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Psychosocial Hazards: Awareness, Occurrence and Impact on Selected Health Workers in Chukwuemeka Odumegwu Ojukwu University Teaching Hospital (Coouth) Amaku-Awka, Anambra State, Nigeria.

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Abstract

➢ ***Background***

Healthcare workers are dedicated to offering a range of preventive and curative services to clients and patients. In doing so, they often face exposure to various hazards that may pose risks to their health and overall well-being. These risks encompass psychosocial challenges, including workplace stress, violence, and harassment, all of which significantly impact the mental well-being of healthcare professionals. Controlling and minimizing these psychosocial hazards among healthcare workers present a unique challenge especially in developing countries.

Hence, we explored the perception, frequency of occurrence and impact of these psychosocial hazards on the health and wellbeing of health workers in Chukwuemeka Odumegwu Ojukwu University Teaching Hospital, Amaku-Awka as well as the impact on productivity and economic costs.

The findings were consistent with previous research studies on the subject matter and we concluded by recommending feasible approaches which would increase awareness of psychosocial hazards among healthcare workers and strategies to mitigate the deleterious effects of these hazards.

➢ ***Methodology***

This study utilized a cross-sectional descriptive approach to explore the awareness, prevalence, and effects of psychosocial hazards among healthcare workers at Chukwuemeka Odumegwu Ojukwu University Teaching Hospital (COOUTH) Amaku, Awka. A stratified sampling technique was employed to select 100 participants from the target population. Data collection was conducted using a semi-structured, self-administered questionnaire.

➢ ***Results***

In this study, the average age of respondents was 35.47 ± 9.51 years. Participants demonstrated substantial awareness of various psychosocial hazards impacting healthcare workers during the delivery of clinical services. The most commonly acknowledged hazards included work-related stress (96 respondents, 98%), work-related fatigue caused by mentally and physically demanding tasks (90 respondents, 91.8%), and workplace abuse in the form of disrespectful behavior (84 respondents, 89.4%). However, awareness was relatively low for hazards such as substance use in the workplace (18 respondents, 18.4%), isolation or exclusion (30 respondents, 30.6%), and assignment of unachievable tasks (32 respondents, 32.7%).

Regarding the occurrence of psychosocial hazards, the most frequently reported included work-related fatigue caused by mentally and physically demanding tasks (50 respondents, 51%), environmental stress (44 respondents, 44.9%), and work-related stress (40 respondents, 40.8%). On the other hand, workplace abuse linked to substance use (82 respondents, 83.7%), sexual harassment such as coercion (84 respondents, 87.5%), and racial discrimination (86 respondents, 87.8%) were identified as the least prevalent psychosocial hazards.

In terms of the impact, a significant proportion (68 respondents, 69.4%) expressed feeling positively influenced by their work, stating they effectively address patients' issues and believe they make meaningful contributions to others' lives. However, the study also identified adverse effects on the health of workers who had experienced psychosocial hazards in the workplace. Musculoskeletal disorders 60 (60%) representing health impairments, sleep disorders 56 (56%) and insufficient physical activity 48 (49%) both representing coping behaviors constitute the most prevalent effects of psychosocial hazards on health. Impact on productivity and economic costs were also evaluated. Reduced motivation, satisfaction and commitment 44 (44%)

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represented the most prevalent effect on productivity while reduced efficiency and accuracy in performance 18 (18%) recorded the least prevalence.

➢ ***Conclusion***

Findings from this study revealed that healthcare workers demonstrated adequate awareness of the various psychosocial hazards they face in the workplace. The frequency of these hazards differed among respondents, with fatigue from work as a result of mentally and physically demanding tasks, environmental stress, and work-related stress emerging as the most commonly experienced issues. Despite these challenges, many healthcare workers maintained a positive attitude toward their roles, viewing their work as meaningful and impactful.

However, the study also identified notable negative effects of psychosocial hazards on workers' health. Common health-related impacts included musculoskeletal disorders, sleep disturbances, and insufficient physical activity, which were recognized as prevalent coping-related issues. In terms of productivity, reduced motivation, job satisfaction, and commitment were among the most reported impacts. Conversely, reduced efficiency and accuracy in task performance were the least frequently noted consequences of psychosocial hazards.

Keywords: *Psychosocial Hazards, Awareness, Health Workers, COOUTH.*

I. INTRODUCTION

A. Background

Hospitals are centers for patient treatment and healing, but they can also present significant hazards to healthcare workers, which may adversely affect their health and safety. Any occupation and career (doctors and nurses inclusive) is exposed to one or more work related hazard. Hence, Occupational hazard is described as the risk, harm, or danger that an individual is exposed to at the workplace[1]. As such, occupational health can be defined as the identification and control of risks arising from work place[2].

The history of occupational hazards dates back to the 18th century, when Bernardino Ramazzini (1633-1714), known as the father of occupational medicine, first acknowledged the impact of occupation on the development of health conditions and diseases [3].

Occupational Hazard has been classified by into: physical, mechanical, chemical, biological and psychosocial hazards.

Psychosocial hazards can be defined as the "interactions between and among work environment, job content, organizational conditions and workers' capacities, needs, culture, personal extra-job considerations that may, through perceptions and experience, influence health, work performance and job satisfaction.[6]

Psychosocial hazards are inextricably linked to work-related stress. Work-related stress is the response people may have when presented with work demands and pressures that are not matched to their knowledge and abilities and which challenge their ability to cope.[7]

Both curative and preventive services are provided by healthcare facilities. As a result, it is important to ensure that the workers of healthcare organizations are in good health as they care for the ill. As a result, it is critical to recognize and minimize psychosocial hazardous exposures in their workplace, as this has an effect not just on their own health but also on patient care.

➢ *Categories of Psychosocial Stress*

These psychosocial hazards can be classified as follows:

- *Job Content;*

Lack of diversity or short work cycles, scattered or pointless work, underutilization of expertise, high insecurity, and constant exposure to people through work are all factors to consider.

- *Workload and Work Place;*

Work overload or under load, high levels of time pressure, and constant deadlines are all factors to consider.

- *Work Schedule;*

Shift work, night shifts, rigid work schedules, irregular hours, and long or unsociable hours are all examples of shift work.

- *Control;*

Limited involvement in decision-making, as well as a lack of control over workload, timing, and other factors.

- *Environment and Equipment;*

Inadequate equipment capacity, suitability, or maintenance; unfavorable working conditions, such as a lack of accommodation, inadequate lighting, or unnecessary noise.

- *Organizational Culture and Function;*

Ineffective coordination, a lack of resources for problem-solving and professional growth, and a lack of definition or consensus on organizational goals.

- *Interpersonal Relationships at Work;*

Social or physical isolation, strained interactions with colleagues, interpersonal strife, a lack of social support, abuse, and intimidation are all examples of social or physical isolation**.**

- *Role in Organization; Role*

Uncertainty, confrontation, and personal obligation.

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- *Career Development;*

Career instability and confusion, non- or over-promotion, low pay, career insecurity, and low social commitment of jobs are all issues that people face.

- *Home-Work Interface;*

Conflicting demands of work and home, low support at home, dual career problems.[7]

The prevalence of these hazards is often unknown, and often physicians and nurses are subjected to a series of exposures without even realizing that such dangers have an effect on their wellbeing and capacity to provide health care.

Doctors and nurses are often overlooked as a vulnerable group, with the assumption that they are immune to occupational hazards, leading to insufficient awareness and protection against psychosocial risks. Stress among doctors and nurses often leads to a substantial loss in job efficiency in the healthcare industry.

Psychosocial stress refers to the reaction individuals experience when faced with work demands and pressures that exceed their knowledge and abilities, challenging their capacity to cope effectively.[1]

Psychosocial stress is increasingly emerging as a widespread occupational health issue. The constant demand to provide high-quality healthcare is placing immense pressure on the well-being and productivity of doctors and nurses. This, in turn, is negatively impacting organizational health outcomes. Studies show a clear link between work-related illnesses and exposure to psychosocial stress.[10]

Psychosocial risks for health care workers are rapidly being recognized as significant public health issues in developing countries. Due to globalization and changes in employment patterns, these threats are no longer limited to the developing world. For many years, concerns about the causes and health impacts of psychosocial risks have been prevalent, particularly in developed countries, and more recently, in developing countries as well. There is a lack of knowledge of, in addition to current challenges in monitoring other more well-known workplace hazards. Psychosocial threats (along with work-related tension, abuse, and harassment), and a scarcity of money to deal with them.

Despite the growing body of research on the psychosocial aspects of work in high-income countries, there is a notable lack of attention to this issue in Africa, particularly in Nigeria. Consequently, there is a pressing need to examine the psychosocial risks faced by healthcare workers in low-income countries. This research could help in the development of tailored occupational health and safety policies and services for doctors and nurses.

With a population exceeding 180 million, Nigeria has one of the largest healthcare workforces in Africa, with a ratio of 1.95 healthcare workers per 1,000 people.[12] There are 3827 doctors per 10,000 population, and 14,524 nurses and midwives per 10,000 population.[13] Nigeria has a ratio of 1.95 healthcare workers per 10,000 people and 14,524 nurses and midwives per 10,000 people. Despite limited research on the prevalence of psychosocial stress among Nigerian doctors and nurses, existing studies show significant disparities in the reported figures. Therefore, it is crucial to gain a clearer understanding of the overall prevalence of psychosocial stress among healthcare workers in Nigeria to inform more effective preventive and therapeutic policies.

The consequences of psychosocial risks frequently have an influence on doctors' and nurses' welfare and effectiveness, as well as their families and workplace. As a result, there is a chain effect and a very vicious circle. And now, there is a high degree of misunderstanding and disregard for these risk factors. As a result, most threats go unnoticed until their full impact on the worker is apparent. It is noteworthy to add that the impact of these factors varies according to individual response. Factors contributing to workplace stress include workload, leadership styles, management issues, relationships with colleagues and other staff, shift work, emotional demands, and a lack of recognition or rewards.[14] Job overload, advancement, publicity, lengthy working hours, shift assignments, and modern technologies are all examples of intrinsic causes in the workplace that can contribute to occupational tension. Another study revealed that nurses experience varying degrees of depression, ranging from mild to severe. This significantly impacts their work, leading to feelings of dissatisfaction and unhappiness with their duties.[15]

On the International Labor Organization's World Day for Safety and Health at Work, April 28, 2016, the consequences of psychosocial dangers were defined as follows:

➢ *The Effects of Stress on Workers' Health, Safety, and Wellbeing.*

- *This Could Further Be Expanded Into;*

Health Impairments such as cardiovascular diseases, Musculoskeletal disorders, Burnout, Psychological disorders, Suicide, Impaired immune system. Coping Behaviors such as, Tobacco use, Social withdrawal, exercising less often, Alcohol abuse, Unhealthy diet, increased cigarette smoking.

➢ *The Effect of Stress on Productivity and Economic Costs.*

- *They Include;*

Increased absenteeism and presenteeism, Diminished productivity, Accidents, Decrease in enthusiasm, Fatigue. However, the overall effects entail a significant reduction in quality of living and health-care delivery.

B. Problem Statement

Health workers should be evaluated for the existence of psychosocial hazards or risk factors in the workplace on a regular basis in an optimal situation. Adequate measures are

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then put in place to improve the psychosocial health of doctors and nurses.[10]

This has not been the case with health workers, especially in developing countries, where doctors and nurses are often believed to be resistant to psychosocial dangers and are severely undervalued. Therefore, little or no assessment of psychosocial health hazards are in place to reduce the effect of these hazards on the outcome of work.[4]

Several studies have examined the prevalence and impact of psychosocial hazards among healthcare workers.

In a national study conducted in India, involving 242 critical care doctors, it was found that 40% of them experienced moderate to severe levels of stress while working in ICU settings.[45].

A study conducted in Cross River State, Nigeria, found that up to 92.8% of healthcare workers reported feeling stressed due to their jobs. Not only did they experience stress, but a significant relationship was also identified between work-related stress and factors such as service delivery, work overload, increased stress, poor managerial support, and staff attitudes toward service delivery.[46]

In Saudi Arabia, a survey of 1,168 healthcare professionals, including 32.2% doctors, revealed that the majority of participants reported moderate to high levels of stress. The overall prevalence of job-related stress among the group was 66.2%.[47]

In a study involving 227 healthcare workers at a Brazilian University Teaching Hospital, including 126 nursing assistants, 75 nursing technicians, and 26 nurses, it was found that 60.8% of participants felt they faced high psychological demands. While 71.8% believed they had substantial control over their work, 85% reported receiving inadequate social support, citing difficulties in interpersonal relationships at the workplace. Additionally, a significant proportion (44.5%) experienced what is known as 'active work,' marked by both high demands and control.[48]

C. Justification of Study

Nigeria is richly endowed with human resources with a population of over two million people, and more so, in the health sector which contributes about a hundred thousand people. [10] This necessitates the collection of statistics and reports on physicians' and nurses' psychosocial wellbeing. Although limited research has been conducted on the prevalence of psychosocial stress among doctors and nurses in Nigeria, the existing data has been highly inconsistent. Therefore, understanding the overall prevalence of psychosocial stress in this group is crucial for making informed decisions regarding preventive measures and clinical policies.

D. Objectives of the Study

- *General Objective:*

- To determine the awareness, occurrence and effect of psychosocial hazards among health workers in COOUTH.

- *Specific Obejectives:*

- To assess the awareness of psychosocial hazards among health workers in COOUTH Amaku-Awka, Anambra State.
- To examine the prevalence of psychosocial hazards among healthcare workers at COOUTH Amaku-Awka, Anambra State.
- To assess the effects of psychosocial hazards on the well-being and performance of healthcare workers at COOUTH Amaku-Awka, Anambra State.

E. Research Questions

- What is the level of Awareness of psychosocial hazards among health workers in COOUTH Amaku-Awka, Anambra State.
- How often do psychosocial hazards occur among the health workers in COOUTH Amaku-Awka, Anambra State.
- What are the effects of psychosocial hazards among health workers in COOUTH Amaku-Awka, Anambra State.

II. LITERATURE REVIEW

Job-related sickness and disability result in work attrition in many countries, according to the World Health Organization (WHO) in 2006**.**

Work-related stress, which is closely tied to psychosocial hazards, comes with significant consequences for both workers' health and organizational productivity, including higher absenteeism and lower job performance.[18] In the United Kingdom, research found that work-related stress leads to the loss of 6.5 million working days each year.[19] In Europe, nearly 28% of workers reported that their mental health was negatively affected by exposure to psychosocial hazards. It is also estimated that work-related stress and psychosocial risks contribute to 50-60% of all lost working days.[20]

- *Doctors and Nurses' Knowledge of Psychosocial work Hazards*

In a study done in Delphi, psychosocial hazards and work-related stress are frequently considered interchangeable, as they share common sources and effects, both posing notable concerns for the workforce. The limited awareness and research in this area prevent meaningful interventions in healthcare settings.[21]

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Another study done in Germany among 435 Doctors showed that the prevalence of perceived psychosocial distress was at a moderate level, while that of perceived psychosocial distress was at high levels.[35]

A study conducted in India with 482 doctors and nurses found that 39% of participants did not initially recognize work-related health hazards, yet they acknowledged exposure to at least one when further questioned. Psychological hazards reported by participants included negative emotions (20.3%) and verbal or physical abuse (20.5%). The findings highlight the need for training programs aimed at behavioral change and the provision of occupational health services.[22]

In Nigeria, a qualitative study on psychosocial hazards among doctors and nurses at a tertiary health facility in the South-South region involved interviews with 18 participants. The study found that work overload was the most commonly recognized psychosocial hazard.[23]

Another study conducted at the University of Port Harcourt revealed that employees in the 36-45 age group (68.3%) and the 26-35 age group (68%) were most aware of psychosocial risk factors. In contrast, the oldest age group (66-75) had the lowest awareness (31.6%). Additionally, female staff (80.7%) were found to be at a higher risk than male staff (60.4%).[30]

- *Occurence of Psychosocial Hazards among Doctors and Nurses*

Violence in healthcare settings has become a growing concern, particularly among doctors and nurses, with nurses being more frequently exposed to various forms of aggression, including physical and verbal abuse. Patients and their families are the primary sources of this violence. While verbal abuse may not leave visible injuries, its emotional toll can lead to significant exhaustion. Hospitals should implement strict zero-tolerance policies against verbal abuse, as it is a major contributor to dissatisfaction within the nursing workforce. Verbal abuse has been linked to higher nurse turnover rates in healthcare organizations[28]

Psychosocial hazards are also prevalent among healthcare staff, as evidenced by a study where Registered Nurses reported experiencing higher levels of verbal abuse from colleagues, particularly those working in non-magnet hospitals. These nurses also expressed lower job satisfaction, weaker organizational commitment, less autonomy, and a diminished intent to remain in their positions. Additionally, they viewed their work environments in an unfavorable light.[29]

In an Indian survey of 392 doctors, 71 (18.11%) had psychological discomfort linked to their profession. There were 49 (12.50%) participants who were experiencing minor stress, 15 (3.83%) who were experiencing stress, and 1.79 percent who were experiencing severe stress.

Similarly, a study involving 100 nurses used the Maslach Burnout Inventory to assess burnout levels. The results revealed that 35% of participants experienced high emotional exhaustion, 17% exhibited high depersonalization, and 11% demonstrated high personal achievement.[36]

In Saudi Arabia, a survey of 1,168 healthcare professionals, including 32.2% doctors, found that most participants reported experiencing moderate to high stress levels, with an overall job stress prevalence of 66.2%.[37]

Another study identified key risk factors for psychosocial hazards among doctors and nurses. Workload was the most commonly reported hazard, with 98.2% of respondents citing it, followed by home-work interface (82%), limited career advancement opportunities (70.1%), lack of career development (58.7%), work content (60%), and constant state of alertness was the least(17.6%).[32]

A study conducted at the University College Hospital in Ibadan, Nigeria, compared burnout among different healthcare professionals. A sample of 260 healthcare providers revealed that nurses consistently scored higher in all burnout categories: emotional exhaustion ($F = 3.60$, $df = 258$, $P < .05$); , personal accomplishment ($F = 3.94$, $df = 258$, $P < .05$), and depersonalization ($F = 4.58$, $df 258$, $P < .01$), when compared to other healthcare professionals.[33]

In a similar study at the University of Port Harcourt, 62.2% of doctors and nurses reported exposure to psychosocial hazards. Workplace bullying was the most prevalent issue, with verbal abuse occurring in 43.9% of cases.

Other common psychosocial hazards included workplace abuse (39.4%) and work-related stress (62.7%). Environmental stress was the most common form of fatigue (52.3%), while unwanted sexual attention and harassment accounted for 6.1%. Racial discrimination was the least prevalent, affecting only 7% of participants. The study also found that workload (98.2%) and home-work interface (82%) were the most significant risk factors. In-service training (76.7%) was identified as the most effective strategy for addressing psychosocial hazards at the University of Port Harcourt.[34]

Lastly, a study by Obasohan and Ayodele assessing psychosocial stress among 290 doctors in Lagos revealed a prevalence rate of 86.2%. The study also highlighted job discrimination as a major risk factor for psychosocial stress, affecting 30.5% of participants.($R\underline{2} = 0.305$; $F = 23.291$; $P > .05$).[42]

- *Impact of Psychosocial work Hazard on Psychosocial work Hazards*

According to the Health and Social Care Information Center (2015), within the 1.3 million workforce of the National Health Service in the United Kingdom, nurses account for more than 28%. One of the primary contributors to emotional exhaustion among nurses is extreme work

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pressure, which in turn leads to decreased morale, job dissatisfaction, and a heightened intention to leave the profession. The combination of work-related stress and the stresses of daily life imposes significant physical and emotional burdens on the body.[27]

A study assessing burnout among 100 nurses using the Maslach Burnout Inventory found that 35% of participants experienced high levels of emotional exhaustion, 17% showed high levels of depersonalization, and 11% reported high levels of personal achievement.[3]

In Canada, a study on work-related psychosocial factors and chronic pain found that work-related stress is a notable risk factor for developing chronic pain or discomfort. The relative risk for medium stress was 1.39 (95% CI = 1.01–1.91), and for high stress, it was 1.80 (95% CI = 1.28–2.52). High psychological demands and low skill discretion were independently associated with pain and discomfort, although no links were found between psychosocial factors and physician-diagnosed chronic conditions such as back problems, arthritis, or migraines. Overall, work-related stress proved to be a significant risk factor for nonspecific pain complaints among workers.[24]

A study conducted in London showed strong evidence linking shift work and work-related psychosocial stress to an increased risk of coronary heart disease, with some association to stroke, another cardiovascular disease. However, research on the connection between stroke and psychosocial stress remains limited, requiring further studies with more comprehensive exposure data and better study designs to explore both long-term and short-term effects.[25]

Similarly, another study revealed that night and relief/combined shift workers were more likely to adjust to irregular schedules and disrupted sleep but reported greater work-related impacts compared to day workers. Permanent night shift workers reported poorer health, higher absenteeism, and lower job satisfaction compared to day workers. Factors contributing to optimal performance and contentment with schedules among shift workers included adequate sleep, evening circadian preference, older age, and organizational satisfaction, while poor health and sleep/wake difficulties were associated with reduced work performance and dissatisfaction with schedules.[26]

In the UK, studies show that nurses often face verbal abuse at work, which can have long-lasting impacts. The consequences of verbal abuse include absenteeism and medical errors. The primary sources of verbal abuse were colleagues, followed by patients' relatives, doctors, patients, residents, and interns. Verbal abuse was the most common disruptive behavior faced by nurses, with those in the early stages of their careers being particularly vulnerable. This abuse was linked to lower organizational commitment, job dissatisfaction, and a higher likelihood of leaving the job.[28]

The link between psychosocial stress and cardiovascular disease (CVD) remains inconclusive. A study in Taiwan involving 576 medical staff members, with a predominance of females (85%) and a mean age of 43 years, assessed arteriosclerosis through brachial-ankle pulse wave velocity (baPWV). Factors like job demands, job control, social support, shift work, work hours, sleep duration, and mental health were examined. Longer work hours and shorter sleep durations were found to be associated with an increased risk of arteriosclerosis.[31]

A study in South Africa with 44 participants, 17% of whom were doctors, found that 52% of the healthcare workers reported experiencing burnout and emotional exhaustion.[38]

Egypt, a study at Tanta University among 523 staff members, 239 of whom were physicians, found that 46.9% scored high on emotional exhaustion, 44.9% had moderate levels of depersonalization, and a majority (97.7%) reported high levels of reduced personal accomplishments.[39]

In Nigeria, a study by Owolabi et al. in Oyo State, involving 324 healthcare workers from mission hospitals, examined the association between psychosocial stress and hypertension. Using the Job Demand-Control Questionnaire to assess psychosocial stress, along with BMI and blood pressure measurements, the study found a combined prevalence rate of psychosocial stress at 26.2% (95% CI: 21.685–31.143). The study also revealed a statistically significant association between psychosocial stress and increased hypertension prevalence.[43]

Finally, a study conducted at the University of Nigeria Teaching Hospital involving 210 nurses identified high levels of burnout in 42.9% of participants in emotional exhaustion, 47.6% in depersonalization, and 53.8% in reduced personal accomplishment. Additionally, 44.1% of the nurses scored positively on the GHQ-12, indicating the presence of psychosocial distress.

III. METHODOLOGY

A. Study Area

The study was conducted at Chukwuemeka Odumegwu Ojukwu University Teaching Hospital (COOUTH) in Amaku – Awka, which was previously known as Anambra State University Teaching Hospital (ANSUTH). The hospital is situated in Awka, the capital city of Anambra State, Nigeria. Awka lies within the Awka South Local Government Area of Anambra and is part of the southeastern geopolitical zone of Nigeria. As per the 2006 national census, Anambra State has a population of 4,177,828 inhabitants.

The primary language spoken in Awka is Igbo, and the main occupations of the residents include farming, trading, and public service. Awka, one of the oldest settlements in Igbo land, holds historical significance as the heart of the Nri civilization, which produced the earliest documented bronze works in sub-Saharan Africa around 800 AD and

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was the birthplace of Igbo culture. Geographically, Awka is strategically located between two major cities in Igbo land: Onitsha and Enugu. The town is currently divided into two local government areas: Awka North and Awka South, with a total of 33 villages.

Originally founded as General Hospital Amaku-Awka in 1956, the institution was later upgraded to a tertiary teaching hospital affiliated with Chukwuemeka Odumegwu Ojukwu University (formerly Anambra State University). The hospital is located along the Onitsha-Enugu Expressway, opposite the Anambra Broadcasting Service (ABS, PMB 5022). Its mission encompasses providing clinical services, offering undergraduate and postgraduate medical training, and serving as a platform for research and the advancement of knowledge in various medical fields and diagnostic services expected of a typical teaching hospital.

B. Study Design

This is a descriptive cross-sectional analysis that was performed using semi-structured questionnaires to determine the perception, frequency, and impact of psychosocial hazards in COOUTH.

C. Study Population

This group includes doctors, nurses and hospital cleaners who work at Chukwuemeka Odumegwu Ojukwu University Teaching Hospital (COOUTH) in Amaku-Awka and are interested in active clinical care of patients.

➢ *Inclusion Criteria*

- Doctors (Consultants, Resident Doctors, Medical Officers and House Officers)
- Nurses
- Hospital cleaners

➢ *Exclusion Criteria*

- Those who are absent during the period of the study.
- Health workers who did not give consent.

➢ *Sampling Procedures*

For sample collection, stratified sampling was used; however, a second-staged stratified sampling was also used for the group of Medical Doctors.

Doctors comprised 40% of the total population, out of which 13% of the doctors are consultants, residents and medical officers comprised about 57%, while house officers comprised about 30%. Nurses were found to comprise of 30% of the total population. While hospital cleaners were found to be 30% of the population.

D. Sample Size Determinaton

Using

$$N_0 = \frac{Z^2pqe^2}{}$$

Where N_0 = Sample size

Z = Confidence Level (1.96 at 95%)
p = Degree of variability (i.e. Prevalence rate in % culled from a previous study);

Prevalence of psychosocial hazards in a study in cross river state = 92.9% (0.93).[44]

q = (1 – p) but p = 0.93

Therefore q = (1 - 0.93) = 0.07

e = level of precision = 5% (0.05)

Therefore. Sample size will be:

$$N_0 = \frac{1.96 \times 1.96 \times 0.93 \times 0.07}{0.05 \times 0.05}$$

$$N_0 = \frac{0.25008816}{0.0025}$$

$$N_0 = 100.035 = 100$$

Using an attrition rate of 15% = 15; the total sample size = 100 + 15 = 115

E. Research Instruments

The research instrument used for this study includes:

➢ *Self-Administered Questionnaire:*

Data was collected about socio-demographic information, awareness, occurrence and effect of psychosocial hazards in their workplace.

➢ *Abbreviated Maslach Burnout Inventory (Mbi):*

The abbreviated MBI consists of 9 items that utilize a 7-point Likert-type scale to measure burnout, with responses ranging from 0 (never) to 6 (every day). The maximum possible total score on the burnout scale is 54. The MBI includes three subscales:

- Emotional Exhaustion (items 1-3): This subscale measures physical and mental fatigue.
- Depersonalization (items 4-6): This subscale assesses negative changes in attitude when individuals begin to treat those they serve in a detached or impersonal manner.
- Professional Accomplishment (items 7-9): This subscale reflects the individual's perception of their ability to positively influence the well-being of others through their work and their overall sense of job satisfaction.
- Burnout is treated as a continuous variable, with a spectrum of low, average, and high levels of burnout. High burnout is indicated by high scores on the emotional exhaustion (maximum score of 21) and depersonalization (maximum score of 18) subscales, along with low scores on the professional accomplishment (maximum score of 21) subscale. An average level of burnout is reflected by middle-range scores on all three subscales. A low level of burnout is

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indicated by low scores on the emotional exhaustion and depersonalization subscales, and higher scores on the professional accomplishment subscale. [41,42,43]

F. Data Collection Methods

The questionnaire underwent a validity and reliability check through a preliminary survey before being utilized to gather data from participants. This was done using a standardized, self-administered questionnaire.

To ensure compliance, questionnaires were sent to healthcare staff after their respective duty hours and attempts were made to collect them the same day.

➢ *The Questionnaire Has Five Sections:*

The preliminary section contains brief description of the study, informed voluntary consent and instructions on how to respond to the questions.

- Section 1 is on the respondents' socio demographic data.
- Section 2 assesses the awareness of psychosocial hazards among healthcare workers.
- Section 3 assesses the occurrence of psychosocial hazards among healthcare workers.
- Section 4 assesses the effect of psychosocial hazards among healthcare workers.

G. Data Management Plan

➢ *Measurement of Variables:*

- Psychosocial hazards in the workplace were assessed using the following parameters: types of hazards, profession, years in the occupation, and number of occurrences of hazards in the previous one month, origin of hazards, preventive measures, and care.
- The effects of psychosocial hazards were assessed using the following parameters: impact of hazards on attitude toward employment, effect of hazards on work performance, and number of days missed from work due to occupational hazards in the previous one month.

➢ *Data Analysis*

Data processing and analysis were conducted using the Statistical Package for Social Sciences (SPSS) version 26.

H. Ethical Considerations

Prior to the distribution of the questionnaires, the study was approved by the COOUTH ethics committee, and verbal consent was obtained from the participants. They were informed about the purpose of the study and assured that their participation was completely voluntary (informed consent). Participants were also guaranteed that their confidentiality would be maintained before, during, and after the analysis. They were informed that the data collected would be used solely for scientific purposes and that the results would be shared with them.

I. Limitations of the Study

- The ability for participants to share information with one another. This was reduced by collecting questionnaires from them on the same day as they were distributed.
- Participants' unwillingness to cooperate due to task overload**.**

IV. RESULTS

A. Socio-Demographic Characteristics of the Respondents

A total of 100 health workers from Chukwuemeka Odumegwu Ojukwu University Teaching Hospital, located in Awka, Anambra State, responded to the questionnaire, out of 115 health workers who were initially approached for participation, yielding a response rate of 86.96%.

In terms of age distribution, 6 (6%) participants were aged 25 years or younger, 44 (44%) were within the 26-30 year age group, 6 (6%) were aged between 31-35 years, 22 (22%) were in the 36-40 year age range, 6 (6%) were between 41-45 years old, and 16 (16%) were aged 46 years or older. The mean age of the respondents was 35.47 years, with a standard deviation of ±9.51 years.

There were 52 (52%) males and 48 (48%) females. With respect to marital status of the respondents, 26 (26%) were single and 74 (74%) were married. All 100 (100%) respondents were Igbo by ethnicity and there were 98 (98%) Christians and 2 (2%) traditionalists.

Six (6%) respondents had primary school education, 20 (20%) had up to secondary school education and 74 (74%) had tertiary education.

By profession, 50 (50%) were medical doctors, 26 (26%) were nurses and 24 (24%) were healthcare assistants. Among the doctors approached for this study, there were 14 (28%) consultants, 18 (36%) registrars, 12 (24%) medical officers and 6 (12%) house officers. 52 (52%) health workers have a work experience of ≤ 5 years, 26 (26%) have a work experience of 6-10 years, 10 (10%) have a work experience of 11-15 years, 4 (4%) have a work experience of 16-20 years, 4 (4%) have a work experience of 21-25 years and 4 (4%) have a work experience of ≥ 26 years.

Table 1 Socio-Demographic Characteristics of the Respondents

Characteristics (N= 100)	**Frequency (n)**	**Percentage (%)**
Age Group		
≤ 25	6	6
26-30	44	44
31-35	6	6
36-40	22	22

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41-45	6	6
≥46	16	16
Sex		
Male	52	52
Female	48	48
Marital Status		
Single (Never married)	26	26
Married	74	74
Ethnic Group		
Igbo	100	100
Hausa	0	0
Yoruba	0	0
Religion		
Christianity	98	98
Islam	0	0
Traditional	2	2
Profession		
Medical doctor	50	50
Nurse	26	26
Healthcare assistant	24	24

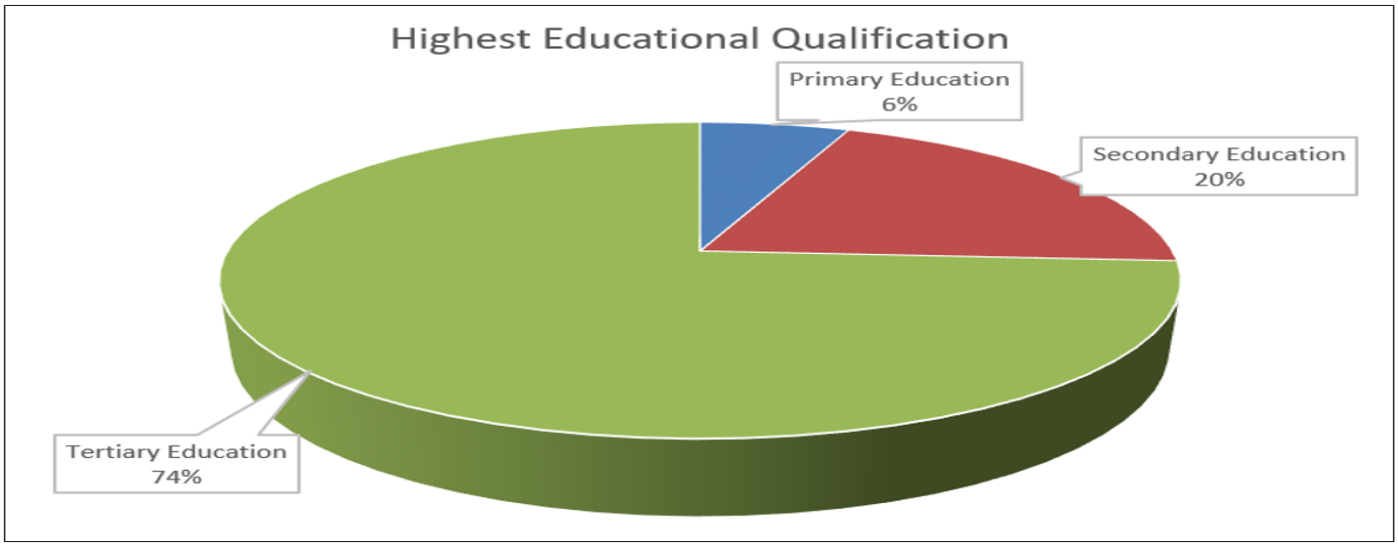

Fig 1 Highest Educational Qualification

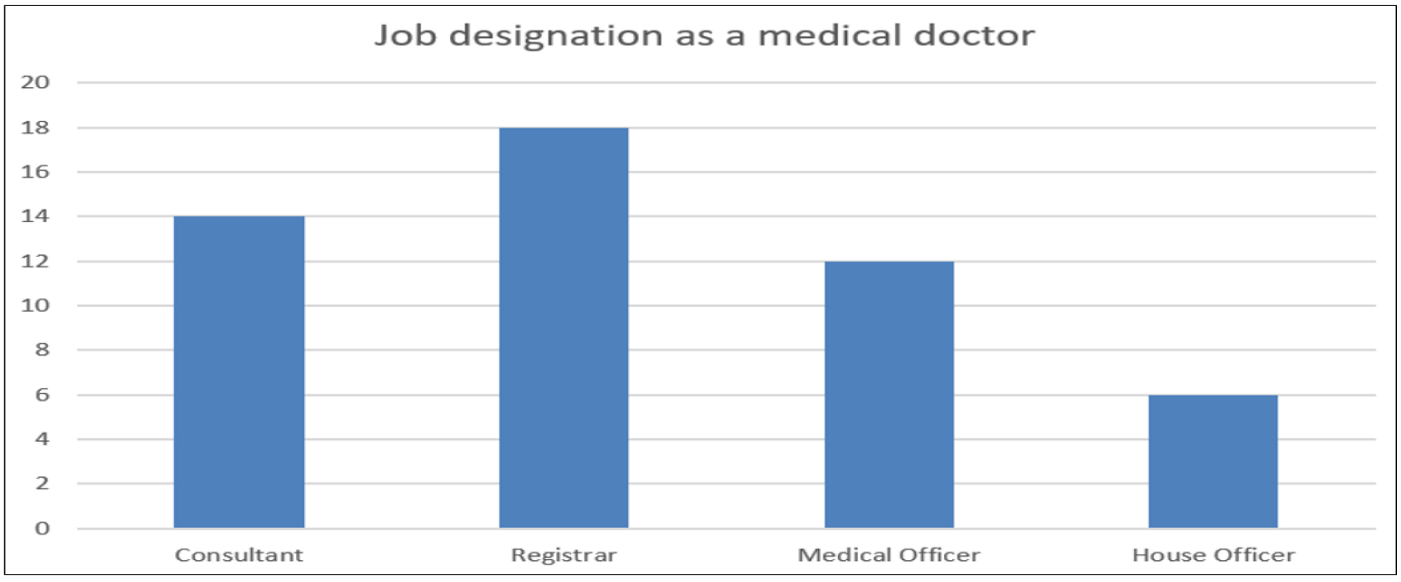

Fig 2 Job Designation as a Medical Doctor

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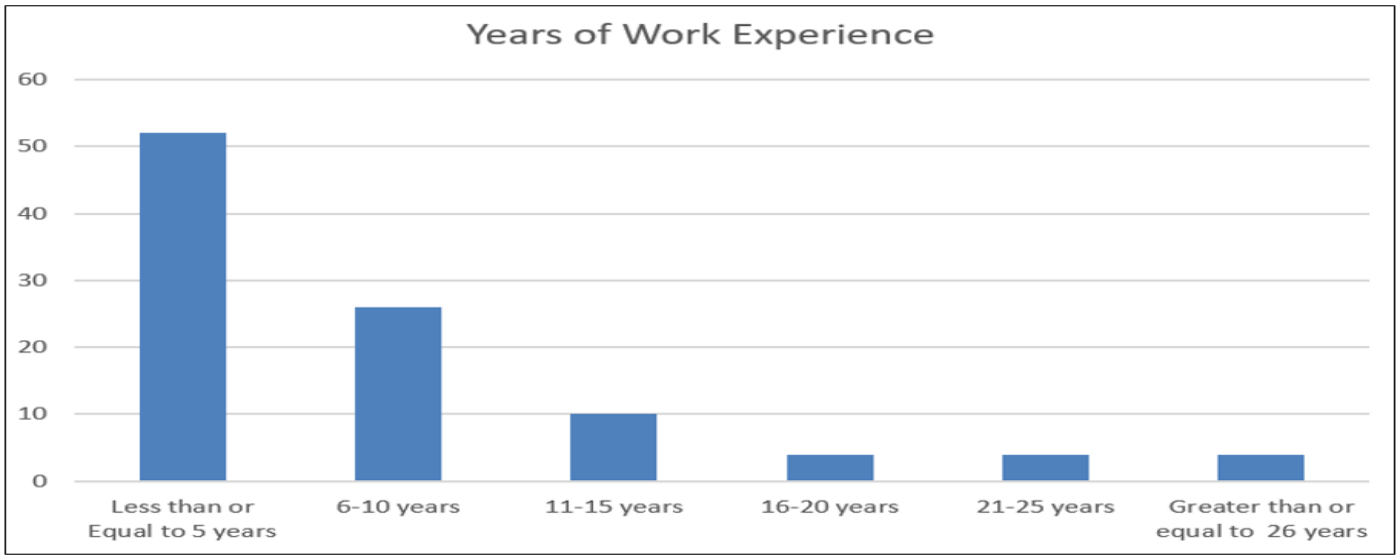

Fig 3 Years of Work Experience

B. Awareness of Psychosocial Hazards

Work-related stress 96 (98%), fatigue from work characterized by mentally and physically challenging tasks, was reported by 90 (91.8%) of the participants and workplace abuse represented by disrespectful behavior 84 (89.4%) account for the most common psychosocial hazards in the hospital which the health workers acknowledged they are aware of. Conversely, workplace bullying represented by assignment of tasks that are impossible to complete32 (32.7%)have a relatively lower level of awareness as psychosocial hazards in the workplace.

Table 2 Awareness of Psychosocial Hazards

Verbal Abuse	**Frequency (n)**	**Percentage (%)**
Yes	74	75.5
No	24	24.5
Being Excluded or Isolated in Workplace		
Yes	36	36.7
No	62	63.3
Harassment of Intimidation		
Yes	78	79.6
No	20	20.4
Assigned Meaningless Tasks Unrelated to Jobs		
Yes	42	42.9
No	56	57.1
Assigned Tasks That are Impossible to Complete		
Yes	32	32.7
No	66	67.3
Changing Work Rosters With Deliberate Intention to Inconvenience Employee		
Yes	44	44.9
No	54	55.1
Threats of Dismissal		
Yes	58	59.2
No	40	40.8
Being Screamed or Yelled at		
Yes	60	61.2
No	38	38.8
Being Sworn at		
Yes	56	57.1
No	42	42.9
Verbal Aggression		
Yes	82	83.7
No	16	16.3
Disrespectful Behavior		

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Yes	84	89.4
No	10	10.6
Isolation/Exclusion		
Yes	30	30.6
No	68	69.4
Threats/Bribes		
Yes	58	59.2
No	40	40.8
Physical Aggression		
Yes	58	59.2
No	40	40.8
Substances Use in Workplace		
Yes	18	18.4
No	80	81.6
Physical Attack		
Yes	58	59.2
No	40	40.8
Sexual Coercion		
Yes	34	34.7
No	64	65.3
Unwanted Sexual Attention		
Yes	40	40.8
No	58	59.2
Gender-Based Hostility		
Yes	50	51
No	48	49
Work-Related Stress		
Yes	96	98
No	2	2
Racial Discrimination		
Yes	36	36.7
No	62	63.3
Mentally and Physically Demanding Work		
Yes	90	91.8
No	8	8.2
Long Periods of Time Awake		
Yes	60	62.5
No	36	37.5
Inadequate Amount of Quality Sleep		
Yes	70	71.4
No	28	28.6
Regular Work at Night		
Yes	56	57.1
No	42	42.9
Environmental Stress		
Yes	80	83.3
No	16	16.7

C. Source of Information Regarding Psychosocial Hazards

Majority of the respondents acknowledged that the source of their awareness of psychosocial hazards in the workplace was from professional bodies 92 (97.9%). No responses were recorded from workshops/seminars or literature as sources of information regarding workplace hazards.

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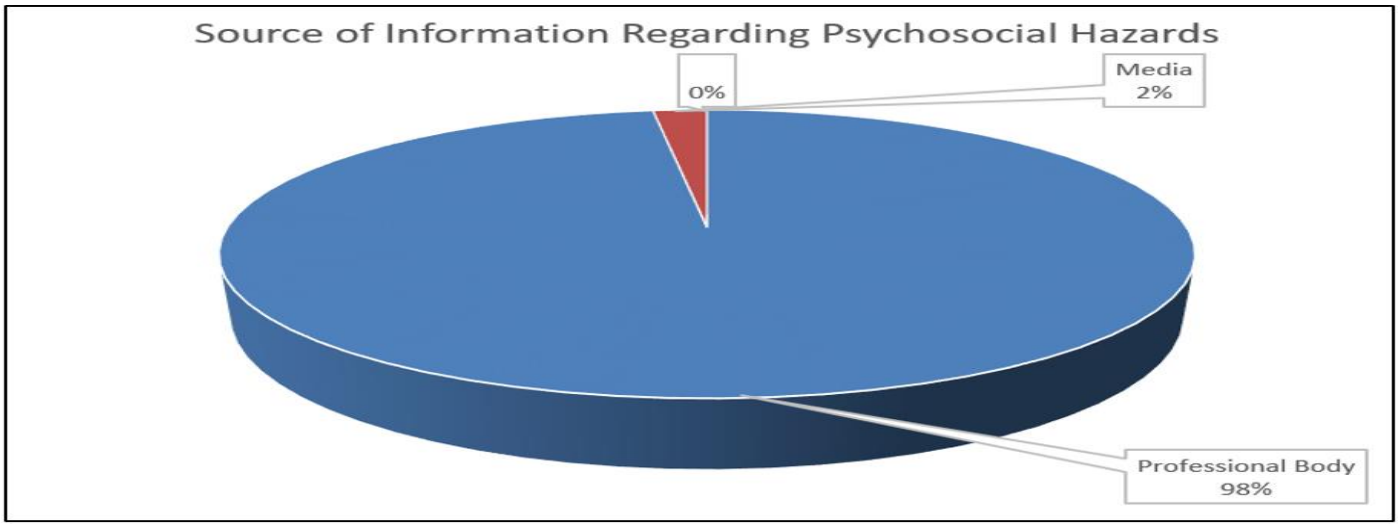

Fig 4 Source of Information Regarding Psychosocial Hazards

D. Occurrence of Psychosocial Hazards

According to the respondents, fatigue from work represented by mentally and physically challenging tasks 50 (51%) and environmental stress 44 (44.9%), and work-related stress 40 (40.8%) constitute the most frequent psychosocial hazardsexperienced by the health workers in the hospital.With respect to rarity of occurrence of psychosocial hazards, workplace abuse represented by substances use in the workplace 82 (83.7%), sexual harassment represented by sexual coercion 84 (87.5%), racial discrimination 86 (87.8%) were the least prevalent psychosocial hazards among the health workers.

Table 3 Occurrence of Psychosocial Hazards

Verbal Abuse	**Frequency (n)**	**Percentage (%)**
Very regular	2	2.3
Regular	16	18.6
Occasional	40	46.5
Rare	28	32.6
Being Excluded or Isolated in Workplace		
Very regular	2	2.1
Regular	8	8.5
Occasional	16	17.0
Rare	68	72.3
Harassment of Intimidation		
Very regular	6	6.1
Regular	12	12.2
Occasional	50	51.0
Rare	30	30.6
Assigned Meaningless Tasks Unrelated to Jobs		
Very regular	8	8.2
Regular	8	8.2
Occasional	18	18.4
Rare	64	65.3
Assigned Tasks That are Impossible to Complete		
Very regular	2	2.0
Regular	8	8.2
Occasional	16	16.3
Rare	72	73.5
Changing Work Rosters With Deliberate Intention to Inconvenience Employee		
Very regular	2	2.0
Regular	8	8.2
Occasional	10	10.2
Rare	78	79.6
Threats of Dismissal		
Very regular	8	8.3
Regular	4	4.2

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Occasional	20	20.8
Rare	64	66.7
Being Screamed or Yelled at		
Very regular	10	10.2
Regular	12	12.2
Occasional	24	24.5
Rare	52	53.1
Being Sworn at		
Very regular	8	8.2
Regular	6	6.1
Occasional	32	32.7
Rare	52	53.1
Verbal Aggression		
Very regular	12	12.2
Regular	16	16.3
Occasional	48	49.0
Rare	22	22.4
Disrespectful Behavior		
Very regular	10	10.2
Regular	14	14.3
Occasional	62	63.3
Rare	12	12.2
Isolation/Exclusion		
Very regular	0	0
Regular	8	8.2
Occasional	16	16.3
Rare	74	75.5
Threats/Bribes		
Very regular	0	0
Regular	16	16.3
Occasional	38	38.8
Rare	44	44.9
Physical Aggression		
Very regular	2	2.1
Regular	6	6.3
Occasional	34	35.4
Rare	54	56.3
Substances Use in Workplace		
Very regular	2	2.0
Regular	8	8.2
Occasional	6	6.1
Rare	82	83.7
Physical Attack		
Very regular	10	10.2
Regular	8	8.2
Occasional	22	22.4
Rare	58	59.2
Sexual Coercion		
Very regular	0	0
Regular	4	4.2
Occasional	8	8.3
Rare	84	87.5
Unwanted Sexual Attention		
Very regular	0	0
Regular	4	4.1
Occasional	24	24.5
Rare	70	71.4
Gender-Based Hostility		

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Very regular	2	2.1
Regular	6	6.3
Occasional	24	25.0
Rare	64	66.7
Work-Related Stress		
Very regular	40	40.8
Regular	26	26.5
Occasional	30	30.6
Rare	2	2.0
Racial Discrimination		
Very regular	0	0
Regular	6	6.1
Occasional	6	6.1
Rare	86	87.8
Mentally and Physically Demanding Work		
Very regular	50	51.0
Regular	20	20.4
Occasional	20	20.4
Rare	8	8.2
Long Periods of Time Awake		
Very regular	22	22.4
Regular	24	24.5
Occasional	28	28.6
Rare	24	24.5
Inadequate Amount of Quality Sleep		
Very regular	28	28.6
Regular	20	20.4
Occasional	26	26.5
Rare	24	24.5
Regular Work at Night		
Very regular	18	18.8
Regular	18	18.8
Occasional	30	31.3
Rare	30	31.3
Environmental Stress		
Very regular	44	44.9
Regular	18	18.4
Occasional	28	28.6
Rare	8	8.2

E. Effects of Psychosocial Hazards on the Health Workers

A considerable number of the health workers admitted that they are not affected by the psychosocial hazards experienced in the workplace. 68 (69.4%) acknowledged that theyfeel they are positively influencing other people's lives and that they deal very effectively with the problems of the patients daily.

Table 4 Effects of Psychosocial Hazards

I Feel Emotionally Drained From My Work	**Frequency (n)**	**Percentage (%)**
Everyday	30	30.6
A few times a week	38	38.8
Once a week	6	6.1
A few times a month	10	10.2
Once a month	4	4.1
Never	10	10.2
I Feel Fatigued When I Get Up in the Morning		
Everyday	20	20.4
A few times a week	48	49.0
Once a week	8	8.2
A few times a month	12	12.2
Once a month	8	8.2

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Never	2	2.0
Working With People all Day Really a Strain For Me		
Everyday	10	10.2
A few times a week	26	26.5
Once a week	6	6.1
A few times a month	16	16.3
Once a month	8	8.2
A few times a year	4	4.1
Never	28	28.6
I Feel I Treat Some Patients As If They Were Impersonal Objects		
A few times a week	6	6.1
Once a week	4	4.1
A few times a month	20	20.4
Once a month	6	6.1
A few times a year	6	6.1
Never	56	57.1
I have Become More Callous Towards People		
Everyday	2	2.0
A few times a week	10	10.2
Once a week	4	4.1
A few times a month	6	6.1
Once a month	8	8.2
A few times a year	2	2.0
Never	66	67.3
I Do Not Really Care What Happens To Some Patients		
A few times a week	2	2.0
Once a week	6	6.1
A few times a month	10	10.2
Once a month	4	4.1
A few times a year	2	2.0
Never	74	75.5
I Deal Very Effectively With The Problems of My Patients		
Everyday	68	69.4
A few times a week	10	10.2
A few times a month	6	6.1
Once a month	4	4.1
A few times a year	6	6.1
Never	4	4.1
I Feel I Am Positively Influencing Other People's Lives Through My Work		
Everyday	68	69.4
A few times a week	16	16.3
Once a week	4	4.1
A few times a month	2	2.0
Once a month	2	2.0
A few times a year	6	6.1
I Feel Exhilarated After Working Closely With My Patients		
Everyday	32	32.7
A few times a week	28	28.6
Once a week	14	14.3
A few times a month	14	14.3
Once a month	6	6.1
A few times a year	4	4.1

F. Effects of Hazards Experienced

Musculoskeletal disorders 60 (60%) representing health impairments and sleep disorders 56 (56%) and insufficient physical activity 48 (49%) both representing coping behaviors constitute the most prevalent effects of psychosocial hazards on health experienced by the health workers.

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They also acknowledged that these psychosocial hazards have some deleterious effects on productivity and economic costs. While reduced motivation, satisfaction and commitment 44 (44%) represents the most prevalent of these effects, reduced efficiency and accuracy in performance 18 (18%) recorded the least prevalence.

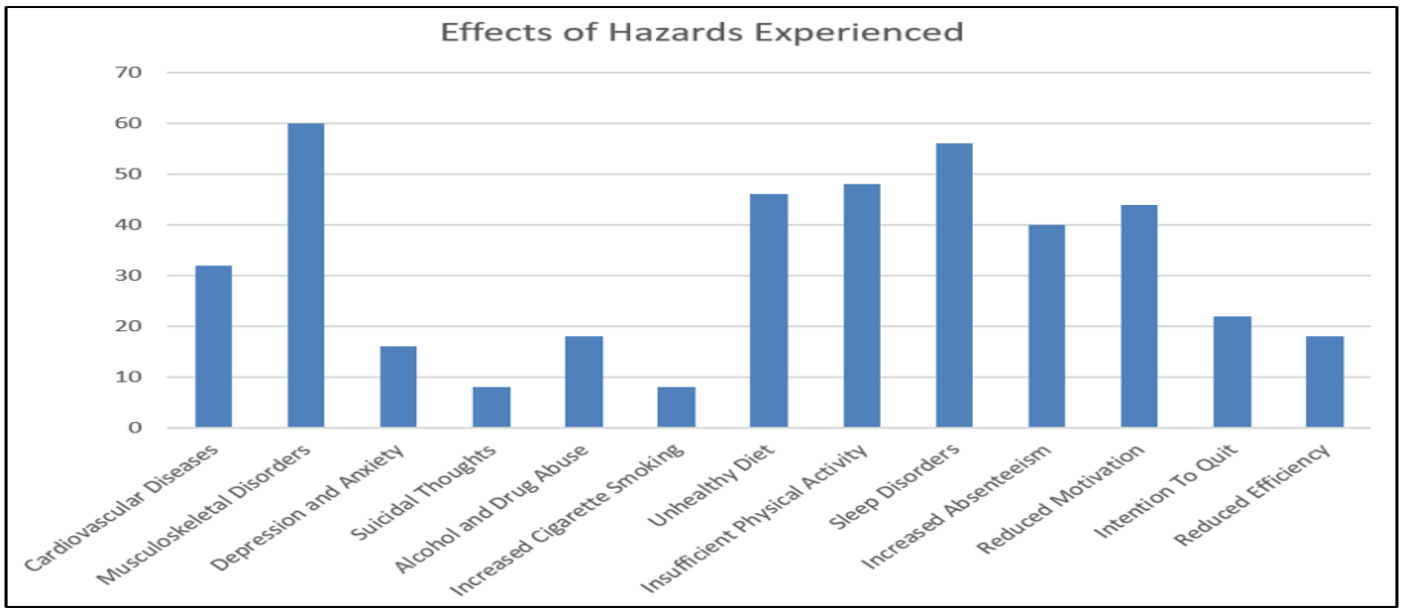

Fig 5 Effects of Hazards Experienced

G. Comparison of Socio-Demographic Factors of the Respondents and Awareness or Occurrence of Psychosocial Hazards in the Workplace

Table 5 Educational Status and Awareness of Mentally and Physically Demanding Work as a Psychosocial Hazard

HIGHEST EDUCATIONAL QUALIFICATION			
MENTALLY AND PHYSICALLY DEMANDING WORK	Primary Education	Secondary Education	Tertiary Education
	4	18	68

The table above shows that majority of the respondents (68) who acknowledged awareness of mentally and physically demanding work as a psychosocial hazard in the hospital had tertiary education. Evidently, they involve the medical doctors and the nurses.

Table 6 Years of Work Experience and Awareness of Work-Related Stress as a Psychosocial Hazard

YEARS OF EXPERIENCE						
	≤ 5 years	6-10 years	11-15 years	16-20 years	21-25 years	≥ 26 years
WORK-RELATED STRESS	50	24	10	4	4	4

From the table above, the highest number of respondents (50) who acknowledged their awareness that work-related stress is a psychosocial hazard in the hospital have a work experience of≤ 5 years.

H. Relationship between Profession and Occurrence of Work-Related Fatigue as a Psychosocial Hazard in the Hospital

Table 7 Profession and Occurrence of Work-related Fatigue

PROFESSION			
	Doctor	Nurse	Hospital ward maids
MENTALLY AND PHYSICALLY DEMANDING WORK	46	18	6

The table above shows that medical doctors (46) account for the greatest proportion of health workers who acknowledged that fatigue as a result of mentally and physically challenging work occur regularly as a psychosocial hazard in the hospital.

Table 8 CHI-SQUARE TEST

Chi-Square Tests			
	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	34.674[a]	2	.000
Number of Valid Cases	100		

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There is a strong evidence that there is a relationship between the profession of the respondents and occurrence of work-related fatigue as a psychosocial hazard in the hospital. The differences are not due to chance; hence null hypothesis is rejected. (Chi-square = 34.674, df = 2, $p < 0.005$).

This finding can thus be extrapolated to infer that the occurrence of various psychosocial hazards in the hospital is dependent on the profession of the respondents.

V. DISCUSSION

This study was a descriptive cross sectional study that utilized a semi-structured, interviewer administered questionnaire to evaluate the awareness, occurrence and effects of psychosocial hazards among health workers in Chukwuemeka Odumegwu Ojukwu University Teaching Hospital (COOUTH) Amaku-Awka, Anambra State.

The mean age of the respondents was 35.47 ± 9.51. The respondents have good knowledge of various psychosocial hazards which can affect health workers in the course of rendering clinical services to patients. Work-related stress 96 (98%), mentally and physically demanding work 90 (91.8%) and disrespectful behavior 84 (89.4%) account for the most common psychosocial hazards occurring in the workplace that the health workers acknowledged they were aware of. This implies that work-related stress, work-related fatigue and workplace abuse are common knowledge as psychosocial hazards which health workers encounter in healthcare institutions. Conversely, the health workers have a relatively low awareness that substance use in workplace 18 (18.4%), isolation/exclusion 30 (30.6%) and assignment of tasks that are impossible to complete 32 (32.7%) are possible psychosocial hazards which health workers face in the workplace. This is similar to In a qualitative investigation conducted within a tertiary health facility in South-South Nigeria, a total of 18 participants from different sections of the hospital were interviewed. The findings revealed that the highest awareness was centered around the psychosocial hazard of work overload. Additionally, the majority of respondents, numbering 92 (97.9%), identified professional bodies as their primary source of information regarding psychosocial hazards in the workplace.

In our study, we demonstrated that fatigue as a result of mentally and physically challenging tasks 50 (51%) and environmental stress 44 (44.9%), and work-related stress 40 (40.8%) constitute the most frequently experienced psychosocial hazards in the hospital. Workplace abuse represented by substances use in the workplace 82 (83.7%), sexual harassment represented by sexual coercion 84 (87.5%) and racial discrimination 86 (87.8%) were the least prevalent psychosocial hazards among the health workers.In contrast, a study conducted at the University of Port Harcourt among doctors and nurses highlighted workplace bullying as the most prevalent psychosocial hazard, with verbal abuse accounting for 43.9%. Workplace abuse, particularly being screamed or yelled at, was the second most common psychosocial hazard, affecting 39.4% of participants. Work-related stress emerged as the most widespread individual hazard, with a prevalence of 62.7%. On the other hand, racial discrimination was the least common hazard, impacting only 7.0% of the respondents across the seven identified hazard categories.

Turning to the impact of psychosocial hazards on health workers, the findings from our study indicated that despite facing various psychosocial challenges, the majority of health workers maintained a positive outlook on their work. A significant proportion, 68 (69.4%), expressed that they felt they were making a positive impact on the lives of others through their work and effectively managed patient-related issues on a daily basis. However, the study also highlighted some negative health consequences resulting from the psychosocial hazards experienced by workers in the workplace.

Musculoskeletal disorders 60 (60%) representing health impairments and sleep disorders 56 (56%) and insufficient physical activity 48 (49%) both representing coping behaviors constitute the most prevalent effects of psychosocial hazards on health. Impact on productivity and economic costs were also evaluated and the respondents acknowledged that these psychosocial hazards have some deleterious effects on productivity and economic costs. While reduced motivation, satisfaction and commitment 44 (44%) represents the most prevalent of these effects, reduced efficiency and accuracy in performance 18 (18%) recorded the least prevalence. This is comparable to a study among 210 nurses in University of Nigeria Teaching Hospital where high levels of burn out were identified in 42.9% of the respondents in the area of emotional exhaustion, 47.6% in the area of depersonalization and 53.8% in the area of reduced personal accomplishment.

VI. CONCLUSION AND RECOMMENDATIONS

- *Conclusion*

We have been able to provide cogent answers to the research questions underlying this study. There is sufficient awareness of the various psychosocial hazards which health workers are predisposed to in their workplace. A significant level of awareness was demonstrated by the respondents regarding work-related stress, fatigue from work as a result of mentally and physically challenging task and workplace abuse represented by disrespectful behavior.

The frequency of psychosocial hazards experienced by the respondents varied. Fatigue from work as a result of mentally and physically demanding tasks, was one of the most commonly reported hazards. and environmental stress, and work-related stress were regularly experienced by the health workers in the hospital. Also, workplace abuse, sexual harassment and racial discrimination were very rare in occurrence among the health workers.

Regarding the impact of psychosocial hazards on the health workers, majority of the health workers acknowledged that despite the various psychosocial hazards

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they experience, they maintained a positive attitude towards their work. A significant proportion of respondents acknowledged a sense of fulfillment, stating that their work positively impacts the lives of others and that they effectively manage patients' challenges on a daily basis. However, the study also uncovered adverse effects of psychosocial hazards on the health of workers who had encountered such challenges in their workplace environment. Musculoskeletal disorders representing health impairments and sleep disorders and insufficient physical activity both representing coping behaviors constitute the most prevalent negative effects of psychosocial hazards on health. Impact on productivity and economic costs were also evaluated and the respondents acknowledged that these psychosocial hazards have some deleterious effects on productivity and economic costs. While reduced motivation, satisfaction and commitment represents the most prevalent of these effects, reduced efficiency and accuracy in performance recorded the least prevalence.

RECOMMENDATIONS

Based on the findings from this study, the following recommendations have been made

- Health education of health workers in the form seminars and workshops should be encouraged and sustained to promote awareness of the deleterious effects of psychosocial hazards on health workers. This would help design preventive strategies and enable the workers function optimally.
- Integration of medical and psychological intervention services for psychosocial hazards by the government and policy makers in hospitals across all tiers of the health system in other to ensure easily accessible therapeutic aid to affected health workers.
- Proper follow up of affected workers to ensure maximum satisfaction with services rendered.
- Further research by community health specialists to ascertain factors that contribute to frequent occurrence of psychosocial hazards in the workplace and concerted efforts should be made to dispel these factors.
- Training and re-training of health insurance workers by the government to readily recognize and efficiently tackle potential psychosocial hazards in the workplace.

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