WORKPLACE VIOLENCE AMONG PRIMARY HEALTH CARE NURSES IN MOLEMOLE SUB-DISTRICT, SOUTH AFRICA.

BY

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DECLARATION

I, Bele Aluwani Allon, hereby declare that the research report titled "***Workplace violence among primary health care nurses in Molemole sub-district, South Africa"*** conducted by me, has not been submitted previously for the degree of this or any degree at any other university, that is my own work in design and in execution, and all reference had been duly acknowledged.

Signature  Date: 03/08/2020

DEDICATION

This dissertation is dedicated to my kids Faresa, Vhugalahawe, and Wavhuthu Bele and my mother Julia Bele, thank you for bringing out the best in me and giving me the purpose to become a better person each day.

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I would like to thank all the primary health care nurses in the Molemole sub-district who participated in this study and warmly welcomed me in their daily activities. I would like to thank them for always welcoming us and thanks for their willingness to participate. They made it easier to cope with the challenges of doing this research. The work that they do is inspiring and challenges us to keep finding ways of improving their health and working conditions. I hope this study contributes to that aim.

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ABSTRACT

Work Place Violence against nurses is a serious and problematic phenomenon all over the world. PHC facilities are meant to provide health services, a safe and secure environment for both patients and nurses. However, many incidences of workplace violence against nurses have been reported and are continuously being reported in both developed and developing countries. Most violence is perpetrated by patients and visitors. In addition to that, the categories of health workers most at risk include nurses and other staff directly involved in patient care, emergency room staff and paramedics. There are more than two million work-related fatalities in the world yearly. The violence against nurses is quite unacceptable. Subsequently, it has not only a negative impact on the psychological and physical well-being of nursing staff but also affects their job motivation (WHO,2019). The purpose of the study was to determine workplace violence among primary healthcare nurses in the Molemole subdistrict, South Africa. A quantitative approach using a cross-sectional descriptive design was used in this study. The total population sampling was used to select 150 PHCWs from a total of eight (8) PHC facilities in the Molemole sub-district. Self-administered questionnaires with closed-ended questions were administered to respondents with at least 1-year working experience and above, who met the inclusion criteria. Ethics approval to conduct the study was obtained from the Ethics Committee of the University of Venda and permission to access facilities was obtained from the Department of Health Limpopo Province. Data were analysed using Statistical Package for Social Science (SPSS version 25) and presented in the form of tables, charts and graphs. Ethical principles were adhered to. findings revealed that the prevalence of workplace violence against nurses was very high. Verbal violence was the most common form of workplace violence. The results further revealed that work unit and workload perception significantly predicted workplace violence. The crosstabulation and the chi-square test was statistically significant, as it showed that work experience influences the occurrence of workplace violence with a conclusion that the more experience a PHC worker has the lesser the likelihood of occurrence of workplace violence (Phi=0.286, Cramer's V =0.203, chi square =0.04). The results further revealed that the occurrence of workplace violence in people who are working in psychiatric was high Based on the results obtained from the study the researcher concluded that Workplace violence in nurses is a problem in the Molemole district and it has the potential to compromise patient care. As such, measures must be taken to minimise workplace violence against nurses and to create a safe working environment for them. Topics on violence against nurses should be included in nursing education programmes and provided during in-service training for qualified nurses to promote their assertiveness and to raise awareness on the existence of violence against them

Keywords: *Nurses, primary healthcare, violence, workplace violence*

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LIST OF ACRONYMS AND ABBREVIATIONS

EN **:** Enrolled Nurse

ENA : Enrolled Nurse Auxiliary

IDP : Integrated Development Programs

OPM : Operational Manager

OHS : Occupational Health and Safety

PHC : Primary Health Care

PHCW : Primary Health Care Workers

PHCf : Primary Health Care facility

RDP : Reconstruction and Development Program

RN : Registered Nurse

TB : Tuberculosis

WHO : World Health Organization

WPV : Work Place Violence

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CHAPTER 1: OVERVIEW OF STUDY

1.1 Introduction

This chapter will review the Workplace violence in the primary health care on a global perspective, national level and locally. It will also outline the significance of this study, its rationale, the research questions which the study strives to answer and the aim of the study

1.2 Background

Workplace or occupational violence refers to any acts or threat of physical violence, sexual, harassment, intimidation, bullying or other threatening disruptive behaviours which creates a risk to the health and safety of an employee or multiple employees at the worksite (FinkSamnick, 2015). Lanctôtand Guay (2014) stated that WPV is categorised into non-physical (verbal abuse and psychological stress) and Physical (assaults, homicide, bullying/mobbing, sexual and racial harassment) types. In Primary Health Care facilities, sources of violence contain patients, students, visitors, intruders and even co-workers (Tirunehet al, 2016). WPV common risk factors include inadequate security staff, difficulty working conditions, limited experience, bad attitudes, working with people who have a history of violence or who substances abusers, working alone, shortage of staff, poor lighting in or outside the primary healthcare facility and many more (Phillips, 2015).

WPV against nurses is a serious and problematic phenomenon all over the world. Primary Health Care (PHC) facilities are meant to provide health services, a safe and secure environment for both patients and nurses. However, many incidences of workplace violence against nurses have been reported and are continuously being reported in both developed and developing countries (Sisawo et al, 2017). As compared to other occupations, nurses are rated16 times more likely to experience WPV than other health workers due to direct contact with patients, relatives and other individuals (Hogarth et al, 2016). Hogarth et al (2016) further stated that each year, more than 1.6 million people worldwide lose their lives in relation to violence, and many more are injured and suffer from physical and non-physical health problems. Historically, WPV is underreported because nurses tend to accept it as just part of the job, which thus jeopardizes self-esteem and quality of work. Nevertheless, Gender, society, race, economic status, religion, and/or culture are the factors affecting workplace violence toward nurses (Fallahi-Khoshknab et al, 2016).

The International studies have indicated that the extremity of workplace violence against nurses varied from 10% to 87% with verbal abuse leading the row. Between 8% and 38% of nurses suffer physical violence (Jacobsen, 2016). Lanctôt and Guay (2014) indicated that psychological abuse 38%, the threat of assault 19%, and physical assault 18% towards

nurses which enhanced low self-esteem were observed in the health settings of Canada. WPV is a leading cause of death in the United States, particularly for women (Rios et al, 2017). Over 2 million workers are exposed to workplace violence each year. High frequencies of workplace physical violence especially bullying has left many nurses with decreased job satisfaction, poorer performance and attrition in PHC situated in the United States of America (Tong et al, 2017). A high rate of absenteeism, lower quality of teamwork, burnout and decreased staff morale due to a phenomenon of abuse and aggression have been noted in Iran. The prevalence of physical violence was between 9.1 and 71.6% with pushing or pitching on the frontline (Najafi et al, 2018).

In South Korea, 82% of nurses indicated being exposed to some form of horizontal violence (Chang & Cho, 2016). Halle et al (2016) indicated that in Asia majority of female nurses frequently encountered sexual assaults, which left some with posttraumatic stress disorder, anxiety, depression and contagious diseases such as HIV and AIDS. According to AgyeiMensah et al (2015), Africa is one continent with so many developing countries where workplace violence is a lively headache. The levels of workplace violence in nursing remain unacceptably high and have become an endemic problem in African health sectors (Cushion, 2018). Physical attacks against nurses differ with countries, 13.4% was noted in Italy whilst 19.6% was also reported In Taiwan (Fallahi-Khoshknab et al, 2016). In Egypt, 69.5% of verbal abuse and 9.3 % physical abuse among nurses was reported as an alarming phenomenon (WHO, 2019).

Although workplace violence against nurses has become a topical issue in the last couple of decades, posttraumatic stress disorder, impaired work performance, and insomnia among Ghanaian nurses were noted as influenced by verbal abuse and sexual harassment (Boafo &Hancock, 2017). According to WHO (2019), WPV in South African society has reached epidemic levels with interpersonal violence the second-highest contributor to years of life lost. Approximately 61.9% of South African nurses encountered at least one incident of physical or psychological workplace violence (bullying, racial harassment and sexual harassment) over the past 12 months (Seun-Fadipe et al, 2019).

Putz-Anderson (2017) stated noted that there are more than 300 000 incidents that take place every year in South Africa and thus, some of the affected nurses are reported to be quitting their jobs, which pose a great threat to the nursing trainees and health faculty at large. According to the study conducted by the Medical Research Council, nurses were the most affected staff with 92.3% of verbal abuse while 36.4% had occasionally been threatened with physical assault (Kilic et al, 2016). Among the 09 South African provinces,

Western Cape has the highest homicide and assault rates towards nurses in their healthcare facilities (Schuurman et al, 2015).

WPV is a serious problem in the primary health cares based in Limpopo and this problem has left many nurses with trauma and an edge to leave their jobs (Ponthieu & Incerti, 2016). Sexual violence in the province has left many nurses with HIV and other sexually transmitted infections (STIs) and unwanted pregnancy and mental health disorders (Mitchell, 2015).

There are regular reports of crime against nurses in Capricorn district and its sub-districts such as Molemole. According to IDP (2018/2019), murder, rape, robbery with aggravated assault, malicious damage to property and burglary at residential and non-residential premises, which pose a plague to the health systems of Limpopo province were noted in Molemole.

There are many available strategies and policies which are aimed to prevent workplace violence against nurses and other healthcare workers in all health settings of South Africa. Brauer (2016) indicated that the Occupational Health and Safety Act, 1993 (No 85 of 1993) aims to prevent accidents and diseases at work and for those in the community who may be affected by the activities around them. It states that every employee is responsible for his/her own health and safety as well as those who may be affected by the work, he/ she does (Brauer, 2016).

1.3 Problem statement

Even though the South African National Department of Health has an Occupational Health Act (OHS Act no. 85 of 1993) and policies to promote the health of PHC nurses, the researcher has observed with a great concern that the Molemole-based PHCf are still experiencing the workplace violence. Thus, the Limpopo health system is plagued with severe staff shortages and absenteeism which is linked to the high prevalence of workplace violence (DHB, 2018/2019). There are regular reports of PHCWs being victims of violent attacks, rape and assaults by criminals towards primary healthcare nurses in the Molemole sub-district. District

Health Barometer (2018/2019) stated that house burgling in the nurses' homes and assaults towards HCWs have increased from 11.8% to 55%. The reports suspect that the criminals might be looking for the luxury belongings of healthcare workers such as cars, laptops, phones, clothes and money which resulted in death, deformity and changed body image of some of the victims. Therefore, the study seeks to determine the prevalence of workplace violence among primary health care nurses in the Molemole sub-district, South Africa.

1.4 Rationale of the study

Several studies have been done in Limpopo province, Capricorn district that is focusing on occupational health but neither of them focused much on workplace violence in Molemole primary health care facilities. For example, Lekgothoane (2012) focused on “Occupational injuries and diseases amongst healthcare workers of the department of health in Limpopo province”. Baloyi (2011) focused on “Health policy implementation challenges in the Capricorn district, Limpopo province, South Africa”. The violence against nurses is a significant problem in the Molemole primary healthcare facilities and remains not researched. Therefore, it is important to conduct this study so that the recommendations may be made for new strategies to manage.

1.5 Significant of the study

Recommendations of the current study may benefit nurses to apply policies and strategies to promote health and prevent harm. The study findings may also benefit PHC staff with an awareness of workplace violence. A need to perform inspections, job safety analysis and collection of accident and disease statistics could be introduced to promote and prevent harm. The findings of the study could also expand the body of knowledge about health and safety risks in PHCs.

1.6 Aim of the study

Most people think of violence as a physical assault however, workplace violence is a much broader problem. It is an act in which a person is abused, threatened, intimidated or assaulted in his or her employment (Gill, Fisher & Bowie, 2013). Therefore, this study aimed to determine workplace violence among primary healthcare nurses in the Molemole sub-district, South Africa.

1.7 Objectives of the study

The following were the objectives of the study:

- To determine the risk factors for workplace violence among primary healthcare nurses in the Molemole sub-district, Limpopo province, South Africa.
- To investigate the frequency of workplace violence among primary health care nurses in the Molemole sub-district, Limpopo province, South Africa.
- To determine existing security measures in place for prevention of workplace violence in the Molemole-based primary health care facilities, South Africa.

1.8 Theoretical framework

The epidemiological triad in Figure 1 shows the three main factors which contribute to the occurrence of workplace place violence are attitude, inadequate security measures delaying patients and shortage of. The identification of the relationship between the agent, environment and the workers is the first step towards a thorough description of the occurrence workplace violence The study was ushered by the epidemiological triad which is an effective triangle shape model used to study diseases and predict future health needs of a community. The triad comprises agent, environment and host (Accutt & Hattingh, 2016). In this study, the host was the primary healthcare nurse. Agents contain attitudes, tensions, stress, inadequate security, moving or pushing patients, shortage of staff and many more. The environment includes verbal abuse, bullying, physical abuse and sexual harassment. Environment, host and agents interrelate in numerous ways to influence workplace violence among primary healthcare nurses in the Molemole sub-district, South Africa T

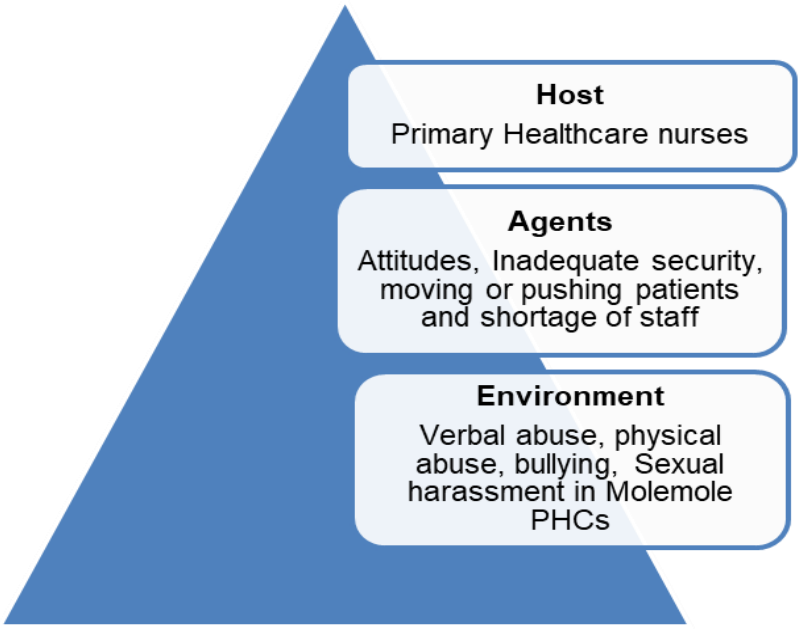

Figure 1: A pyramid showing the interrelation between host, agent and environment.

1.9 Definitions of operational terms

- **Primary healthcare Nurse:** Is an individual who delivers care and services for minor illnesses and injuries (WHO, 2017). In this study, it shall mean an individual with nursing qualifications who perform their routine jobs in the clinics.

- **Primary health care facility:** is a place that usually provides community care and home-care programmes for disabled people and people with chronic or terminal illness (Jamison et al, 2017). In this study, it shall mean the environment where the primary healthcare nurses perform their jobs.
- **Verbal abuse:** is the intentional use of language that humiliates and degrades respect for the dignity and worth of an individual that creates fear, intimidation and anger to the worker (Sethole et al, 2019). In this study, it shall mean vigorous words that hurt primary health nurses.
- **Physical violence:** refers to beating, kicking, slapping, stabbing, shooting, pushing, pinching, scratching and biting that cause physical or sexual harm to the worker (Alshehri, 2017). In this study, it shall mean any intentional act causing injury or trauma to the nurse.
- **Psychological violence:** Refers to threats that can result in harm to mental, spiritual, moral and social development (Farnsworth, 2014). In this study, it shall mean a form of abuse among nurses,

1.10 Outline of the dissertation

This study is divided into six chapters as follows:

Chapter 1 introduces the study, states the problem, purpose, significance, aim, objectives and definition of key terms.

Chapter 2 is centred on a literature review, which highlights the overview of workplace violence in primary healthcare nurses

Chapter 3 outlines research approaches that were used in data gathering, collection, presentation and analysis.

Chapter 4 is the interpretation of the study findings.

Chapter 5 offers the discussion of findings.

Chapter 6 presents the conclusions and suggested recommendations

CHAPTER 2: LITERATURE REVIEW

2.1. Introduction

The previous chapter presented the overview of the study therefore this chapter presents a literature review of the epidemiology, prevalence and Incidence of workplace violence, different types of workplace violence, types of workplace violence, causes of workplace violence as well as the risk factors and its impact on the nursing workforce.

The literature reviewed assisted the researcher by providing a basis for comparison when interpreting findings of the current (Brink et.al, 2012). it had provided a critical analytical appraisal of recent scholarly works on the topic as the researcher tried to determine what was already known about the topic and to obtain a comprehensive picture of the existing state of knowledge. Furthermore, it placed the study in the context of the general body of knowledge and minimised the possibility of unintentional duplication and increased the probability to make a valuable contribution. To obtain clues to the methodology and instruments. This exercise provided the researcher with information on what has and has not been attempted regarding approaches and methods, and on what types of data-collecting instruments exist and work or do not work. Had assisted the researcher to refine certain parts of the study, specifically the problem statement, hypothesis, conceptual framework, design and data-analysis process and to compare the findings of existing studies with those of the study at hand. This process assisted with the relevance of the latter findings to the existing body of knowledge (Brink et.al., 2012). In addition, the literature reviewed helped during recommendation writing (Brink et.al., 2012).

2.2. Global overview of workplace violence

Globally, the workplace has become a major public health issue and is identified among the leading causes of death for people aged 15–44 years. The prevalence of abuse against nurses varies in different countries and cultures. A growing body of evidence indicates that violence at work affects the lives of millions of people worldwide (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002; World Health Organization Geneva [WHO], 2003). In the US, violence ranks third most leading common cause of occupational death and the second most leading cause of death among working women. In 2001 alone, there were 639 work-related homicides (US Department of Labor, Bureau of Labor Statistics, 2002) with about two million non-fatal workrelated violence annually (Warchol, 1998). Studies show an increase in non-fatal work-related violence risk among healthcare workers(Toscano, 1996; LaMar, Gerberich, Lohman, et al., 1998; Carmel & Hunter, 1989). Other studies of workers in selected healthcare occupations revealed annual injury rates of 27 registered nurses, 88 licensed

practical nurses, 116 medical managers, 222 occupational therapists, 289 nursing aides and 457 health aides per 100 000 persons versus a 16.7 overall rate. It was also found that most of the physical healthcare violence was committed by patients/ clients (LaMar, Gerberich, Lohman, et al., 1998; Hashemi and Webster, 1998; Pane, Winiarski & Salness, 1991; Peek-Asa, Howard, Vargas et al.,1997; Williams, 1996; Gerberich, Church, McGovern, et. al., 2004; Hurrell, Worthington & Driscoll, 1996).

2.3. Workplace violence in South Africa

Western Cape Province in South Africa has the highest homicide and assault rates in the country (South African Police Service 2011:27-29) and the supposition is, therefore, that the ripple effect of societal violence will become evident even in healthcare settings. This supposition that violence is rife in these clinical settings is confirmed by several local studies.

Results from studies done by Maureen and Kenned in 2013 indicated that the impact of crime and violence on health services delivery in the Western Cape by Steinman was high it included that 62.9% of the sample (of which nurses formed 62.5%) indicated that working conditions have worsened; 61.1 % frequently had to deal with crime and violence in the workplace; 46.9% of the doctors regarded violence as being 'part of the job'; 42% perceived that workplace safety was not a priority for the Provincial Department of Health or the City Council; 76.1% did not receive training to defuse threatening and aggressive behaviour; 63.2% were unsure about the availability of workplace violence-related counselling services. According to Steinman's seminal work (2003:32), the incidence and risks of workplace violence differ significantly between public and private healthcare settings. In the public sector, 67.4% of healthcare workers reported being attacked physically, whilst 42.5% had witnessed physical violence in the workplace, compared with 42.5% and 19.2% respectively in the private sector. However, recent studies in the health sector in Cape Town indicate an upward trend in violence in the general and psychiatric hospitals as well as community healthcare settings (Kajee-Adams & Khalil 2010:187; Khalil 2010:191).

2.4. Impact of Violence Against Nursing Workforce

Violence against nurses may result in psychological consequences such as fear, frustration, and mistrust in hospital administration as well as reduced job satisfaction. Early career nurses are the most affected since it may result in professional disillusionment. Violence affects the professional perspective of nurses, undermines recruitment as well as retention efforts which may eventually threaten patient care, particularly during a pervasive nursing shortage. Hostility due to workplace bullying among nurses may result in medical errors, poor satisfaction among patients plus higher healthcare costs. A study by the Joint

Commission [JC] (2008) found that nursing retention rates correlate d with workplace bullying in hospital units. Among the various negative actions of bullying behaviour are verbal abuse, threats as well as humiliation, intimidation plus job performance interference behaviours (Einarsen & Hoel, 2001). Bullying may also extend to allegations of incompetence even with a history of excellence, gossiping about co-workers, keeping pertinent patient care related information from other practitioners, feeling of constant stress and fear for more bullying events, remarks such as “get tougher skin” or “work out your differences” from a supervisor regarding bullying or screaming/ yelling at a colleague before others to besmirch him/her (Murray, 2009).

Workplace behaviours can demoralize and victimize an individual who may be experiencing bullying (Longo & Sherman, 2007). According to The Institute for Safe Medication Practices (2004), negative workplace behaviours impacted widely medication errors. For instance, about half of the subjects indicated that intimidating behaviours influenced unsafe medical administration. Approximately 7% of the subjects claimed to have committed medication errors because of bullying actions. In another study by Rosenstein & O’Daniel (2005), 54% of nurses indicated that workplace bullying influenced patient safety while 25% of them believed that bullying contributed to patient mortality. There is much evidence that workplace bullying may lead to low job satisfaction or increased job stress and absenteeism among nurses as well as low retention rates and increased intention to leave the job (Johnson, 2019) which eventually results in the high shortage of nursing workforce. Workplace bullying negatively impacts nurses, patients, and the overall healthcare system. Bullied nurses report symptoms such as weight loss/ gain, hypertension, and cardiac palpitations as well as gastrointestinal disorders, headache to insomnia plus chronic fatigue (Bigony, Lipke, Lundberg, McGraw, Pagac, & Rogers, 2009). There are also reports of negative psychological effects such as higher levels of stress, low self-esteem, anxiety as well as depression plus suicidal ideation (Johnson & Rea, 2009; Quine, 2002). A study in Britain showed that 25% of nurses opined that workplace bullying impacted their physical health (Quine, 2001). It is well established that nurses are more likely to perform poorly in stressful situations caused by workplace bullying. There is a body of evidence that abuse of nurses produces a range of negative effects from exhaustion, sleeping disorders and nightmares to stress, continuous headaches and chronic aches to spasm, loss of self-confidence and/or health to self-dissatisfaction, disappointment, short-tempered and symptoms of amnesia after being hit, phobia, depression and alcohol consumption or smoking plus suicide.

Physical violence may result in permanent physical problems, including backache, and even death (Anderson, 2002; Gates, Fitzwater & Mayer, 1999; Lee, Gerberich, Waller, Anderson

& McGovern, 1999; Nolan, Soares, Dallendre, Thomson & Arnetz, 2001; Pejic, 2005; Rippon, 2000). Exposure of nurses during duty may cause loss of concentration, lack of attention to ethical guidelines, higher rates of errors, missing shifts, recurring absenteeism, lack of attention to patients, reduced job satisfaction, job dislike, and work refusal due to stressful wards. This result is a significant increase in treatment costs to health facilities and the community (Farrell, Bobrowski, & Bobrowski, 2006). Back injuries plus back pain present a major concern to nursing staff as well as healthcare organizations. These injuries negatively impact on quality of life and overall well-being of the worker, and organizational productivity (Gropelli, 2011). It is well established that healthcare workers are at risk of musculoskeletal disorder (MSD) compared to construction mining and manufacturing workers (Centers for Disease Control [CDC], 2009).

A study in the US showed that 52% of nurses reported chronic back pain (Association, American Nursing, 2012) despite a lifetime prevalence of up to 80% (Edlich, Winters, Hudson, Britt, & Long, 2004). According to the American Association of Nursing (2012), 38% of nurses had severe occupational-related back pain that warrants work leave. The condition appears to be ubiquitous among many nurses who accept it as part and parcel of their job (Gropelli, 2011). A study by Adriaenssens, et al. (2012) provided an analysis of 248 emergency room nurses who experienced WPV. The nurses all experienced traumatic events in their work and were found to have depression, anxiety, difficulty sleeping, and PTSD. The conclusion referenced how these traumatic events not only affect the nurses personally, but also impact the quality of care (Adriaenssens, et al., 2012).

A study by Agnew et al.,(2008) consisted of 2,168 registered nurses and others in nursing service provided insight into job satisfaction, job retention, absenteeism, and presenteeism in individuals who experienced WPV and those that had not. This study also explored the difference between psychological violence and physical violence in this population. These studies provide support for the impact of WPV on absenteeism and the potential impact on quality of care. It is important to understand the prevalence, incidence, types, causes, risk factors, and epidemiology of WPV so that healthcare leaders can help develop programs and to decrease WPV in the healthcare setting while focusing on improving safety for employees. The elements bring to light areas of possible intervention for leaders. These elements also have relevance for healthcare leaders as they examine ways to provide better post-violence care to employees. Provision of proper mental and physical care after employees suffer episodes of WPV may decrease the impact these incidents have on productivity and delivery of quality care. Nursing staff, identified as nurses and nursing assistants provide the majority of the direct care provided to patients in the healthcare setting

(Bureau of Labor Statistics, 2008). The nursing staff is among the most exposed healthcare workers to verbal, emotional, physical, and sexual abuse (Gerberich, Church, McGovern, Hansen, Nachreiner, & Geisser, 2005; Islam, Edla, Mujuru, Doyle, & Ducatman, 2003). Thus, the prevalence, causes, types, and risk factors of WPV and the correlation to days missed from work is of importance to healthcare leaders. Productivity, patient safety, quality of care, and increasing need for other staff to work overtime can be impacted when nursing staff miss days (Farrell, Bobrowski, & Bobrowski, 2006).

2.3 Types of workplace violence

Nurses experience different types of violence at their workplace categorised broadly into physical violence or psychological violence (Celik, Celik, Agirbas & Ugurluoglu, 2017; Kwok et al., 2016). Other terms used to describe workplace violence include ". . . physical assault, abuse, verbal abuse, harassment, kicking, punching, spitting, pulling hair, biting, stalking, sexual harassment, sexual assault, and acts of aggression or intimidation" (Taylor & Rew, 2015). The use of varying terminologies from study to study to describe workplace violence makes it hard to compare the findings or generalise findings from one study to a different setting.

2.3.1 Physical Violence

The different types of physical violence had been categorised into two, with a weapon or violence without a weapon (Kansagra, Rao, Sullivan, Gordon, Magid, Kaushal, Camargo & Blumenthal, 2018). McKinnon and Cross (2018) reported that the occurrence of physical violence with a weapon against nurses in Australia was 14.3%. In Iran, AbuAlRub et al. (2017) also found that 14.3% of the respondents reported having experienced physical violence in which a weapon was used. A study conducted in the United States of America reported that guns or knives were brought into Emergency departments daily by patients and/or their visitors (Kansagra et al.,2018); however, there was no mention of whether these weapons were used against nurses. Physical violence without a weapon has been reported to occur in the form of restraining (25.5%) and punching (15.9%). Other reported forms of physical violence without a weapon were wrestling with a patient, being stalked and held hostage and being bitten by a patient's dog (McKinnon & Cross,2018). In other instances, physical violence against nurses has occurred in the form of property damage (McKenna, Poole, Smith, Coverdale & Gale, 2013). This property could belong to the hospital (McKenna et al., 2013:13) or the individual nurse (Opie et al., 2014).

2.3.2 Psychological Violence

There is a consensus in findings from studies that psychological violence occurs more often than physical violence. Senuzun Ergun and Karadakovan (2015) reported that over 98% (n = 66) of nurses who participated in a study in Turkey had experienced psychological violence compared to 19% who experienced physical violence. Celik et al. (2017) established that 91% (n = 622) of the respondents had been victims of psychological violence before. They also found that of the 33% who reported to have experienced physical violence, all of them had also been victims of psychological violence. A study in Kuwait reported that 48% (n = 5876) of the participating nurses had experienced psychological violence in the previous six months prior to the study, compared to 7% who experienced physical violence (Adib et al., 2015). Psychological violence occurs in many forms such as verbal aggression, bullying and sexual harassment (Senuzun Ergun & Karadakovan, 2015)

Another form of psychological violence that has not been reported much is economic violence. A study in Sweden found that of those who had experienced violence, 0.5% was economic violence (Astrom, Bucht, Eisemann, Norberg & Saveman, 2017). This was experienced by 1 person out of the 201 nurses who reported to had experienced some form of violence. This was a case where the nurse was falsely accused of stealing money (Astrom et al., 2017). Economic violence in nursing is an issue that needs further investigation and a clearer description of what it entails. Verbal aggression has been reported in several studies as the most common form of psychological violence against nurses (Abe & Henley, 2017). A study conducted in Philadelphia, the USA found that over 96 % of the 307 nurses who participated reported to have experienced verbal aggression at work (Rowe & Sherlock, 2015). In this study, verbal aggression was reported to have been expressed as anger, judging, criticising, or condescension. Khalil (2019) identified six types of workplace violence amongst nurses described as psychological, vertical, covert, horizontal, overt and physical.

The study also found that covert violence mostly occurred in the form of gossiping. Horizontal violence (also referred to as lateral violence) relates to behaviours among individuals who consider themselves peers with equal power but overall without power within the system (Stanely, Martin, Michael, Welton & Nemeth, 2017). Horizontal violence occurred mostly in the form of bullying (Khalil, 2009:212). A study in Turkey found that the most common form of bullying reported by nurses was being spoken to in a belittling manner (Yildirim & Yildirim, 2017). Other reported forms of bullying were being blamed for things that one was not responsible for and being controlled when working.

Incidents of sexual harassment against nurses have been reported. Sexual harassment can be in the form of physical or psychological violence McKenna et al.(2015). Sexual

harassment is reported by male and female nurses. The overall reported prevalence of sexual harassment is low; 30% in McKenna et al. (2015). Other studies do not mention the occurrence of sexual harassment against nurses. Sexual harassment, however, is a traumatising experience for the victims. Kamchuchat et al. (2018) suggested that the reason why sexual harassment is underreported could be because of fear of stigmatisation and the psychological effect of the event. It is therefore important to recognise that the prevalence of sexual harassment against nurses could be higher than it has been reported in studies.

2.4 Perpetrators of workplace violence

2.4.1 Patient-Related Violence

Violence against nurses in the workplace originates from various sources. Mullan and Badger (2017) found that 98% of violent acts experienced by nurses in aged care were perpetrated by patients. Similar findings where patients were the frequent perpetrators of violence have been reported by Senuzun Ergun and Karadakovan (2015) and Hegney et al. (2016). Although more incidents of violence are reported to have been perpetrated by patients, most of those incidents are by a few patients (Weizzmann-Henelious & Osuutala, 2017). A study in a Finnish forensic psychiatric hospital found that 778 (80.2%) of reported violent incidents had been perpetrated by five patients only (Weizzmann-Henelious & Osuutala, 2017). There are differing reports about whether male or female patients are more likely to demonstrate violence against nurses. Mullan and Badger (2017) established that male patients are the ones who are most violent against nurses whereas Weizzmann-Henelious and Osuutala (2017) reported that female patients were most likely to be violent.

Kwok et al. (2016) in Hong Kong compared the prevalence of violence against nurses working in male wards and nurses working in female wards and found that it was 91% and 82% respectively. With such variations in findings, it remains inconclusive if the patients' sex is a determinant for being a risk for violence against nurses.

2.4.2 Patients' relatives/Visitor related violence

Patients' visitors/relatives are another common source of violence against nurses (Campbell,

Messing, Kub, Agnew, Fitzgerald, Fowler, Sheridan, Lindauer, Deaton & Bolyard, 2011). A study in Iran found that 84% of violent incidents were perpetrated by patients' relatives (Esmaeilpour, Salsali & Ahmadi, 2011). The study also revealed that most incidents of violence occurred during visiting hours in the hospitals, a time when the patients' relatives and visitors were around. Kamchuchat et al. (2018) found that 51.9% of reported incidents of violence against nurses were perpetrated by patients' visitors or relatives.

2.4.3 Colleague/Nurse related violence

Other reported perpetrators of workplace violence against nurses are fellow nurses, nursing management, other managers, doctors, and allied health professionals (Hegney et al., 2006:224). Campbell et al. (2017) found that 7.6% of physical violence was instigated by coworkers, 1.5% by physicians and 1.7% by supervisors. They also established that 35.5% of psychological violence was instigated by co-workers, 22.8% by physicians, and 11.3% by supervisors. In Turkey, Yildirim and Yildirim (2017) revealed that workplace bullying was perpetrated by administrators (75.8%), co-workers (17.1%) physicians (4.1%) and subordinates (3%). Co-workers were reported to be the most common source of sexual harassment against nurses compared to patients and patient's relatives (Kamchuchat et al., 2008). Although it has been established that workplace violence against nurses is perpetrated by various sources, there is no mention of the sex of these perpetrators except for the case with patients. As aforementioned, nurses are sometimes perpetrators of violent incidents against fellow nurses (Abe & Henly, 2015). This applies to nurses of all cadres and positions. Violence amongst nurses mostly occurs in the form of bullying (Johnson & Rea, 2019). Johnson and Rea (2019) in a USA study reported that 27.3% of the 249 nurses who responded to the survey had experienced workplace bullying in the three months prior to the study. Most were bullied by their seniors whilst a few were bullied by subordinates (Johnson & Rea,2019). Abe and Henly (2010) in Japan found that nurses, who had been victims of workplace violence from fellow nurses, also experienced other negative acts at work such as someone withholding information, being humiliated, and being shouted at. Khalil (2019) reported that professional nurses were identified as the main perpetrators of violence against fellow nurses. Woelfel and McCaffrey (2017) condemned the occurrence of violence amongst nurses and argued that although there are explanations for why violence occurs among nurses, it cannot justify the violence among people in a profession built on caring.

2.5 Effects of workplace violence

2.5.1 Physical effects

Violence against PHC nurses has physical and psychological effects on the victims (Franz, Zeh, Schoblon, Kuhnert & Nienhouse, 2014). A study in Australia explored the severity of physical effects that nurses experience because of workplace violence ranged from mild injuries such as bruises to serious injuries such as fractures (McKinnon & Cross, 2018). Other types of minor injuries that nurses experienced reported in the same study were scratches, cuts, abrasions, sprains. Major injuries reported were muscle tears and fractures (McKinnon & Cross, 2008:13). Physical reactions such as feeling tired, having a headache, alterations in appetite and having gastrointestinal problems have also been reported in

nurses who experience workplace bullying (Yildirim & Yildirim, 2017). Nurses who have been victims of sexual abuse are also at a high risk of contracting sexually transmitted infections (STI) from the assailants (Allsworth, Anand, Redding & Peipert, 2009).

Franz et al. (2014) in Germany found that of the nurses who reported to have been victims of violence within the preceding year, 44.7% experienced physical impairment, 10.9% of whom had to receive medical treatment. Another study found that high levels of perceived distress in nurses following an assault from a patient are directly correlated to the perceived seriousness of the injury (Nhiwatiwa, 2013). Nurses who perceived that the experienced assault was serious were found to have high levels of distress when assessed using the Impact of Event Scale and the General HealthQuestionnaire (Nhiwatiwa, 2013).

2.5.2 Psychological effects

Being a victim of workplace violence has been found to make the nurses feel extremely bothered by the event and to experience repeated disturbing memories, thoughts and images of the attack (Esmaeilpour et al., 2011). Incidents of Post-traumatic stress disorder (PTSD) have also been reported in nurses who experienced violence at the workplace (Inoue, Tsukano, Muraoka, Kaneko & Okamura, 2006:33). Inoue et al. (2016) assessed the psychological impact of verbal abuse or violence by patients on nurses working in psychiatric departments in Japan using the Impact of Event Scale-Revised (IES-R) to measure the psychological impact. This is a self-rating scale for the measure of PTSD. 21% of the nurses who had been exposed to verbal abuse or violence had high scores, suggestive of PTSD (Inoue et al., 2016). Some nurses are reported to have attempted suicide or contemplated suicide as a result of being a victim of workplace violence (Kwok et al., 2016; Yildirim & Yildirim, 2017). In Hong Kong, a nurse attempted suicide following verbal and physical abuse (Kwok et al., 2016) and in Turkey, 10% of nurses who reported to have experienced workplace bullying stated that they had contemplated suicide because of the bullying (Yildirim & Yildirim,

2017).

2.5.3 Work-related effects

Workplace violence influences the work of the nurses who have been victims (Celik et al., 2017 Franz et al., 2014). Violence against nurses compromises the quality of care that nurses provide to their patients. Roche et al. (2019) found that an increase in violence against nurses increased medication errors and patient falls. Mackinnon and Cross (2018) revealed that 96.6%of the respondents who had been victims of violence at the workplace were afraid at work whilst 72.2% felt that being a nurse compromised their safety. Other

reported effects of being a victim of violence at work by nurses from another study are anxiety, tension and having less fun at work (Franz et al.,2014).

On the positive side, some nurses who had been victims of violence at their workplace became more careful when working so that they could not fall victim again (Franz et al., 2014). Yildirim and Yildirim (2017) also found that nurses who had been victims of workplace bullying reported that they started working more carefully, harder and became more organised to avoid criticism. The finding that being a victim of workplace violence makes nurses more careful and prevents further victimisation is questionable because others have reported that most nurses who experience workplace violence are subjected to repeated incidents of violence of over ten times a year (Hutchinson et al., 2016; Kamchuchat et al., 2018; Kwok et al., 2016).

Nachreiner, Gerberrich, Ryan and McGovern (2017) conducted a nested case-control study in Minnesota, United States of America (USA) with nurses to identify rates of violence against nurses and their perceptions of the work environment. A total of 1475 nurses who had experienced workplace violence in the previous 12 months were the cases and some 1425 nurses who had not experienced any workplace violence within the same time frame were the controls (Nachreiner et al., 2007). The study revealed that those who had experienced violence were more likely than those who had not experienced violence to report higher levels of work stress. Those who experienced workplace violence also expressed that violence was an expected part of the job (Nachreiner et al., 2017). On the other hand, those who had not experienced violence were more likely to perceive higher levels of morale and had a positive attitude towards the work environment (Nachreiner et al., 2017).

Some PHC nurses have expressed the desire to leave the nursing profession as a result of being a victim of violence (Farrel et al., 2016). Other nurses who have been victims of workplace violence seriously consider quitting their jobs or seeking alternative employment (Yildirim & Yildirim, 2017). Yet other nurses, have resigned from their work due to the experience of workplace violence (King & McInerney, 2016). It is therefore suggestive that workplace violence influences the retention of nurses in the health care workforce and this is an issue that needs further research.

2.6 Summary

Research done in several countries mentioned in the literature provides evidence that nurses are victims of workplace violence. The extent of violence differs from country to country. The nature of violence experienced is largely psychological and to a lesser extent physical.

Violence affects nurses' lives and performance at work. Nurses working in different units and different speciality areas within hospitals experience different levels of violence and are affected differently by the violence. All the above-cited studies were conducted in institutions that have different staff levels, equipment and culture from the Molemole district in South Africa. With most studies being done in the Westernised countries, there is a gap in literature wherein there are few studies done in a rural set up like Molemole district as his makes it difficult to generalise the findings from those studies to a South African setting. The next chapter (chapter 3) provides the research methodology.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 Introduction

Research methodology is the specific procedures or techniques used to select, identify, analyse, and process information about the topic under study (Veal, 2017). This section discusses the study approach and design that was used, the study area, study population and sampling procedure and reliability and validity of the instrument, data collection, data management and ethical considerations

3.2 Study Approach

The quantitative approach was used. A quantitative approach is a formal methodological inquiry which is primarily focusing on the collection of data in the form of words, the examination of relationships and descriptions of various associations (Kumar, 2019). A quantitative approach was adopted for it enhanced the valid results, reliable and generalizable to a larger population. It downplays the researcher's bias as compared to the qualitative approach.

3.3 Study Design

A descriptive cross-sectional design that observed the phenomenon in a completely natural and unchanged natural environment was used. Cross-sectional studies are carried out at one point in time or over a short period (McLean et al, 2014). The researcher will conduct the study in the PHC of Molemole because data were collected at one point in time.

3.4 Study Setting

The study was conducted in the Molemole sub-district which was located about 60 km North of Polokwane within the Capricorn District, Limpopo province, South Africa. It is bordered to the South by Polokwane, North-West by Blouberg, South-East by Greater Letaba, and to the north by the Makhado sub-district. According to Kyei (2017), the total population served is approximately 108321 per statistics South Africa (2011). IDP (2016/2017) observed the highest proportion of people without schooling, 3% completed primary whereas 18, 4 % completed matric (Municipality, E., 2016). High prevalence of HIV and AIDS, substance abuse and high levels of poverty are challenges pertaining to health and social development in the area. There are three police stations, but the crime rate (especially house burgling) is still high. The Molemole sub-district is graced with 8 PHCF where it requires 5 to 7 km to

access health services. This area was selected because it falls amongst the district in Limpopo with a high crime rate leading to increased workplace violence (DHB, 2018/2019).

3.5 Study Population

The study population of this study combined of all categories PHC nurses working in the Molemole Sub-district. The nursing career was divided into three categories: professional nurses with four years, enrolled nurses with two years and nursing assistants or auxiliaries with one year of training. There are about 150 nurses which 11 are in PHC A (Nthabiseng), 10 in PHC B (Ramokgopa), 10 in PHC C (Eisleben), 15 serving under PHC D (Matoks), whereas PHC E (Makgato) has 12. The North-west side of Molemole was graced with three PHCs namely PHC F (Dendron) with 10 nurses, PHC G (Mohodi) with 16 nurses and, PHC H (Persie) with 13 nurses.

The table below is showing the population frame of HCWs working in eight PHCs of the Molemole Sub-district.

Table 1: Population Frame

Primary health nurses	**PHC A**	**PHC B**	**PHC C**	**PHC D**	**PHC E**	**PHC F**	**PHC G**	**PHC H**	**Grand Total**
OPM	01	01	01	01	01	01	01	01	08
R/N	07	06	07	14	08	06	10	17	81
E/N	02	10	10	02	02	02	03	06	37
E/N/A	01	07	02	05	01	01	02	05	24
Total	11	24	20	22	12	10	16	29	**150**

3.6. Sample and sampling

3.6.1 Sampling of PHCF.

The Molemole sub-district is purposefully selected because the researcher has observed workplace violence as an alarming crime rate in the PHC facilities given its challenges of

high unemployment and use of the substance. The sub-district consists of 8 PHCs/clinics; hence all 8 facilities formed part of the study, thus total population was used.

3.6.2. Sampling of respondents.

A Sampling of participants will include all nurses serving in Molemole based PHCs. Nurses were sampled per their categories and scope of practice. A sample of nurses included; operational managers, registered nurses, enrolled nurses and enrolled nurse assistants.

3.6.3. Sampling Size

Total sampling was used, therefore all nurses working in Molemole Sub-district primary healthcare facilities formed part of the study, thus 150 participants were included in this study.

3.7 Data Collection instrument

Data collection is the process of gathering and measuring information on variables of interest, in an established systematic fashion (Creswell & Creswell, 2017). The researcher designed a Self-administered questionnaire with closed-ended questions which was used for the collection of data. This helped in safeguarding respondents' privacy. The questionnaire was administered in English because all the Healthcare professionals at Molemole sub-district can read and write English. the questionnaire is comprised of three sections. Section A: Biographical information, Section B: risk factors and extent of workplace violence among primary healthcare nurses in the Molemole sub-district and Section C: Available strategies and intervention.

3.8 Validity and Reliability of the Study

The study adopted content validity and construct validity. Content validity refers to whether the instrument measures all aspects of the content is supposed to measure (Onen, 2016). Construct validity is the degree to which a test measures what it claims, or purports, to be measuring (Kopcha et al, 2014). Maree (2016) defines validity as the degree to which research measures what is supposed to measure. Maree (2016) further stated that reliability refers to whether the same instrument can be used at different times or administered to different participants from the same population, which should produce the same findings. To ensure validity in this study, the questionnaire was evaluated by the supervisors of this research, The supervisors went through the instrument, corrected it before accepting it to be used in accordance with the questions outlined in the research, modifications on the questionnaire were done inorder to suit the study

3.8.1.1 Content Validity

To ensure content validity, experts were consulted to check whether the instrument covers aspects of health and safety risks. list them e.g. supervisors, statisticians etc.

3.8.1.2 Construct Validity

To ensure construct validity, questionnaires were presented to the supervisors and Higher degree committee for examination, therefore questionnaires were modified based on the feedback given by the panel of experts.

3.8.2 Reliability

The reliability of the instrument was ensured by the test-retest technique. Reliability is the substance of whether a specific method applied recurrently to the same object yields the same results each time (Babbie, 2015), a structured questionnaire was used to collect data from respondents by the researcher. Consistency in responding to the questions was evaluated using the test-retest method wherein a similar set of questions were given at different times to a small sample of 10 PHC nurses who did not form part of the study to observe if they give comparable answers. The outcomes of the first responses by each individual were equated to the answers they gave on the second occasion after a period of a week and to see whether there was consistency. Testing of reliability helped the researcher in correcting the instrument to make sure that there was consistency

3.9 Pre-test

Ten (10 %) of the respondents was selected from nurses who were not part of the study to pre-test the instruments. The main aim was to evaluate if the questionnaires if it is well understood by the participants and for the researcher to be familiar with the instruments.

3.10 Plan for data collection

In this study, the researcher used a closed-ended questionnaire to gather or collect data. After explaining the aim, the ethical principles to be adhered to and giving the respondents the informed consent form, the researcher gave questionnaires to those who met the inclusion criteria. The researcher explained the format of the questionnaire to the respondents and also urged them to fill the questionnaire honestly and also not to write their names to ensure anonymity. Data was collected by the researcher for over 14 days. The respondents were approached in different working departments and the questionnaires were given at set appointments according to their choices.

According to Cohen, Manion and Morrison (2007) making the respondents fill in the questionnaires as you hand them is useful as it permits any queries or doubts to be

addressed immediately with the researcher and it also decreases the rate of non-response. It also decreases information bias through sharing of information if the respondents complete and returns the questionnaire instantly. Therefore, in this study, the researcher waited for the respondents to fill in the questionnaire while present and collected the questionnaire on the same day to reduce the non-response rate but ensuring confidentiality.

Prior to ethical clearance from UNIVEN, DOH and Molemole 's PHCF, arrangements of the meetings with the managers was made, they agreed on the date for data collection. The respondents answer the questionnaire at their respective PHCF. The duration of filling the questionnaire was for about 20 to 35 minutes to fill the questionnaires. The researcher was available during the session to give clarity. The questionnaires were collected from the participants the same day. The data collection process took 2 to 3 months.

3.11 Data Analysis

Data collected was entered into excel sheet and analysed SPSS version 26. Categorical data will be interpreted using tables, pie charts and bar graphs, the crosstabulation and the chi-square test was statistically significant, as it showed that work experience influences the occurrence of workplace violence with a conclusion that the more experience a PHC worker has the lesser the likelihood of occurrence of workplace violence (P=0,000, x2-25,42, df=2).

3.12 Ethical consideration

Ethical Considerations can be specified as one of the most important parts of the research. And dissertations may even be doomed to failure if this part is missing (Bryman, 2016).

3.12.1 Ethical Clearance

The research proposal was submitted to the University of Venda Ethics Committee for ethical clearance to conduct the study (Appendix 5). Thereafter the approval of the study and ethical clearance was obtained from the University of Venda.

3.12.2 Informed consent

The consent form was given to each participant to sign. The researcher ensured that all the essential information such as the purpose of the study and its significance, as well as voluntary participation, were in the information letter attached to the consent form **Annexure A** to enable the participants to make informed decisions before signing it. Participants were informed of their rights to refuse to participate in the research if they so wish or that they might withdraw at any time if the need arise

3.13 Permission to conduct the study

The researcher was permitted to conduct the study by the provincial Department of Health, the provincial permission letter was used to access selected facilities Capricorn district and Molemole Sub-district. After the permission was granted the researcher then conduct the study.

3.14 Confidentiality

The researcher took responsibility to maintain the confidentiality of the given information by participants. According to Saujani, 2016 confidentiality is all about protecting a persons' private information from unlawful access. Researchers have a strong obligation to ensure that they know and shield the rights and overall wellbeing of their participants, irrespective of the nature of their research. In this research the respondents have been assured anonymity in answering the questionnaires and to achieve this, respondents did not write their names or provide any other identification. Every respondent on the research was entitled to privacy about their thoughts, beliefs, ideas and personal understanding. The data was kept classified at all times and was discarded right away on completion of the study.

3.15 Anonymity

The researcher ensured that participants remain anonymous, their names or any other identification was not recorded or written anywhere or made public.

3.16 Protection from harm

According to Onen (2016), researchers must take specific care to ensure that individuals are not abused or harmed in any way during the research. When conducting research on people, harm and risks must be reduced while benefits are maximized. Moreover, any ethnic, spiritual, governmental, societal, gender or other variances in a research population should be considerably and appropriately handled by researchers, during the research. The researcher made sure that no harm be it, emotional or physical was caused to the respondents. The researcher appropriately constructed questions to avoid causing uneasiness and emotional distress throughout the course of answering the questionnaire. Additional potential hazards like psychological stress were considered and the researcher safeguarded them.

3.17 Human Dignity

In this study, human dignity was respected and observed at all costs. Respect for human dignity is the fundamental aspect underlying research ethics and is anticipated to safeguard

the interest, physical, psychological or cultural honour of a person (Canterbury Christ Church University, 2006). The researcher treated all the respondents with uttermost respect.

3.18 Dissemination of results

The hard copy was submitted to the University of Venda's department of Public health and library. The findings of the current study will be published in peer-reviewed journals and presented at workshops, seminars, national and international conferences. The results will also be presented at Molemole as research feedback.

3.19 Summary

Chapter 3 was the presentation of the research methods which the investigator used in conducting the research. The chapter outlined the techniques in which the methods were used to address the objectives of this study. Some of the methods used are research design and approach, sampling procedures, plans for data collection, instrumentation, ethical considerations and data analysis. After these methods were utilized data was collected and that is leading to the next chapter (Chapter 4) which is the presentation of the findings.

CHAPTER 4: PRESENTATION OF THE RESULTS

4.1. Introduction

This chapter presents the results of the study obtained from data analysis. The results included demographic characteristics of the respondents, questionnaire responses. The results are presented in tables, bar graphs and pie charts which are explained by brief write-ups to describe the trend in the tables and charts. The results are statistically presented in form of frequencies and percentages with the chi; square test and cross-tabulation. The response rate was 100% meaning all the participants answered the questionnaire. The results were presented addressing the following objectives: determine the risk factors for workplace violence among primary healthcare nurses in Molemole sub-district, South Africa; investigate the frequency of workplace violence among primary health care nurses in Molemole subdistrict, South Africa and determine existing security measures in place for prevention of workplace violence in the Molemole-based primary health care facilities, South Africa. The breakdown of the presentation was as follows:

- Demographic characteristics
- The types and frequency of workplace violence among nurses
- The existence of prevention/management of workplace violence among nurses

4.2 Demographic characteristics

Table 2: Representing demographic characteristics

Age	**Frequency**	**Percentage %**
20-30	40	27
31-40	41	27
41-50	39	26
51-60	30	20
Total	**150**	**100**

Gender		
Male	30	20
Female	120	80
Total	**150**	**100**
Race		
African	149	99.3
Whites	1	0.7
Total	150	100
Marital status		
Single	58	38.7
Married	8	5.3
Divorced	62	41.3
Widowed	22	14.7
Total	**150**	**100**

Table 4 presents demographic characteristics among primary healthcare nurses in the Molemole sub-district. One hundred and fifty questioners were distributed among primary healthcare nurses in different working departments. The demographic characteristics include age, gender, race and marital status. Most the respondents were female 80% (n=120), male 20%(n=30). The age group which had the highest number of respondents was 31-40 (n=40) years , the majority race was Africans 99,3% (n=149) and 0,7% (n=1) white person. Out of 150 participants 41.3%(n=62) were divorced, 38.7% (n=58) were single and only 5.3% (n=8) was married

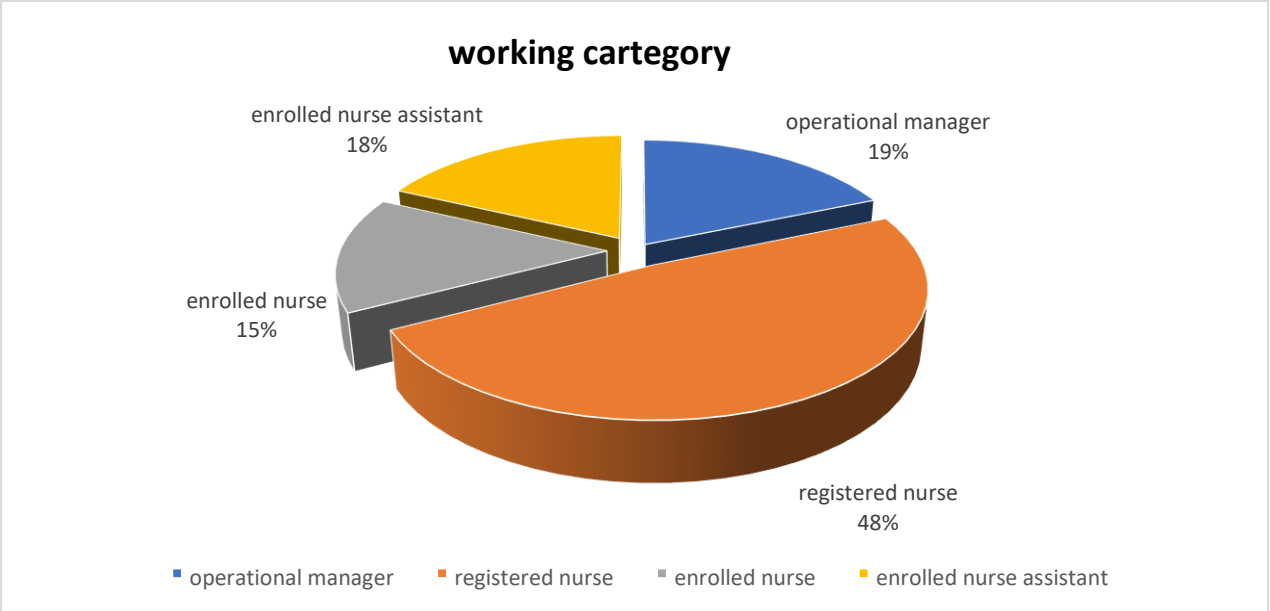

Figure 2: Working category

The illustration above shows the different working categories of the primary healthcare nurses in Molemole Sub-district, majority of the participants were registered nurses 48%(n=72) and the working category which had the least of participants have enrolled nurses 15% (n=23)

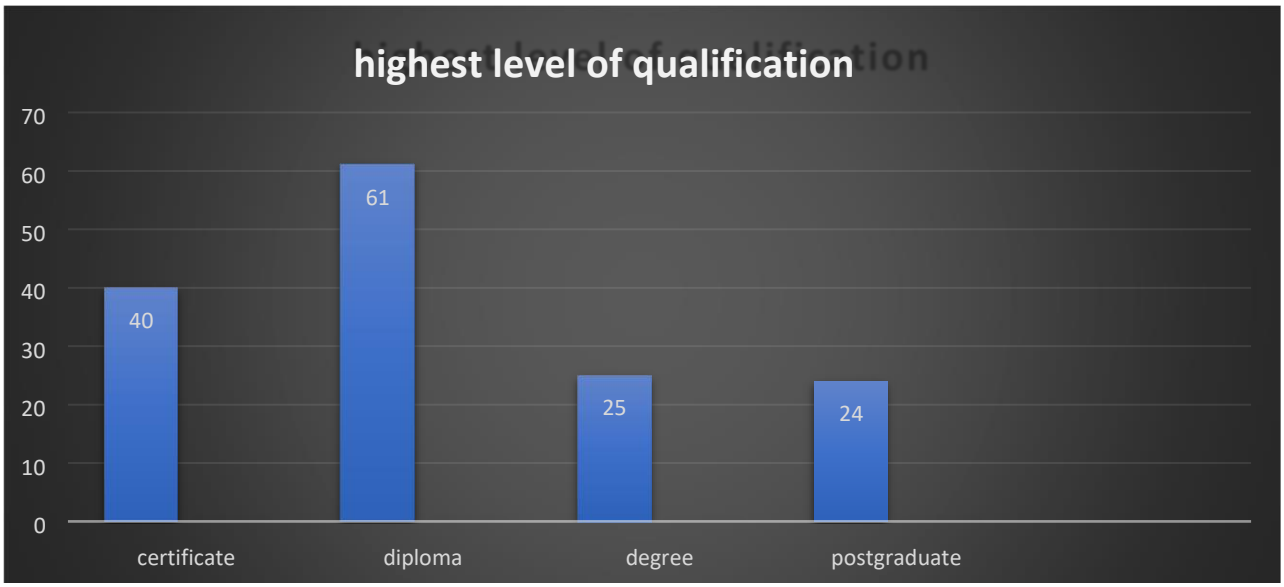

Figure 3: The highest level of qualification

Out of 150 participants who took part in the study 40.7% (n= 61) had diplomas, 27% (n=40) had certificates, 17% (n=25) had degrees and 16% (n=24) had postgraduate qualifications

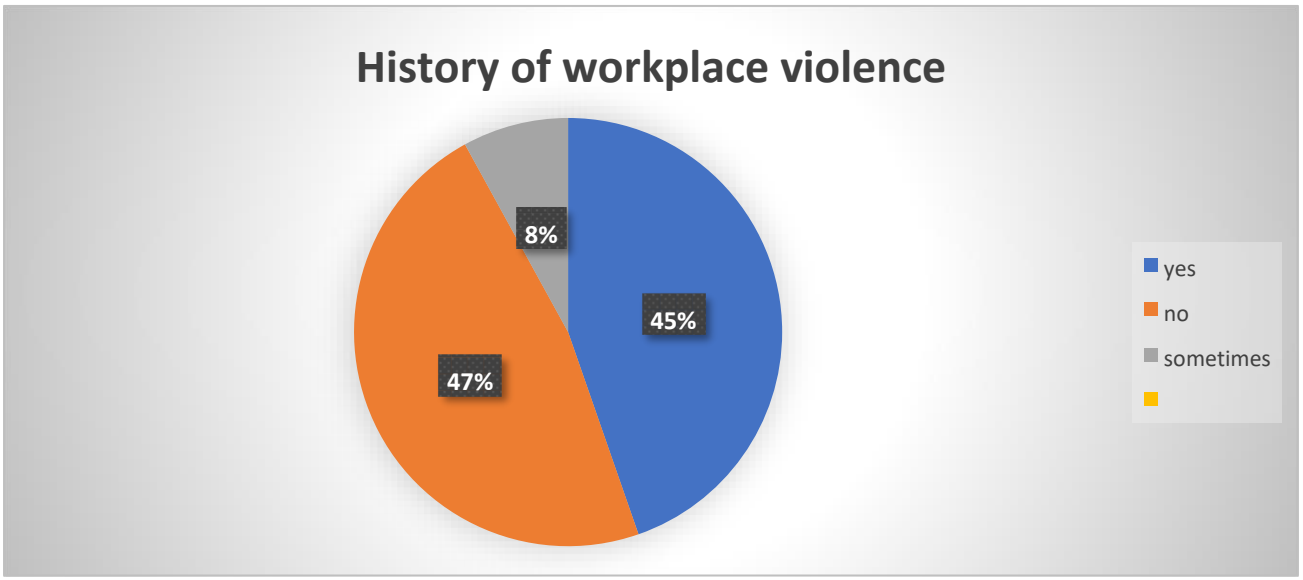

Figure 4: History of workplace violence

When participants were asked if they had encountered any workplace violence the primary healthcare workers at Molemole sub-district agreed to have a history of workplace violence 45% (n=68) answered yes, 47% (n=71) answered no and 8%(n=12) mentioned that they sometimes encounter workplace violence

4.3. The types and frequency of workplace violence among nurses

Table 3: Threats

		Frequency	Percent %
	yes	62	41.3
	no	62	41.3
	sometimes	26	17.3
	Total	150	100.0

Out of the 150 participants who were interviewed 41.3% (n=62) answered yes when they were being asked if they had received threats before, the same results were being obtained to disagree on not receiving threats 41.3% (n=62) and 17.3%(n=26) responded that they sometimes receive threats

Table 4: Physical abuse

Physical abuse		Frequency	Percent%
responses	yes	27	18.0
	no	117	78.0
	sometimes	6	4.0
	Total	150	100.0

Participants were asked if they once experience any form of physical abuse before the majority 78%(n=117) answered no and 18%(n=27) answered yes

Table 5: History of sexual harassment at work

		Frequency	Percent%
	yes	11	7.3
	no	132	88.0
	sometimes	7	4.7
	Total	150	100.0

The table above shows the responses that were given by the Molemole Primary healthcare workers about the history of sexual harassment at work. The majority 88%(n=132) answered no and only 7.3%(n=11) agreed to have encountered sexual harassment at work

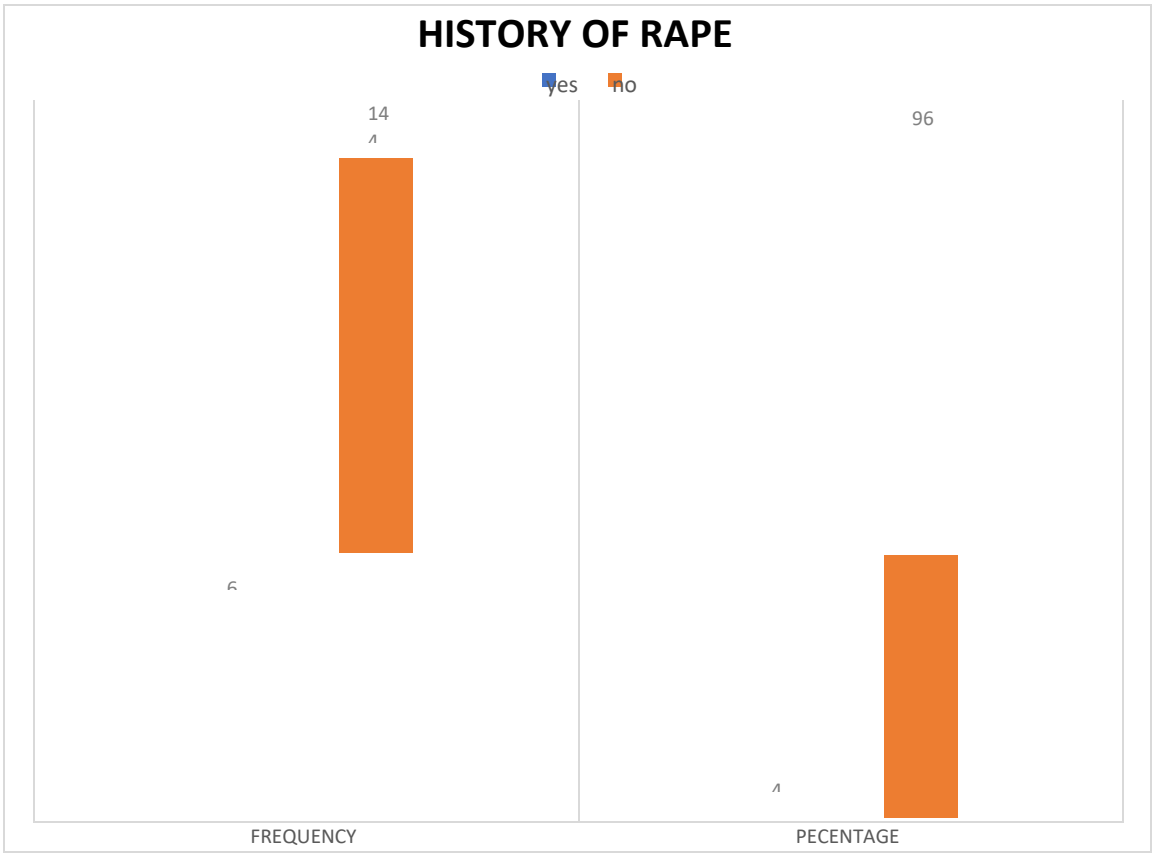

Figure 4: History of rape

The bar graph illustrates the frequency and percentage and frequencies from participants regarding any history of rape 96%(n=144) said no and 4%(n=6) answered yes

Figure 5: History of workplace violence

The majority 56% (n=55,3) of participants responded yes to having a history of verbal abuse at work, 41,3%(n=62) answered no and 3.3% (n=5) said they sometimes encounter verbal abuse at work

4.4. The existence of prevention/management of workplace violence among nurses

Table 6: The existence of prevention/management of workplace violence among nurses

Statements	Responses					
	Yes		No		Sometimes	
	n	%	n	%	n	%
Check-in procedures to staff	86	57.3	22	14.7	44	28
Restricted public access	100	71.3	24	16	19	12.7
Reduced periods of working alone	66	44	58	38.7	26	17.3
Alarms and monitors (including panic buttons)	7	4.7	142	94.7	1	0.7
Availability of restraints and policies for abuse	58	38.7	82	54.7	10	6.7
Availability of escorts	30	20	87	58	33	22
Emergency response team in place	37	24.7	95	63.3	18	12
Personal protective equipment	85	56.7	29	19.3	36	24
Metal detectors usage	25	16.7	108	72	17	11.3
Workplace violence awareness training is provided	19	12.7	117	78	14	9.3
Training on identifying characteristics associated with aggressive and violent behavior from clients/patients	41	27,3	72.7		_	_

When the participants were asked about the available management strategies to reduce workplace violence 78%(n=117) answer that there was no available awareness and training provided regarding workplace violence, 12.7%(n=19) agreed to have had workplace violence awareness and training provided. 63.3%(n=95) participants answered no to not

having an emergency response team in case of any emergence. Out of the 150 participants, 142 =94.7% responded that they did not have alarms, monitors and panic buttons in case of emergency situations

Table 8a: Working experience and history of work place violence Crosstabulation

		History of workplace violence			Total
		Yes	No	Sometimes	
Working experience	1-5	15	25	0	40
	6-10	20	22	5	47
	11-15	13	11	2	26
	16-20	8	5	3	16
	21-25	3	1	1	5
	26-30	6	6	1	13
	31-35	2	1	0	3
Total		67	71	12	150

Table 8b: Chi Square Test for Working experience and history of work place violence

Chi-Square Tests			
	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	12.311[a]	12	0.0421
Likelihood Ratio	14.934	12	0.245
Linear-by-Linear Association	0.184	1	0.668
N of Valid Cases	150		

11 cells (52.4%) have expected count less than 5. The minimum expected count is 0.24.

Table 8c: Symmetric measures for Working experience and history of work place violence

Symmetric Measures			
		Value	Approximate Significance
Nominal by Nominal	Phi	0.286	0.421
	Cramer's V	0.203	0.421
N of Valid Cases		150	

The table 8a, b and c shows the study findings on working experience and history of workplace violence, the results from the crosstabulation indicates that the primary healthcare nurses with less work experience were the ones who were experiencing workplace violence more. The participants who had more working experience had fewer encounters with workplace violence. The crosstabulation and the chi-square test was statistically significant

as it shows that work experience influences the occurrence of workplace violence with a conclusion that the more experience a PHC worker has the lesser the likelihood d of occurrence of workplace violence. The symmetric measures showed that there was significant difference between WPV and working experience (Phi =0.421, Cramer's V =0.421)

Table 9a: History of workplace violence and working with psych Crosstabulation

History of workplace violence and working with psych Crosstabulation					
		Working with psych			Total
		yes	No	sometimes	
History of workplace violence	Yes	100	0	11	110
	No	15	2	10	27
	sometimes	12	0	11	23

Table 9b: Chi Square Tests of workplace violence and working with psych

Chi-Square Tests			
	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	4.549[a]	4	0.337
Likelihood Ratio	6.962	4	0.138
Linear-by-Linear Association	1.193	1	0.275
N of Valid Cases	150		

Table 9c: Symmetric measures of workplace violence and working with psych

Symmetric Measures			
		Value	Approximate Significance
Nominal by Nominal	Phi	0.174	0.337
	Cramer's V	0.123	0.337
N of Valid Cases		150	

The table 19a, b and c illustrates the study findings on working with psychiatric patients and history of workplace violence. From the cross-tabulation, most of the participants who were working with psychiatric had encountered workplace violence. The cross-tabulation and the chi-square test was statistically significant, as it shows that the occurrence of workplace violence in people who are working in psychiatric was high. The symmetric measures showed that there was significant difference between WPV and working with psyc patients (Phi =0.337, Cramer's V =0.337)

4.5. Summary

The prevalence of violence in the facilities that were sampled was high. The highest prevalence was reported in PHC nurses working with psychiatric patients. The chi square test was statistically significant as it showed that there is an association between workplace violence and work experience. The next chapter discusses the results with the support of literature and gives recommendations and a conclusion

CHAPTER 5: DISCUSSION OF THE RESULTS

5.1. Introduction

This chapter will present interpretation and discussion with the support of literature. The discussion is discussed in line with the objectives of the study and based on the output of the descriptive statistical analysis. The overall response rate of this study was 100%(150) all the participants participated in the study. This means the results are adequately represented out of the target from which it was drawn. This chapter discusses the results presented in Chapter 4 under the following headings: the problem of violence against nurses including the history of threats, physical violence, working category; and also discussed the results according to the objectives.

5.2 Working category

From the results obtained by the researcher, PHC nurses working with psychiatric patients had the highest prevalence of violence, with all the nurses who responded indicating that they had experienced some form of violence in the preceding year. All forms of violence were significantly higher at the psychiatric facility. types of violence that the nurses experienced in the psychiatric hospital were mostly verbal abuses, followed by threatening behaviours, then physical assaults and sexual harassment. The finding that the psychiatric hospital had the highest prevalence of violence is consistent with findings by Bilgin (2019) in Turkey; Lawoko et al. (2014) in England and Sweden; Maguire and Ryan (2017) in Ireland; and Franz et al. (2010) in Germany supporting the finding from this present study . This study also found that most of these violent incidents were perpetrated by psychiatric patients. Male patients perpetrated more incidents of violence against nurses than female patients. Psychiatric patients tend to be violent against nurses mostly due to confusion (May & Grubbs, 2012; Mullan & Badger, 2017). As such, psychiatric hospitals are regarded as violent “hotspots” for nurses (Hegney et al., 2016)

5.3 History of workplace violence

The study results show that violence against nurses is considered a problem in Molemole subdistrict South Africa. The study results concur with those reported by Estryn-Behar (2018:) in Europe; Farrel et al., (2016) in Australia; Feringa (2018) in Botswana; Khalil (2018) in Cape Town, South Africa and Shield and Wilkins (2009) in the USA. This confirms that violence against nurses is a global concern as has been suggested by Needham et al. (2018). The period prevalence of reported workplace violence against nurses for all the five facilities for the preceding twelve months was 71%. A similar rate of violence (76%) within a

12-month period was reported by Kwok et al. (2016) in Hong Kong. This contrasts with findings reported by Abbas et al. (2010) in Egypt where only 27.7% of the nurses reported to have experienced workplace violence in the twelve months preceding their study. High rates of violence against nurses have been attributed to the predominance of women in the nursing profession worldwide, who generally have a submissive character (Ferns, 2016) (see comment above)

5.4 Threats

In this study, the researcher noticed that psychological and physical forms of violence were reported to have been experienced by the nurses who participated in this study. The form of violence reported as being the most prevalent was psychological violence and this is consistent with findings from preceding studies (Celik et al., 2017).The study results showd that threat violence was experienced in the form of verbal abuse; threatening behaviour; sexual harassment; Verbal abuse was found to be the most common experience form of psychological violence in all departments and this is consistent with findings from other studies (Abe & Henley, 2017; Celik et al., 2017).

5.5 Physical abuse

The reported incidents of physical violence in this study occurred. The prevalence of physical assaults was high. Other studies elsewhere have also found that violence against nurses with the use of a weapon was low (Kansagra et al., 2018 McKinnon & Cross, 2018). Although the prevalence of physical assaults (with or without a weapon) was low, it is very dangerous. In the USA there have been media reports where physical assaults at the workplace had resulted in the loss of nurses' lives (Carrol,2018).

5.6. Risk factors for workplace violence among primary healthcare nurses

Studies done by Gerberich and Hansen in 2015 indicated that nurses are exposed to various risk factors of physical or verbal violence from both patients and visitors. Some of these risk factors include serving in the public sector, transporting and delivering passengers items and working with more violent people or working in areas with high crime, working at night time and early in the morning, guarding valuables or working alone (The National Institute for Occupational Safety and Health[NIOSH], 1996). The present study shows most of the primary healthcare workers at Molemole sub-district agreed to have a history of workplace violence with they sometimes encounter workplace violence and the crosstabulation from the present study indicated that the patients working in psychiatric wards had more encounters of workplace violence this supports the studies done by (Lee, Gerberich, Waller,

Anderson, & McGovern, 1999;) which stated that Individuals working on psychiatric units are at greater risk of WPV.

Furthermore, Estabrooks, Reimer, Giovannetti, Hyndman, and Acorn (2003) indicated psychiatric nurses experienced varying WPV with physical assault, threats of physical assault, and a minimum of one verbal assault in a period of one working week. The literature is replete with studies on demographic risk factors of WPV in staff and perpetrators (Steinert, 2002; Flannery, Rachlin, & Walker, 2001; Woods, & Ashley, 2007). The present study showed that most participants responded yes to having a history of verbal abuse at work, 41,3%(n=62) answered no and said they sometimes encounter verbal abuse at work. According to Flannery, Rachlin, and Walker (2001) individuals with psychosis and violent episode history and drug misuse do not constitute major risk factors. Some authors concluded that demographic factors alone were inconsistent and not reliable enough for predicting violent episodes compared to clinical diagnoses such as schizophrenia, mania or some organic syndromes (Woods & Ashley, 2007).

5.7. The frequency of workplace violence among primary health care nurses in Molemole sub-district, South Africa.

The present study indicated that primary healthcare workers working o with psychiatric patients had high incidences of workplace violence. From the cross-tabulation done, most of the participants who were working with psychiatric had encountered workplace violence. The cross-tabulation and the chi-square test was statistically significant, as it shows that the occurrence of workplace violence in people who are working in psychiatric was high, these results agreed with the study by Stevenson in 2014 which indicated that acute care psychiatric nurses are exposed to high violence rates perpetrated by patients. Stevenson (2014) demonstrated that patient-related violence impacts negatively on nurses, patients, and the overall organization. The study found that this form of violence was considered as part and parcel of the job, while some nurses experienced role conflict about their duty to provide care and individual duty required to provide care after a critical violence incident. Moreover, the results showed that power, control, plus stigma influenced the perception and responses of nurses to patient violence. Among the interventions used by nurses during their practice for safety, prevention, and management of patient violence are increased education, administrative and colleague support, and debriefing and/or improved working environment.

Per Stevenson understanding the nurses' perspectives and experiences within acute inpatient psychiatry settings provides greater knowledge about patient violence and effective development of evidence-based nursing interventions for prevention and response to patient violence and support of nurses in these settings. The study highlighted the need to explore a

clear definition of violence, factors hindering reporting of violent incidents, development of violence-related best practice guidelines, particularly for patients (Stevenson, 2014).

5.8. Existing security measures in place for prevention of workplace violence in the Molemole-based primary health care facilities, South Africa.

The results from the present study show that there are limited existing security measures in Molemole primary healthcare facilities When the participants were asked about the available management strategies to reduce workplace violence the majority answered that there was no available awareness and training provided regarding workplace violence, most participants agreed to have had workplace violence awareness and training provided. Most of the participants answered no to not having an emergency response team in case of any emergence. Most participants responded that they did not have alarms, monitors and panic buttons in case of emergencies the results and response obtained by this study agreed with the study done by Stevenson 2014 which articulated that most WPV are because of poor security measures at work.

5.9 Recommendations

From the results of this study, the following recommendations were made:

5.9.1 Recommendations for policymakers

In order to prevent and minimise the incidence and impact of violence against nurses, there should be clear policies for all health care facilities. In particular, a policy on reporting, provision of support for victims where necessary and management of perpetrators should be developed and implemented. Consultation with nurses and hospital managers is essential in the development of the policy.

In addition, reported acts of violence should be analysed to identify what caused them and to find possible means of preventing such situations in future. There is also a need for managers in health facilities to conduct a continuous risk assessment for workplace violence to find possible solutions for minimising those risks. Policymakers should have strategies on how to improve security in the health facilities to prevent violence for nurses and all other workers. All other staff members in health facilities should be trained in the prevention of workplace violence and the effects thereof.

5.9.2 Recommendations for nursing education

Topics on nurses' rights, types of violence, prevention of violence and dealing with violence should be included in nursing education at the undergraduate level and provided during

inservice training for qualified nurses. This would help to promote nurses' assertiveness and encourage nurses to recognise violence and deal with this with minimal risk to themselves.

Nurses should be supported in claiming their right to a safe working environment and never feel inferior to any other person who violates their rights.

5.9.3. Recommendations for nursing practice

In order to minimise the risk of interpersonal violence among nurses, use the appropriate structures should be encouraged. These would include support services for the nurse when working in particularly stressful settings, effective management structures, training in the management of potentially risky situations for health care administrators. Collegial support should be encouraged. Effective interpersonal communication skills should be a component of all in-service training programmes. This should include recognition and management of potentially violent situations.

5.9.4 Recommendations for research

There is a need for more research with a larger sample and more health facilities to examine the risk factors for violence and to develop and evaluate strategies for reducing violence against nurses. Studies that incorporate qualitative data would provide an in-depth understanding of some of the issues raised in this study.

5.10 Conclusion

The findings indicate that nurses are experiencing physical threats, verbal abuse, psychological and imminent violence regularly. While WPV is not a new phenomenon, it has become a very serious concern for healthcare workers. This study provided evidence of the significance of the topic of WPV for nursing staff. The results of the analysis provided evidence of a higher incidence of WPV for Health care workers in Molemole This study provides relevant data for healthcare leaders and organizations as they evaluate how to improve safety in the workplace for nursing staff, thereby impacting social change in the healthcare work environment

5.11. Summary

This chapter discussed the results with the support of literature and other previous studies under the following headings: the problem of violence against nurses including the history of threats, physical violence, working category; and discussed the results according to the objectives. The next chapter discusses recommendations from the study which were made for policymakers, nursing education, nursing practice and further research.

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Appendix 1: Research Questionnaire

Workplace violence among primary healthcare nurses in Molemole sub-district, South Africa.

Instructions:

Please complete the following questionnaire, do not write your name or number on the paper, do not tear any page

Respondent`s code (For official use only)

Section A: Biographical information

1. Age: _____ years 2.
What is your gender?

Male	1
Female	2
Other	3

3. Race?

African	1
White	2
Indian	3
Coloured	4

4. Highest qualification?

Certificate	1
Diploma	2
Degree	3
Postgraduate	4

5. Working experience in PHCs? _____ years

6. What Category Are You?

OPM	1
R/N	2
E/N	3

E/N/A	4

7. Which Primary Healthcare facility do you work at?

Nthabiseng PHC	1
Ramokgopa PHC	2
Eisleben PHC	3
Matoks PHC	4
Makgato PHC	5
Dendron PHC	6
Mohodi PHC	7
Persie PHC	8

8. Residence?

Inside the PHC	1
Outside the PHC	2

Section B: Risk factors for workplace violence among nurses Key:

Yes	Y
No	N
Sometimes	S

Mark with an **X**

Statements	Y	N	S
1. Working in male wards			
2. Working with psyche patients			
3. History of workplace violence			
4. Marital status single			
5. Marital status divorced			
6. Marital status widow			
7. Location of the facility (rural, overcrowded, high crime)			
8. Long waiting periods of patients			

9. Apartheid legacy/ prestigious white dominance areas			

Section C: The types and frequency of workplace violence among nurses

Mark with an **X**

Statements	Y	N	S
1. Threats			
2. Physical abuse			
3. Sexual harassment			
4. Rape			
5. Verbal abuse			
6. Theft or burglary			

Section D: The existence of prevention/management of workplace violence among nurses Mark with an X

Statements	Y	N	S
1. Check-in procedures to staff			
2. Restricted public access			
3. Reduced periods of working alone			
4. Alarms and monitors (including panic buttons)			
5. Availability of restraints and policies for abuse			
6. Availability of escorts			
7. Present or rounding security personnel			
8. Emergency response team in place			
9. Personal protective equipment			
10. Reducing overcrowding			

11. Metal detectors usage			
12. Workplace violence training is provided			
13. Workplace violence awareness training is provided			
14. Training on proper techniques for de-escalation (reducing conflict or potential violence situations)			
15. Training on specific evasion techniques			
16. Training on proper patient containment measures			
17. Training on identifying characteristics associated with aggressive and violent behaviour from cliets/patients			
18. Others			

Appendix 2: Request Letter to the Provincial Department of Health

University of Venda

P. Bag X5050

Thohoyandou 0950

The PHC Executive Officer

Private Bag x9302

Provincial Department of Health

Polokwane

0700

05 August 2019

Dear Sir/Madam

RE: REQUESTING PERMISSION TO CONDUCT A RESEARCH ON

I am currently employed as a Profession nurse grade one at Matoks clinc. I am presently studying for a Master's in public health at the University of Venda. As a stipulation before being awarded the qualification, I am expected to conduct a research project of my choice.

My study is focusing on workplace violence among primary health care nurses in Molemole sub-district, South Africa**.** Questionnaires will be used to collect data. The information obtained will be treated with confidentiality and the findings and their respective conclusions and recommendation will be in the form of research report which will be made available to the agency and the Agency and educational institution, University of Venda.

I hope this study will help to the department of health with the identification of the health and safety risks among healthcare workers working in the primary health care facilities, therefore health experts will come up with strategies and policy to manage the health hazards I will highly appreciate your deeds if you consider my request

Yours faithfully

_____ _____

Bele A. A Date

Appendix 3: Request Letter to the District Department of Health

University Of Venda

P. Bag X5050

Thohoyandou 0950

The PHC Executive Officer

Private Bag x9530

Capricorn District

Polokwane

0700

05 August 2019

Dear Sir/Madam

RE: REQUESTING PERMISSION TO CONDUCT A RESEARCH ON

I am currently employed as a Profession nurse grade one at Matoks Clinic. I am presently studying for a master's in public health at the University of Venda. As a stipulation before being awarded the qualification, I am expected to conduct a research project of my choice.

My study is focusing on health and safety risks among workplace violence among primary health care nurses in Molemole sub-district, South Africa. Questionnaires will be used to collect data. The information obtained will be treated with confidentiality and the findings and their respective conclusions and recommendation will be in the form of research report which will be made available to the agency and the Agency and educational institution, University of Venda. I hope this study will help to the department of health with the identification of the health and safety risks among healthcare workers working in the primary health care facilities, therefore health experts will come up with strategies and policy to manage the health hazards

I will highly appreciate your deeds if you consider my request

Yours faithfully _____

_____

Bele A. A Date

Appendix 4: Information sheet and consent form

RESEARCH ETHICS COMMITTEE

UNIVEN Informed Consent

Appendix 6

LETTER OF INFORMATION

Title of the Research Study: Workplace violence among primary health care nurses in Molemole sub-district, South Africa.

Principal Investigator/s/ researcher: Bele Aluwani Allon, Master of Public Health

Co-Investigator/s/supervisor/s: **Dr Malwela T, Dr Makhado L**

Brief Introduction and Purpose of the Study: Primary healthcare nurses are at high risk of violence all over the world. Between 8% and 38% of nurses suffer physical violence at some point in their careers. Many more are threatened or exposed to verbal aggression. Most violence is perpetrated by patients and visitors. Categories of health workers most at risk include nurses and other staff directly involved in patient care, emergency room staff and paramedics. There are more than two million work-related fatalities in the world every year. WPV is a serious problem in the primary health cares based in Limpopo and this problem has left many nurses with trauma and an edge to leave their jobs (Ponthieu & Incerti, 2016). Therefore, the purpose of the study is to determine workplace violence among primary healthcare nurses in Molemole sub-district, South Africa.

Outline of the Procedures: The researcher will be collecting data using a closed and openended questionnaire in English. Respondents are expected to participate voluntarily.

Risks or Discomforts to the Participant: No risks are anticipated.

Benefits: The researcher will benefit from the participants in order to finish the master's degree and publish. The participants may benefit when the research has been published, their plights might be heard.

Reason/s why the respondent may be withdrawn from the Study: There will not be any adverse consequences if the respondents wish to withdraw from the study. Respondents can withdraw if they no longer wish to be part of the study.

Remuneration: There will not be any monetary payment to respondents for participating in this study.

Costs of the Study: Respondents will not cover any of the study costs. The study will be funded by

Confidentiality: Respondent's names will be kept confidential, meaning that the researcher will not use the respondent's real names when conducting the study. Furthermore, there will be no names of respondents on the questionnaires. Completed questionnaires will be kept in a locked safe place, in order to promote confidentiality.

Research-related Injury: There are no research-related injuries anticipated. The researcher will allow the respondents to withdraw from the study if the respondent feels they no longer want to participate in the study.

Persons to Contact in the Event of Any Problems or Queries:

Please contact the researcher 072 594 5779, my supervisor's Dr Mashau N.S 0828710586 and Dr Makhado L 061 147 2002 or the University Research Ethics Committee Secretariat on 015 962 9058. Complaints can be reported to the Director: Research and Innovation, Prof GE Ekosse on 015 962 8313 or Georges Ivo.Ekosse@univen.ac.za

CONSENT

Statement of Agreement to Participate in the Research Study:

- I……..hereby confirm that I have been informed by the researcher about the nature, conduct, benefits and risks of this study –
- Research Ethics Clearance Number:……...
- I have also received, read and understood the above-written information (Respondent Letter of Information) towards the study.
- I am aware that the results of the study, including personal details towards my sex, age, and date of birth, initials and diagnosis will be anonymously processed into a study report.
- In view of the requirements of research, I agree that the data collected during this study can be processed in a computerized system by the researcher.

- I may, at any stage, without prejudice, withdraw my consent and participation in the study.
- I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study.
- I understand that significant new findings developed during the course of this research which may relate to my participation will be made available to me.

Full Name of Participant Date Time Signature

I, …….. …… ……. ……..

(Bele Aluwani Allon) here by confirm that the above respondent has been fully informed about the nature, conduct and risks of the above study.

Full Name of Researcher

…… Date……..

Signature…… Full Name of Witness (If applicable)

…….. Date……..

Signature……..

Full Name of Legal Guardian (If applicable)

Signature……

Date……..

Appendix 5: Ethical clearance certificate

ETHICS APPROVAL CERTIFICATE

RESEARCH AND INNOVATION
OFFICE OF THE DIRECTOR

NAME OF RESEARCHER/INVESTIGATOR:
Mr AA Bele

STUDENT NO:
11637758

PROJECT TITLE: Workplace violence among primary health care nurses' in Molemole Sub-district, South Africa.

PROJECT NO: SHS/20/PH/17/2407

SUPERVISORS/ CO-RESEARCHERS/ CO-INVESTIGATORS

NAME	INSTITUTION & DEPARTMENT	ROLE
Dr T Malwela	University of Venda	Supervisor
Dr L Makhado	University of Venda	Co - Supervisor
Mr AA Bele	University of Venda	Investigator – Student

Type: **Masters Research**
Risk: **Minimal risk to humans, animals or environment**
Approval Period: **July 2020 – July 2022**

The Human and Clinical Trails Research Ethics Committee (HCTREC) hereby approves your project as indicated above.

General Conditions
While this ethics approval is subject to all declarations, undertakings and agreements incorporated and signed in the application form, please note the following.

- The project leader (principal investigator) must report in the prescribed format to the REC:
  - Annually (or as otherwise requested) on the progress of the project, and upon completion of the project
  - Within 48hrs in case of any adverse event (or any matter that interrupts sound ethical principles) during the course of the project.
  - Annually a number of projects may be randomly selected for an external audit.
- The approval applies strictly to the protocol as stipulated in the application form. Would any changes to the protocol be deemed necessary during the course of the project, the project leader must apply for approval of these changes at the REC. Would there be deviated from the project protocol without the necessary approval of such changes, the ethics approval is immediately and automatically forfeited.
- The date of approval indicates the first date that the project may be started. Would the project have to continue after the expiry date; a new application must be made to the REC and new approval received before or on the expiry date.
- In the interest of ethical responsibility, the REC retains the right to:
  - Request access to any information or data at any time during the course or after completion of the project,
  - To ask further questions; Seek additional information; Require further modification or monitor the conduct of your research or the informed consent process.
  - withdraw or postpone approval if:
  - Any unethical principles or practices of the project are revealed or suspected.
  - It becomes apparent that any relevant information was withheld from the REC or that information has been false or misrepresented.
  - The required annual report and reporting of adverse events was not done timely and accurately,
  - New institutional rules, national legislation or international conventions deem it necessary

ISSUED BY:
UNIVERSITY OF VENDA, RESEARCH ETHICS COMMITTEE
Date Considered: July 2020

Name of the HCTREC Chairperson of the Committee:

Signature: MSMapaulle

Director Research and Innovation

Signature: .....GIEEkosse..... 06 August 2020

UNIVERSITY OF VENDA
OFFICE OF THE DIRECTOR
RESEARCH AND INNOVATION
2020 -08- 06
Private Bag X5050
Thohoyandou 0950

University of Venda
PRIVATE BAG X5050, THOHOYANDOU, 0950, LIMPOPO PROVINCE, SOUTH AFRICA
TELEPHONE (015) 962 8504/8313 FAX (015) 962 9060
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Appendix 6: Provincial letter for approval and permission to access the facilities

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

Department of Health

Ref : LP-2020-09-016
Enquires : Ms PF Mahlokwane
Tel : 015-293 6028
Email : Kurhula.Hlomane@dhsd.limpopo.gov.za

Aluwani Bele

PERMISSION TO CONDUCT RESEARCH IN DEPARTMENTAL FACILITIES

Your Study Topic as indicated below;

Workplace Violence Among Primary Health Care Nurses in Molemole Sub District, South Africa

1. Permission to conduct research study as per your research proposal is hereby Granted.
2. Kindly note the following:
   a. Present this letter of permission to the institution supervisor/s a week before the study is conducted.
   b. In the course of your study, there should be no action that disrupts the routine services, or incur any cost on the Department.
   c. After completion of study, it is mandatory that the findings should be submitted to the Department to serve as a resource.
   d. The researcher should be prepared to assist in the interpretation and implementation of the study recommendation where possible.
   e. The approval is only valid for a 1-year period.
   f. If the proposal has been amended, a new approval should be sought from the Department of Health
   g. Kindly note that, the Department can withdraw the approval at any time.

Your cooperation will be highly appreciated

Head of Department

15/10/2020
Date

Private Bag X9302 Polokwane
Fidel Castro Ruz House, 18 College Street. Polokwane 0700. Tel: 015 293 6000/12. Fax: 015 293 6211.
Website: http/www.limpopo.gov.za

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