ORIGINAL ARTICLE

Debunking the Obstacles to Reporting Workplace Violence Among the Healthcare Workers in Melaka, Malaysia: A Qualitative Study

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ABSTRACT

Introduction: Workplace violence (WPV) among healthcare workers (HCWs) is highly preventable and remains an ongoing public health concern among workers in Malaysia. **Methods:** Basic qualitative study design was employed to explore the individual experiences of healthcare workers with history of violence at workplace that hinders them to report the incidents. Informants were conveniently screened and identified based on underreporting of previous WPV experience, of any type. In-depth interviews among consented eligible HCWs were conducted using a semi-structured validated interview protocol. Transcribed data were thematically analyzed using an inductive approach. **Results:** A total of 11 informants and 11 coding were generated, with three themes emerged from the inductive thematic analysis, namely the perceived norms, process barriers, and attitude/ beliefs towards reporting WPV, with process barrier being the most frequently shared experience by the informants. **Conclusion:** The process barriers demotivate the HCWs from reporting the incidents, with their attitudes and beliefs shaped by their perceived norms towards WPVs among HCWs. Improvement of the existing reporting process is urgently needed. Training of workers is not only necessary to enhance their related knowledge and skills, but also to reduce the false belief and perceived norms towards WPV among HCWs.
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INTRODUCTION

Workplace violence (WPV) is complex and multifaceted, as well as a dangerous occupational hazard and is refers to any events related to staffs being abused, threatened, or assaulted in circumstances related to their work, including commuting to and from work, with potential explicit or implicit challenge to their safety, well-being, or health. It was defined by the National Institute for Occupational Safety and Health (NIOSH) as violent acts (including physical assaults and threats of assaults) directed toward individuals at work or on duty (1). WPV takes many forms and ranges from as mild as verbal abuse to the extreme of homicide, with some professions more susceptible than others.

The healthcare sector has been recognized as an occupational sector with a high prevalence of WPV (2). According to multi-centered case studies involving Brazil, Bulgaria, Lebanon, Portugal, South Africa and Thailand, the prevalence of WPV among healthcare workers varies, but was reported as high as 75.8% in Bulgaria, 61% in South Africa, 60% in Portugal, 54% in Thailand, and 46.7% in Brazil (3). Meanwhile, in a cross-sectional survey done in North Chinese Hospitals involving a total of 1899 healthcare workers in 2016, 83.3% reported exposure to WPV, with 68.9% reported non-physical violence (4). Another cross-sectional study conducted in 2016, involving 134 healthcare workers in the emergency department in a hospital located in Ismailia, Egypt yielded 59.7% of them had experienced WPV (5).

In Malaysia, official report and statistical data from the Ministry of Health (MOH) stated that there was an increase in WPV against the MOH healthcare workers in 2018, with 432 cases reported compared to 167 cases in 2017 and a total of 44 cases between 2013 and 2016, which was a total increase of 8.8 times within a time span of two years (6). However, the increased prevalence was partly contributed by a more systematic

and comprehensive reporting system following the launch of the Guidelines on Preventing and Dealing with Violence Against Members at the Facilities of the Ministry of Health Malaysia in April 2017 (6). However, the actual extent of the problem is thought to be higher than what was reported. This can be seen by the figures obtained by researches conducted around the same period as the official MOH's statistics. For example, a cross-sectional study done in 2018 involving 136 healthcare workers working in only two out of 28 clinical services departments at one of a hospital in Kuala Lumpur showed that a one-year WPV prevalence of 71.3% was observed (7). This translated to 97 HCW who experienced WPV while working in those two departments in a hospital in that year alone, making up almost 22.5% of the official statistics in 2018 that was supposedly representing the situation nationwide.

Many studies indicate that violence against nurses is underreported, with emergency departments highlighted as the hotspot where violent incidents are likely to be significantly underreported (8). Among the reported reasons were unsatisfaction with how their previous violent events were handled or unsatisfactory actions were taken to perpetrator, belief that violence is part of the job, absent of policies guaranteeing justice, insufficient time to report or time-consuming process, belief that no harm was inflicted on them, and they can handle it and ability to defend themselves by changing how they treat that particular patient (8).

Underreporting of WPV has been defined as failure of victimized employees to report these events to their employers, the police, or other officials (9). The reported statistics, however, represent only the tip of the iceberg. underreporting results in an underestimation of the true extent of the problem, thus indicating less of a need for prevention of possible negative effects than may be warranted (10). Furthermore, without knowledge of the full spectrum of violent events to which workers are exposed, prevention efforts can only be designed to affect limited aspects of the problem (11,12). Many factors were believed to act as barriers as well as enablers towards reporting of WPV. This qualitative study was conducted to explore the individual experiences of healthcare workers with history of violence at workplace that hinders them to report the incidents.

MATERIALS AND METHODS

Field visits and sampling procedure

This study employed the basic qualitative study design, exploring the individual experiences that contribute towards the act of underreporting of WPV among public hospital healthcare workers in Melaka. Several field visits to the public hospitals in Melaka were conducted to build rapport with the study populations and familiarize them with the study location to identify potential candidates and setting prior to data collection. Informants were identified conveniently based on the screening questions on experience of WPV (of any types) and underreporting act. Identified HCWs who did not report WPV within the past 12 months prior to data collection were invited for an in-depth interview at their convenient time and day.

Data collection

In-depth interviews were conducted between December 2021 to March 2022. As opposed to quantitative study, the sample size was not fixed prior to data collection, and were determined based on saturation point of information, where no more new insights or themes being observed to answer the research questions (13,14). Saturation was the most used principle or criterion in which researchers determined whether they have achieved enough sample size for qualitative studies and subsequently discontinue data collection (15). According to Hennink, Kaiser, and Marconi (16), nine interviews would have determined the code saturation whereas 16 to 24 interviews were needed to reach the meaning saturation.

Semi-structured interview (SSI) was used in this study as it was the most suitable method. SSI have been identified to be appropriately suited if the researcher needs to ask probing, open-ended questions and want to know the independent thoughts of each individual, particularly on topics that informants might not be fully open if sitting with peers in a focus group (17). The core advantage of semi-structured interviews is that informants have the chance to voice out their opinions without fear, whereas the interviewer (researcher) could still control the direction of the interview.

The interview was guided by an interview protocol. The interview protocol that was developed by the researcher contained a set of open-ended, leading, and probing questions according to the research questions to get a better and deeper understanding on the informants' barriers to report WPV among public hospital HCWs in Melaka. The interview protocol was developed by the researcher together with a qualitative expert in the research team and guided by literature on the topic. The interview protocol was subsequently tested on two HCWs to test and improve the interview protocol. Some of questions were simplified and reworded accordingly based on the understanding observed during the testing interviews. The average duration of the interview was about an hour depending on the willingness of the interviewee to talk and the time constraints of the interviewee.

All the interviews were voice recorded using a portable voice recorder. Consent was obtained from the informant prior to the recording started. Each interview started with an icebreaking session to ensure that both the researcher and the informant are comfortable with each other. General questions such as the sociodemographic

information and working experience were asked first, before proceeding to questions stated in the interview protocol. This was done after the researcher felt that the informant is at ease, comfortable, and a good rapport has been established.

Data analysis and management

Each interview was transcribed verbatim, analyzed, and coded independently prior to the conduction of the next interview, in order to constantly comparing the ideas and coding generated, as well as to identify the emerging of new coding or theme which should also be explored in the next consecutive interview sessions. Cumulative frequency tables were used and when there was no new coding generated, the researcher extended an additional two informants to ensure saturation point was truly achieved before deciding to discontinue data collection process.

Data analysis in the qualitative phase is a continuous process once the interview audio has been transcribed, as the initial findings obtained by the researcher provides a hint and probe for subsequent interviews with the next informant, a method known as 'zigzag method' (18) to achieve saturation point of information. A series of discussions were held to explore key themes and further resolve discrepancies in interpretation between the researchers in the team, which lead to the development of coding matrices for thematic analysis.

Inductive thematic analysis (TA) was used to analyses the data involving six steps. TA is preferred as it added strength which include flexibility, the extent of commentary possible, the capability to summarize the data competently and the possibility for a rich, thick description (19). The first stage is familiarization, which involves repeatedly and attentively listening to the interview and reading the transcript to facilitate the realization of ideas into emerging themes. Reading and checking the complete transcript several times before coding process is necessary to ensure complete understanding of the interview content. The second step involves identifying the key features of the interview that represent a specific category in the margins, called coding of the data.

The third step is identifying the themes by combining the codes into themes. This step includes scrutinizing the codes to identify significant ones, but broader patterns of themes. Subsequently, data were organized into a particular theme which is most appropriately applied. In the next step, themes emerged in each transcript were then reviewed and compared to determine whether these data can provide answers to the research questions. In this regard, the themes should be meaningfully connected to the codes identified earlier and should be differentiable.

The fifth step involves refining, defining, naming, and lastly finalizing the themes. This process includes a comprehensive analysis of each theme and focuses on the 'story' of each determining theme. Informative names for each theme were also identified in this step. Lastly, a report is produced, which was done once TA provides a good set of themes. Researchers used Computer Assisted Qualitative Data Analysis Software NVivo 12 to assist with the qualitative data management and analysis.

Ensuring Rigor

To ensure rigor of this qualitative study, the principles of trustworthiness were applied. According to Koch and Harrington (20), to establish trustworthiness in a qualitative inquiry, the study appeals to the criteria of credibility (internal validity), transferability (external validity), dependability (reliability) and confirmability (objectivity) as parallel terms to be used instead of validity and reliability used by the positivist in quantitative type of research. In this study, credibility was ensured through active engagement during data collection to reach saturation point. Member checks were used to avoid misinterpretation. Thick and rich descriptions of the research process were provided for transferability. A detailed explanation, commonly known as an audit trail, was maintained for dependability. Verbatim quotes linked findings to the data and research context for confirmability. Detailed field notes helped understand respondents' perspectives during data analysis, and audio verification ensured transcription accuracy.

Ethical clearance

The study was conducted in accordance with the Declaration of Helsinki and approved by the Medical Research Ethic Committee (MREC) of Ministry of Health, Malaysia (NMRR-20-1836-56140). Informed consent was obtained from all subjects involved in the study.

RESULTS

Characteristics of participants

A total of 11 healthcare workers participated in the in-depth interviews. The sociodemographic of the informants is provided in Table I. Informants' age ranged from 26 to 44 years old, and majority of them aged between 30 to 39 years old (54.5%). Eight of them were female (72.7%) and Malays (72.7%), two were Indians (18.2%) and one Chinese informant (9.1%). Most of them work as doctors (54.5%) and have working experience of more than 10 years (54.5%). To maintain and ensure confidentiality, pseudonyms using alphabets were used. Table II below displays the coding generated from each informant.

There was no new coding found after the ninth respondent. However, to confirm that saturation point of information had truly been achieved, the researcher recruited two additional informants, the tenth and eleventh participants. Code saturation was determined to have been achieved by looking at the code identification,

Table I: Socio-demographic characteristics of interview informants

Informant	Age (years)	Gender	Ethnicity	Occupation	Working experience (years)
A	33	Female	Malay	Doctor	9
B	26	Female	Malay	Doctor (HO)	2
C	40	Female	Indian	Doctor	14
D	32	Male	Malay	Doctor	8
E	39	Female	Malay	Doctor	15
F	31	Female	Malay	Staff Nurse	8
G	41	Female	Malay	Community Nurse	16
H	36	Female	Malay	Pharmacist	12
I	32	Male	Indian	Medical Assistant	7
J	44	Female	Malay	Staff nurse	19
K	40	Male	Chinese	Doctor (Specialist)	16

[1] HO = House Officer

Table II: Summary of codes generated from interviewed informants

Informants	Coding (total/old/new)	Cumulative coding
A	3/0/3	3
B	4/3/1	4
C	3/2/1	5
D	5/4/1	6
E	4/3/1	7
F	4/3/1	8
G	3/2/1	9
H	5/4/1	10
I	4/3/1	11
J	6/6/0	11
K	5/5/0	11

code prevalence, and codebook stability. Qualitative research is often an iterative process, with researchers going back and forth between data collection, coding, and analysis. Code saturation is typically assessed periodically during this process to determine when data collection can be reasonably concluded.

Fig. 1 shows the number of new codes identified from each successive interview in the order in which they were conducted. A total of 11 codes were identified in this study, with nearly one-third (27%) of the codes identified from the first interview. Each subsequent interview identified an additional code; by interview number four, more than half (55%) of the total codes had been identified, and by interview number nine, 100% of all new codes had been identified. The remaining two interviews did not yield any new codes.

In terms of codebook stability, it was noted that the code definitions began to stabilize after reviewing nine interviews. For starters, out of 11 codes developed, five codes (45%) did not change at all throughout the code development process. On the other hand, the remaining six codes underwent a total of nine changes involving its definitions. Two-third of these changes occurred while

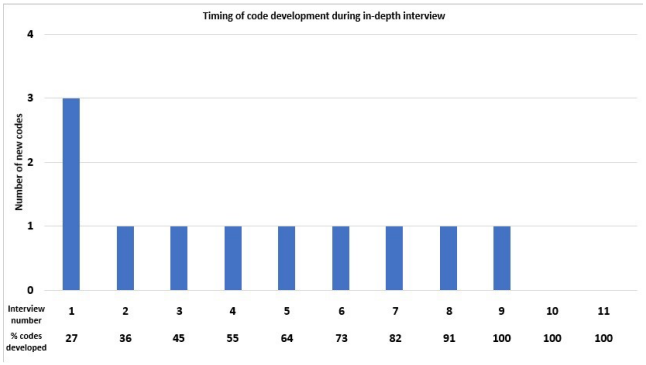

Figure 1: Timing of code development during in-depth interview

reviewing interviews number two to five, while 100% of definition changes were made by interview number nine.

Fig 2 displays each code along with the interview in which it was initially developed and the number of interviews in which it was subsequently used. Additionally, a horizontal dashed line represents the study's average, which is six interviews. Codes above or below this line indicate prevalence levels higher or lower than the dataset's average. It's worth noting that the first three codes were initially developed in the first interview and were subsequently used in all 11 interviews. Furthermore, within this dataset, there were five high-prevalence codes and six low-prevalence codes. The data also indicates that 40% (2 out of 5) of high-prevalence codes were already identified in the first interview, 80% (4 out of 5) by the third interview, and all 5 high-prevalence codes were established by the fifth interview.

Based on the information provided above, it has been established that code saturation was achieved during the ninth interview (Informant I). This determination is grounded in the combination of factors, including complete code identification (100% of codes were identified), complete high-prevalence code identification (100% of high-prevalence codes were identified), and stable codebook definitions (100% of code definition changes had been made).

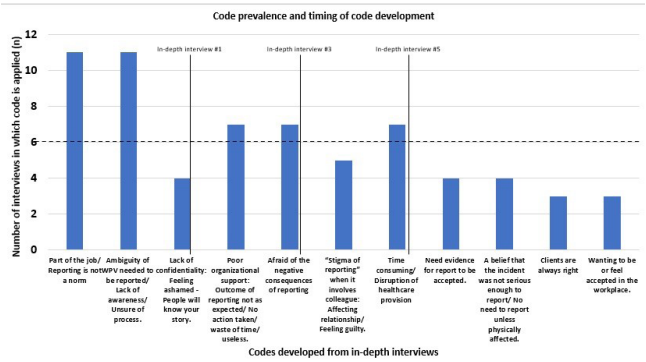

Figure 2: Code prevalence and timing of code development

Barriers towards reporting of WPV

Inductive thematic analysis (TA) was used to extract the information from the transcript. Three themes emerged from the analysis which were presented in Table III, with theme related to process barrier were the most frequently shared by the informants during the interviews, generating five out of ten coding.

Theme 1: Perceived norms

Three coding were identified under this theme which are "part of job", "no need to report unless physically affected" and the perception that "clients are always right". Majority of the informants had wrongly perceived that WPV in healthcare sectors is "part of the job", reflecting its frequent occurrence, as well as the possibility of poor support received with reporting behavior, which will be elaborated under the process barrier theme. As our Informant C, a 40-year-old doctor stated, "[After] all, you get used to the usual mild verbal abuse here and there, not worthy of reporting it. Usually if it is a minor one, I don't report. Isn't it a norm nowadays?"

Furthermore, those who were reporting the WPV will be perceived as outliers or out of norms, with a high likelihood to be marginalized. Hence, to some informants, underreporting is necessary in order to be part of the norms and accepted by colleagues. Informant B who is a 26-years old horsemanship officer stated that "I fear of being alienated by friends, colleagues, superiors. Maybe could be labelled as whistle-blower". A few of the informants were also wrongly applied the "Clients are always right" motto for WPV, which indirectly influenced their decision to report violence committed by the clients.

Theme 2: Process barriers

Five coding were emerged from the inductive thematic analysis, which are mainly related to managing the reporting process. These include time-consuming, lack of confidentiality, poor organizational support and availability of evidence. One coding was related to the victim involving their awareness and knowledge on the procedure of reporting.

The majority of the informants were complaining about the tedious process involved to make a report related to WPV, which may cause disruption of healthcare provision. Informant D who is a 32-years old doctor stated that "it will take a lot of time, you know, gathering the evidence, making police report, seeing your supervisors. And you know how we [doctors] have a lot of things to do, it is not like we just sit around during our working shift. time would probably be spent just filling up forms!". Furthermore, the poor support from the superiors, as well as lack of confidentiality in the reporting and management process also suppress the reporting intention of the victims. Additionally, presenting valid evidence is also a barrier towards reporting WPV because non-physical WPVs may not leave any visible evidence such as verbal WPV. Meanwhile, from the perspectives of the victims, some were not aware of the procedure as well as the types of WPVs that can be reported, especially among new staffs.

Theme 3: Attitude/ beliefs

Themes related to the attitude and beliefs of the informants also frequently emerged during the analysis of the transcript. Several informants expressed their fear of reporting WPV due to the potential negative consequences or impact, which makes them afraid to report. One informant, a 36-year-old pharmacist, stated that it would affect her mental well-being, saying, "when we report this, we are prone to keep on thinking about the incident again and again." Another informant, a 31-year-old staff nurse, stated, "it is likely for us who will be blamed [by the supervisor].. or it's the patient who will take the issue outside of working hours, out there, at any time." The stigma of reporting WPV committed by colleagues is also an important barrier faced by the healthcare workers, triggering feelings of guilt and disrupting relationships, as stated by informant B, a 26-year-old housemanship officer, "I would also feel guilty, because it might have started because of my

Table III: Summary of qualitative data analysis for factors contributing towards underreporting of workplace violence among the HCWs

Themes	Sub-theme	Categories	Coding
Perceived norms	▪ Beliefs of important referents	▪ Job norm	▪ Part of the job/ Reporting is not a norm. ▪ Clients are always right.
	▪ Motivation to comply to underreport WPV	▪ Belongingness	▪ Wanting to be or feel accepted in the workplace.
Process barriers	▪ Control beliefs	▪ Lack of control of factors that hinders reporting WPV	▪ Time consuming/ Disruption of healthcare provision. ▪ Lack of confidentiality: Feeling ashamed - People will know your story. ▪ Poor organizational support: Outcome of reporting not as expected/ No action taken/ waste of time/ useless. ▪ Need evidence for report to be accepted.
Attitude/ Beliefs	▪ Perceived power	▪ Lack of skills or resources needed for reporting WPV	▪ Ambiguity of WPV needed to be reported/ Lack of awareness/ Unsure of process.
	▪ Behavioural belief	▪ Negative impact of reporting WPV	▪ Afraid of the negative consequences of reporting. ▪ "Stigma of reporting" when it involves colleague: Affecting relationship/ Feeling guilty.
	▪ Evaluation of outcome versus effort exerted	▪ Unworthiness of reporting WPV	▪ A belief that the incident was not serious enough to report/ No need to report unless physically affected.

own mistakes.. reporting the event will just make the feeling worse...". Furthermore, some of the informants had false beliefs that the incidents are not serious unless there is physical involvement.

Further analysis of the themes revealed their similarities and were comparable to the constructs of the Theory of Planned Behavior (TPB), as illustrated in Fig. 3. Intention may act as a mediator between attitude or beliefs and perceived norms with the reporting or underreporting behavior. Meanwhile, although the perceived behavioral control (PBC) construct was not emerged as one of the themes during the analysis, further exploration may reveal its close relationship with process barriers. PBC may emerge as a theme if the interviews were also conducted among HCWs who were reported the WPVs.

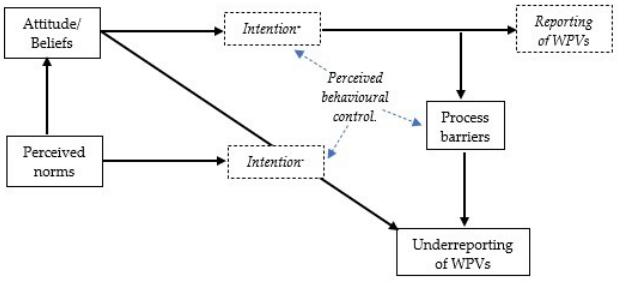

Figure 3: Inter-relationship between the themes and the constructs of TPB

DISCUSSION

This study has successfully identified three main barriers to reporting WPVs which are perceived norms, process barriers and attitude or beliefs, which are comparable to some of the constructs of the TPB. According to the TPB, an individual's behavior is influenced directly by behavioral intention, which is shaped by the attitude, perceived behavioral control and subjective norms (21).

TPB has been used to understand unethical behavior. A study investigating the applicability of TPB to understand whistleblowing behavior or the reporting of wrongdoing in an organization showed that attitudes and subjective norms as TPB variables have a significant impact on whistleblowing intention (22). However, PBC did not affect whistleblowing intentions in that research. On the other hand, another study used the TPB to predict the intention to report crime and found that the TPB did predict an individual's intention to report a crime and that adding variables such as the seriousness of the crime did not improve the predictability of the TPB model (23).

This theory has also been tested in the context of WPV among healthcare workers. In a cross-sectional study involving 220 nurses in general hospitals in Israel, significant correlations were noted between the dependent variable, intention to report, and three independent variables: behavioral attitudes, subjective norms, and feelings of self-efficacy (24). Additionally, a significant correlation was observed between intention and actual reporting. The researchers concluded that the Theory of Planned Behavior could be considered suitable for predicting both intention and the actual reporting of WPV toward HCWs in the workplace.

The violence against healthcare workers has far reaching consequences, and not only affecting their own health and wellbeing, but also the nature of health care delivery and the ability of the healthcare workers to provide quality patient centered care (25). Workplace violence can be divided into physical violence (including hitting, shooting, kicking, slapping, pushing, biting, pinching, wounding using sharp objects, and sexual assault and rape) and psychological violence (including verbal abuse, threats and sexual harassment) (26). It is a major issue in health care organizations and is estimated to affect 95% of workers, presenting an enormous risk for workers and employers (27). Unfortunately, it is commonly underreported, ubiquitous, and a persistent problem that has been tolerated and largely ignored in the healthcare sector (28) and was also reported to influence the turnover intention of nurses (29). WPV is a serious concern for healthcare workers, healthcare organizations, patients and society as a whole, due to its widespread negative effects (25).

Perceived norms

The perception of violence as part of job norms in the healthcare sector is one of the prevalent reasons behind underreporting of WPV and has been repeatedly published. Healthcare personnel consider WPV as part of their 'daily' job, developing a sort of 'normalization' of violence in the workplace (26). According to a qualitative study using a phenomenological approach among nurses in emergency departments, the underreported of violent incidents were associated with nurses accepted violence as part of their normal working day, and the incidents were not defined as 'violence' if there were no physical injury was sustained (25). Similar finding was also reported in a similar study conducted in Australia, with nurses at the emergency departments acknowledged that violence at work had become an intrinsic part of their job and they tend to focus on coping mechanisms (27). The perceived norms were associated with the beliefs that the hospital paid greater attention to patients rather than staff (30), which is commonly linked with the "the customer is always right" motto. Although customers' or clients' rights are an important aspect in the provision of healthcare services, some informants have wrongly applied the concept for WPV. The motto or slogan exhorts service staff to give a high priority to customer satisfaction, suggesting that a customer always comes first, but at the same time does not compromise WPV.

Process barriers

This study also revealed the important issue related to process barrier which demotivates the victims from reporting the WPV. The formal reporting system was perceived as difficult and time consuming, causing

the HCWs to report the violence using methods other than the designated reporting system (25). Numerous literatures highlighted that the reporting mechanism is time-consuming, complicated, impractical and onerous, suggesting that the use of user-friendly and time-saving registration systems could facilitate the reporting of violent events (31).

According to the findings of a recent study conducted in China, almost half of the nurses (49.6%) stated that the hospital had no reporting system, or they were uncertain of how and what types of violence to report, reflecting the urgent needs for a clear definition of workplace violence and reporting procedures, as well as the establishment of a facile system for reporting (30). Training of HCWs is needed not only to familiarize them with the reporting system, but also to enhance healthcare workers' knowledge, skills, and competence when managing aggressive behaviors displayed by patients or clients.

Additionally, violent incidents were more often reported verbally than in written form or through a computer reporting system (30,31), which also contributed to the massive underreporting of WPVs. Verbal reporting is easier, more easily available, and takes less time than written reports. However, verbal reporting may not always be available to upper management for policy decisions, and therefore formally documented reporting is required to provide accurate data (32). Considering the disadvantages of the paper-version reporting system, such as missing data, a time-consuming process, and errors in coding or entering data into the database, a simplified electronic reporting system may be urgently needed.

The poor organizational support as well as the lack of confidentiality in the reporting or management process further reduced the motivation to report WPV among the HCWs. In a cross-sectional study conducted among Chinese nurses in tertiary hospitals, perceived organizational support served as a mediator between workplace violence, job satisfaction, burnout and turnover intention, and it had a significantly negative impact on turnover intention (33). Perceived organizational support refers to the overall perception and beliefs of employees about how organizations view their contributions and care about their interests (34).

Another barrier revealed by the analysis is the inability to provide evidence in order for the report to be valid. Verbal abuse is an example of WPV with lack of evidence unless it is recorded, or witness is present during the incident. Although victims are more negatively affected psychologically and at work than witnesses, WPV has detrimental effects on both victims and witnesses (35). According to Zhou et al. (35), witnesses of violent acts might experience similar psychological and behavioral outcomes as direct victims, which may influence the willingness of the witnesses to participate in the reporting process. Furthermore, verbal abuse does not only lack valid evidence, but also the most common type of abuse in healthcare settings (7), reported to be three times more likely to occur than physical violence (36), reflecting the high prevalence of underreporting of WPVs among HCWs.

Attitude and beliefs

The hectic working schedule among the healthcare workers may lead to the underreporting of "less serious" WPVs, particularly those involving verbal or non-physical abuse. The attitudes and beliefs of the HCWs towards WPV are closely related to their perceived norms towards violent incidents. The commonality of such incidents, as well as other factors previously discussed such as organizational support and the potential negative impacts of reporting on them, contribute to ignorance towards the incidents unless they are physically inflicted.

Strengths and limitations

There were several strengths of this research. One of them is the contribution of the research to provide evidence on the reporting behavior of WPV among the Malaysian HCW which were lacking in comparison to research solely focusing on WPV. The utilization of in-depth interviews in this study allows detailed exploration of barriers related to reporting of WPVs among the HCWs based on individual experiences. The knowledge gained from this research provides baseline understanding and general overview of the issue among the HCWs, which will inform future interventions and research.

Additionally, the use of a validated interview protocol ensured that culturally relevant and appropriate questions were asked during the semi-structured interview sessions, resulting in the collection of quality and culturally represented data. The diverse background of the participants in terms of occupation, ethnicity, age, and sociodemographic background adds to the richness of the findings by providing a range of views on the phenomenon under study.

However, this study is without limitations. The utilization of qualitative study approach and convenient sampling of informants limits the generalization of findings to other HCWs. However, the intention of this research was not to generate national or generalizable inferences but to provide valuable baseline insights and scientific evidence on the issue, to assist the stakeholders and relevant authorities to plan for effective strategies and policies, as well as future related research. Furthermore, the interpretation of data may be influenced by the judgement on the members of the research team, which can be interpreted differently by a different research team.

CONCLUSION

Barriers to reporting of WPV among the HCWs was influenced by both individual and organizational related factors. The process barriers towards reporting the incidents such as lack of organizational support and time consuming demotivate the HCWs from reporting the incidents. Meanwhile, the perceived norms that WPV is part of job scope in the healthcare sector influenced and shaped the attitudes and beliefs of the HCWs towards reporting of such incidents. Improvement of the existing reporting process is urgently needed, with the use of user-friendly and time-saving registration systems such as smartphone apps has been suggested in previous research. Periodic training and seminars on WPV are necessary not only to improve awareness, as well as enrich their related knowledge and skills, but also to reduce the misperception towards the norms of WPV among the HCWs.

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