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Work place violence and its management in Uganda's Regional Referral Hospitals

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Abstract

Incidences of work place violence are on the increase, and as a consequence, acts of violence in the work setting have been added on the list of occupational hazards. This study therefore sought to identify prevalent forms /nature of workplace violence (WPV), the perpetrators and victims as well as the casual factors of WPV. Other objectives of this were to identify the effects of WPV, coping mechanisms for victims and the possible remedial measures for WPV. Conducted from six regional referral hospitals of Uganda, the study used a descriptive cross-sectional design that employed both quantitative and qualitative methods of data collection and analysis. Data was collected from both health workers and the hospital managers. The 3 leading forms of WPV were; verbal abuse (63.6%), physical abuse (31.6%) and tribal harassment (30.5%). Sexual abuse though the least occurring form of WPV (8.1%), was the most traumatizing. Patients were the leading perpetrators of WPV occurrences for all forms and the most victimized health workers were the nurses. We recommend establishment of functional institutional WPV policies and committees in all hospitals. This entails assessment of hospitals for WPV needs, training of health workers about WPV and their rights, putting in place community mechanisms and deliberate measures to curb the occurrence of WPV. At the individual level, there is need for commitment to support anti-WPV actions. Partnership with the service recipients (Community) is needed to establish a common ground on the origins of WPV and how both the community and the hospitals can work towards reducing occurrence of WPV incidences, for purposes of better service provision.

Keywords

Work Place Violence (WPV), Bullying, Physical Abuse, Sexual Abuse, Harassment on Tribal Grounds

1. Introduction

Workplace violence has been defined as incidents where staffs are abused threatened or assaulted in circumstances related to their work including commuting to and from work, involving explicit or implicit challenges to their safety, well-being or health (ILO, ICN, WHO, PSI 2000). On the global scene, it has been noted that incidences of work place violence are on the increase, and as a consequence of this, acts of violence in the work setting have been added on the list of occupational hazards in institutions with fully functional Occupational Hazards systems especially in developed economies such as Canada, United States of America (USA), United Kingdom (UK), France and some Scandinavian countries. A study by Vittorio (2003) revealed, workplace violence in health services globally is increasing by the day. Consequently, it is has created a negative impact on the human resources for health in that it breeds aspects of disharmony and lack of cohesion amongst health workers.

In Canada, Schaffner et al (2005) revealed that 6,010 newly recruited nursing graduates had resigned from their jobs within six months from the date of assuming duty, due to workplace violence. In America, Fletcher et al (2000) noted that Workplace Violence had serious effects on the mental status of health workers mainly causing high degrees of work related stress. Similarly, in Portuguese hospitals, Ferrinho et al

(2000) reflected that various forms of workplace violence were rampant amongst health workers. This had created poor interpersonal relationships amongst them and a negative attitude towards their jobs and the patients. A study conducted in Egypt reported incidences of workplace violence to be higher among the female nurses (67.8%) than male nurses (32.8%). As a result, many nurses were demotivated and were considering relocating to other countries they perceived as having measures for controlling workplace violence. In Uganda, it was noted by the minister of primary health care in 2000 that between 10% and 30% of health workers were likely to develop mental illnesses due to stressful working environments"(Wabudeya in Vittorio, 2005).

The contemporary global position in regard to Workplace violence in the health sector is that the prevalence of Workplace violence in health facilities across all continents has reached a crisis level, and is bound to increase if left unabated (Needham et al., 2008). In Uganda to date, workplace violence incidences have been reported by the media such as in Jinja hospital where hospital activities were halted due to mob violence incited by relatives of a patient who had died during surgery (Kiirya, 2012). It is also on record that overtime; workplace violence culminates into series of human resources challenges. These include; high rates of abseentism and turnover, high degrees of work related stress, de-motivation of workers and loss of interest in their jobs and professions among others (Vittorio, 2003). Other associated challenges from the same study include; low patient satisfaction, poor working environment as a result high stress levels, highly inefficient workforces, high degree of sundries pilferage and misuse of available materials.

Ultimately, the challenges mentioned above, either in combination or isolation may lead to poor service delivery in regard to poor recovery rates of patients, higher incidence of adverse events, avoidable deaths and associated medico-legal costs. The presence of these factors creates tension amongst the health workers themselves or even between the patients and the health workers. It is this kind of tension that provides fertile ground for workplace violence incidences to occur. As clearly depicted above, workplace violence affects both the providers (i.e. it cuts across all cadres of healthcare workers) and the recipients of these services i.e. all categories of patients ranging from neo-nates to the elderly. It is against this background, coupled with the need to ensure that health care delivery is provided in a violence-free environment that this study was carried out.

2. Goal and Objectives

The goal of this study was to generate information about work place violence which stakeholders can utilize to identify and address the challenges associated with work place violence. This will in turn help to facilitate the process of enhancing the quality of service delivery in hospitals in Uganda. More specifically, this study aimed to:

- Establish the various forms of work place violence in the hospitals under study
- Identify victims and perpetrators of work place violence in the regional referral hospitals
- Identify factors which contribute to the occurrence of work place violence in the regional referral hospitals
- Identify consequences of Workplace on the victims
- Establish the mechanisms and remedial strategies used by health workers and institutions to cope with work place violence in the hospitals

3. Methodology

The study was conducted in six out of the eleven regional referral hospitals of Uganda i.e. Mubende, Arua, Jinja, Masaka, Fort Portal and Mbarara. These were selected purposively from the different regions of the country to have a country - wide perspective of the subject. All health workers who had worked for at least two years in the hospital were eligible to participate in the study. The hospitals had a total staffing population of 192, 327, 421, 331, 299 and 315 health workers respectively. Thus in total 1,830 health workers were eligible to participate out of whom we sampled 306. However, only 276 responded yielding a response rate of 90.2%. Out of these respondents, 159 (58%) were female while the rest were males. From each hospital, the sample size required was calculated using selection criteria based on the ratios of each number of health workers of a given hospital in the total population of all hospitals under study. Therefore the six hospitals of Mubende, Arua, Jinja, Masaka, Fort Portal and Mbarara had a representation of 33, 40, 61, 43, 49, and 50 (11.9%, 14.5%, 22.1%, 15.6%, 17.8% and 18.1%) health workers respectively. For purposes of getting an appropriate number of respondents for each cadre of staff, quota sampling technique was applied depending on the size of each cadre of the staff in the hospital.

In total, 22 key informants who were either the Medical Director, Hospital Administrator, Principal Nursing Officer or Personnel officer (in charge of human resources in the hospital) participated in the study.

Both qualitative and quantitative methods of data collection were used. Quantitative data were collected using pre-tested structured self-administered questionnaires, administered to health workers by researcher and research assistants. Qualitative data were collected from key-informants (top hospital managers) using key informant guides. Data collection took place between August 2012 to April 2013 aiming at determining the various forms of work place violence; victims and perpetrators of work place violence and factors that contributed to the occurrence of work place violence. The study also intended to identify consequences of workplace violence on the victims as well as establishing the mechanisms and remedial strategies used by health workers and managers of the Institutions to cope with work place violence in the hospitals. The interviews were recorded with a recorder and notes taken during the sessions.

The study sought for forms of WPV ever experienced by health workers that included; physical and verbal abuses, sexual assault, tribal abuse and bullying and any other types of

work place violence. An attempt was made to establish who had been the perpetrator for each form of violence experienced. Respondents were required to suggest the probable reasons for the occurrence of the work place violence incidences they had experienced and to mention the way work place violence had affected them in their lives or their jobs. The study further determined the coping mechanisms by the victims of the WPV as well as strategies the hospitals had put in place to manage and prevent work place violence in the hospitals.

Data analysis for the qualitative data was carried out thematically by identifying responses with similar themes and some coded data was analysed using SPSS version 16.0. Microsoft excel was used to analyse the generated data and to generate frequencies for the different variables such forms of WPV, perpetrators of the violence and the victims and presented using tables, charts and graphs. Association between socio-demographic characteristics and as well as comparison of the level of work place violence between categories of health care professionals, were assessed for statistical significance using the 'chi-square' test of association where findings with a P value of 0.05 and below were taken to be significant.

Permission to carry out this study in the hospitals was sought from the respective hospital ethical committees and from the Ministry of Health. Prior to administering the questionnaires, the aims and objectives of the study were clearly explained to the participants and informed consent obtained from each respondent. The subject was fairly new to the participants therefore the researcher needed more time to explain to enable the participants to conceptualise it. Some aspects of workplace violence, such as sexual abuse, were sensitive in nature and thus many respondents were not willing to open up.

4. Results

4.1. Prevalence and Victims of Work Place Violence in the Hospitals under Study

In determining the type of work place violence respondents were asked to mention what type of violence they had experienced in the previous two years before the study. For each type of violence mentioned, an attempt was made to identify which cadre of health workers experienced it most. Experiencing any form of WPV in the hospitals studied was reported by approximately 32% of the health workers. Physical abuse had been experienced by 31.6%, while 63.6% of the respondents reported they had been verbally abused. Health workers who reported having been sexually abused were 8.1%, whereas 30.5% of the respondents reported they had been abused on tribal grounds and those who had been bullied where 26.5%. Sexual abuse was the least prevalent form while verbal abuse was the most prevalent. Of the health workers who had been physically abused, 26% had been attacked with a weapon. The main causes of the physical abuse were staff fighting over a disagreement, or aggressive attendants of patients hustling hospital guards especially at the non visiting hours.

In the assessment of the victims of WPV, it was recognized that physical abuse had been experienced largely by support staffs and nurses while verbal abuse had been experienced on the whole by midwives, nurses and medical officers. Medical officers and support staffs were bullied most. It was more pronounced in the age groups <25-44 (p value 0.013) and among the single, widowed and divorced (p value 0.023). Sexual violence appeared most among the administrative staffs, support staffs and nurses while violence on tribal grounds was experienced most by nurses and allied health professionals. Overall, medical officers and nurses were on the receiving end of most of the violence as indicated in Figure 1.

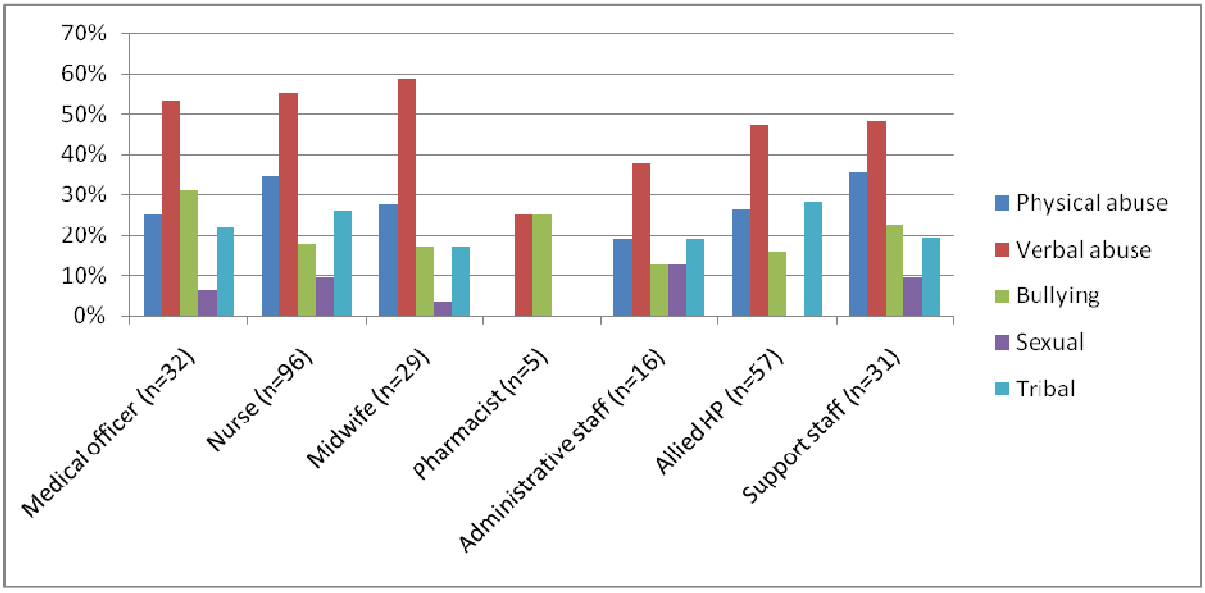

Figure 1. *Victims of each form of Work Place Violence*

Table 1. *Perpetrators of the work place violence*

Forms of work place violence	Perpetrators					
	Patients	Relatives of patients	Staffs	Manager/ supervisor	External colleague	General public
Physical abuse (n=81)	40.4%	0.0%	39.2%	6.3%	3.8%	2.50%
Verbal abuse (n=147)	42.2%	38.8%	44.2%	19.7%	6.8%	15.6%
Sexual violence (n=17)	17.6%	11.8%	52.9%	5.9%	11.8%	0.0%
Bullying (n=52)	34.7%	14.3%	28.6%	18.4%	2.0%	0.0%
Tribal (n=62)	18.6%	10.2%	44.1%	13.6%	11.9%	1.7%

4.2. Perpetrators of Work Place Violence

In order to determine the perpetrators of the work place violence, respondents were asked to indicate the person responsible for the violence that the health worker had experienced. As indicated in table 2, physical abuse, verbal abuse and bullying of health workers was evenly perpetrated mainly by patients and fellow staffs. Surprisingly, the incidents of sexual abuse and harassment experienced by health workers were mainly committed by fellow staffs.

4.3. Time of Work Place Violence Occurrence

Respondents were asked to indicate the time of the day and period in the week when the WPV experienced took place. The physical violence incidents occurred mainly in the day time shifts i.e. according to 54% of respondents. Unlike physical abuse, verbal abuse did not have a particular time/shift of occurrence while mobbing incidents occurred mainly in the day shifts i.e. according to 68% of respondents. The sexual harassment incidents occurred mainly in the night and weekend shift with 96% of the respondents having experienced it at that time.

4.4. Consequences of Work Place Violence Events

Respondents were asked about what happened to them in the aftermath of the work place violence event they had experienced, and detailed below are the results to this effect for each type of violence. The assessment of the consequences of work place violence was carried out on mainly three issues. The study intended to establish whether the violence caused repeated disturbing memories or images to the victim, whether the victim as a result avoided thinking or avoided having feelings about the violence and whether as a result the victim became watchful about the incident. In all the forms of violence, sexual abuse created the highest reactions after the incidences with nearly all victims having repeated memories about it, victims avoiding to think or talk about it and then becoming super alert for any of a repeated incident. This was closely followed by violence due to tribal grounds.

Table 2. *Consequences of WPV to the victims by form of violence experienced*

Response	Physical (n=81)	Verbal (n=147)	Bullying (n=52)	Sexual (n=17)	Tribal (n=31)
Repeated, disturbing memories or images of the attack	60.5%	57.8%	61.5%	94.1%	85.5%
Avoided thinking about it or talking about the attack or avoided having feelings related it.	61.7%	59.9%	51.9%	94.1%	82.2%
Became "super-alert" or watchful and on guard	55.6%	47.6%	94.2%	100%	91.9%

Table 3. *Mechanisms by which the victims dealt with each type of WPV experienced*

Response	Physical abuse (n=81)	Verbal abuse (n=147)	Bullying (n=52)	Sexual abuse (n=17)	Tribal harassment (n=62)
Took no action	28.4%	29.9%	36.5%	23.5%	43.5%
Tried to pretend it never happened	17.3%	38.8%	32.7%	17.6%	30.6%
Told the person to stop	21%	24.5%	34.6%	52.9%	12.9%
Tried to defend myself physically	29.6%	-	-	-	-
Told friends and family	28.4%	17%	26.9%	11.8%	16.1%
Sought counselling	14.8%	15.6%	11.5%	23.5%	4.8%
Told a colleague	39.5%	33.3%	36.5%	47.1%	21%
Told it to a senior staff member	34.6%	24.5%	25.0%	11.8%	6.5%
Transferred to another position	9.9%	0.7%	3.8%	-	-
Sought support from the health worker's association	6.2%	2.0%	1.9%	-	1.6%
Sought help from the union	6.2%	3.4%	-	-	-

4.5. Mechanisms by Which the Victims Immediately Handled the Work Place Volence They Experienced

The study investigated the different coping mechanisms that respondents used to deal with the violence as it occurred. Respondents had to give answers to the statement, *"For each type of violence experienced, mention the actions you took after the incident in order to cope with the violence"*. Multiple responses could be given for how the victims immediately handled the violence. For physical violence talking to a colleague and to a senior staff were the commonest coping

mechanisms followed by those victims trying to defend themselves physically. For verbal abuse, as a coping mechanism, majority of the victims coped with this violence by trying to pretend that nothing had happened and telling a colleague. Victims who had been bullied coped with it mainly by telling a colleague, telling the person to stop and taking no action about the problem. For sexual abuse, the victims coped with the violence by requesting the perpetrator to stop as well as telling the colleague to stop the act. With tribal harassment, many of the victims took no action about the abuse and those who tried to pretend nothing had happened came next. Various ways in which the victims handled the violence are highlighted in Table 4.

4.6. Reporting of the Violence to the Authorities When It Occurred

Health workers who had reported having experienced violence were asked whether they had later reported the act to the higher authorities. Respondents had to answer the question *"For the violence experienced above, did you latter report it to the authorities in the hospital?"* Majority of the victims did not bother to report that they had experienced work place violence as indicated in Table 5. The violence that had the highest number of victims reporting it to higher authorities was physical abuse reported by only 44.4 % of the victims.

Table 4. *Whether victims reported the violence to authorities when it occurred*

Type of WPV	Percent
Physical Abuse (n=81)	44.4
Verbal abuse (n=147)	27.2
Bullying (n=52)	38.5
Sexual abuse (n=17)	35.3
Tribal harassment (n=)	25.4

4.7. Satisfaction of the Victims Who Reported by the Manner in Which the Matter was Handled after They Reported the Violence They Had Experienced

Respondents who had reported the violence to higher authorities where further asked whether they were satisfied with the manner in which the issue was handled when they reported it. In regard to this, we found that 75% of those who reported having been verbally abused were satisfied with the way it was handled. Of the respondents who had experienced physical abuse, only 28.4% were satisfied with the way it was handled by management. On bullying, only 7.7% of the respondents were satisfied. With sexual violence victims who reported, 66.7% were satisfied with the way the incident was handled while of the respondents who had experienced tribal harassment, 11.3% were satisfied with the way the incident was handled. Results are indicated in table 6.

Table 5. *Satisfaction with the way the violence reported had been handled*

Type of WPV	Percentage
Physical abuse (n=36)	28.4%
Verbal abuse (n=40)	75.0%
Bullying (n=20)	7.7%
Sexual harassment (n=6)	66.7%
Tribal harassment (n=16)	11.3%

4.8. Reasons given by Victims for Not Reporting the Work Place Violence as per Each Type of Violence

The study further sought from the victims who had not reported the WPV to mention why they had not informed higher authorities about the violence by answering the question, "*Why didn't you report the violence to higher authorities when it occurred to you?"* Mixed responses were given for each form of violence. With physical abuse, the remarkable response for not reporting was being afraid of the negative consequences. Victims of verbal abuse who had not reported mainly did not because they felt it was not important. On the other hand, sexual harassment victims who did not report the violence were due to the fact that they felt ashamed about it. For bullying, victims did not report due to being afraid of the negative consequences that could arise. Table 6 further illustrates the various reasons given for not reporting the incidents.

4.9. Presence of Remedial Measures against Work Place Violence

The study sought to know whether there were any measures in place to protect health workers from WPV. To obtain this information, all respondents were asked about measures that were available in their hospitals to protect them against WPV. The most significant measure in place to prevent WPV mentioned by the respondents was the availability of security measures such as guards, alarms and portable mobile phones

Table 6. *Reasons given for not reporting the violence experienced*

Response	Physical abuse (n=45)	Verbal abuse (n= 107)	Sexual harassment (n=11)	Bullying (n=32)	Harassment on Tribal grounds (n=46)
It was not important	20%	42.3%	0.0%	31.2%	46%
Felt ashamed	6.6%	7.4%	63.6%	6.2%	7.6%
Afraid of negative consequences	24.4%	21.5%	18.2%	43.8%	32%
Useless	13.3%	7.4%	0.0%	6.2%	6.4%
Did not know who to report to	4.4%	17.8%	9.1%	3.1%	4.5%
Felt guilty	2.2%	1.9%	9.1%		3.2%

Table 7. *Remedial measures in place against WPV*

Measure	Frequency (n=276)	Percentage
Security measures (e.g. Guards, alarms, portable telephones)	175	63.4
Improve surroundings (e.g. Lighting, noise, heat, cleanness etc.	117	42.4
Change shifts or rotas (i.e. Working times)	110	39.9
Special equipment or clothing (e.g. Uniform or absence of uniform)	96	34.8
Restrict exchange of money at the workplace (e.g. Patient fees)	92	33.3
Restrict public access	79	28.6
Patient screening (to identify previous aggressive behaviour)	75	27.2
Training (e.g. On workplace violence, coping strategies, communication skills, conflict resolution, self-defence)	75	27.2
Investment in human resource development (training for career advancement, retreats, rewards for achievement, etc.)	74	26.8
Patient protocols (e.g. Control and restraint procedures, transport, medication, activities programming, access to information)	73	26.4
Increased staff numbers	58	21.0
Less shifts with only one staff	50	18.1
Check-in procedures for staff (especially for home care)	38	13.8

5. Discussion

This study was an attempt to identify the prevalence, common types, victims and perpetrators of WPV. The study also assessed how WPV was being managed in the hospitals. Indeed WPV existed in the hospitals with several health workers reporting having experienced some form of WPV. Other research findings on workplace violence revealed that 25 % of all the violent incidents globally, occur in the health sector and more than 50% of all health workers in both the developing and developed countries have been violated in the course of duty (ILO, ICN, WHO, PSI 2002). The three leading forms of violence were verbal abuse, physical abuse and tribal harassment and the least form was sexual abuse. The nursing cadre was most affected with work place violence. The main perpetrators of work place violence for physical abuse and bullying were patients whereas for other forms of violence, the main perpetrators were staffs. This implies that WPV is within the means of health managers and health professionals to solve. It calls for improved interpersonal relations among health professionals, quick measures to solve conflicts among health professional teams and improved relationships with clients because these have the potential to improve relations that can address WPV.

The main factors that lead to work place violence in the hospitals are issues of human resources, such as inadequate staffing levels leading to heavy work overload hence delayed patient treatment/service accesses, low motivation levels, poor time management, and lack of teamwork, poor supervision and poor interpersonal skills. The patients expect to see a doctor when they come to hospital, but when the doctors are not able to handle the overwhelming patient load, this leads to frustration by both the patients and health workers hence breeding a fertile ground for violent incidents.

Health workers were not satisfied with the way the violence had been handled. Even for cases that are reported, there were no definite and known punitive and deterrent measures for the perpetrators. The victims were therefore left with no option but to accept to live with work place violence leading to disturbing memories of the violence experienced. This also easily leads to stress amongst the workers. The knock on effect of the stressed workforce is poor customer care and poor service delivery. The combination of these factors culminates into patient dissatisfaction and unmet patient expectations. Chapman et al (2009) demonstrated that in situations where employees undergo work place violence with no clear measure to address it, there is a tendency for the employees to vent their anger onto their clients for example by avoiding or denying them a service. When these are exacerbated by shortage of medical supplies, the final product is a highly charged environment, ripe for work place violence.

In most of the occasions, victims of work place violence became cautious and super alert against the perpetrators. Schofield et al (1990) revealed that in the aftermath of work place violence employees are seen to adhere more to organizational code of conduct in regard to patient handling. It was further revealed that this is mainly as a result of the fact that there are no known procedures for reporting work place violence save for some of the victims especially those of tribal harassment who sought refuge in telling friends/family, so as to mitigate the impact of the abuse. The major consequences for the victims were that of resignation to their fate as observed with health workers who had experienced sexual abuse and could not report the incident because they felt ashamed. Some believed that it is part of the job to be violated especially since the clients are in most cases emotionally and physically challenged. This is in line with the research conducted by Hoobler and Swanberg (2006) where it was stated that some health workers have accepted work place violence as part of their jobs, hence their sense of resignation towards aggressive behaviour. Other victims were noted to have taken no action following the violent incident mainly due to fear of what the perpetrator would do to them. In case of

sexual assault /harassment it was mainly due to shame and fear of others getting to know about the incident. Available literature by Ferinho et al (2003) on work place violence states that staffs have been forced to resign as a result of work place violence in situations where a place of leadership is sought and lost.

It was noted that most managers do not perceive work place violence as a managerial problem and have therefore not put in place mitigating measures to this effect. Where managers do not bother to put in place work place violence measures, violence continues to happen and this affects the quality of health service delivery.

6. Conclusion

The study findings show that WPV actually exists mainly through physical and psychological abuse perpetrated largely by the patients and their relatives. Though health workers were predominantly ignorant about work place violence, all the health professionals were victims of work place violence in hospitals studied with the main causes of WPV being; shortage of staff and heavy patient load, inconsistent flow of drugs, and sundries and ultimately poor communication skills of health workers. Consequences of work place violence include work related stress, constant fear of attack by the public and loss of affection towards work and the organization.

Recommendations

The MoH should liaise with international bodies for updates on work place violence and contemporary strategies for addressing work place violence. They should include work place violence in the curriculum of health training institutions so that health workers get to know causes of WPV, the main perpetrators and how to avoid it. The same ministry together with the ministry of Labour and Gender should sensitise managers and employees on the employment act as well as issuing guidelines on how to deal with this evil in hospitals. Ministry of health needs to improve staffing levels in hospitals to solve the issue of staff shortage that leads to work overload and thus perpetrating WPV.

At hospital level, managers should institute work place violence committees to handle assessment of work place violence needs and prevention strategies in hospitals. Hospital leaders should sensitize all employees and management about the negative impact of work place violence on health workers' health and their delivery of health care services so that all measures possible to prevent it are implemented at all levels. Proper counselling units in hospitals, equipped to handle both victims and perpetrators of work place violence should be established.

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