

# **Workplace violence in the health sector**

## **Country case studies**

**Brazil, Bulgaria, Lebanon, Portugal, South Africa,  
Thailand and an additional Australian study**

Synthesis report

by

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## Foreword

Violence at work has become an alarming phenomenon worldwide. The real size of the problem is largely unknown and recent information shows that the current knowledge is only the tip of the iceberg. The enormous cost of violence at work for the individual, the workplace and the community at large is becoming more and more apparent. Although incidents of violence are known to occur in all work environments, some employment sectors are particularly exposed to it. Violence includes both physical and non-physical violence. Violence is defined as being destructive towards another person. It finds its expression in physical assault, homicide, verbal abuse, bullying, sexual harassment and threat. Violence at work is often considered to be just a reflection of the more general and increasing phenomenon of violence in many areas of social life which has to be dealt with at the level of the whole society. Its prevalence has, however, increased at the workplace, traditionally viewed as a violence-free environment. Employers and workers are equally interested in the prevention of violence at the workplace. Society at large has a stake in preventing violence spreading to working life and recognizing the potential of the workplace by removing such obstacles to productivity, development and peace.

Violence is common to such an extent among workers who have direct contact with people in distress, that it may be considered an inevitable part of the job. This is often the case in the health sector (violence in this sector may constitute almost a quarter of all violence at work).<sup>1</sup> While ambulance staff are reported to be at greatest risk, nurses are three times more likely on average to experience violence in the workplace than other occupational groups. Since the large majority of the health workforce is female, the gender dimension of the problem is very evident. Besides concern about the human right of health workers to have a decent work environment, there is concern about the consequences of violence at work. These have a significant impact on the effectiveness of health systems, particularly in developing countries. The equal access of people to primary health care is endangered if a scarce human resource, the health workers, feel under threat in certain geographical and social environments, in situations of general conflict, in work situations where transport to work, shift work and other health sector specific conditions make them particularly vulnerable to violence. In such situations the best educational system, labour market policies and workforce planning may have little or no impact.

The International Labour Office (ILO), the International Council of Nurses (ICN), the World Health Organization (WHO) and Public Services International (PSI) launched in 2000 a joint programme in order to develop sound policies and practical approaches for the prevention and elimination of violence in the health sector. When the programme was first established and information gaps were identified, it was decided to launch a number of country studies as well as cross-cutting theme studies and to conclude by drafting guidelines to address workplace violence in the health sector. This working paper presents the Synthesis Report of the commissioned country reports to stimulate further discussion in the area of workplace violence, encourage fact-finding research in other countries and support sound policy-making.

<sup>1</sup> Nordin, H. (1995). *Fakta om vaold och hot I arbetet*, Solna: Occupational Injury Information System, Swedish Board of Occupational Safety and Health.

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## Contents

	<i>Page</i>
Foreword .....	iii
Acknowledgements .....	vii
Executive summary .....	ix
1. Targeting an unknown area .....	1
1.1. Original methodology .....	3
1.2. Literature analysis (highlights) .....	5
1.3. Group discussions and interviews.....	8
1.4. Survey .....	8
2. Definitions, perceptions and cultural background.....	11
3. Society, change and transition.....	14
4. A unique new vision .....	16
4.1. The dimension of the problem .....	16
4.2. Physical and psychological.....	16
4.3. Perpetrator and victim.....	17
4.4. Part of the job?.....	19
4.5. Where it concentrates.....	20
5. The origin of workplace violence: Causes and reasons .....	21
5.1. Individual factors .....	22
5.2. Societal factors.....	22
5.3. Organizational factors.....	23
6. Assessing the impact of workplace violence.....	26
6.1. The magnifying cycle stress-violence.....	26
6.2. The cost for the organization .....	27
7. Building an effective response .....	29
7.1. Reporting .....	29
7.2. Strategic or immediate? .....	30
7.3. Policies.....	32
8. Recommendations from the country studies .....	34
9. Critical issues .....	39
<b>Appendix</b>	
List of documents .....	41

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## Acknowledgements

The Joint Programme wishes to thank the author of this Synthesis Report:

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This report is based on the country reports conducted in the various countries. In each country the case studies have been carried out with sincere commitment and engagement of the researchers and their teams. The Joint Programme wishes to thank all persons involved for their valuable contributions. These are:

**Brazil:** Marisa Palácios, Mônica Loureiro dos Santos, Margarida Barros do Val, Maria Imaculada Medina, Marcia de Abreu, Lídia Soares Cardoso, Basílio Bragança Pereira and their students.

**Bulgaria:** Liuben Tomev, Nadejda Daskalova, Violeta Ivanova, Tatiana Michailova, Zinaida Naydenova, Diana Trakieva, Slava Zlatanova, Ivan Kokalov.

**Lebanon:** Mary Deeb.

**Portugal:** Paulo Ferrinho, Ana Rita Antunes, André Biscaia, Claudia Conceição, Inês Fronteira, Isabel Craveiro, Isabel Flores, Osvaldo Santos.

**South Africa:** Susan Steinman.

**Thailand:** Kasara Sripichyakan, Pathraporn Thungpunkum, Bungorn Supavititpatana.

**Australia:** Claire Mayhew, Duncan Chappell.

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## Executive summary

### **Background**

For long a neglected issue, workplace violence in the last years has gained increasing attention. Health workers are known to be particularly at risk of workplace violence, with almost one quarter of all violent incidents at work concentrating in this sector.

ILO, ICN, WHO and PSI launched a joint programme on workplace violence in the health sector in the year 2000 with the aim to fill major information gaps and to develop guidance materials for the development of policies addressing violence at work. Besides several cross-cutting theme studies, the programme initiated country case studies in Brazil, Bulgaria, Lebanon, Portugal, South Africa and Thailand. The present report synthesizes the main findings from those country reports, including results of a concurrent independent Australian research.

### **Definition**

For the purpose of the surveys workplace violence was defined as: *“Incidents where staff are abused, threatened or assaulted in circumstances related to their work, including commuting to and from work, involving an explicit or implicit challenge to their safety, well-being or health”*.<sup>1</sup> It includes physical and psychological violence, such as verbal abuse, harassment, bullying/mobbing and threat.

### **Methodology, quality of data**

Having used standardized quantitative and qualitative methodologies and instruments (literature review, confidential survey and focus group discussions), with required adaptation to the local context, the country case studies provide a range of worldwide evidence wider than that currently existing. Because of the significant effort of stratification and randomization carried out the data largely reflect the overall situation in the geographical area covered. Possibly they are also indicative of major trends at national level. They are not however statistically representative of the national situation and even at the local level of investigation their generalization should be considered with some care. Despite these limitations the country cases provide, for the first time ever, a balanced, significant and reliable insight of the extent, patterns and impact of workplace violence within the health sector on a worldwide scale.

### **Dimensions of the problem**

Across borders, the country reports indicate a general common understanding of the concept of workplace violence, though cultural and linguistic differences are in operation which need to be addressed properly.

It has been revealed that violence at work against health personnel is an existing and widespread problem in developing and transition countries as well as it was shown before for the industrialized world. More than half of the responding health personnel have

<sup>1</sup> Wynne, R.; Clarkin, N.; Cox, T.; Griffiths, A. (1997). *Guidance on the prevention of violence at work*. Luxembourg: European Commission, DG-V.

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experienced at least one incident of physical or psychological violence in the previous year: 75.8 per cent in Bulgaria; 67.2 per cent in Australia; 61 per cent in South Africa; in Portugal 60 per cent in the Health Centre complex and 37 per cent in the hospital; 54 per cent in Thailand; 46.7 per cent in Brazil.

Workplace violence affects significantly all professional groups, both gender and all work settings in the health sector. The highest rates of offences however were reported by ambulance staff, nurses and doctors. All health facilities are at risk, particularly large hospitals in suburban, densely populated or high crime areas, as well as those located in isolated areas.

Main perpetrators appear to be patients and staff, though significant differences exist among countries and depending on the type of violence. In several countries a pattern seems to emerge whereby patients are the main perpetrators of physical violence while staff are the main perpetrators of psychological violence. The country surveys confirm the difficulty of establishing a profile of the perpetrator of workplace violence and highlight the risks associated with generalization and stereotyping in this area.

Psychological violence is more prevalent than physical violence. This form of violence at work is widespread everywhere with verbal abuse right on the top and bullying and mobbing as second main areas of concern. The results of the country studies unveil for the first time the worrying dimension of bullying or mobbing in the developing world and in countries in transition, where these two forms of psychological workplace violence were virtually unknown up to very recently.

The reasons and causes for workplace violence are identified at organizational, societal and individual levels, showing complex interrelationships. The accumulation of stress and tension in demanding health occupations under the strain of societal problems and the pressure of the reform of the health systems are explicitly mentioned in the reports as generators of violence. Considering the single factors named by respondents, the personality of patients ranks first followed by the social and economic situation in the country and, well behind, work organization and working conditions. The total of all contributing factors, however, being categorized into individual, societal and organizational factors, shows the equal importance of all three areas to be considered in the analysis of risks, with organizational factors playing a key role.

The recognition of workplace violence as an important generator of post-traumatic stress disorders is an uncontroversial major finding of all country surveys. The figures highlight the tremendous negative effects of all forms of psychological violence on the victims' health, having been underestimated in the past. Between 40 per cent up to 70 per cent of the victims report significant levels of PTSD symptoms, such as being "super-alert" and watchful, trying not to think or talk about what happened, feeling chronic fatigue or being bothered by repeated memories of the incident. One important finding of the Australian study identified a highly significant relationship between exposure to bullying at work and emotional injury, stressing the paramount importance of psychological violence in stress generation vis à vis the traditional view giving priority significance to the physical severity of the incidents.

This correlation between violence and stress is of the greatest significance not only in assessing the overall impact on the individual but also in determining their global impact in terms of cost and efficiency for the organizations. Cost factors have emerged as an important element in group discussions especially with managers. Workplace violence, they summarize, negatively affects the performance and efficiency of the organizations mainly through increase in sick leave, absenteeism and turnover, lower productivity and motivation as well as professional dissatisfaction, leading to decreased quality of care and negative repercussions on the image of the institution.

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## **Response**

Reporting is an essential precondition for an effective response. In many cases, reporting procedures are lacking, proper investigation does not follow, the perpetrator is not persecuted and the victim feels dissatisfied of the way the incident has been handled. These weak response structures and missing victim support are leading to significant underreporting: victims of workplace violence do not report the incident because they think it would be useless, they feel humiliated or fear negative consequences.

In the majority of cases no specific policy on workplace violence is in operation. The limited development of workplace policies, as stressed in the country reports, is a major impediment to effectively dealing with workplace violence.

Looking for effective responses, the central role of prevention in handling workplace violence is directly or indirectly highlighted in all the country reports. Some reports mention the need for a long-term, strategic perspective and the importance of an enabling framework focusing on values and organizational solutions rather than just on a case by case approach. Analysing the origins and risk factors of violence in the health workplace is a precondition to develop policies and action in an appropriate way, to identify priority areas and allocate accordingly the usually limited resources. However, currently existing measures to tackle workplace violence focus on a more immediate and physical type of response, such as security measures and improvement of the physical environment, than on strategic and organizational factors.

## **Recommendations**

The recommendations from the country reports on how to address effectively workplace violence in the health sector reflect a common understanding of an approach that integrates interventions at organizational, societal and individual level with a clear priority on preventive action.

A comprehensive overview on the different levels of interventions is provided by the Portuguese researchers, stressing the importance of priority setting to avoid overlapping of action. Interventions at macro-level focus on the general conditions in society and legal framework with a long-term impact. At a meso level, the focus is on normative interventions, such as guidelines and management competencies with an estimated mid-term impact of three to the years. At micro level, the purpose is to achieve changes on a short term basis, with interventions on environmental and individual level.

In most of the countries strategies have to go a long way, starting with raising awareness and building authentic understanding among health personnel and other parties concerned at all levels. Effective action requires the involvement of all stakeholders in the development and implementation of policies and strategies, legislation and on-site measures.

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## 1. Targeting an unknown area

For long a neglected issue, workplace violence, particularly psychological violence, has in the last decade, gained attention and momentum to become a central topic of policy shaping and action in the areas of health and safety, human resource management and organizational development.

In 1994, the ICN released a position statement highlighting the widespread presence of workplace violence in health facilities and the dramatic negative impact this violence has on personnel and the quality of care provided. *Guidelines on coping with violence at the workplace*<sup>1</sup> were developed and revised in 1999 to contribute to efforts to reduce workplace violence.

In 1998, the ILO published *Violence at work*, by Duncan Chappell and Vittorio Di Martino, the first international study on the general situation of violence at the workplace.<sup>2</sup> In 1999 the Advisory Committee on Safety, Hygiene and Health of the European Commission set up an ad hoc group on “Prevention of violence at work” and in 2001 the European Foundation for the Improvement of Living and Working Conditions, Dublin, published the results of its third Survey on Working Conditions in Europe confirming the amplitude and complexity of the problem.<sup>3</sup>

In 2001 the issue of workplace violence became a priority within the context of the North American Agreement on Labour Cooperation/NEFTA with experts from Canada, Mexico and the United States gathering in Montreal for the first conference involving both developing and industrialized countries. As a result of a long-lasting interest in this area, the World Health Organization is releasing in 2002 the first World Report on Violence and Health which addresses the problem of workplace violence in the broader context of violence in general.<sup>4</sup>

While shedding new light on this emerging area, the above studies and initiatives strongly hint at the need for further research that would explore in greater depth the multiple factors leading to workplace violence, the dimension and interaction of different types of violence at the workplace and their impact on different sectors and occupations.

From the start the health sector appeared to need special attention. Violence, as this report will show, may affect more than half of all workers in this sector. A number of specific studies, mostly developed in recent years, have addressed this problem in regard to particular situations. In 1998, the ILO held a meeting on “terms of employment and working conditions in health sector reforms”.<sup>5</sup> It was concluded that health workers were

<sup>1</sup> International Council of Nurses (1999). *Guidelines on coping with violence in the workplace*. Geneva: International Council of Nurses.

<sup>2</sup> Chappell, D.; Di Martino, V. (1998, first edition, 2000 second edition). *Violence at work*. Geneva: International Labour Office.

<sup>3</sup> Paoli, P. ; Merllié, D. (2001). *Third European survey on working conditions 2000*. Dublin: European Foundation for the Improvement of Living and Working Conditions

<sup>4</sup> [http://www5.who.int/violence\\_injury\\_prevention/main.cfm?p=0000000117](http://www5.who.int/violence_injury_prevention/main.cfm?p=0000000117)

<sup>5</sup> International Labour Organization (1998). Terms of employment and working conditions in health sector reforms: Report for discussion at the Joint Meeting on Terms of Employment and



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particularly at risk of violent acts and it also reaffirmed the need for governments and employers to be held responsible for creating safe workplaces. However, up to recently, no national study on the health sector had been made available, no comparative analysis had been developed, and very limited coverage had been provided of the developing world.

Eventually, in the year 2000, a joint programme of ILO/ICN/WHO/PSI was initiated on violence at work in the health sector. The programme was intended to provide an overview of workplace violence in the health sector as well as framework guidelines for addressing the problem in this sector.<sup>6</sup>

A first state-of-the-art paper on the incidence of workplace violence in the health sector was produced.<sup>7</sup> Further studies were undertaken on the interaction between stress and violence,<sup>8</sup> on victim management,<sup>9</sup> and on existing guidelines and codes of practice.<sup>10</sup>

The programme also commissioned a number of country case studies: Brazil,<sup>11</sup> Bulgaria,<sup>12</sup> Lebanon,<sup>13</sup> Portugal,<sup>14</sup> Thailand<sup>15</sup> and South Africa<sup>16</sup> were selected to

Working Conditions in Health Sector Reforms. Geneva: International Labour Office, Sectoral Activities Programme.

<sup>6</sup> ILO/ICN/WHO/PSI(2002). *Framework guidelines for addressing workplace violence in the health sector*. Geneva: ILO/ICN/WHO/PSI Joint Programme on Workplace Violence in the Health Sector.

<sup>7</sup> Cooper, C.; Swanson, N. (2002). *Workplace violence in the health sector – State of the art*. Geneva: ILO/ICN/WHO/PSI Joint Programme on Workplace Violence in the Health Sector.

<sup>8</sup> Di Martino, V. *Relationship of work stress and workplace violence in the health sector*. Geneva: ILO/ICN/WHO/PSI Joint Programme on Workplace Violence in the Health Sector, forthcoming working paper.

<sup>9</sup> Richards, J. *Management of workplace violence victims*. Geneva: ILO/ICN/WHO/PSI Joint Programme on Workplace Violence in the Health Sector, forthcoming working paper.

<sup>10</sup> Wiskow, C. *Guidelines on workplace violence in the health sector – Comparison of major known national guidelines and strategies: United Kingdom, Australia, Sweden, USA*. Geneva: ILO/ICN/WHO/PSI Joint Programme on Workplace Violence in the Health Sector, forthcoming working paper.

<sup>11</sup> Palácios, M.; Loureiro dos Santos, M.; Barros do Val, M.; Medina, M.I.; de Abreu, M.; Soares Cardoso, L.; Bragança Pereira, B. *Workplace violence in the health sector – Country case study Brazil*. Geneva: ILO/ICN/WHO/PSI Joint Programme on Workplace Violence in the Health Sector, forthcoming working paper.

<sup>12</sup> Tomev, L.; Daskalova, N.; Ivanova, V. *Workplace violence in the health sector – Country case study Bulgaria*. Geneva: ILO/ICN/WHO/PSI Joint Programme on Workplace Violence in the Health Sector, forthcoming working paper.

<sup>13</sup> Deeb, M. *Workplace violence in the health sector – Lebanon country case study*. Geneva: ILO/ICN/WHO/PSI Joint Programme on Workplace Violence in the Health Sector, forthcoming working paper.

<sup>14</sup> Ferrinho, P.; Antunes, A.R.; Biscaia, A.; Conceição, C.; Fronteira, I.; Craveiro, I.; Flores, I.; Santos, O. *Workplace violence in the health sector – Portuguese case studies*. Geneva: ILO/ICN/WHO/PSI Joint Programme on Workplace Violence in the Health Sector, forthcoming working paper.

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provide a range of evidence broader than that which currently exists. This report synthesizes the main findings from those country reports as made available by the national teams at the end of May 2002.

Extracts from a concurrent Australian study have also been included.<sup>17</sup> This study has been developed independently, using its own methodology which does not necessarily correspond to that used by the other country teams which is detailed below. It has been co-opted while the planned research was already in progress and, as such, it should be considered an “addition”, albeit an important one, to the core country reports.

## **1.1. Original methodology**

The country studies were required to combine three methodological approaches:

### ***Literature survey***

Review of research undertaken, existing and available information and literature in the country on the issue of violence at work in the health sector.

### ***Group discussions and qualitative interviews***

Group discussions would involve all categories concerned: representative organizations (unions, associations, employers’ organizations); private owners of health services; health sector personnel; health authorities (at central and decentralized levels of the health care system); management (senior and middle management); patients/clients; occupational health and safety specialists; labour lawyers.

If, in respect of certain categories of target population, it appeared difficult or impossible to create a focus group, the alternative was given of carrying out qualitative interviews with individuals, key informants or representatives of those groups, following the same guideline as for the focus group discussion.

### ***Survey***

The quantitative element of the study consisted of a survey using a standardized, confidential questionnaire. The following criteria were to be used in the elaboration of the sample.

<sup>15</sup> Sripichyakan, K.; Thungpunkum, P.; Supavititpatana, B. *Workplace violence in the health sector – A case study in Thailand*. Geneva: ILO/ICN/WHO/PSI Joint Programme on Workplace Violence in the Health Sector, forthcoming working paper.

<sup>16</sup> Steinman, S. *Workplace violence in the health sector – Country case study: South Africa*. Geneva: ILO/ICN/WHO/PSI Joint Programme on Workplace Violence in the Health Sector, forthcoming working paper.

<sup>17</sup> Mayhew, C.; Chappell, D.(forthcoming): *Occupational violence in the NSW health workforce: Establishment of baseline data*.

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## Stratification of health facilities

There were three levels of stratification with each level being divided into groups of strata based on specific categories:

- I. size of the health care facility/service;
- II. level of care provided, including:
  1. leading referral hospitals of a major city;
  2. regional and district hospitals;
  3. health care centres, clinics, community health posts, ambulance services (if independent from hospitals), outreach services (home care);
  4. rehabilitation centres, long-term care facilities;
  5. general practitioners' offices, other independent health care professionals;
- III. location of the facility (rural/urban).

According to the methodology, out of each category (strata) a minimum number of health facilities were to be chosen, at least one from levels of care 1 and 2 and five from levels 3-5.

## Stratification of target population

- I. Staff were to be categorized according to the following professional groups:
  - physician;
  - nurse/midwife;
  - pharmacists;
  - managers;
  - auxiliary/ancillary;
  - ambulance;
  - administration/clerical;
  - professions allied to medicine (therapists/radiographers/assistants);
  - technical staff (laboratory/sterilization);
  - support services (security, catering, kitchen, maintenance, reception).

All major disciplines within the health care settings were to be covered: general medicine, surgery, emergency, psychiatry, paediatrics, etc.

- II. A separate random sample was to be selected from each group. For facilities or services with large numbers of workers, a sample of at least 10 per cent was to be taken from each category of worker. For small facilities or services with few personnel (up to ten persons) all listed workers were to be included in the sample.

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### III. Sample size:

The desirable sample size was to be determined by the expected variation in the data. The more varied the data, the larger the sample so as to obtain an adequate level of accuracy in generalizing the results. It was recommended having 1,000 participants from each country to ensure a statistically significant number of responses given the range of variables under investigation.

The original methodology proved, in several cases, difficult to fully implement. A number of adaptations, sometimes important ones, had to be made taking into account the specific situation and constraints of each country. The way this was done, and the results obtained, are explained in the following paragraphs and chapters.

## 1.2. Literature analysis (highlights) <sup>18</sup>

The analysis of research carried out and literature available in the countries under investigation revealed that the issue of workplace violence in the health sector had received limited attention.

In Bulgaria at present there are no accurate and reliable statistics available, neither on violence as such nor on workplace violence in its different forms. Literature on violence at the workplace is practically non-existent. However, in recent years, some surveys have been carried out primarily focusing on domestic violence and sexual harassment.

In 1997-98 a joint project on “Sex discrimination and sexual harassment in the workplace in Bulgaria” was undertaken by the Minnesota Advocates for Human Rights together with the Bulgarian Centre for Human Rights and the Gender Project for Bulgaria Foundation. Some 490 women and 110 men in different cities, industries and services – trade union representatives, attorneys, human rights activists – were interviewed. The survey found that sex discrimination and sexual harassment in employment are serious and pervasive problems for women in Bulgaria, both in the form of quid pro quo sexual harassment and a hostile work environment due to sexual discrimination.

Another project entitled “Higher citizen involvement in privatization: Women’s rights in the process of economic transition”, carried out jointly by the Bulgarian Gender Research Foundation and the Women, Law and Development Institute, Washington, DC, confirmed the importance and seriousness of the problem of sexual harassment at the workplace. The participants agreed that the workplace in both the public and private sectors is just another scene of violence against women. Women face a much higher risk of violence in the informal sector due to their isolation and the lack of any legal protection. The legal guarantees of security which exist at least in theory in the public sector are often totally out of their reach.

In Thailand there is neither empirical nor theoretical literature regarding workplace violence. Most of the existing studies and literature focus on related issues such as job stress and conflict. Workplace violence has not been conceptualized yet; neither has its prevalence and incidence been reported.

<sup>18</sup> Country studies will be released with a copyright ILO/ICN/WHO/PSI in 2002 and will also be made available on the sponsoring organizations’ web sites. Specific page references will not be included in this synthesis report as the final editing of these studies has not yet been completed.

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In Portugal a literature review found only one publication dealing with violence against health workers in the workplace; an analysis of official reports on workplace violence from five health care centres and two hospitals revealed the characteristics of 22 cases; and a national press analysis of over a 12-month period revealed nine articles concerning the subject.

In South Africa an Internet communication survey conducted by S. Steinman in 1998-99 showed for the first time, the magnitude of the problem with 78 per cent of respondents reporting that they had been victimized at least once during their careers. These initial data are now substantially confirmed by a series of recent studies further disclosing the significant levels of workplace violence.

In 2001 the Medical Research Council carried out a study on “The impact of crime and violence on the delivery of state health care Services in the Western Cape”. The study reveals that 60 per cent of respondents have to deal with workplace crime and violence frequently; 92.3 per cent had been verbally abused in the last two years; 36.4 per cent had occasionally been threatened.

In the same year the Ethics Institute of South Africa released the results of an audit on the Chris Hani Baragwanath Hospital (the largest, but not the most problematic public hospital in South Africa). The audit showed that workplace violence was a problem in that hospital. Two-thirds of those interviewed agreed that the number of security staff was inadequate; 76 per cent felt that they were poorly equipped to do their jobs; 57 per cent believed that the screening of visitors was problematic.

In 2001-02, an Australian *Taskforce on the prevention and management of violence in the health workplace* commissioned three discussion papers on occupational violence, prior to commencement of the empirical study. Each of these focuses on a different aspect of violence in the health industry:

- Mayhew and Chappell (2001a), *Occupational violence: Types, reporting patterns and variations between health sectors*;<sup>19</sup>
- Mayhew and Chappell (2001b), *Prevention of occupational violence in the health workplace*;<sup>20</sup> and
- Mayhew and Chappell (2001c), *Internal violence (or bullying) and the health workforce*.<sup>21</sup>

<sup>19</sup> Mayhew, C.; Chappell, D. (2001a). *Occupational violence: Types, reporting patterns, and variations between health sectors*. Taskforce on the Prevention and Management of Violence in the Health Workplace, Discussion Paper No. 1; School of Industrial Relations and Organizational Behaviour and Industrial Relations Research Centre, Working Paper Series 139; University of New South Wales.

<sup>20</sup> Mayhew, C.; Chappell, D. (2001b). *Prevention of occupational violence in the health workplace*. Taskforce on the Prevention and Management of Violence in the Health Workplace, Discussion Paper No. 2; School of Industrial Relations and Organizational Behaviour and Industrial Relations Research Centre, Working Paper Series 140; University of New South Wales.

<sup>21</sup> Mayhew, C.; Chappell, D. (2001c). “*Internal*” *violence (or bullying) and the health workforce*. Taskforce on the Prevention and Management of Violence in the Health Workplace, Discussion Paper No. 3; School of Industrial Relations and Organizational Behaviour and Industrial Relations Research Centre, Working Paper Series 141; University of New South Wales.

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In Brazil, a 2000 survey<sup>22</sup> carried out in two emergency services in the city of Rio de Janeiro, identified the main reasons for violence as being due to excessive delay in attending to patients; the relatives wishing their patient to be given immediate and special treatment; perceived negligence on the part of workers in their attendance on patients; imminence of patient's death; invasions of armed gangs in the physical spaces of the emergency areas.

In the same year research on a sample of 21 employees interviewed from an emergency service in Rio de Janeiro, which is considered a standard in Latin America, identified their perception of assault by clients as a work accident in 14 per cent of cases.<sup>23</sup>

Also in 2000 the Doctors' Syndicate of São Paulo (Simesp) conducted a survey in the geographical area of Great São Paulo on a sample corresponding to 1.52 per cent of the doctors' population.<sup>24</sup> About 23 per cent of doctors interviewed stated that they had been exposed to violent acts three to four times and about 18 per cent over five times. The reports of violence differed significantly between public hospitals and private hospitals: 74 per cent and 26 per cent, respectively. Workers in first-aid facilities suffered high levels of violence (about 62 per cent), followed by those in outpatients' wards (about 24 per cent) and in clinics (about 14 per cent). The Syndicate (Simesp) suggested preventive actions based on the conclusion that there is a "lack of security" in public units.

In 2001 a study among nursing personnel in a service dealing with infectious and parasitic diseases/AIDS revealed that they experienced situations of fear with drug users considered potential aggressors (and real according to interviewees).<sup>25</sup>

More recently, the health personnel of the National Institute of Cancer (INCA) promoted an inter-institutional debate on the subject of violence against professionals involved in palliative care and homecare.<sup>26</sup> Problems with agents of drug trafficking involving firearms were reported.

In Lebanon, no previous systematic research on violence in the health sector was found.

<sup>22</sup> Deslandes, S.F. *Violência no cotidiano dos serviços de emergência: representações, práticas, interações e desafios* [Violence in the daily life of the emergency services: Representation, practices, interactions and challenges]. Tese de Doutorado. Rio de Janeiro: ENSP/FIOCRUZ, 2000.

<sup>23</sup> Merino, C.; Aguiar, I.; Dantas, J.; Rodrigues Jr., J.; Borges, J.; Steinbruck, K.; Pereira, L.; Pereira, M.; Gomes, M.; Penha, M.; Cariello, P.; Bellizzi, V. *Saúde e Trabalho: o que acontece na emergência do Souza Aguiar?* [Work and health: What happens in the emergency of Souza Aguiar?]. Rio de Janeiro: UFRJ, mimeo, June 2000.

<sup>24</sup> SIMESP. *Violência contra médicos* [Violence against physicians]! São Paulo, May 2000.

<sup>25</sup> Loureiro dos Santos, M. *Cuidado paliativo e Organização do Trabalho: a concepção na atividade de técnicas e auxiliares de enfermagem* [Palliative care and work organization: The conception in the activity of nursing] tese de Doutorado. Rio de Janeiro: COPPE/UFRJ, 2001.

<sup>26</sup> BRASIL/MS/INCA – *I Fórum Saúde e Violência: Cuidar para não Excluir* [I Forum health and violence: To take care to not exclude], coordinated by the National Institute of Cancer (INCA), State Health Secretary (SES/RJ) and Municipal Health Secretary (SMS/RJ). Rio de Janeiro, 21 September 2001.

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### 1.3. Group discussions and interviews

The following focus groups, workshops and interviews were organized and carried out:

- Brazil: four focus groups and four interviews with authorities and one meeting with seven representatives of district health councils and the State Health Secretary to discuss the preliminary results.
- Bulgaria: six focus groups with 45 participants and nine semi-structured interviews with owners of private health establishments and experts in labour law.
- Lebanon: three focus groups and five interviews with stakeholders.
- Portugal: semi-structured interviews with 28 stakeholders.
- South Africa: 18 focus groups and a workshop with 38 participants.
- Thailand: 15 focus groups and interviews with participants.

The analysis of this qualitative part of the research will be carried out in conjunction with that of the survey results.

### 1.4. Survey

The data and results of the survey should be appreciated within the scope of the above methodological context. Because of the significant effort at stratification and randomization, they not only largely reflect the overall situation in the geographical area covered, but are possibly also indicative of major trends at the national level. They are not however, statistically representative of the national situation and even at the local level of investigation, their generalization should be considered with some care.

In the case of Portugal, for instance, the sample size is much smaller than the envisaged one and drawn from two case studies only – a health centre and a hospital – which precludes joining the data from the two into a single database and makes cross-data analysis problematic even within each single case study. In the South African case, the researcher complained of denied access, managerial interference and problems with the random choice of participants.

In the Thai case some professional groups were hardly contacted; and a number of questionnaires, considered too long by some participants in the survey, were left incomplete in their final part. In Lebanon high rates of refusal to cooperate were reported, especially among physicians.

The Australian study used its own methodology. This study involved 400 face-to-face semi-structured interviews with health workers employed in 45 different public hospitals, 14 ambulance stations and a number of community health centres in both urban and rural areas.

Despite these limitations the country cases provide, for the first time ever, a balanced, significant and reliable insight into the extent, patterns and impact of workplace violence within the health sector on a worldwide scale. For many developing and transition countries this is practically the first insight into this area. Taken together, they represent the most extensive body of information on workplace violence in the health sector and one of the most important in the field of workplace violence in general.

The field of observation effectively covered by each study is shown in table 1.

**Table 1. Area of observation per country**

Country	Geographical coverage	Health services	Type	No. of participants	Gender	Profession	Age/seniority
Australia	Across rural and urban areas of State of New South Wales	45 hospitals, 14 ambulance stations, plus a number of community health centres linked to hospitals	100% public	400	68.5% women	50% nurses 10% physicians 10% allied health 10% ambulance officers 20% ancillary staff	0.75% – 21 or under 6% – 21-24 25% – 25-34 33% – 35-44 26% – 45-54 8% – 55-64 0.5% – 65+
Brazil	Rio de Janeiro City	14 facilities and private offices and clinics	51.6% public 48.4% private	1 569	70.46% women	19.7% physicians 6.5% nurses 23.1% auxiliary	30.3% aged 30-39 25.3% with 1-5 years of experience
Bulgaria	Sophia City	27 facilities and 14 individual GPs	68.5% public 31.5% private	508	80.3% women	30.7% physicians 27.6% nurses	More than half between 40-54 years old/40.4% more than 20 years' service
Lebanon	Beirut	13 facilities	majority private	1 016	69.8% women	59% nurses 11.6% administrative/clerical 10% physicians	The age distribution is spread but more concentrated on ages 20 to 40 years. The majority have 1-10 years' experience
Portugal	Lisbon Metropolitan Region	One health centre complex and one medium-sized district hospital	100% public	221+277 = 498	77% women in the health centre complex and 79.9% in the hospital	In the health centre complex: 24.3% nurses 27% physicians 23.9% administrative In the hospital: 25.6 % nurses 11.2% physicians 9% administrative	In the health centre: concentrated between 35 and 54 years of age; 45% with more than 20 years of experience and 33% with 13 or less years of experience In the district hospital: about half are concentrated between 35 and 49 years of age; 30% more than 20 years of experience and 32% with 8 or less years of experience
South Africa	Greater Johannesburg Metropolitan Region	32 facilities and services	52.9% public 47.1% private	1 018	78% women	39.5% nurses 8.2% midwives 14.2% physicians 14.7% auxiliary 3.4% pharmacists 1% ambulance staff 5.4% administrative staff 6.2% professions allied to medicine 9% technical staff 4.1% support staff and other 2.6%	Quite spread but few in 19-29 bracket due to a lack of new recruits to the nursing profession and the tendency of young professionals to leave the country.
Thailand	Chiangmai Province (urban, suburban, rural areas)	61	70.9% public 29.1% private	1 090	72.7% women	45.5% nurses/midwives	22.8% aged 25-29/ 27.7% with 1-5 years' experience



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Because of the significant effort at stratification and randomization, the data and results of the survey not only largely reflect the overall situation in the geographical area covered, but are possibly also indicative of major trends at the national level. They are not, however, statistically representative of the national situation and, even at the local level of investigation, their generalizations should be considered with care.

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## 2. Definitions, perceptions and cultural background

For the purpose of this survey workplace violence was defined as:

Incidents where staff are abused, threatened or assaulted in circumstances related to their work, including commuting to and from work, involving an explicit or implicit challenge to their safety, well-being or health.<sup>1</sup>

It includes physical and psychological violence as defined below:

### ***Physical violence***

The use of physical force against another person or group, that results in physical, sexual or psychological harm.<sup>2</sup> It includes among others, beating, kicking, slapping, stabbing, shooting, pushing, biting and pinching.

### ***Psychological violence (emotional abuse)***

Intentional use of power, including threat of physical force, against another person or group, that can result in harm to physical, mental, spiritual, moral or social development.<sup>3</sup> It includes verbal abuse, bullying/mobbing, harassment and threats.

Terms related to violence were also defined as follows:

- *Assault/attack*

Intentional behaviour that harms another person physically, including sexual assault (i.e. rape).

- *Abuse*

Behaviour that humiliates, degrades or otherwise indicates a lack of respect for the dignity and worth of an individual.<sup>4</sup>

- *Bullying/mobbing*

Repeated and over time, offensive behaviour through vindictive, cruel or malicious attempts to humiliate or undermine an individual or groups of employees.<sup>5</sup>

<sup>1</sup> Adapted from European Commission (Wynne, R.; Clarkin, N.; Cox, T.; Griffiths, A. (1997). *Guidance on the prevention of violence at work*. Luxemburg: European Commission, DG-V.)

<sup>2</sup> Adapted from WHO definition of violence.

<sup>3</sup> Adapted from WHO definition of violence.

<sup>4</sup> Alberta Association of Registered Nurses.

<sup>5</sup> Adapted from ILO (Chappell, D.; Di Martino, V. (2000). *Violence at work*. Geneva, ILO).

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- *Harassment*

Any conduct based on age, disability, HIV status, domestic circumstances, sex, sexual orientation, gender reassignment, race, colour, language, religion, political, trade union or other opinion or belief, national or social origin, association with a minority, property, birth or other status that is unreciprocated or unwanted and which affects the dignity of men and women at work.<sup>6</sup>

- *Sexual harassment*

Any unwanted, unreciprocated and unwelcome behaviour of a sexual nature that is offensive to the person involved, and causes that person to feel threatened, humiliated or embarrassed.<sup>7</sup>

- *Racial harassment*

Any threatening conduct that is based on race, colour, language, national origin, religion, association with a minority, birth or other status that is unreciprocated or unwanted and which affects the dignity of women and men at work.<sup>8</sup>

- *Threat*

Promised use of physical force or power (i.e. psychological force) resulting in fear of physical, sexual, psychological harm or other negative consequences to the targeted individuals or groups.

Although the above concepts and definitions are loaded with cultural significance and despite the fact that they were certainly perceived in different ways by the participants in the survey, both as individuals and as a national sample, it would appear that a general, common understanding of workplace violence could be reached on this basis across the various countries involved in the survey. No major problem has been reported in this respect by the researchers and even though the term *workplace violence* is not yet a commonly used term, such as in the case of South Africa, the idea and meaning of the word was “immediately conceptualized”.

The term *workplace violence*, once properly defined and explained in its variety of forms, seems able to capture a series of situations, including both physical and psychological violence, that are relevant at the same time for the developing and the industrialized world. Within this general shared understanding, cultural and linguistic differences are certainly in operation that need to be taken into full account and properly addressed.

Sometimes it is simply a matter of finding the terms most appropriate to the specific situation, such as in the case of Portugal where workplace violence was typified as *verbal, moral, against property, discrimination (including racial harassment), physical and sexual*, or just to “add a few words” as in the case of South Africa.

In other cases the cultural influence is more relevant and requires greater attention. The Thai researchers mention their culture of seniority whereby employees are unlikely to

<sup>6</sup> Human Rights Act, United Kingdom.

<sup>7</sup> Irish Nurses’ Organization.

<sup>8</sup> Adapted from Human Rights Act, United Kingdom.

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### 3. Society, change and transition

Whenever violence is imbedded in a society it will be reflected in the workplace. Several country surveys strongly hinted at direct inroads of societal problems into the workplace with violence as one of the major issues. This exposure and permeability were already known to be important factors in the triggering of workplace violence. It is now revealed to be of extreme relevance as far as the health sector is concerned. The sector appears, by the very nature of the activities that are carried out therein, to be particularly exposed to external influences and as such, especially vulnerable to violence from the outside.

In Bulgaria violence is a normal element of life:

Violence is all-pervasive; it is present in the life of all social strata, occupations and ethnic groups. Its psychological foundation is be found in people's dependence based on the hierarchy of power, i.e. being dependent on those above you. A society where the centre of control has always been outside the individual (such as the patriarchal, paternalist and totalitarian societies) turns out incapable to cope with violence once the external control is taken away. In the absence of any interior moral norms or, in other words, interior inhibitions, many Bulgarians turn to violence as a model to regulate family, social, interpersonal and institutional relations and society is well on the way to accepting that as a norm.

In South Africa violence in society permeates the workplace:

The very high level of workplace violence [in the public sector] is symptomatic of a greater problem with its roots in the socio-economic realities of South Africa. It is impossible to capture the impact of management styles, the shortcomings in the management and administration of South Africa's health system, the lack of commitment to ethical conduct, the impact of societal violence on the psychosocial development of health care workers in one study.

According to the executive director of the Institute of Future Studies for Development in Thailand, Thailand is changing from the Land of Smiles to the Land of Violence:

In the past, some forms of violence, such as wife battery and the physical punishment of children, were acceptable if the perpetrators and the victims were related but unacceptable if they were strangers. Rape is a crime only if the victim is not the wife of the perpetrator. Marital rape is not an illegal act. Currently, Thai people are aware of violence and accept it as a national social problem.

The important processes of change occurring in the societies covered by the country studies are a major cause of these developments with the health sector right at the centre of these processes.

Widespread restructuring in the health sector through privatization and rationalization are deeply affecting conditions of work and employment. These processes may be accompanied, although with different degrees of intensity from country to country and from situation to situation, by downsizing, job insecurity, lay-offs, freezes or cuts in salaries, heavier workloads and faster pace of work, longer hours of effective work, less comfortable shifts and working in unsocial hours, more subcontracting, and an increase in temporary and occasional work. These are all potential stressors and fuelled by uncertainty, growing exasperation and vulnerability, may eventually lead to the building up of a climate of violence.

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These interactions are fully confirmed by the country reports. Bulgaria is experiencing a difficult period of transition from a state and centralized system to a market economy. The restructuring of the health sector has been accompanied by a drastic reduction of jobs and available hospital beds. Over the 1999-2000 period the number of jobs available in the health sector was cut by 23,080; the available number of hospital beds per 100,000 people fell from 1,061 in 1995 to 749 in 1999. According to 63.9 per cent of the respondents restructuring has occurred in their workplace in the past two years, resulting in a reduction in staff and resources of 60.7 per cent and 23 per cent respectively.

Nearly half of the respondents considered that the work situation for staff has worsened and one-fourth that the situation for patients has worsened. According to the researchers the restructuring and downsizing in the field of health, the insufficient financing of that sector and the insecurity of the population and the individuals working in that sphere, account for rising tensions and conflicts in the health establishments. They form the basis for the rise of different forms of violence between individual groups of health personnel and between health personnel and patients.

In South Africa, where the entire society and the health sector are undergoing dramatic processes of change, the study has established a link between such changes and the emergence of workplace violence: "*Sweeping changes in most organizations seem to be associated with abnormally high levels of workplace violence.*" In Brazil, according to the researchers, inequities generated by an unbalanced globalization process are pronounced. The consequences are felt in the health care area, where the distress and the diseases due to poverty bring increasing numbers of people into the services and in turn, generate distress among healthcare workers who are aware that social issues cannot be treated with medicine.

Even in Portugal, where working conditions in the health sector were perceived by a majority of the participants in the survey as being *adequate*, the impact of change which has occurred in recent years was mainly perceived as a negative one.

This linkage between change and violence is not, however, an absolute linkage. Change *per se* is not necessarily an evil; the conditions and manner in which it is effected influence the nature of its impact on the health sector. As the Thai report clearly indicates, the incidence of violence, particularly physical violence, was greater when a reduction of staff had been effected and less where resources were increased to cope with the new situation.

<p>Several country surveys strongly hint at direct inroads of societal problems into the workplace with violence as one of the major issues. This exposure and permeability have always been known to be important factors in the triggering of workplace violence. It is now shown to be of extreme relevance as far as the health sector is concerned. The sector appears, by the very nature of the activities that are carried out therein, to be particularly exposed to external influences and as such, especially vulnerable to violence from the outside.</p>
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express their needs, opinions and feelings to their employers and supervisors. This may lead to an excessive accumulation of tension and stress and eventually to episodes of violence. In the Thai context health care workers frequently live on the health facility campus and violence perpetrated there outside working hours, is still considered workplace violence. A broader definition of workplace violence had to be used for the Thai survey in order to accommodate these situations. According to the researchers in Brazil, disregard of the contracts and established agreements between employers (public and private) and employees, is also considered violence. This kind of violence could be called institutional violence. Difficulty in gaining access to justice and fear of reprisals stimulate this kind of violence. Forcing someone to work more than his/her regular work assignment without payment, making an employee do what he/she has no capacity to do, low salaries in public and private sectors, indecent work conditions and the coexistence of multiple types of work contracts to do the same work for different salaries, are examples of how this violence reveals itself.

In the area of sexual offences perceptions and understanding of cultural differences play a major role. According to the researchers, sexual harassment at the workplace in Bulgaria is associated with deeply ingrained stereotypes of behaviour based on the roles of women and men in society. In their view, because of the traditional perception of women as objects of sexual desire and their subordinate role in society and in the family, women are most frequently victims of sexual harassment at the workplace. That tendency would be reinforced by the patriarchal stereotypes and oriental models of behaviour signifying male domination and women's economic and emotional dependence on men, for they help justify such an attitude to women and make it seem as if it is the normal order of things.

In a number of cultures the very inclusion of sexual harassment at work within the definition of workplace violence is questioned. In South Africa, men indicated in focus group discussions that there is no such thing as sexual harassment as it is "nature" while the women were amused. However, according to the researcher, South Africa has the highest incidence of rape in the world.

Confirming previous concerns about low levels of reporting of workplace violence, some country studies stress the likelihood of under-reporting of sexual harassment.

Although in the Bulgarian survey sexual harassment is reported as constituting 2 per cent of cases of violence, according to the researchers it is extensively present. The cited report on "Sex discrimination and sexual harassment in the workplace in Bulgaria" by the Minnesota Advocates for Human Rights with the Bulgarian Centre for Human Rights and the Gender Project for Bulgaria Foundation revealed that 10 per cent of the female respondents had faced questions of a sexual nature during a job interview and that almost 15 per cent had been subjected to unwelcome sexual contact by their co-workers, supervisors or both.

In Lebanon, according to the researcher, the definition of sexual harassment is restricted to an actual physical act, which most probably hides the real magnitude of the phenomenon.

Although the above concepts and definitions are loaded with cultural significance and they were certainly perceived in different ways by the participants in the survey, both as individuals and as a national sample, it would appear that a general, common understanding of workplace violence could be reached on this basis across the various countries involved in the survey. Within this general shared understanding, cultural and linguistic differences are certainly in operation that need to be taken into full account and properly addressed.

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## 4. A unique new vision

### 4.1. The dimension of the problem

The dimension of the problem of workplace violence emerging from the country reports is a shattering one. More than half of the health care workers surveyed had experienced at least one incident of physical or psychological violence in the twelve months previous to the survey: 75.8 per cent in Bulgaria and 67.2 per cent in Australia; 61 per cent in South Africa; in Portugal 60 per cent in the Health Centre complex and 37 per cent in the hospital; 54 per cent in Thailand; 46.7 per cent in Brazil.

These are extremely high figures that go far beyond the evidence emerging from previous studies and become even more significant in regard to specific types of violence, professions or settings.

### 4.2. Physical and psychological

Within this overall context, the magnitude of psychological violence appears in general more significant than that of physical violence. These data confirm a decisive shift in the understanding and awareness of the significance of non-physical violence in developing and industrialized countries. While attention has traditionally been focused on physical violence, the new profile of workplace violence in the health sector emerging from the country studies emphasizes the importance of both psychological and physical violence.

Physical violence is substantially present in most of the countries investigated. In Bulgaria 7.5 per cent of the respondents reported having been physically attacked in the previous year; 6.4 per cent in Brazil; 5.8 per cent in Lebanon; 10.5 per cent in Thailand; 9 per cent in the private sector and up to 17 per cent in the public sector in South Africa. Even in Portugal, where the percentage is limited to 3 per cent, physical violence has been indicated as being very important for emergency care crews.

The extremely high level of physical violence in the public health sector in South Africa comes as a shock even to the country researcher. Even more shocking when one considers that up to 71.1 per cent of the respondents in the public sector, as against 51.6 per cent in the private one, reported having experienced at least one incident of workplace violence, while 25.5 per cent in the public sector and 10.1 per cent in the private sector had witnessed episodes of physical violence in the previous twelve months. The public sector appears particularly vulnerable to violence with more crime-related incidents such as robberies, criminals hiding in big hospitals, gang wars being continued in the hospitals, patients with firearms and convicted criminals attacking the staff. At the same time it also has the highest levels of overcrowding, staff shortages plus long waiting times, less resources for training and human resources development, shortage of beds and resources, budget cuts and inadequate or old equipment. It comes as no surprise then, that almost a third of all respondents in the public sector indicated that they are “very worried” about this situation.

Psychological violence is widespread everywhere with verbal abuse at the top of the list. In Brazil 39.5 per cent of the respondents had experienced verbal abuse in the last year; 32.2 per cent in Bulgaria; 52 per cent in South Africa with 60.1 per cent in the public sector; 47.7 per cent in Thailand; 51 per cent in the health centre complex and 27.4 per cent in the hospital in Portugal; 40.9 per cent in Lebanon and up to 67 per cent in Australia.

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The second main area of concern is that of bullying and mobbing which had been experienced by 30.9 per cent in Bulgaria, 20.6 per cent in South Africa, 10.7 per cent in Thailand, 23 per cent in the health centre complex and 16.5 per cent in the hospital in Portugal, 22.1 per cent in Lebanon, 10.5 per cent in Australia and 15.2 per cent in Brazil. Until recently the typical profile of violence at work largely featured isolated, major incidents. In more recent years however, attention is also being focused on violence which is perpetrated through repeated behaviour, of a type which by itself may be relatively minor but which cumulatively can become a very serious form of violence. Bullying or mobbing, which have appeared as a new topical issue in developing countries only in the last decade, were virtually unknown to the developing world till then. The results of the country studies have unveiled for the first time the worrying dimension of these two forms of psychological violence in the developing world and in countries in transition.

Racial harassment and sexual harassment follow with smaller percentages: 2.2 per cent and 0.8 per cent respectively in Bulgaria; 4.7 per cent and 2.3 per cent in Lebanon; 0.7 per cent and 1.9 per cent in Thailand. In Portugal racial harassment is reported at 4 per cent and 8 per cent in the health centre and the hospital respectively with sexual harassment at 1 per cent and 2.7 per cent.

The exception is South Africa with sexual harassment at 4.6 per cent and racial harassment at 22.5 per cent. with significantly higher figures in the public than in the private sector. The incidence of racial and sexual harassment was not collated in the Australian survey.

As already mentioned the figures for sexual harassment may be disclosing only a part of the reality. The high incidence of racial harassment in South Africa, a country where, according to the researcher, the term majority identifies "black" South Africans while "white" South Africans and immigrants are perceived as a minority, is indicative of the persistence of disturbed relationships among racial and ethnic groups in society and at the workplace which would require further investigation.

It is finally important to stress that the various forms of physical and psychological violence do not operate in isolation but are closely interrelated and often overlap at the workplace. According to the Portuguese report moral pressure, physical violence and violence against property are closely associated with verbal violence. The association is total in the case of sexual harassment and verbal violence, while all cases of discrimination are also associated with verbal violence and, in most cases, with moral pressure or bullying too.

### **4.3. Perpetrator and victim**

The country surveys confirm the difficulty of establishing a profile of the perpetrator of workplace violence and the risks associated with generalization and stereotyping in this regard. Patients and staff would appear to be the main perpetrators, with patients taking the lead overall, although significant differences exist among countries and depending on the type of violence.

In several countries under investigation a pattern seems to emerge whereby patients are the main perpetrators of physical violence while staff are the main perpetrators of psychological violence. In Bulgaria physical violence generally occurs along the line of conflict between "patient-doctor" with aggressive patients being the perpetrators in 65.8 per cent of the cases. Psychological violence is more frequent along the conflict line of "subordinate-supervisor" with staff or supervisors being responsible for 55 per cent of the cases of verbal abuse and 51 per cent of cases of bullying and mobbing.



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In South Africa patients were the perpetrators in 45 per cent of incidents of physical violence in the public sector and staff appear to have been the perpetrators of more incidents of psychological violence than they had been at the receiving end from patients in both the public and private sectors. In Thailand patients are the perpetrators of 72 per cent of the cases of physical violence while in the majority of cases of verbal abuse – 36.5 per cent – responsibility lay with staff members. In Lebanon, the patients (62.9 per cent) or their relatives (25.9 per cent) were the main perpetrators of physical violence while in relation to bullying and verbal abuse, sexual and racial harassment, it was mainly a staff member or a colleague or a supervisor who was responsible.

Somewhat different, but not contradictory, patterns seem to emerge from the Portuguese, the Australian and the Brazilian reports. Patients are the main perpetrators of both physical and psychological violence in the Portuguese health centre with co-workers playing a role only so far as psychological violence is concerned: verbal (17 per cent), moral (3 per cent) and discrimination (33 per cent). In the Portuguese hospital on the other hand, co-workers are not only the main perpetrators of psychological violence – discrimination (95 per cent) and moral pressure (69.8 per cent) – but also play a major role in sexual harassment (42.9 per cent) and physical violence (20 per cent).

In Australia, particular forms of violence tended to be perpetrated by specific types of perpetrators. The “hot people” for *assaults* in the Australian study were reported as patients (particularly those with dementia 30 per cent, drug and alcohol problems 16.2 per cent, and mental health conditions 12.5 per cent, as well as a wide range of other circumstances). The most commonly cited perpetrators of *threats* of violence were also patients with mental health, dementia, drug and alcohol conditions, or those under significant stress. *Bullying* was reported to be predominantly perpetrated by staff members. Only *verbal abuse* was perpetrated by a spectrum of people, predominantly clients and their relatives. In Brazil patients or their relatives perpetrated 56.3 per cent of all acts of aggression and staff or managers 29.1 per cent. As for verbal abuse, patients and relatives were the main perpetrators (60.4 per cent), while in relation to bullying, the aggression was primarily perpetrated by staff members and management (45.7 per cent).

Even more difficult is to establish the profile of the victim of workplace violence. Both men and women appear at risk with women being the victims in the majority of cases of workplace violence. According to the country reports, this situation is due to the fact that the majority of workers in the health care system are women. This is the case in Australia, Brazil, South Africa, Bulgaria and Thailand where the female profile of the victims perfectly coincides with that of a gender-biased sample. The only exception is Portugal, and only in the health centre, where female exposure to violence appears statistically significant for all types of violence.

When specific types of violence are considered, however, gender-based differences do appear. In Bulgaria and Portugal (only in the health centre) women are more subject to verbal abuse than men, while in Thailand men are more prone to be the victims of physical violence, bullying/mobbing and racial harassment. In the Portuguese hospital, all types of violence (except for sexual harassment) were more prevalent among men. In Lebanon men were at higher risk of physical violence or racial harassment.

Generalization in this area could however be misleading. While the Lebanese report indicates that women were at a significantly higher risk of sexual harassment than men the Portuguese report shows that men at the health centre were more frequently victims of sexual harassment than women, and highlights the danger of stereotypes. In Brazil higher frequencies are detected for men with regard to sexual harassment. According to the researchers, the men’s understanding of sexual harassment or the women’s fear of speaking publicly on this subject, could have interfered with the categorization of the numbers of victims gender-wise. This does not mean that men cannot be victims of this

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type of violence, especially considering the fact that there are other sexual orientations besides the heterosexual. The effect of women's occupation of management positions in the health sector should also be studied, in relation to sexual as well as moral harassment.

Among the other attributes of a victim of workplace violence, age does not appear to play a major role except for the older age brackets when experience associated with seniority become an important factor in diffusing violence. In Portugal the risk of exposure to workplace violence decreases considerably for workers in the health sector aged 45 or more. In Lebanon single respondents seemed to be at a significantly higher risk of sexual harassment and verbal abuse than married ones.

The personality and attitude of workers are also relevant in considering the risks of victimization. Some staff members are better than others at handling difficult situations – a quality which is usually associated with an individual's less tangible personality characteristics and style of behaviour. The ways in which victims react to aggressive behaviour appear to be important in determining whether that aggression diminishes or escalates. The Thai report highlights the importance of these factors. The subjects with fewer years of work experience were more likely to be victims of workplace violence than those with more experience. Nurses with low levels of self-confidence and poor defence skills were more likely to be victimized while *“quick-witted persons tended to be invulnerable”*.

#### **4.4. Part of the job?**

Workplace violence significantly affects all occupations in the health sector. Ambulance staff would appear to pay the highest price. Their level of exposure to the risks of violence is not only extremely high in all countries investigated but cut across all types of violence. In South Africa 70 per cent had been subject to verbal abuse; 50 per cent to physical violence, bullying and mobbing; 40 per cent to racial harassment; and 30 per cent to sexual harassment. In Australia, up to 77.5 per cent of ambulance staff reported that they had been subjected to verbal abuse, 67 per cent to threats, 42.5 per cent to assaults, 2.5 per cent to bullying and 20 per cent to some other form of violence. The only exception was Brazil where only 2 of 8 ambulance staff interviewed reported that they had been subjected to verbal abuse. Here the ambulance group is comprised of well trained teams and the service is offered by the Firemen, an institution quite respected by the population.

Nurses report very high levels of exposure to workplace violence everywhere. In Brazil nurses constitute the group with the largest proportion of victims (62 per cent). In Bulgaria half of the nurses interviewed had experienced verbal abuse and bullying in the 12 months previous to the survey; in South Africa 58 per cent of nurses had been victims of verbal abuse during the same period; in Portugal 74 per cent of nurses in the health centre and 54 per cent in the hospital had been exposed to at least one type of violence in the previous year. In Australia, 61.5 per cent of nurses interviewed reported that they had been subjected to verbal abuse, 13 per cent to threats, 9 per cent to assaults, 6 per cent to bullying, and 5 per cent to some other form of violence.

High levels of exposure were also reported by doctors. In the 12 months preceding the survey 50 per cent had experienced verbal abuse and 40 per cent bullying and mobbing in Bulgaria; 40.6 per cent had been the victims of verbal abuse in South Africa. In Australia, up to 62.5 per cent of medical officers interviewed reported that they had been subjected to verbal abuse, 45 per cent to threats, 17.5 per cent to assaults, 15 per cent to bullying and 5 per cent to some other form of violence. In Brazil 5.7 per cent of physicians interviewed reported that they had been the target of physical assault, 45.6 per cent of verbal abuse and 14.9 per cent of bullying. In Portugal 58 per cent in the health centre and 52 per cent in the hospital had been exposed to at least one type of violence.

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Other professional groups are far from immune. Violence is widespread among the staff of support units in Thailand and Bulgaria; among technical staff in South Africa; among administrative staff in Brazil and Portugal; and among allied health workers (psychologists, social workers, occupational therapists, etc.) in Australia. Violence is a pandemic manifesting itself in different forms and crossing all occupations in the health sector. It is certainly becoming a “part of the job” for many workers in this sector.

#### 4.5. Where it concentrates

From the country studies workplace violence appears not only to spread among all categories of staff but also over a wide range of health care facilities and services within such facilities, with most of the cases occurring within institutions rather than outside.

Hospitals, particularly large ones and those in suburban, densely populated or high crime areas are particularly vulnerable. We have already observed the special risks for such institutions in South Africa due, among others, to their permeability to an unfavourable external context. Similarly, in Thailand, hospitals in suburban areas are at special risk and those along certain border areas are reported at very high risk because of terrorism. In Australia violence is widespread across metropolitan and rural hospitals with quite specific risks faced by those working in isolated rural settings which could be 250 km from other small towns.

The type of employment sector plays a role in so far as it may reflect different conditions of work, quality of service and general level of performance. Thus while workplace violence concentrates in the public sector in South Africa as psychological violence does in Bulgaria, in Thailand the private-non profit sector is the most susceptible. In Brazil, the proportion of victims among hospital worker populations is 52 per cent in the public services and 44 per cent in private services. When compared to private services, workers in public services face higher levels of verbal abuse (43.2 per cent), bullying (18.5 per cent) and racial harassment (6.5 per cent).

More than half of the health care workers surveyed had experienced at least one incident of physical or psychological violence in the twelve months previous to the survey. Within this overall context, the magnitude of psychological violence appears in general more significant than that of physical violence. Patients and staff would appear to be the main perpetrators, with patients taking the lead overall, although significant differences exist among countries and depending on the type of violence. Workplace violence significantly affects all occupations in the health sector with ambulance staff, nurses and doctors paying the highest price. All health facilities are at risk, particularly large hospitals in suburban, densely populated or high crime areas, as well as those located in isolated areas.

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## 5.1. Individual factors

In the Bulgarian report, every third respondent – 36.7 per cent and 31.7 per cent respectively for physical and psychological violence – perceives the patients' individual characteristics as a factor for physical or psychological violence at the workplace. An increasing aggressiveness in the patients' behaviour is observed. Enraged, angry or distraught for one reason or another, alcohol- or drug-affected patients are the chief cause of violence in the health institutions or facilities.

The growing number of patients suffering from acute or chronic mental disorders who remain outside mental institutions without any adequate follow-up treatment due to the prevailing poor situation of society, family and the health care system, constitute a threat to health care personnel. According to the respondents, the mental or senile condition of the patients in a number of health institutions, i.e. mental clinics, dispensaries and homes for the elderly, is at the origin of physical violence in 20.6 per cent of cases and the cause of psychological violence in 9.1 per cent of cases.

Table 3 shows the overall significance of individual factors in Bulgaria.

Table 3. Bulgaria: Individual factors – percentage of answers

Factors	Physical violence	Psychological violence
Personality of the patients	36.7	31.7
Specific groups of patients	20.6	9.1

## 5.2. Societal factors

In a period of transition characterized by poverty, unemployment and a high crime rate among both health care personnel and patients, the socio-economic situation in the country is mentioned as a factor generating physical violence by 18.8 per cent of all respondents. A significantly larger number – 26.2 per cent – indicate it as a factor contributing to psychological violence.

Insufficient information about the reforms and the fact that the situation is not understood by the patients, the non-availability of financial resources in the health institutions, the high level of hospital indebtedness, staff downsizing and low pay, were cited by 16.1 per cent of the participants in the survey as being among the factors generating physical violence and by 23 per cent as being among the factors generating psychological violence at the workplace.

Table 4 shows the overall significance of social factors in Bulgaria.

Table 4. Bulgaria: Societal factors – percentage of answers

Factors	Physical violence	Psychological violence
Social and economic situation in the country	18.8	26.2
Health care reform	16.1	23.0
Stress and social tension	11.9	19.4

## 5. The origin of workplace violence: Causes and reasons

Once the dimension and patterns of workplace violence are identified and before rushing into action, experts strongly recommend the drawing up of an analysis of the reasons and causes of violence. Understanding the way violence is generated and the factors at stake is an essential, often underestimated step and a precondition to the development of appropriate policies and action. Most important, it allows for the formulation of an informed and balanced decision making process with focused allocation of usually limited resources to priority areas.

The Bulgarian report provides an in-depth analysis of the factors generating physical and psychological violence. Table 2 shows the various factors involved and their relative importance according to the respondents.

Table 2. Bulgaria: Factors contributing to workplace violence – percentage and rank

Factors	Physical violence	Rank	Psychological violence	Rank
Social and economic situation in the country	18.8	III	26.2	II
Health care reform	16.1	IV	23.0	III
Stress and social tension	11.9	VII	19.4	V
Personality of the patients	36.7	I	31.7	I
Specific groups of patients	20.6	II	9.1	VII
Management style	7.8	VIII	23.4	IV
Relations in the workplace	6.9	X	16.3	VI
Work organization and working conditions	14.7	V	16.3	VI
Lack of security measures and control	13.8	VI	7.5	VIII
Lack of special bodies and procedures	7.3	IX	7.5	VIII
Others	22.9	26.6		
No violence in the workplace	7.6	8.7		
No answer	34.9	17.5		

In this analysis when each factor is considered in isolation, the personality of patients ranks first, followed by the social and economic situation in the county and, well behind, work organization and working conditions. However, when the same factors are organized in three main groups – individual factors, societal factors, and organizational factors – according to their nature and characteristics, a quite different picture emerges. It is one that also recognizes the key role of organizational factors, gives equal emphasis to the three areas and sees in the inter-relationship of individual/organization/society, the basis for understanding how violence builds up at the workplace and the way it should be effectively addressed.

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### 5.3. Organizational factors

About 15 per cent of the respondents in the Bulgarian report emphasized that the workplace in the health sector is characterized by inefficient organization and bad working conditions including a 12-hour working day, work intensification due to insufficient personnel, understaffed night work teams which necessitates the need to work alone at night, and excessive paper work that needs to be done in compliance with the requirements of the National Health Insurance Fund. These result in long lines of patients waiting to be attended to. They become irritable and aggressive due to the long wait.

Table 5 shows the overall significance of organizational factors in Bulgaria.

Table 5. Bulgaria: Organizational factors – percentage of answers

Factors	Physical violence	Psychological violence
Management style	7.8	23.4
Relations in the workplace	6.9	16.3
Work organization and working conditions	14.7	16.3
Lack of security measures and control	13.8	7.5
Lack of special bodies and procedures	7.3	7.5

The importance of a combined consideration of all types of factors leading to workplace violence is confirmed by the South African report. It not only identifies a wide range of factors contributing to workplace violence as indicated by the respondents but also, as shown in the following table, indicates how each factor may have a different ranking depending on whether it is considered in the context of physical or psychological violence and in respect of the public or the private sector.

**Physical violence:** Patients/relatives/staff problems rank first in the private sector as a contributing factor and only fifth in the public sector. Interpersonal and public relations issues are the highest contributing factor in the public sector while they are ranked second in the private sector. Staff-related problems are ranked second in the public sector and fourth in the private sector. While stress (including depression and burnout) is ranked third in the private sector, economic issues (poor financing of facility, poverty and unemployment, lack of equipment, poor remuneration and income disparity and money-lenders) are ranked third in the public sector. Security issues such as poor and inadequate security, unsafe surroundings and the location of the facility rank fourth in the public sector but only seventh in the private sector.

**Psychological violence:** Interpersonal and public relations issues rank highest followed by staff-related problems in the private sector while staff-related problems rank highest in the public sector, followed by interpersonal and public relations issues. Again stress is ranked third in the private sector while economic issues are ranked third in the public sector. Race-related, ethnic and political issues are ranked fourth in both the private and public sectors.

Table 6. South Africa: Factors contributing to workplace violence – Number of answers/ranking

	Physical violence				Psychological violence			
	Priv.	Rnk.	Pub.	Rnk.	Priv.	Rnk.	Pub.	Rnk.
Security issues	18	7	51	4	4	11	14	10
Crime	9	11	11	11	1	13	4	15
Patients/relative/staff problems	42	1	48	5	15	6	45	5
Substance abuse	11	10	19	9	1	13	9	12
Interpersonal and PR (image) issues	41	2	124	1	69	1	102	2
Economic issues	17	8	53	3	7	9	59	3
General situation in country	8	12	10	11	1	13	8	13
Poor laws and policing	1	14	3	14	1	13	4	15
Staff-related issues	32	4	123	2	46	2	116	1
Race/ethnic/political issues	25	6	25	8	43	4	58	4
Emotional violence	20	7	32	7	42	5	41	7
Inadequate HR development	16	9	6	12	14	7	16	9
Change and restructuring	0		0		2	12	8	13
Lack of policies	5	13	11	10	8	8	7	14
Stress	36	3	6	12	45	3	44	6
Lack of beds	5	13	11	10	1	13	9	12
Management-related problems	0		45	6	5	10	33	8
Unions	0		8	13	0		1	17
HIV/AIDS	0		0		1	13	2	16
No comments/do not know/N.A.	184		305		295		195	

In the Brazilian report, the factors contributing to violence were organized between those of a general nature relating to public policies and those related to the work process and its immediate context.

According to the report, factors of a general nature include:

- lack of education for the population that increases the cultural distance between those seeking medical attention and the health care personnel especially those who have university-level education;
- unemployment, due to which people are already stressed and in need. It also results in a great number of people falling sick;
- lack of adequate policies on safety.

Factors directly related to the work process in health care facilities include:

*Accounting for the aggressions perpetrated by patients and relatives:*

- lack of attendance;
- attendance of bad quality;
- overload of patients;

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- lack of communication between health care personnel and patients and a lack of respect for a patient's dignity;
  - lack of basic material needed for attending on patients;
  - lack of humanity in treating patients;
  - non-resolution of the health problem for which attention was sought;
  - health care personnel lacking in technical training;
  - lack of clear limits to areas of public access;
  - aggressiveness/stress of patients.

*Relating to the aggressions perpetrated by staff and managers:*

- impunity;
- lack of labour rights and collective agreements;
- lack of consensus in health teams;
- lack of discussion spaces to deal with conflicts in the team;
- lack of training in leadership;
- unhealthy conditions of work;
- low wages;
- threat of unemployment;
- insecurity concerning retirement;
- stress;
- no replacement of losses in personnel;
- work overload;
- work intensification;
- excessive numbers of trainees taking the place of graduate professionals;
- simultaneous existence of several types of work contract in the public sector, with different wages for performing same or similar functions.

When each factor is considered in isolation, the personality of patients ranks first, followed by the social and economic situation in the country and, well behind, work organization and working conditions. However, when the same factors are organized in three main groups – individual factors, societal factors, and organizational factors – according to their nature and characteristics, a quite different picture emerges. It is one that also recognizes the key role of organizational factors, gives equal emphasis to the three areas and sees in the inter-relationship of individual/organization/society, the basis for the understanding of how violence is built up at the workplace and the way it should be effectively addressed.



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## 6. Assessing the impact of workplace violence

### 6.1. The magnifying cycle stress-violence

In the health sector stress and violence are widespread. Several occupations, such as those of doctors, nurses and social workers, are high on the list of occupations with high stress levels while violence in the health sector constitutes almost a quarter of all violence at work. When stress and violence interact at the workplace as they often do, their negative effects cumulate rapidly and activate a vicious circle which is very difficult to unravel.<sup>1</sup> The country reports fully confirm this interrelationship and provide further insight into this area.

The accumulation of stress and tension in demanding health occupations under the strain of societal problems and the pressure of reform of the health system, is explicitly mentioned in the reports as a generator of violence.

In Bulgaria:

The fear and insecurity related to the abovementioned factors [reform] generate a high level of stress and social tension both among health personnel and patients. According to every ninth person they may potentially lead to physical violence and according to every fifth to psychological violence.

In Thailand:

... many hospitals are reorganizing their working systems. A great number of health personnel are facing substantial changes and having much workload. The situation can lead them to experience more stress and conflict and possibly cause violence in the workplace.

The recognition of workplace violence as an important generator of post-traumatic stress disorders is a non-controversial major finding of all country surveys. In South Africa an average of about two-thirds of all those who had been victims of workplace violence had experienced disturbing memories, avoided thinking about the incident, were hyper vigilant or experienced chronic fatigue. Up to almost 40 per cent had become “extremely” hyper vigilant as a consequence of physical violence or mobbing and bullying.

In Bulgaria verbal abuse generated disturbing memories and thoughts to an average to high degree in 56 per cent of the men and 67 per cent of the women subjected to that form of violence while over 60 per cent of the women tried not to think or talk about what happened. A significant number of respondents – about 60 per cent of the men and nearly 70 per cent of the women – have become “super-alert” and watchful. The impact of bullying/mobbing on the victims of violence is similar with more than half of the victims repeatedly going back to what happened, closing up and becoming watchful and hyper-alert.

In Portugal, where the impact of workplace violence was measured on a 1(never) to 5 (always) scale, victims complained of hyper vigilance as a consequence of all forms of

<sup>1</sup> Di Martino, V. *Relationship of work stress and workplace violence in the health sector*. Geneva: ILO/ICN/WHO/PSI Joint Programme on Workplace Violence in the Health Sector, forthcoming working paper.

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violence rating their impact from 3.1 to 4.1 – almost total in the case of discrimination. In Thailand the majority of the victims had disturbing memories and avoided thoughts of the incident, although at a mild level overall. The researchers argued that these results from the survey may be due to the coping capacities of the victims and that the health care personnel were unlikely to feel stressful if the perpetrators were patients. However, in focus group discussions, personnel working with psychiatric patients declared that they felt discouraged, anxious, frustrated, resentful, angry, uncertain, unsafe and unhappy.

In Lebanon the relationship between exposure to violence in the workplace and emotional stress is reflected in the case of verbal abuse with 50 per cent of the respondents reporting “being super alert” and feeling chronic fatigue. A similar pattern is observed for bullying/mobbing. In relation to sexual and racial harassment, up to 27 per cent and 23 per cent respectively were extremely bothered by repeated memories of the incident and avoided thinking about it.

In Australia, the abbreviated 12-point General Health Questionnaire (GHQ) instrument was utilized during interviews to gather data on emotional injury following violence. The GHQ has pre-set questions with numerical scores allocated for each response; these are then totalled to give an overall score. Past studies have indicated that, using the Liker scaling method, a GHQ-12 score of between 8 to 10 is relatively normal with a threshold of around 11 or 12; a person with a score higher than 14 probably requires urgent assistance. The overall GHQ mean score for all interviewees in all health occupational groups was 11.42 with 22.5 per cent above the clinically significant figure of 14. An analysis of variance (ANOVA) identified a highly significant relationship between exposure to bullying at work and elevated GHQ while the relationship between exposure to an assault and elevation of GHQ score was not found to be significant. This is an extremely important finding that, if confirmed, would reveal the paramount importance of psychological violence in stress generation vis à vis the traditional view giving priority and significance to the physical severity of the incidents.

This correlation between violence and stress is of the greatest significance not only in assessing the overall impact on the individual but also in determining its global impact in terms of cost and efficiency for the organizations.

## **6.2. The cost for the organization**

Although not included in the questionnaire, cost factors have emerged as an important element in group discussions as summarized in the Portuguese report. Repeatedly, in such discussions, the detrimental impact of workplace violence on performance and productivity has emerged as a key factor engaging the attention of the parties concerned, particularly NHS managers.

It is well known that violence and stress cause immediate and often long-term disruption to interpersonal relationships, the organization of work and the overall working environment. Cost factors include direct costs such as those deriving from absenteeism, turnover, accidents, illness, disability and death, and indirect costs including diminished functionality, performance, quality and timely production and competitiveness. Increasing attention is also focused on the negative impact of violence on intangible factors such as company image, motivation and commitment, loyalty to the enterprise, creativity, working climate, openness to innovation, knowledge-building, learning, etc.

Altogether it has been estimated by a number of reliable studies that stress and violence possibly account for approximately 30 per cent of the overall costs of ill-health

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and accidents. Based on the above figures it has been suggested that stress/violence may account for approximately 0.5 to 3.5 per cent of GDP per year.<sup>2</sup>

The conclusions from the group meetings of HNS managers in Portugal confirm the outcome of previous research in this area. According to such managers workplace violence negatively affects the performance and efficiency of the organizations in the following ways:

- conditions professionals to be overcautious, resulting in professional behaviour that consumes too many resources unnecessarily;
- leads to an increase in the number of professionals reporting sick;
- increase in absence on grounds of sickness results in lower productivity, less staff being available for work overtime and overwork for the personnel remaining on duty;
- results in lower motivation, professional dissatisfaction and poor performance;
- leads to increased turnover and general absenteeism;
- reduces the quality of individual and institutional care;
- has negative repercussions on the image of the institution.

The realization and quantification of the cost of violence is extremely important for the elaboration of anti-violence strategies in both the developing and the industrialized world. The spread of informal, precarious and marginal situations at work increasingly focuses attention on the need for an economically self-sustainable response in which the key role of programmes and actions that are cost-effective and naturally fit into the socio-economic development of the enterprise, is highlighted and used as an enhancer for further initiatives.

In the health sector stress and violence are widespread. Several occupations, such as those of doctors, nurses and social workers, are high on the list of occupations with high stress levels. The accumulation of stress and tension in demanding health occupations under the strain of societal problems and the pressure of reform of health systems is explicitly mentioned in the reports as a generator of violence. This correlation between violence and stress is of the greatest importance not only in assessing the overall impact on the individual, but also in determining its global impact in terms of cost and efficiency for the organizations.

<sup>2</sup> Hoel, H.; Sparks, K.; Cooper, C. (2000). *The cost of violence and stress at work and the benefits of a violence and stress-free working environment*. University of Manchester Institute of Science and Technology, <http://www.ilo.org/public/english/protection/safework/whpwb/econo/costs.pdf>

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## 7. Building an effective response

### 7.1. Reporting

Reporting is an essential precondition for an effective response. In many cases, reporting procedures are lacking, the victim of workplace violence does not report the incident; proper investigation does not follow, the perpetrator is not prosecuted and the victim feels dissatisfied with the way the incident has been handled and suffers from its aftermath.

In Bulgaria only 23 per cent of the respondents indicated that there is some type of reporting procedures. In two-thirds of the cases of physical violence, the respondents kept the humiliation to themselves and did not report the incident to anybody. Over half of the respondents (57 per cent) said that reporting was useless, and 14 per cent did not report because they were afraid of negative consequences. The situation in regard to verbal abuse and bullying/mobbing is similar – about 61 per cent did not report the incidents because they believed that reporting would serve no purpose and nearly 30 per cent were afraid of negative consequences. About 10 per cent did not know whom to report to and about 15 per cent thought that the incident was not important. Only between 1 and 6.5 per cent indicated that action was taken to investigate the causes of the different types of violence.

In Thailand 38.5 per cent of the victims pretended that nothing had happened and only 37 per cent of all incidents of violence which were reported, were investigated. When investigation took place, in 63.4 per cent of cases it was not pursued to a conclusion and in 44.4 per cent of cases no action was taken against the perpetrators. Data from focus group interviews revealed that reporting procedures were limited mostly to incidents where patients/clients were victimized by health care personnel. Consequently, many workers had negative attitudes about completing the incident reporting form. In addition, there was no particular authority responsible for handling cases of violence. Very similar situations emerge from the South African and the Portuguese reports.

In South Africa, particularly in the case of psychological violence, many incidents were unreported and, when reported, in the vast majority of cases no action was taken, the perpetrator was not prosecuted and the victim felt dissatisfied with the way the incident had been handled:

... it is abundantly clear that health care workers have very good reason to be dissatisfied with the manner in which psychological violence is handled. The counts where management offered counselling and gave employees the opportunity to speak about the incidents are very unsatisfactory. Employers do not investigate workplace violence adequately and perpetrators get away with it. Unions, associations and the community also lag behind in supporting the victims of workplace violence and unions play, in fact, an insignificant role in protecting their members against workplace violence. Victims mostly report to managers and colleagues about incidents, with the exception of sexual and racial harassment where it appears that victims have less opportunity to be open about their situation.

In Portugal only from 7 to 14 per cent (in the health centre complex) and 1 to 17 per cent (in the hospital) of the victims reported the incident in writing. Most told the boss, friends or colleagues or pretended that nothing had occurred. When reported, procedures for further handling of the case are often lacking or limited to major cases of violence. Of the five health professional associations studied, two investigate all cases brought to their attention, but the other three do not have any support procedures available to their members.

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In Australia, although 79 per cent of health workers reported that there were procedures in place through which to formally report violent incidents, only between 8 per cent to 12 per cent of all incidents of violence were estimated to have been reported. At least 50 per cent of perpetrators were reported to have experienced no negative consequences following their violent behaviour. A verbal warning from a security officer was the most severe consequence likely (15 per cent), with very few prosecuted (0.2 per cent). In Brazil, 37 per cent of the respondents mentioned that there were procedures for reporting violence in the workplace and 71 per cent of them stated that they knew how to use them. However, when asked if they were encouraged to report episodes of violence, 72.4 per cent of them replied in the negative.

## 7.2. Strategic or immediate?

The central role of prevention of workplace violence which involves looking at the causes of violence rather than its effects, is directly or indirectly highlighted in all the country reports: “*instead of the traditional practice of ‘building a shed following the loss of cows’, prevention of violence in the workplace should be a priority*” (Thailand).

Some reports also explicitly mention the need for a long-term, strategic perspective and the importance of an enabling framework focusing on values and organizational solutions rather than adopting an ad hoc or a case by case approach. The Bulgarian report highlights the importance of long-term strategies to reduce the level of violence at the workplace by providing solutions to the larger economic and social problems in all their variety and complexity – problems such as unemployment, poverty, crime, low educational levels, etc. It was stressed that reform of the health care system needed to be efficiently carried out since it was perceived as being an important factor in the reduction of workplace violence in this sector. It was suggested that the legal framework and the interactions with the National Health Insurance Fund should be improved; that routine paper work and the number of documents to be filled in should be reduced as also the number of paid health services. It was also recommended that the specialists’ examination procedures should be simplified and that supplementary health insurance funds should be set up.

In South Africa, Focus Group participants said that training in skills, stress management, communication and conflict management, would be very useful. More communication, better orientation of new staff members, refresher courses, a culture of dignity and respect and regular meetings to “ventilate” and get to know staff members from other sections were called for. They believed that staff who had been physically attacked at the workplace should be treated with more care and understanding than they receive at present and that management should become more involved with staff members. It was stated that health care providers should act against outsiders including even doctors who violate the rights of staff members. They expressed the view that certain minority groups such as auxiliaries should have the opportunity to get together and discuss their problems with a senior staff member. It was emphasized that team building is essential and that there should not be as strict a demarcation of tasks as there is at present because it prevents teamwork.

However, on the issue of measures to be introduced by the management to effectively deal with workplace violence and on an assessment of the helpfulness of such measures, the first priority, in all country reports, was on the introduction of security measures, such as guards, alarms, or portable telephones.

In Thailand *the use* of security measures to deal with workplace violence was reported by 82 per cent of the participants in the survey while 77 per cent reported improvements in workplace surroundings. Such measures as patient screening, patient

protocol, restricted public access, investment in human resource development, special equipment/clothing and training were mentioned by 31-42 per cent. Measures such as increase in the number of staff, change in shifts, check-in procedures, restricted cash exchange and reduced periods of working alone were reported by less than 20 per cent of the participants.

Similarly, the most widespread type of intervention to combat workplace violence among health care institutions in Bulgaria was reported to be security measures by 70.8 per cent of the respondents followed by improvement of the surroundings by 48.8 per cent, special equipment and clothing by 31.0 per cent, and restricted public access by 27.3 per cent. The same ranking order was substantially reflected in the opinion of the Bulgarian respondents on *the effectiveness* of the measures to deal with workplace violence. The respondents believed that most effective in their work setting would be security measures – 77.5 per cent; improved surroundings – 72.4 per cent; reduced periods of working alone – 63.3 per cent; restricted public access – 58.9 per cent and staff training – 56.8 per cent.

In Australia, the most widespread interventions to combat violence were duress alarms (56.5 per cent), locks and bars (52 per cent), procedures (53.5 per cent), training (50 per cent), security officers (66.5 per cent), other (4.5 per cent).

This ranking of the effectiveness of anti-violence measures at the workplace, particularly security measures and improved surroundings, is largely shared by the respondents in South Africa as the following table clearly indicates:

**Table 7. South Africa: Effectiveness of anti-violence measures**

Measure	% Very	% Moderate	% Little	% Not at all
Security measures	66.2	17.5	13.8	2.5
Improve surroundings	56.2	23.0	16.8	4.0
Restrict public access	52.9	23.7	19.6	3.8
Patient screening	47.1	27.9	20.9	4.2
Patient protocols	45.4	26.9	23.1	4.6
Restrict exchange of money in the workplace	45.2	19.6	25.2	9.9
Increased staff numbers	55.1	17.8	18.4	8.8
Check-in procedures for staff	40.2	24.6	25.1	10.2
Special equipment and clothing	38.4	21.3	29.5	10.8
Changed shifts or rotas	33.5	24.3	27.5	14.8
Reduced periods of working alone	47.7	20.4	22.9	9.0
Training	58.9	20.6	17.1	3.5
Human resources development	55.1	19.7	20.6	4.6

However in Brazil, when asked, “To what extent do you think these measures would be helpful in your work setting?”, the respondents answered “very much” more frequently for “*human resources development*” and “*training*” than for “*security measures*” which ranked only third.

Similarly, in the group discussions in Portugal, while recognizing the importance of security measures, some representatives of the professional associations and councils indicated that “only these will not solve the problem” and a health centre manager expressed the opinion that “these measures are unnecessary if the prevailing working conditions are good”. In all group discussions the importance of additional measures focusing on policies, the quality of the service, the enhancement of professional know-

how, and interaction with the citizens was also highlighted and interventions in these areas were recommended.

A somewhat contradictory approach seems thus to emerge from the reports between the key role of prevention, strategic and organizational factors in dealing with workplace violence as perceived by the respondents, and their perception of the effectiveness of the measures to be implemented by focusing on an immediate physical type of response such as security measures and improvements in the physical environment. It is a crucial point for consideration and one that should be properly addressed by the development of specific policies on physical and psychological violence at the workplace. This is not often the case.

### 7.3. Policies

In the majority of cases no specific policy on workplace violence is in operation. In Bulgaria only 35 per cent of the employers have introduced specific policies on workplace violence while 68.7 per cent have general health and safety policies in operation which, though not directly addressing violence, still create some conditions to prevent and reduce violence at the workplace. About one-third of the respondents reported that the employer had developed some policies regarding verbal abuse and sexual harassment. However the Focus Groups with the participation of nurses, physicians and managers of health institutions, agreed that the measures being undertaken were mainly within the framework of disciplinary procedures rather than being aimed at dealing with workplace violence, a problem that was not yet the subject of special consideration in the health sector.

Similarly the Brazilian report, as shown by table 8, reveals greater institutional concern for “health and safety” policy issues rather than for specific policies dealing with violence at the workplace. Such specific policies are available only in a limited number of organizations.

Table 8. Brazil: Policies in place

	Yes	No	Don't know
Health and safety	59.4%	24.6%	16.0%
Physical violence	24.7%	46.1%	29.2%
Verbal abuse	22.3%	48.7%	29.1%
Sexual harassment	17.1%	48.0%	34.9%
Racial harassment	17.5%	47.8%	34.8%
Bullying	20.9%	47.3%	31.8%
Threat	20.6%	46.7%	32.7%

In South Africa the majority of management, in both the public and private sectors, have either not set policies in place or do not communicate these policies to health care workers. The situation is particularly serious in the public sector. Only 25.1 per cent of respondents in this sector – as against 43.7 per cent in the private sector – confirmed that their employers do have policies in place against physical violence. Some 50.6 per cent – 38.2 per cent in the private sector – did not know if there were policies in place. The situation seems worse in relation to psychological violence where specific policies existed in as few as 12 per cent and no more than 36 per cent of the surveyed workplaces depending on the type of violence and sector.

In Australia zero tolerance policy documents were under development, following completion of the empirical survey. In Thailand 42 per cent of the respondents reported

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## 8. Recommendations from the country studies

### *Prevention factors*

In addition to the analysis of the situation, several recommendations have been made in the country reports on the best initiatives and means which could be adopted to tackle workplace violence in the health sector. These recommendations have been organized by type and level of intervention as follows: Br for Brazil, B for Bulgaria, SA for South Africa, T for Thailand.

#### Knowledge and awareness building

- *Raising awareness* as well as building a real understanding of and positive attitudes towards the issue among health care personnel at all levels as the initial strategy (T).
- Higher *public awareness* of this phenomenon and a more active role for the institutions directly concerned with violence (B).
- It is necessary to *draw the attention of the public* through the active involvement of trade unions and professional-occupational organizations and the promotion of understanding and recognition of the existence of the problem (B).
- Also necessary are *surveys* and *information* in order to gain a clear idea of the phenomenon, its spread, its causes and consequences (B).
- *Information and media campaigns* are necessary to increase awareness of the problem (B).
- Encouraging the *participation* of the community in the life of the hospital, with the mediation of the community's health councils, or expanding the negotiation channels between the community's interests and the capacities of the local health system (Br).

#### Legislation, policies, plans and reform

- *Regulation* of measures for the prevention and control of violence in the health sector should be effected at the national and organizational levels (T).
- *Legislative changes* – to amend and complement current laws (B).
- *Incorporation in the Health Sector Collective Agreement* of provisions aimed at the elimination of violence at the workplace (B).
- *Development of a programme* focused on measures to eliminate/contain violence at the workplace with the participation of trade unions, employers and their organizations, the professional guilds and organizations of physicians, dentists and pharmacists, the Association of Medical Nurses, the Ministry of Health, the National Health Insurance Fund and other parties concerned (B).
- *Enhance the efficiency of the health care reform* and create conditions for the provision of high quality health care services (B).
- *Intensify the work of the institutions* concerned with violence (B).



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- *Unite the efforts* of the social partners and NGOs at the national level with those of the Ministry of Health, the Ministry of Labour and Social Policy, the Ministry of Education and Science, the Chief Labour Inspectorate, etc. to counteract the incidents of violence at health institutions (B).

#### Approach

- Instead of the traditional practice of “building a shed following the loss of cows”, *prevention* of violence in the workplace should be a priority (T).
- Motivation of personnel to be *actively involved* in the implementation of the programme and its measures (B).

#### Assessment

- *Evaluation* of the workplaces in relation to the risk of violence (B).

#### Workplace planning

- The institution of *prevention programmes* at each health care setting should be encouraged and supported (T).
- A *programme* must be drawn up in consultation with staff members to reduce and/or eliminate workplace violence. It should identify interdepartmental teams, ombudspersons and involve all staff members in actively driving the programme. Reporting procedures should be introduced and meticulous records kept to monitor the situation and devise timely interventions (SA).

#### Organizational intervention

- Measures to improve the *organization of work* (B).
- Recruit and employ *more staff*. There are staff shortages in all hospitals and vacancies should be filled immediately (SA).
- Improvement of the *climate* at the workplace in the health sector; overcoming fear and insecurity which lead to stress that has the potential to turn into violence (B).
- Increased *information* for health personnel concerning the measures taken (SA).
- More *latitude in the scope of assignments* at different levels (SA).
- Restrict the *exchange of money* (SA).
- Better controls over *staff movements* (SA).
- *Change in shifts* of staff members should be more frequent, but should be effected in consultation with the staff member (SA).
- The periods when staff members *work alone should be reduced* (SA).
- *Patient* protocols or a code of conduct must be compiled, distributed and displayed (SA).
- Setting aside a special place and time of a regular workday to be used for *discussion among colleagues* on themes related to work and its organization (Br).

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## Environmental intervention

- Inadequate *ventilation* when there are a large number of patients in one location leads to workplace violence. *Lighting* should be improved in all areas, soothing music played to calm large crowds; food and water available on the premises as well as toilet facilities should be hygienic (SA).
- Provision of *security measures* and technical devices and higher administrative control (B).
- Ensuring that the best measures are in use for the *safety and security* of all at public and private hospitals (SA).
- *Mobile police stations* at large health care facilities and at those in high risk areas would serve as a deterrent to criminals and the presence of the police would also be helpful in case of crisis or where staff are threatened with firearms and also in case of a robbery (SA).

## Individual-focused intervention

- Potentially dangerous patients should be *screened* and health care workers alerted to the fact that the patient has a record of violence (SA).
- *Staff training* to cope with situations of violence, including how to identify potentially violent behaviour and how to control it (B).
- Introduce *training* in cultural diversity, self-defence, interpersonal communication and relationships, teamwork and provide information on sexual harassment and workplace violence (SA).

## After- the-event intervention

- *Reporting* incidents should be encouraged. Procedures for reporting should be practical and simple. More importantly, positive attitudes toward reporting must be developed among health care personnel (T).
- Introduce special procedures for *reporting* and encourage personnel to report incidents of violence (B).
- There should be particular persons or *committees* responsible for handling cases of workplace violence whose duties would also include surveillance and monitoring, documenting, investigation, victim compensation, assistance for victims and perpetrators, and perpetrator punishment (T).
- Programmes aimed at the victims of violence: *counselling, therapy, rehabilitation, support* (B).
- When workplace violence occurs and is reported, there must be a thorough *investigation characterized by transparency and also feedback* (SA).
- *Discussion groups*, facilitated by someone who is familiar with the phenomenon and who could focus a group to support individuals who have been victimized, would be very useful (SA).
- Staff who have been subjected to physical and prolonged psychological violence need to be *counselled* and the necessary procedure for this with either consultants outside or internal staff, should be available and widely known (SA).

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- *Perpetrators would also need counselling* and training in understanding and controlling emotions; training life skills and management of aggression and anger would be helpful where applicable (SA).

## Monitoring and evaluation

- *Monitoring* the measures introduced to combat violence (B).

The Portuguese report has summarized recommendations and levels of intervention using figure 1 in the next page. The approach considers several levels of intervention. At a more preventive level it is possible to identify macro, meso and micro level interventions, which differ in length of time for impact:

- The macro level interventions focus on the general conditions in society (cultural aspects, education, level of information, etc.), on the legal framework and on policies and strategies addressing the issue of violence in general. The impact horizon for interventions at this level is probably ten years or more.
- At a meso level the focus is on normative interventions: guidelines for managers, health workers, patients, occupational health doctors, union representatives, etc. But it also stresses management competencies, general working conditions and ease of access to health care. The impact horizon for interventions at this level is probably three to ten years.
- At a more micro level the purpose is to try to change what can be changed on a short term basis, i.e., one to two years. Interventions at this level would focus on issues such as security systems, reporting mechanisms, training in communication and conflict management, counselling /mediation, etc.

The Portuguese summary constitutes a useful reference framework to prioritize resources and action and avoid overlapping of interventions. The framework should be used in a flexible way and adapted to specific circumstances and needs. Long, medium and short-term interventions are not mutually exclusive but should co-exist in respect of different objectives. The time frame indicated will be adjusted according to the particular situation under consideration. The important message here is the recognition of the key role of prevention at all levels of intervention. Only if prevention fails, and violence occurs, must there be mechanisms available to deal with the violent episode and its consequences for all the individuals affected, the organization in which they work and the larger community in which they live.

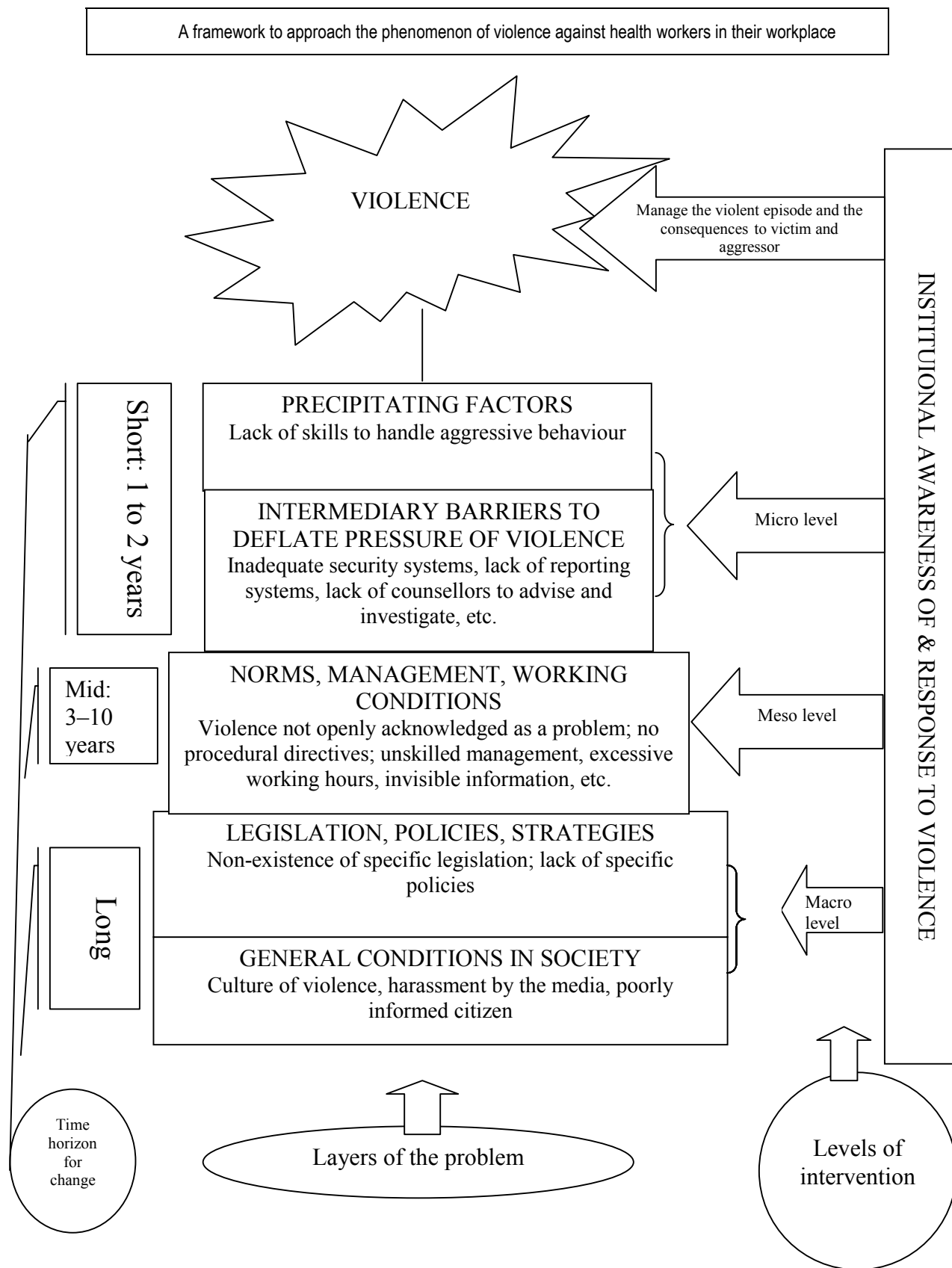
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that there were policies to address verbal abuse, 35.8 per cent for physical violence, 25,7 per cent for sexual harassment and 13.3 per cent for racial harassment

The limited existence of workplace policies, as stressed in the country reports, is a major impediment to effectively deal with workplace violence. However, the introduction of such policies should not be seen as a panacea solving all problems at once. In Thailand the experience of overall violence was not significantly affected by the availability of policies and measures for preventing and controlling workplace violence. It was found that incidents of physical violence were even more prevalent in workplaces in which a policy on physical violence had been established. Similarly, incidents of verbal abuse were found more in workplaces in which a policy about verbal abuse was established. It was also found that in general, violent incidents were more prevalent in situations where a number of positive conditions were in place such as the availability of protocols for aggressive patients, increase in staff members, reduced periods of working alone and personnel training. These findings can perhaps be explained by the fact that workplaces with a high prevalence of violence were more prone to develop policies and provide measures for preventing and controlling violent incidents. Their apparent incongruence confirms the importance of policies that are not one off but are the expression of management commitment up to the highest level, and which are fully integrated with measures and practices at the operational level, and actively sustained for a substantial period of time to allow for the positive effects to materialize. In the Thai report the case is made of a psychiatric hospital where the introduction of guidelines to deal with aggressive patients led to an improvement in the situation and ensured safer conditions for the workers once an adequate period of time for implementation had elapsed.

In the majority of cases no specific policy on workplace violence is in operation and, where they are in existence, this is not always communicated to health care workers. Often reporting procedures are lacking; the victim of workplace violence does not report the incident, proper investigation does not follow, the perpetrator is not prosecuted and the victim feels dissatisfied with the way the incident has been handled and suffers from its aftermath. Measures to tackle workplace violence focus on a more immediate and physical type of response, such as increased security measures and improvements in the physical environment rather than on strategic and organizational factors.

Figure 1. Framework of approach (Portugal)



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## **9. Critical issues**

A series of critical issues emerge from the overall reading of the country reports. They are crucial to the development of policies and action concerning workplace violence in the health sector. Solving these issues is the challenge ahead.

### ***Universal values and cultural differences***

The reports indicate that there is a general, common understanding of the concept of and values associated with combating workplace violence across the various countries involved in the survey. Within this general shared understanding, cultural and linguistic differences are in operation that need to be taken into account and properly addressed. How to combine universal perceptions and values with the specifics of the different cultures, is a first essential area for consideration.

### ***Developing and industrialized countries***

Against the common belief that workplace violence, especially psychological violence, is a main issue for industrialized countries only, the reports show that developing and transition countries are affected as well and that the seriousness of the problem in such countries is of equal, if not greater magnitude, than in industrialized ones. This requires a broadening of the strategies, attention, interventions and resource allocations devoted to reduce workplace violence.

### ***General and focused interventions***

The reports confirm that the health sector is at the forefront as far as workplace violence is concerned and provide a new, unique insight into the situations and professions at major risk. This allows, for the first time, the development of targeted interventions and the concentration of resources in the more critical areas. On the other hand, there is a need to address the problem globally and in a strategic dimension both in the health sector and with regard to the other sectors affected by workplace violence. Finding the right balance between these needs is another important problem to be addressed.

### ***Cost, performance and self-sustainability***

Increasingly the costs associated with workplace violence in general, and in the health sector in particular, are quantified and their burden on health institutions highlighted. Even if not all reports addressed this point in detail, such costs emerge as a key-issue in a number of group discussions, while the disclosure of the very dimension and impact of the problem of workplace violence in this sector, as reported in the country surveys, makes reducing such costs a high priority.

### ***Strategic and immediate response***

A comprehensive, multi-level and sometimes contradictory approach thus seems to emerge from the reports, between the key role of prevention, strategic and organizational factors in dealing with workplace violence as perceived by the respondents, and their perception of the effectiveness of the measures to be implemented by focusing primarily on physical types of response such as increased security measures and improvements in the physical environment. How to combine strategic and immediate responses is a crucial point for consideration and one that should be properly addressed.

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## ***Violence and other major health concerns***

In the health sector stress and violence are widespread. The accumulation of stress and tension in demanding health occupations under the strain of societal problems and the pressure of reforms of the health systems, is explicitly mentioned in the reports as generators of violence. It is also becoming clearer how stress and violence do not only interact with each other but also with a range of other major health-related concerns, such as HIV/AIDS and the use of alcohol, drugs, and tobacco. Noting these interactions are of the greatest importance when formulating effective and adequate responses to workplace violence in the health sector.

## ***National and international initiatives***

While the reports insist on the development of a series of national initiatives to promote awareness, organize resources and prioritize the best means to combat workplace violence in the health sector, international action could prove an essential catalyst at this stage. A major international initiative could be considered in order to attract the widest possible attention to the problem and trigger action at the national levels.

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## Appendix

### List of documents

#### ***ILO/ICN/WHO/PSI Joint Programme on Workplace Violence in the Health Sector***

##### Study reports and working papers

ILO/ICN/WHO/PSI (2002). *Framework guidelines for addressing workplace violence in the health sector*. Geneva: ILO/ICN/WHO/PSI Joint Programme on Workplace Violence in the Health Sector.

Di Martino, V. (2002). *Workplace violence in the health sector – Country case studies Brazil, Bulgaria, Lebanon, Portugal, South Africa, Thailand, plus an additional Australian study: Synthesis Report*. Geneva: ILO/ICN/WHO/PSI Joint Programme on Workplace Violence in the Health Sector, forthcoming working paper.

##### Country case studies

Palácios, M.; Loureiro dos Santos, M.; Barros do Val, M.; Medina, M.I.; de Abreu, M.; Soares Cardoso, L.; Bragança Pereira, B. *Workplace violence in the health sector – Country case study Brazil*. Geneva: ILO/ICN/WHO/PSI Joint Programme on Workplace Violence in the Health Sector, forthcoming working paper.

Tomev, L.; Daskalova, N.; Ivanova, V. *Workplace violence in the health sector – Country case study Bulgaria*. Geneva: ILO/ICN/WHO/PSI Joint Programme on Workplace Violence in the Health Sector, forthcoming working paper.

Deeb, M. *Workplace violence in the health sector – Lebanon country case study*. Geneva: ILO/ICN/WHO/PSI Joint Programme on Workplace Violence in the Health Sector, forthcoming working paper.

Ferrinho, P.; Antunes, A.R.; Biscaia, A.; Conceição, C.; Fronteira, I.; Craveiro, I.; Flores, I.; Santos, O. *Workplace violence in the health sector – Portuguese case studies*. Geneva: ILO/ICN/WHO/PSI Joint Programme on Workplace Violence in the Health Sector, forthcoming working paper.

Steinman, S. *Workplace violence in the health sector – Country case study: South Africa*. Geneva: ILO/ICN/WHO/PSI Joint Programme on Workplace Violence in the Health Sector, forthcoming working paper.

Sripichyakan, K.; Thungpunkum, P.; Supavititpatana, B. *Workplace violence in the health sector – A case study in Thailand*. Geneva: ILO/ICN/WHO/PSI Joint Programme on Workplace Violence in the Health Sector, forthcoming working paper.

##### Theme studies

Cooper, C.; Swanson, N. (2002). *Workplace violence in the health sector – State of the art*. Geneva: ILO/ICN/WHO/PSI Joint Programme on Workplace Violence in the Health Sector.

Di Martino, V. *Relationship of work stress and workplace violence in the health sector*. Geneva: ILO/ICN/WHO/PSI Joint Programme on Workplace Violence in the Health Sector, forthcoming working paper.



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Richards, J. *Management of workplace violence victims*. Geneva: ILO/ICN/WHO/PSI Joint Programme on Workplace Violence in the Health Sector, forthcoming working paper.

Wiskow, C. *Guidelines on workplace violence in the health sector – Comparison of major known national guidelines and strategies: United Kingdom, Australia, Sweden, USA*. Geneva: ILO/ICN/WHO/PSI Joint Programme on Workplace Violence in the Health Sector, forthcoming working paper.