The most significant effect of workplace violence on HEW identified by interview participants were mostly those related with job dissatisfaction. participants 3 stated as:

“I feel unappreciated. We are doing one of the most important jobs, but the way we are treated makes it feel like we don’t matter.”

participant 1 stated that even if she liked her profession and she also believed that it her calling some incidences sparks feeling of hesitation on outreach sessions.

“I sometimes wonder why I even keep working at this job. We, Health extension workers, attempt to help individuals every day, but we get rejected, humiliated, and occasionally attacked. It makes me think twice before knocking on someone's door.”

Participant 4 who is a senior HEW with years of experience acknowledged that she was on the verge of quitting the field. with several years of experience in the field, expressed deep emotional exhaustion and professional dissatisfaction stemming from the continuous exposure to workplace violence and systemic neglect.

“To be honest, I would resign if I had another choice. Serving the community has become less important to this work than just getting by each day. Being frequently on guard makes it impossible to work with affection.”

Her experience highlights the psychological strain and the gradual erosion of professional passion that occurs when workers are left to navigate hostile environments with minimal support or recognition. This also underscores the urgency of addressing workplace safety and emotional resilience in urban healthcare settings.

Theme 2: Low Morale of work

As participants (2 and 5) stated a repetition of unwelcoming threats of the community makes them less engaged on health package implementation and supervision

“Before, I used to greet everyone with a smile and spend time talking during visits. Now all I want is to do the work swiftly and depart. I do not feel safe. I avoid some spots completely if I've had a bad experience there before.”

HEWs shared how they had altered their work behaviors to protect themselves emotionally and physically. participant 2 started avoiding certain neighborhoods where violence was more common, while others rushed through their home visits to minimize interaction. Either after encountering or hearing a scaring incidence from coworkers

“There are some places we avoid to go with my coworkers after one of our friend told us what she faced while working in that area. Even there was some guy we avoid ”

If a violent incidence bothering them is not addressed, will inevitably result in turnover rates and the loss of excellent professionals. As workplace violence spawns an unseen wound that appears as burnout, disengagement, and ultimately, a pull-out from the profession weakening the healthcare system's strength in the long run.

4.2.3. Lack Of Reporting Mechanism And Institutional Response

When asked about formal reporting systems or institutional support mechanisms, the responses of HEWs revealed an alarming lack of institutional reporting mechanisms and a culture of silence surrounding workplace violence. participants were unaware of any formal procedures for reporting abuse, and even those who tried to report received little or no support.

When asked why they don't report such incidences

Participant 4: *“I have never heard of such thing I mean reporting incidences. When we face a difficulty we either discuss the matter with our friend or coworkers and through time things mostly got forgotten.”*

Another respondent who was a victim of psychological intimidation said that

Participant 5 *“Once, I tried to disclose a physical threat to my supervisor. They listened, but nothing happened. There is no follow-up or support, only silence.”*

This lack of institutional responsiveness promotes a culture of silence in which HEWs feel unheard and discouraged from speaking out. Without formal reporting standards or accountable structures, workplace violence becomes normal, forcing victims to deal with the impact alone.

Participant 2 *“Even if I wanted to report it, I'm scared of being seen as weak or incapable. I believe that we are expected to tolerate such things.”*

The oath health professionals make at the time of graduating to not harm their client/patients while serving has put a pressure to believe violent incidences to be a part of the work therefore reporting is for the weak and the have already believed reporting make them to be seen as incompetent for the position they hold. Another respondent replied that circumstance regarding reporting incidences has made her believe that reporting is for the weak

Participant 1 *“There's always this unspoken rule that if you can't ‘manage the field,’ you might not be strong enough to do this job.”*

When personal experience of unfavourable incidence are left unsaid the chain of violence can't be cut, managed or prevented. This enhances normalization of violence as part of the work. Respondents wish for the establishment of a feasible reporting means that is functional and capable of providing solution.

Participant 3 *“There is a need for an official framework to report violence to get protection. Otherwise, nothing will change.”*

When an accessible, reliable and responsive party exist or is establish the professionals will be confident believing their institution/ agency has their back and provide to their best performance plus culture of being seen as weak for reporting violent incidence can be broken. Otherwise without proper reporting facility violent

incidences will be hidden whether the cause harm or not and force the professionals believed they are unheard and unsupported as it has been doing.

Participants believe even when a feasible and effective solution aren't given, expressing an unfavorable incidences and discussing a concern regarding violent or aggressive behaviour of their client can ease the burden of feeling uncertain about what will happen at the field work. They currently rely either on chatting with colleague and their beloved ones or leaving what happen a side.

4.3. Discussion

Workplace Violence Experience Of Hew

The study showed that verbal violence was the most frequently reported form of workplace violence among HEWs in Kolfe Keranyo Sub-City. Participants shared experiences of being insulted, humiliated, and disrespected during both facility-based and home-to-home services. Such findings are consistent with literature from Bekalu and Wudu (2023), which identified verbal abuse as the most prevalent form of violence in healthcare settings.

Physical violence, though less frequent, was also reported, particularly during community outreach visits. Incidents ranged from attempted robbery to being attacked by community members or their pets. These findings align with Martinez (2016), who noted that frontline health workers in uncontrolled environments are particularly susceptible to physical aggression.

Psychological intimidation, including threats and coercion, emerged as another significant theme. One alarming instance involved a participant who was threatened after attempting to intervene in a gender-based violence case. This finding supports Adhikari et al. (2024), who emphasized that psychological violence can create a prolonged sense of fear and vulnerability, leading to chronic stress.

These various forms of violence reflect a complex interplay of societal disrespect, lack of awareness about HEWs' roles, and inadequate institutional protection.

respondents also illustrate that violence against HEWs is not limited to a single domain but occurs in both community and institutional contexts.

Effect On Psychological Health And Job Satisfaction

The cumulative effect of workplace violence on the mental well-being and job satisfaction of HEWs was substantial. Respondents reported emotional exhaustion, burnout, fear, and low morale. Some questioned their career choices or expressed a desire to leave the profession altogether. This is consistent with Al-Qadi (2021), who noted that WPV can significantly undermine healthcare workers' confidence, emotional stability, and willingness to remain in their roles.

The emotional toll of repeated rejection, humiliation, and safety threats was reflected in participants' hesitance to engage deeply with clients. This sense of helplessness and alienation from the community they serve illustrates the far-reaching consequences of WPV, including reduced motivation, disrupted service delivery, and strained provider-client relationships.

Participants also reported behavioral changes, such as avoiding certain neighborhoods, minimizing community interaction, and rushing through visits. This corroborates findings by Davey et al. (2020), who suggested that fear of violence can influence clinical decision-making and reduce the quality of patient care.

Effectiveness Of Reporting Mechanisms

The study uncovered a lack of structured, accessible, and effective reporting systems within the health centers of Kolfe Keranyo. Most participants either did not report incidents or relied on informal coping strategies such as peer support or silence. Some feared being perceived as weak, while others viewed reporting as futile due to the absence of institutional response. These findings align with Mukhtar et al. (2024), who identified stigma, fear of retaliation, and weak organizational response as major barriers to reporting WPV.

One participant who reported a threat received no follow-up or protection, reinforcing a culture of institutional silence and inaction. The normalization of violence and the

absence of accountability mechanisms further discourage victims from seeking redress.

The desire among HEWs for a formal and functional reporting framework was unanimous. Participants stressed the need for structured processes, immediate institutional support, and protective measures. This call echoes recommendations from Bhattacharjee (2021), who emphasized the role of organizational interventions in creating a safer work environment.

Social Work Implications

The findings highlight a cyclical relationship between exposure to violence, emotional distress, and poor institutional response. This cycle perpetuates a hostile work environment that undermines both HEWs' well-being and the efficacy of health interventions in the community. From a social work perspective, these findings underscore the urgency of advocating for vulnerable frontline workers. The invisibility of HEWs in the broader WPV discourse and their systemic neglect demand targeted policy reforms, capacity-building, and community sensitization.

Social workers have a critical role in designing intervention programs that address both institutional gaps like reporting frameworks and protective policies and individual needs (such as counseling, trauma recovery). There is also a need for collaborative advocacy to recognize HEWs as essential professionals deserving of dignity, safety, and institutional backing.

CHAPTER FIVE

CONCLUSION AND RECOMMENDATION

5.1. Conclusion

To summarize, this study explored the experiences of urban Health Extension Workers (HEWs) in Kolfe Keranyo Sub-City with various forms of workplace violence (WPV), the psychological and professional effect of such incidents, and the existing gaps in institutional reporting mechanisms. The findings revealed that verbal abuse, physical assault and psychological intimidation were the most form of violence encountered by the interviewees and the perpetrator were the community members in the catchment area of the health center where the HEW provide service . These experiences are not isolated but occur regularly during both community outreach and facility-based work, exposing HEWs to significant emotional, physical, and mental harm.

The cumulative effect of repeated violence has resulted in emotional exhaustion, fear, low morale, and widespread job dissatisfaction among HEWs. Participants reported feeling unappreciated, demotivated, and, in some cases, driven to the point of reconsidering their career paths. The psychological toll not only affects individual well-being but also undermines the quality of health services delivered to communities, as professionals become reluctant to fully engage or avoid certain areas perceived as unsafe.

A critical issue emerging from the research is the absence of effective and reliable institutional reporting systems. There were, HEWs that felt unsupported and unheard, and opted for silence or informal peer conversations rather than formal reporting. This lack of institutional responsiveness not only perpetuates a culture of silence but also normalizes violence as an expected part of the job.

In light of these findings, there is an urgent need for targeted interventions at both institutional and community levels. Institutions must develop and implement robust, confidential, and responsive reporting mechanisms while ensuring that HEWs receive

psychological support, legal protection, and acknowledgment for their work. At the community level, awareness campaigns are needed to foster respect for the role of HEWs and reduce the stigma or misconceptions surrounding their work.

Ultimately, ensuring the safety and dignity of front line health workers is not just an occupational concern but a public health priority. Addressing workplace violence is essential to sustaining a motivated, resilient, and effective workforce that can serve the community with the dedication and empathy that the role demands.

5.2. Recommendation

Recommendation for the health center

1. Capacity Building and Safety Training of HEWs

HEWs should be regularly trained on personal safety, conflict management, and violence de-escalation techniques. This will better prepare them to deal with difficult situations while interacting with the community or visiting homes. Capacity-building sessions can also include assertive communication techniques, self-defense, and how to document and report incidents correctly.

2. To create safe and secured working environment for health care workers.

Creating a safe and secure working environment for healthcare workers is essential to ensure the delivery of quality health services and to protect the physical and psychological well-being of those on the front lines. It is imperative that government institutions, healthcare administrators, and community leaders collaborate in developing and enforcing policies that promote zero tolerance toward violence in healthcare settings. This includes implementing clear reporting mechanisms, providing adequate security personnel, and offering regular training on conflict resolution and de-escalation strategies. Furthermore, establishing a supportive workplace culture where workers feel valued, heard, and protected can significantly reduce the incidence of violence and foster a more resilient and motivated workforce. Ensuring the safety of healthcare workers is not just a labor issue, it is a public health priority that directly influences the quality and continuity of care provided to communities.

3. To create suitable and confidential form of reporting mechanism for WPV.

Among the most urgent suggestions for action is instituting an official, available, and confidential system for reporting workplace violence incidents. Institutions should design standardized protocols where HEWs can safely report cases of verbal abuse, physical attack, or psychological intimidation without fear of retaliations or judgment. The mechanisms should include anonymous reporting segments, clear documentation, and responsible personnel to follow up. The reporting mechanism should also include feedback and accountability mechanisms so that HEWs feel heard and their voices are responded to. Having this system in place will not only reduce under reporting but also enable institutions to identify trends and respond in a preemptive way.

Recommendation for social work policy

1. To Strengthen Legal and Policy Frameworks on WPV issues

At the policy level, Ministry of health should work with ministry of labor force to formulate and enforce laws and regulations that protect healthcare workers from violence. There should be legal consequences for individuals who harass, assault, or threaten healthcare professionals. Furthermore, institutional policies should include zero-tolerance statements on workplace violence, as well as clear disciplinary actions for offenders. These frameworks should also promote gender-sensitive protections, given that many HEWs are women and may face gender-based violence specifically.

Recommendation for social work practice

1. To set up counseling services with psycho-social support.

Because workplace violence takes such an emotional and psychological toll on HEWs, there is a dire need for institutionalized psycho-social support services. All HEWs, especially those who have encountered traumatic events in the field, need to have access to mental health counseling. These services can be either offered through health centers via trained staff or by liaising with social workers and mental health agencies.

2. Organize Community Awareness and Outreach Campaigns

A majority of the violence is due to misunderstandings, mistrust, or lack of knowledge by the communities regarding their roles. In order to fill this gap, there need to be community sensitization campaigns to promote the role and importance of HEWs. Health offices, local administration, and social workers can collaborate in harmony to facilitate communication between HEWs and the community members, debunk myths, and foster respect for one another. These messages can be communicated through town hall meetings, radio debates, posters, and community leaders.

3. Incorporate Social Work Services into Health Institutions.

Social workers have a key role to play in advocating for vulnerable populations, such as front line health workers. Professional social work services are suggested to employ in healthcare organizations in order to assist health extension workers who experience workplace violence. Social workers are trained to give counseling, guide through reporting mechanisms, serve as mediators in conflicts, and advocate for structural changes. Social workers can also conduct workplace evaluations and be engaged in planning interventions that aim at workers' well-being.

Recommendation for Future Research Direction

1. Due to its qualitative and localized nature, the findings may not fully capture the scope and variation of workplace violence experienced by HEWs in other sub-cities or regions. Future studies could employ a larger, more diverse sample across multiple geographic areas to enhance generalization. In addition, mixed-methods or longitudinal research could better.
2. Further exploration of the perspectives of supervisors, community members, and policymakers would also deepen understanding and support more comprehensive, systemic interventions. Such research is essential for informing national policy, institutional reform, and the design of effective support systems that protect front-line healthcare workers.

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Appendix

ST. MARY'S UNIVERSITY
SCHOOL OF GRADUATE STUDIES
MASTERS OF SOCIAL WORK

My name is Thitina Abebe, and I am conducting a research on "Workplace Violence Against Healthcare Workers: The Case of Urban Health Extension Workers in Kolfe Keraniyo Sub-City, Addis Ababa, Ethiopia." to pursue Master degree of social work. If you are willing, I would like to have an interview with you.

The interview will last approximately 30-45 minutes, during which you will discuss your experiences with workplace violence, its impact on your professional and personal well-being, and your perspectives on reporting mechanisms and possible solutions. With your permission, the interview may be recorded for accuracy in data collection and analysis.

All information you provide will be kept strictly confidential, and no personally identifiable details will be included in the final research report. There are no foreseeable physical risks, but discussing workplace violence may bring emotional discomfort, and you are free to pause or stop the interview at any time.

If you have read and understood the information provided, please sign below to indicate your voluntary participation.

Participant's Signature: _____

Date: _____

Thank you for your participation!

Appendix

Section-1 Demographic Data

Age _____

Sex _____

Work experience _____

Section-2 Types of Workplace Violence Experienced by HEWs

1. Have you ever experienced or witnessed workplace violence? If yes, can you describe the incident(s)?
2. What forms of workplace violence have you encountered? (Physical, verbal, psychological, sexual harassment, etc.)
3. In your experience, who are the most common perpetrators of workplace violence? (Patients, family members, colleagues, supervisors, community members, etc.)
4. Do certain situations or environments make you feel more vulnerable to workplace violence? If so, can you describe them?

Section-3 Effects of Workplace Violence

1. How has experiencing workplace violence affected your mental and emotional well-being?
2. Have these experiences influenced your confidence and ability to perform your job effectively?
3. Have you noticed any impact on your relationships with client and community members due to workplace violence?
4. Have you ever considered leaving your job as a result of workplace violence? If so, what factors contributed to this thought?

Section-4 Existing Reporting Mechanisms and Their Effectiveness

1. Are you aware of any formal mechanisms for reporting workplace violence in your institution?

2. Have you ever reported an incident of workplace violence? If yes, what was the response from your supervisors or institution?
3. What challenges or barriers do you face when trying to report workplace violence?
4. How effective do you believe the current reporting mechanisms are in addressing incidents of workplace violence?
5. What improvements do you think should be made to the reporting process?
6. What measures do you think should be implemented to prevent workplace violence against HEWs? Or What additional support or training would help HEWs handle workplace violence more effectively?
7. If you have any additional information that you haven't mention in the previous section or you want to add to this section please feel free to add

Thank you for your time and insights. Your contributions are invaluable to this study.