



International Labour Office **ILO** International Council of Nurses **ICN**
World Health Organisation **WHO** Public Services International **PSI**

Joint Programme on Workplace Violence in the Health Sector

WORKPLACE VIOLENCE IN THE HEALTH SECTOR

CASE STUDY BULGARIA

GENEVA 2003

This document enjoys copyright protection through the sponsoring organisations of the ILO/ICN/WHO/PSI Joint Programme on Workplace Violence in the Health Sector. As an ILO/ICN/WHO/PSI Joint Programme Working Paper, the study is meant as a preliminary document and circulated to stimulate discussion and to obtain comments. The responsibility for opinions expressed in this study rests solely with their authors, and the publication does not constitute an endorsement by ILO, ICN, WHO and PSI of the opinion expressed in them.

**ILO, ICN, WHO, PSI WORKPLACE VIOLENCE IN THE
HEALTH SECTOR PROJECT
INSTITUTE FOR TRADE UNION AND SOCIAL RESEARCH
-BULGARIA**

**WORKPLACE VIOLENCE IN
THE HEALTH SECTOR**

CASE STUDY - BULGARIA

Research Team:

1. Res. Ass. Liuben Tomev, Ph.D. – National Coordinator
2. Res. Ass. Nadejda Daskalova, Ph.D.
3. Res. Ass. Tatiana Michailova
4. Zinaida Naydenova
5. Violeta Ivanova
6. Diana Trakieva
7. Slava Zlatanova

Doctor Ivan Kokalov – consultant

The Final report is written by:

Res. Ass. Liuben Tomev, Ph.D.
Res. Ass. Nadejda Daskalova, Ph.D.
Violeta Ivanova

SECTION A BACKGROUND

1. CONCEPT OF VIOLENCE

1.1. Definition of violence in general

Violence is usually associated with **aggression**. The simpler and most popular definition of aggression in modern social psychology is that it is evil-generating behavior. According to Freud's theory the individual is "doomed" to be aggressive and aggression is inherent in all societies. Other theories maintain that aggression is the effect of **frustration*** generating anger and aggression. The theory of social studies provides evidence that one turns aggressive when one observes and studies aggressive patterns of behavior.

According to the World Health Organisation "Violence is an intentional use of physical force or power, threatened or actual, against oneself, another person, or against group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation".¹ Another definition states that "Violence isn't limited to the kinds of incidents that make headlines. It includes a range of behavior from verbal abuse, threats, and unwanted sexual advances to physical assault and at extreme, homicide".² Along with that "violence also represents a serious threat to individual human rights, as it undermines health, the right to live and the right to be treated with respect".³

Individuals who have experienced violence describe it as injury, trauma, heartburn, and violation of both physical and personal integrity.

Violence is all-pervasive; it is present in the life of all nations, all social strata, occupations, age and ethnic groups. Its psychological foundation is to be found in people's dependence based on force and the hierarchy of power, i.e. being dependent on those above you and who is stronger than you – parent – child, teacher – student, managing – subordinate, etc. Furthermore, violence may be an element of human behavior and human relations at all levels and in all situations, manifested in different forms and resulting in the victims physical and mental injury and suffering.

1.2. Definition of workplace violence

Defining the WPV has generated considerable discussions. The variety of behaviours which may be covered under the general rubric of violence at work is so large, the borderline with acceptable behaviours is often so vague, and the perception in different contexts and cultures of what constitutes violence is so diverse, that it becomes a significant challenge to both describe and define this phenomenon. In practice violence in the workplace may include a wide range of behaviour, often continuing and overlapping.^{4, 5}

Broader is the definition of the Workplace Violence Research Institute (WPVRI): "Any act against an employee that creates a hostile work environment and negatively

* Frustration is a mental state caused by objectively insurmountable or subjectively perceived as such difficulties arising on the road to achieving the objective.

affects the employee either physically or psychologically. These acts include all types of physical or verbal assaults, coercion, intimidation and all forms of harassment".⁶ Considerable part of researchers linked violence at workplace with the right to equal treatment in the workplace and with the right to a healthy working environment.

Most studies to date focused primarily on physical injuries, since they are clearly defined and easily measured. But as suggested by some researchers the profile of violence in recent years is changing and gives equal emphasis to physical and psychological behaviour and full recognition to the significance of minor acts of violence not limited to a specified workplace.⁷

During the discussion of the definitions suggested by the project leaders in the focus groups the following suggestions were made:

Concerning the general definition:

According to the participants in the focus groups that definition could be accepted in principle; some thought however that it is more closely associated with physical violence. In speaking about wellbeing it could be more clearly indicated that the point at issue concerns emotional (mental), social and physical wellbeing. The nurses suggested "*underestimated and humiliated*" to be added to the definition.

Furthermore it was pointed out that the definition of violence at the workplace should have a stronger accent on the link with the social and labor rights of the individual. The focus group of the representatives of medical employees' trade unions and professional organizations suggested and accepted the following more general definition as more appropriate, for it covered both physical and mental violence:

"Any act or activity at the workplace derogatory to human dignity and human, civil and professional rights within the framework of the existing laws and generally accepted rules and norms of society".

Another general definition was suggested in the focus group of the nurses: ***"Behavior manifested in the form of physical and mental encroachments on the dignity and personality of the separate individual".***

The definitions of the individual types of physical and psychological violence suggested for the purposes of research were generally accepted by the participants in all focus groups. It was noted that such forms of violence as beating, slapping, kicking, pushing, stabbing, verbal abuse, bullying/mobbing, psychological harassment, abuse, insults, threats as well as different forms of sexual harassment, i.e. suggestive teasing, pinching, fondling, sexually suggestive comments, direct and indirect propositions for sexual contacts and, more rarely, raping can be observed in the health care establishments.

The physicians' focus group suggested that the following could be included in the definition of psychological violence: ***"behavior related to any deliberately created obstacles to exercise one's profession, lack of adequate judgement and tolerating some individuals at the expense of others".***

The focus group of representatives of institutions suggested that **abuse be defined as** ***"Deviation from the normal behavior in the interpersonal relations leading to derogation of the prestige of one of the subjects of communication."***

According to the research team, with regard to the workplaces in health, some doubts and debates may occur in connection with the **general definition of psychological violence** (emotional abuse) as **"intentional use of power..."**, since it presupposes the existence of hierarchical relations or stronger position by presumption. Violence however

may be committed by patients or peers who are not in stronger positions. Secondly, bearing in mind the situation in health care and particularly in health care establishments working with deviant patients, for example the mental health clinics and establishments and the homes for the elderly, the manifestations of psychological (and even physical) violence **may not be intentional** since they are generated by the very health disorder or status of the patient himself/herself.

A further argument along these lines is the opinion expressed by the participants in most focus groups that such actions on the part of the patients and especially of deviant patients are not regarded as **intentional** violence by the medical staff but as part of those hazards of the profession that are difficult to prevent. This is one of the reasons of underreporting of such cases in Bulgaria as we shall see later on in Section B.

Despite the absence of any **reliable data permitting a comparison of the manifestations of violence in the different sectors of employment**, the media publications indicate that physical violence, including assaults and murders, is typical of the spheres working with money and associated with thefts, i.e. exchange offices, petrol stations, shops. Victims of violence and even murders are security officers at different sites, taxi cab drivers and police officers. Physical violence and murder become more widespread in the country in connection with competition and account settlement in the criminal business. According to the opinion of the participants in the focus groups **psychological violence and especially violence along the vertical line of relationships is much more widespread in the health sector**. The reasons for that are linked with the crisis in society and its consequences affecting both health care staff and patients on the one hand and, on the other, the deficiencies of health reform giving rise to many bureaucratic barriers, stress and social tension.

1.3. Role of national and occupational culture. Social and cultural context

All researchers of violence recognise that the violence is embedded in the cultural, social, economic and political conditions in society and in people's socio- psychological stereotypes and attitudes. Until recently the subject of violence at the workplace, including sexual harassment as one of its extreme forms was a "taboo" in the country. That type of phenomena were considered alien to the socialist realities and hence – non-existent. Today we find that they had been and continue to be part of our life.

As shown by most public opinion surveys, most Bulgarians live with the feeling of danger, insecurity, helplessness and pessimism in the conditions of economic and spiritual crisis in the Bulgarian society. These feelings are generated by the higher crime rate and impunity of the criminals. Robberies at home and in the street, assaults, rape, murders to settle accounts are almost a daily phenomenon. Even more alarming are the ever more frequent cases of unmotivated violence and sheer outburst of aggressiveness when innocent unknown people are beaten or murdered at schools, barracks, soccer playgrounds, discos and on the street. It may sound exaggerated, yet we could say that violence has, in one form or another, entered all Bulgarian homes.

Yet even now in the conditions of democracy violence in the Bulgarian society is perceived with tolerance and is still shrouded in silence. Police officers, judges, investigators, chiefs, teachers, parents ignore the truth about violence committed in the social groups to which they belong. The approach of the institutions is much similar. Failing to interfere, they tacitly encourage and legitimise violence. The victim is blamed that she/he is responsible for what happened and subjected to victimisation.⁸

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 conflicts and society is well on the way of accepting that as a norm. That norm is taught and approved by the patriarchal family having deep roots in our culture. In that type of culture where relationships are based on subordination to and dependence on the elder and the stronger, violence is often perceived as natural. In fact all the wealth of roles played by people in the process of their communication are reduced to two roles: father and child, boss and subordinate, strong and weak. If the understanding that you have to be on top and trample on others or else be trampled upon is shared by more and more Bulgarians^{**} and the popular press is greatly contributing to that, it is no wonder than many choose to identify with the oppressor.⁹ **These conclusions are rather pessimistic, yet they are another indication that this problem is calling for attention and that appropriate actions have to be undertaken.**

Sexual harassment as a widespread although unrecognized form of violence at the workplace in Bulgaria is associated with deeply ingrained stereotypes of behaviour based on the roles of women and men in society. Because of the traditional perception of woman as an object of sexual desire and her subordinated role in the society and in the family women are the most frequent victim of sexual harassment at the workplace. That tendency is reinforced by the patriarchal stereotypes and oriental models of behaviour requiring male power domination and women's economic and emotional dependence on men, for they help justify such an attitude to women and make it seem normal and in the order of things. Many women interviewed in some surveys indicated that they had experienced requests for sexual favours from a supervisor or co-worker. Both men and women reported that women must engage in sexual relations with their bosses simply to keep their jobs. Some of the respondents said sexual relations between supervisors and subordinates were "very common." Many male supervisors took for granted that their female subordinates would engage in sexual activities with them.¹⁰ In that social and cultural context sexual violence takes the form of physical violence, threats, repression, exploitation, coercion and discrimination.

The participants in all focus groups shared that health professionals very often have more acceptance and tolerance for violence committed by patients as they perceive such acts as part of the hazards of the medical profession that are rather difficult to prevent. The sick person is considered to have lost his/her balance; physical suffering generates mental suffering and the patient is forgiven even if he/she is aggressive. "They are sick and regardless of their conduct we are obliged to help them because we have taken the Hypocratic oath". On the other hand, it was also pointed out during the discussions that in

^{**} A survey among Bulgarian high school students in Stara Zagora City showed that nearly 50% the students aged between 14 and 17 believe that one may achieve wealth and prosperity through violence, 22% believe one may gain self-esteem through violence, for 35% violence is a factor for political power and 24% think it guarantees easy life. According to the researchers the opinions of the students reflect the attitudes in society. Moreover, the TV made wrestling fighters Stonecold, The Rock, Undertaker become favorite heroes of the children with whom they try to identify, applying their fighting tricks their models of verbal communication and behavior. Almost forgotten are children's fairy tales with good always conquering evil; today we are flooded with violence from the TV screen.

health establishments acceptance and tolerance for verbal abuse and insults are greater due to the rather rude and unquotable language and manner of communication in the **professional culture** of the health care professionals even though they would be regarded as offensive and unacceptable and be even treated as violence in other professional settings.

2. EXISTING VIOLENCE MEASUREMENT MECHANISMS

2.1. Definition of health services sector and its workplaces

As of 31 December 2000 the health care network in Bulgaria encompassed:

- **Hospitals – 304, including:**

General hospitals 127; Specialized hospitals – 107, including hospitals for lung diseases (12), for mental disorders (11), for rehabilitation (18), dispensaries (50), including for cancer (11), for dermatological and venereal diseases (12), for lung diseases (13); university hospitals – 12, national centers - 7.

They provide diagnostic, treatment and rehabilitation services.

- **Outpatient clinics, – 1 103, including:**

Diagnostic-consultative centers – 101; medical centers – 292; medical-dental centers – 33; dental centers – 93; diagnostic and technical laboratories – 28; individual and group primary medical aid practices; individual and group specialized medical and dental aid practices, others – 147, including: emergency centers – 28 and hospices – 23. Medical and dental services are provided in the field of health prevention, early discovery of health disorders, first aid, consultations, health promotion, prevention and screening, medical laboratory and technical services.

- **Hygiene and sanitary inspectorates:** – 28 regional HSI managed and funded by the Ministry of Health and providing services in the field of public health: state sanitary control, preventive and epidemiological measures. Health prevention and promotion, consultations for personal and public health protection and health strengthening.

- **Pharmacies** – 3163 (0.38 per 1000 people) and drug stores – 195 providing services in the field of retail trade with medicines and preventive aids.

- **Health professionals: physicians** – 27 526 (33,8 per 10 000 population); dentists – 6 778 (8,3 per 10 000 population; health personnel with secondary medical education – 49 841, including nurses – 31 480; midwives - 4 131.

The workplaces in the above health institutions pose, though to a different degree, a potential risk of violence, because of the minimum number of staff in some of them and the specific contingent of patients posing a threat of violence or the nature of activities and the services provided in others.

2.2. Information sources of workplace violence

One can judge about the extent of violence at the workplace in Bulgaria only by the media publications and reportage. On the whole the workplace violence is not on the society agenda. There is no transparency and public concern and no measures for violence prevention and adequate protection of the victims of violence.

There are only several **non-governmental organisations** dealing with this kind of issues whose main task is to help women victims of domestic violence and, more rarely, women victims of violence at the workplace (Nadia Foundation, Animus Association,

Gender Project in Bulgaria, etc.). The Animus Association receives calls on its hotline from women victims of domestic violence. Many of the women who receive counselling services for domestic violence at the Animus Association also report experiencing sexual harassment in their workplaces and some of them have been compelled to quit their jobs because their bosses were pressuring them to have sexual relations with them.

Some violations of worker rights including beating and physical and mental abuse have also been registered in the course of the **Confederation of Independent Trade Unions in Bulgaria Campaign** for Protection of the fundamental rights at the workplace under way since 1998 in support of the ILO Declaration on fundamental rights and principals in the workplace. Moreover, Confederation of Independent Trade Unions in Bulgaria (CITUB) has found that only a few workers dare to complain frankly because of the fear of revenge or job loss. For that for the Confederation it is very difficult to undertake appropriate measures and to look for support of state bodies.

In Bulgaria at present there is no accurate and reliable **statistics** available neither on violence as such nor on workplace violence in its different forms. The National Statistical Institute publishes data on extreme cases of criminal violence, such as: intentional homicides, assault and battery, debauchery, rape, theft, provided by Ministry of Interior. No distinction was made between violence at workplace and out of workplace or occupational groups. (See Annex №1). The less flagrant forms of physical violence and psychological violence are not at all reflected in the statistical data due to the lack of procedures for reporting and collecting data.

The measuring of the spreading and scales of violence in the health sector as well as in all other sectors of employment is rendered especially difficult owing to the fact that for various reasons to be discussed in Section B, the cases of violence at the workplace are very rarely reported to the management or to any other authorities.

3. CURRENT KNOWLEDGE ON WORKPLACE VIOLENCE IN THE HEALTH SECTOR IN THE COUNTRY: PUBLICATIONS AND RESEARCH

The attempted analysis of the surveys and literature on violence at the workplace is very problematic, simply because they are non-existent. To the extent such surveys exist, they have only been carried out in recent years by NGOs and their main focus is domestic violence or sexual harassment at the work place considered from the position of women as victims of violence^{11 12, 13}. Due to their non-representative character the Surveys did not determine the degree of the spread of the sexual harassment in the workplace but only registered its presence.

It was found from the surveys that sex discrimination and sexual harassment in employment are serious and pervasive problems for women in Bulgaria. **Responses to the Surveys and interviews suggest that both quid pro quo sexual harassment*** and a hostile work environment are a prevailing characteristic at the Bulgarian workplace.**

*** Both the United Nations and the European Union definitions of sexual harassment include two types of conduct in the workplace. The first, quid pro quo sexual harassment means that an employer conditions the granting of economic or job benefits upon the receipt of sexual favours from a subordinate or punishes a subordinate for refusing to comply with such sexual demands. The second creates a hostile work environment. A hostile work environment exists when women are subjected to unwelcome requests for sexual favours, jokes of a sexual nature, pornography, sexual bantering, fondling and, in extreme cases, rape.

The female respondents, who had been subjected to questions of a sexual nature during a job interview, part of them reported that they had experienced unwelcome sexual contact from their co-workers, supervisors or both. If they refused the sexual advances, they have suffered negative consequences such as reduced status, decreased pay, dismissal or forced job leaving. In addition, many women reported that they had experienced jokes, comments or other conduct of a sexual nature – displaying of pornography, unwanted fondling or other unwelcome sexual attention on the part of their bosses and colleagues. The surveyed agreed that the work place in both the public and private sector is just another scene of violence against women in line with the domestic violence and the violence in the streets. 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 at least formally existing in the public sector are often totally out of their reach. On the other hand, conversations on sexual topics are accepted as normal in the Bulgarian culture and as a rule are not perceived as something offensive or indecent.

SECTION B

COUNTRY CASE STUDY

1. METHODOLOGY

1.1. Methods Used for Data Collection and Analysis

In choosing the method of research we were guided by two considerations as a matter of principle: **first**, this study is part of an international project and the methods had to be agreed in advance, i.e. there is a methodological framework that cannot be changed at random because one has to compare results; **second**, in view of the aims of the national research we had to consider the specificity of this problem in Bulgaria, the absence of adequate sources of information and how to compensate for that absence to our satisfaction with the help of reliable methods of analysis.

Three main methodological approaches were followed, which made it possible to cover the phenomenon “violence at the workplace” from different angles in its different areas and aspects of manifestation.

- **Consulting, examination and content analysis of the information and research available.** This initial stage proved to be very valuable for the success of the research carried out later on. Following consultations with experts in this area a realistic picture of the problem in the country has emerged: an exceptionally low level of awareness of the violence at the workplace among the broad public and absence of any system of statistical observation and reporting. Furthermore a considerable amount of research was carried out in the form of review, content analysis and systematization of the Bulgarian and foreign surveys available, scientific literature and periodicals concerning violence at the workplace.
- **Qualitative aspect of the research.** On the basis of previously agreed questionnaires 6 focus groups were conducted with target groups as follows:
 - ➡ Representative health workers organizations persons: 9 representatives of the trade union federations of CITUB and PODKREPA CL., the Bulgarian Physicians’ Union, the Union of Dentists, the Union of Pharmacists, The Nurses’ Association and employer organizations;

- ➡ Physicians from different type of health establishments and individual and group GPs – 8 persons;
- ➡ Nurses from hospitals, intensive wards, dispensaries, individual and group general practices – 8 nurses;
- ➡ Patients/Clients – 7 persons;
- ➡ National and middle level managers in the health sector: representatives of the Ministry of Health, National Health Insurance Fund (NHIF), Regional Health Directorates, the Parliamentary Health Commission – 6 persons;
- ➡ Top and middle-level managers of health establishments: hospital and medical centers managers, heads of hospital wards – 7 persons.

The total number of participants in the individual focus groups was 37 people on the same hierarchical level as a condition for an open discussion as equals.

➡ Furthermore, semi-standardized interviews were conducted with 4 owners of private health establishments and 5 experts in labor law.

- **Quantitative aspect of the research.** An confidential sociological survey was carried out in selected health establishments in Sofia with the help of standardized questionnaire. 508 medical staff from different types of health care establishments were interviewed with due attention to the need of all professional groups to be represented.

1.2. Methodology for sample design

The selection of Sofia City as the site of the survey was justified by the large number of health establishments of different profile, some of them of national significance, others - primarily regional or municipal and still others – associated with a specific contingent of patients (dispensaries and family GPs). There are both general and specialized hospitals in Sofia, covering the whole range of necessary health services. The mode of operation of most health institutions (including some private ones) is determined by their relationship with the NHIF, but due to the incomplete stage of the health reform many among them are still providing paid health services. In our approach we have sought to cover all cases in their different forms.

To that end all possible statistical data were collected from the Ministry of Health and the Regional Health Insurance Fund in Sofia concerning the number and type of health institutions and facilities on the territory of the city and the number of staff (Annex № 2). All information was summed up and a 6 % proportional sample was developed on the basis of staff employed, covering 23 clusters + 19 individual GPs. In the process of the survey however the initially planned number of 536 individuals to be interviewed from the above clusters had to be modified as a result of the fact that the survey was conducted in a period of dynamic transformation of the health institutions as part of the structural health reform in Bulgaria. That process was accompanied by significant staff reductions, elimination of units, transformation from one type of hospital or health institution to another, separation and differentiation of activities etc. Eventually some clusters had to be added to the sample (27 + 14 individual GPs and a total number of 508 interviewees due to refusals and failure to return the questionnaire (Annex 3).

In the third phase the interviewers working with the staff of the health facilities developed a sample covering different staff categories: managers, physicians, nurses, auxiliary personnel, technical personnel etc, depending on the specific characteristics of the health facility. A step was defined for each of these categories to enable random selection of the staff to be interviewed.

The method of quantitative information registration being used was through direct individual questionnaire with the health personnel.

1.3. Demographic and Professional Profile of the Respondents (Quality and Representative Nature of the Data from the Survey)

Representatives of **all age groups** were included in the sample. Due to the disparity of the age scales used in the survey and for statistical purposes it was not possible to make a full comparison between the interval distributions; nonetheless the summarized data concerning the four best represented age groups between 35 and 54 years of age show some similarity: – 63.4% according to statistical data by the middle of 2001 and 70.4% in the sample. The relative share of the individuals being surveyed drops when age becomes lower. The same is true when age exceeds 54 years.

Table 1

Age distribution	
Age	Relative share - %
20 – 24	2,8
25 – 29	8,1
30 – 34	11,8
35 – 39	14,2
40 – 44	18,9
45 – 49	18,7
50 – 54	18,7
55 – 59	5,7
60 +	1,2

Women are largely predominant in the sample **distribution by gender** – 80.3%. The disproportion by gender is due to the fact that mostly women are working in the health sector. The data from the middle of 2001 indicate that women represent 77.9% of all employees in the health sector in Bulgaria while men account for 22.1% respectively. The slight numerical superiority of the relative share of women respondents in the sample over those actually employed is to the advantage of the survey as by presumption women are more likely to become victims of violence.

Nearly 2/3rd of all respondents are married; the single respondents are 11.8%, and as for the other characteristics – lives with a partner, divorced and widowed, the relative share of the respondents is within the range from 4.3% to 8.7%.

What makes impression is the fact that the representatives **of ethnic minority** groups are much fewer in number- 2.6%. On the one hand, that is due to the fact that Sofia City is not a pronounced ethnicity culture region, i.e. the predominant part of the population belongs to the major ethnic group. Besides the ethnic minority representatives employed in health care are a relatively small part of the total number of staff and work mostly as auxiliary personnel.

The individuals being surveyed come from all possible **professional groups** in health care. The group of physicians/dentists is best represented – 30,7%, followed by nurses 27,6%. The considerable difference in the relative share of the first two groups and all the rest is due to the fact that they are best represented in the general aggregate of staff employed in the health sector. The health statistics for 2000 show that physicians and

dentists account for 40.3% and nurses – for 30.2% of the employees in that sector in the country. The health reform was accompanied by mass staff reductions and those employed in medical transport as well as the auxiliary and technical personnel were brought to their optimal minimal number. Owing to that reason the relative share of respondents from the above groups is significantly lower than that of physicians and nurses. However their more drastic reduction in the sample in keeping with their precise actual ratio would not be expedient from the viewpoint of the resulting frequencies of the individual professional groups in the survey.

Table 2
Distribution by Professional Groups

Category	Relative share %
Physician/dentist	30,7
Nurse	27,6
Midwife	4,3
Pharmacist	4,1
Ambulance	1,2
Auxiliary/ancillary	8,1
Administration/clerical	6,9
Professions allied to medicine	6,1
Technical staff	2,0
Support staff	5,1
Other	3,9

Another peculiarity of the respondents is that 40.4% of them have over **20 years of service** in the health sector, followed by 17.6% with 16-20 years of service. That justifies the confidence in the reliability of the information collected since the respondents have been observing the phenomenon being studied over a longer period of time.

Concerning **health establishment ownership** - 31.5% of the respondents work in private health establishments and 68,5% - in state-owned. That is consistent with the situation in Bulgaria where those employed in the public health sector are considerably more numerous as compared with those employed in the private health sector. An accurate analogy with the actual state of the sector in Sofia as of today cannot be made due to the very dynamic development of the process of privatization. * The proportional method of sample formation reflects the actual structure of the health care establishments in Sofia and the staff distribution by demographic and professional characteristics throughout the health sector in the country. For obvious reasons however the data concerning some less represented groups (such as ethnic minorities and medical transport) are separate and can be interpreted only in the general context of the survey. Therefore the application of quality methods of analysis was extremely helpful for the purposes of a more extensive and profound analysis.

2. MAGNITUDE, CHARACTERISTIC AND SCOPE OF WORKPLACE VIOLENCE IN THE HEALTH SECTOR

2.1. Public awareness

The public and particularly the staff employed in the health sector are still unaware of the problem of workplace violence. Its significance is largely underestimated and it is interpreted in the context of the hardships facing people in their daily life, the stress due to the negative consequences of the long painful reform and the violence and crime as part of the transition. That becomes evident both from the lack of interest of part of the respondents asked to complete the questionnaires and the registered refusals to participate. As far as the qualitative aspect of the survey is concerned, we have to note that through the creation of a favorable atmosphere for open discussion more opportunities were provided for a deeper awareness of the problem and for some interesting views and responses.

In fact as social individuals we rarely come to think about the essence of the phenomena that face us on a daily basis as we go to work or work at the workplace because we consider them to be a normal element of everyday life. It is only when we are guided to an open discussion that we become aware that the aggressive conduct of the patient, the psychological harassment on the part of some hospital ward chiefs, the “tender” hints of the colleague, the unceremonious pressure of the institutions are forms of violence in public health. While it is naturally part of the violence and stress in the society at large, that kind of violence has its own specific characteristics and nuances.

Public health is a system with actors (patients, physicians, nurses, auxiliary and support staff, hierarchical supervisors, institutions related to the functioning of the system, professional associations, trade unions) which form a complex multi-layer matrix of links and connections concealing the potential possibilities for the rise of conflicts and violence. They may arise as a result of the direct contact between the individual actors or indirectly, for example in connection with the inadequate responses on the part of some institutions, lack of information concerning one's rights and obligations etc. In all cases however there is a specific subject and victim of violence. In particular, our survey is focused on the victim of violence with the aim of identifying the quantitative parameters (magnitude and scope) and eventually performing an in-depth quality analysis of the links, causes, consequences and effects.

2.2. Physical Workplace Violence

The data from the survey show that this form of violence is not typical for the health sector in Bulgaria. On the other hand however we have to conclude that it is not an exception either: 7,5% of the respondents indicate that they had been a victim of physical violence in the past 12 months. As a rule it is in the form of unarmed aggressive assaults. There is only one registered case of armed violence. The respondents who have been a victim of physical violence are divided in their mind if that is a typical phenomenon at their workplace. Slightly less than half of the victims evaluate the incident as typical (47,4%).

Relatively higher is the relative share of respondents who had **witnessed physical violence at the workplace** -10,2% of the persons being surveyed (11,5% of those who have answered that question). Most of the witnesses however (73,1%) think that incidents of that type are more of a rarity than a frequent phenomenon: isolated cases or between 2 and 4 incidents in the past 12 months.

Physical violence generally occurs along the line of conflict between patient and doctor. The aggressive patients are perpetrators in 65,8% of the registered cases. The incidents caused by friends and relatives of the patient, outsiders, colleagues, line managers and other staff members are insignificant in terms of their number and relative share. The results from the discussions in the focus groups show that the aggressiveness of patients has different subjective or objective motives, often combined in their impact and multiplying the ultimate result, i.e. escalated tension and its growth as physical encounter. The subjective motives may be linked with the individual's specific traits of character, his mental state, propensity to alcohol and drug abuse etc. The objective irritants are related to the organization of work, the process of treatment itself and a number of negative effects from the reform carried out in the field of public health affecting both patients and health care providers. In this case the aggression displayed by the patients appears as a defensive reaction influenced by external factors beyond the control of the health care provider; that reaction is obviously not in the right direction. Nonetheless the victim of violence is the health personnel.

Victims of physical violence in the health sector are both women and men. The higher relative share of women victims of physical violence (71.1%) is predetermined by the specific characteristics of the sample related to the feminization of health care. However as can be seen from the data in the Table below the relative share of registered cases within the gender aggregations is higher for men than for women.

Table 3

Registered physical violence by victims' gender

Object of violence –victim	Female	Male	Total
Number of cases	27	11	38
Relative share in total	71.1%	28.9%	100%
Relative share in gender aggregation	6.6%	11.0%	7.5%

By types of **profession** physical violence is most widespread among nurses, physicians and support staff (hospital attendants). Yet the midwife and medical transport professions can also be regarded as high-risk professions, the more so that the relative share within the group is rather high - 13.6 and 50.0% respectively (naturally, largely influenced by the small number of the participants in the survey).

97.4% of the cases of physical violence refer to workplaces and professions requiring a **direct contact with patients and clients**. As indicated by the data, physical violence is primarily manifested at the following workplaces and health care establishments: hospitals - 50.0% of the cases, rehabilitation centers (dispensaries) – 18.4%, health centers (DCC and MC) – 15.8%. In terms of ownership physical violence is more widespread in the public than in the private health care institutions and facilities - from 78.9 to 21.1% of the registered cases respectively.

Table 4

Registered Physical Violence by Professional Groups

Object of violence – victim	Physician	Nurse	Midwife	Ambulance	Auxiliary	Administration	Profession allied to medicine	Support staff	Total
Number of cases	9	11	3	3	8	1	1	2	38
Relative share in total	23.7%	28.9%	7.9%	7.9%	21.1%	2.6%	2.6%	5.3%	100%
Relative share in professional aggregation	5.8%	7.9%	13.6%	50.0%	19.5%	2.9%	3.2%	7.7%	7.5%

The temporal characteristics of physical violence show that it occurs most often **in the morning hours and after midnight**. No strong link is observed with the different days of the week. As a rule, violence takes place in the health institutions and facilities (78,9% of the cases) and less frequently – outside them..

2.3. Psychological Workplace Violence

The most widespread form of psychological workplace violence is the **verbal abuse**. 37,2% the respondents have been subjected to it and according to most of them that is a typical example of violence.

Second in scale is **bullying/mobbing**. 30,9% of the respondents indicate that they have been subjected to this form of violence in the past 12 months. The data from the survey and the opinion of the participants in the focus groups of physicians and nurses testify that it is also typical of the workplaces in the health sector. As a rule the frequency of both forms of psychological violence is periodical and irregular. Only 5.7 and 3.2% of the respondents have been subjected to continuous verbal abuse and bullying.

In contrast to physical violence with the patient as its primary subject, with psychological violence the number and relative share of incidents with a staff member or line manager as a perpetrator has been growing.

Table 5

Perpetrator (as % of the cases)

Perpetrator	Physical Violence	Verbal abuse	Bullying/ mobbing
Patient	65.8	43.4	44.6
Relative of patient	7.9	11.1	19.1
Staff member	2.6	27.0	24.2
Management/supervisor	7.9	28.0	26.8

The data show that psychological violence is much more frequent along the conflict line “subordinate-supervisor” than is the case with physical violence. Verbal abuse and bullying among peers and along the hierarchy depend on the qualities and character of the separate individuals and management staff; yet stress and tension in the team, fed by the negative effects of the health reform in Bulgaria and the pessimistic expectations are additional incentives for psychological violence.

There is no clear-cut relationship of the manifestations of psychological violence between the different age groups. Almost equally subjected to verbal abuse (between 33 and 42%) are health workers in the age groups of up to 54 years. A more significant reduction is observed after that age – 24.1% in the group of 55-59 years and 16.7% over 60 years. Almost the same trend can be observed with bullying/mobbing.

The data concerning the distribution of psychological violence by gender show that **women are more affected by verbal abuse while men and women are almost equally affected by bullying.**

Table 6

Registered psychological workplace violence by gender

Verbal abuse	Female	Male	Total
Number of cases	161	28	189
Relative share in total	85.2%	14.8%	100.0%
Relative share in gender Aggregation	39.5%	28.0%	37.2%
Bullying/mobbing	Female	Male	Total
Number of cases	126	32	158
Relative share in total	79.7%	20.3%	100.0%
Relative share in gender aggregation	30.9%	32.0%	31.1%

As for the distribution of psychological violence by **professional groups** in the health system physicians and nurses come out first again. However the careful analysis of the data (See Annex 4) shows that if staff distribution is proportionate to the respondents in the sample, then that type of violence becomes typical of nearly all professional groups, including technical, support and administrative staff. In other words, psychological violence is generally taking place in the health system in Bulgaria and in quite a few cases it manifests itself on the administrative-organizational level and along the supervisor-subordinate line.

What makes impression is a clear trend as follows: **the higher the number of staff** present at the same work setting, the higher the relative share of the psychological violence indicators within the group.

Table 7

Registered Verbal Abuse by Number of Staff Present at the Same Work Setting

Number of staff	None	1-5	6-10	11-15	Over 15	Total
Number of cases	11	83	30	17	46	187
Relative share in total	5.9%	44.4%	16.0%	9.1%	24.6%	100.0%
Relative share in team Aggregation	33.3%	32.9%	34.1%	40.5%	52.9%	37.3%

Registered Bullying/Mobbing by Number of Staff Present at the Same Work Setting

Number of staff	None	1-5	6-10	11-15	Over 15	Total
Number of cases	4	71	26	16	40	157
Relative share in total	2.5%	45.2%	16.6%	10.2%	25.5%	100.0%
Relative share in team Aggregation	12.1%	28.2%	29.5%	38.1%	46.0%	31.3%

These two forms of psychological violence are more frequently observed in public health care establishments than in private ones. 31.6% of the respondents in the private sector testify of verbal abuse whereas in the public one they are 39.7%. The data for bullying/mobbing are 26.6 and 33.1% respectively.

Only 2.2% of the respondents share that they had been subjected to **sexual harassment** in the past year. We have to note however that the data are largely influenced by two significant factors. On the one hand that is a rather sensitive issue and many avoid to speak openly about it or to share anything with friends, relatives or peers at the workplace. On the other hand there is no explicit prohibition of sexual harassment at the workplace in our laws and no disciplinary or other punishments are envisaged for any such acts. In order to identify whether any behavior is sexual harassment one has to consider the type of behavior, how it is accepted (as desirable or undesirable) and what are its outcomes. There may be sexual harassment even when the perpetrator has no intention to abuse and that is merely a joke, innocent flirtation or flattery from his/her perspective. What is important is whether they are perceived as such by the victim. From a legal point of view however the unwanted behavior must incur some kind of damage in order to be qualified as sexual harassment. Thus in the absence of any legal regulations the chances for any reaction are limited.

The low absolute number of sexual harassment cases (11) does not allow any analysis of two and three-dimensional distributions. As a summary of these characteristics we can describe the typical object of sexual harassment as follows:

She is a nurse^{*} or a doctor between 25 and 29 years of age. As a rule she is married or lives with a partner. She works in a public health care institution and does not necessarily have to work at night. Her workplace is a hospital and she performs her duties in a large team of colleagues. The workplace violence is a concern, but not a strong one. She accepts it as part of everyday life and the existing attitudes.

Racial violence is not typical in Bulgaria, at least for present. 4 cases have been registered in the survey (0,8% of the respondents) on the basis of ethnicity, i.e. violence against members of minority groups – Turks, Roma. Interestingly some of the respondents indicating **ethnic violence** have also indicated another type of violence, i.e. physical or verbal abuse and bullying which leads us to assume that the violence against them is rooted in their ethnicity. That problem was discussed in the focus group of nurses. They put a somewhat different accent on that relationship. The work of hospital attendants is unattractive and low-paid in the extreme. To the extent there are Roma employed in the health sector, most of them occupy this type of workplaces. They are at the lowest level of the hierarchy, which is a prerequisite for them to be harassed and humiliated by all the rest; on the other hand however they are in permanent contact with patients; in most cases these patients are bed-ridden and it is a public secret that the care for them depends on small amounts of money and tips. That is another line of conflict in which violence becomes rather complicated in character, i.e. it takes place between the hospital attendants themselves and is in most cases mutual.

^{*} In Bulgaria nurses are only female

Ethnic violence is an important problem for society at large, though it is rather difficult to study it as such in the sphere of public health. On a social scale the conflict is generated by the huge gap between prevailing and minority ethnicities in terms of their educational and skill level. The system of public health does not permit any lower skill and educational level than the one required at the workplace concerned (with the exception of the above examples). That largely guarantees the rights of ethnic minorities in the health care establishments, i.e. they are respected as much as those of the rest of the staff. Naturally they are not immune to the above forms of violence at the workplace, but that is **violence brought about by the general factors in operation rather than violence on a purely ethnic basis**. In that sense the effects generated by that type of violence are not essentially different from those described above.

2.4. General Remarks

In summary we would like to note that the assessment of the actual scales of the phenomenon of workplace violence is rendered even more difficult by the fact that as already mentioned no statistics and no system of reporting cases are available. The main conclusion is that the incidences of violence at the workplace in the health sector are underreported and the phenomenon is largely undocumented. That was explicitly underlined by the participants in all focus groups.

The risk exposure of the different professional groups and professions in health may be different too. That is also true of the different kinds of health care institutions. Particularly risky in that regard are the dispensaries for mental disorders, the hospital emergency wards and intensive units (see Annexes No. 4 and 5 for specific data concerning the demographic characteristics and workplaces of the victims of violence).

Although all professional groups are affected by certain forms of violence, the **nurses are at highest risk** as they are in direct continuous contact with the patients and sometimes appear as a buffer between physician and patient. That situation is further complicated by their status in the hierarchy and official subordination to the physicians.

As shown by the results from the survey the cases of physical violence and especially those of violence with the use of arms are not typical for the health system in Bulgaria. Though there are some data on physical violence mainly perpetrated by mentally deviant or more aggressive patients, the cases of verbal abuse and bullying are more widespread..

3. INFLUENCING FACTORS IN THE CONTEXT OF WORKPLACE VIOLENCE

The survey results show that the factors generating violence are rooted in a broad social, economic, organizational and cultural context. At the same time some specific characteristics of the health care system are shown to heighten the risk for workplace violence: feminized sector, shift work, working alone during examinations and procedures, daily contact with patients suffering from different health complaints and with their relatives, work at night, pressures caused by the lack of time. Along with that the multi-faceted and complex nature of the factors and their interaction contributing to the cases of violence at the workplace was revealed in the questionnaires received and during the discussions in the focus groups. (Annex №№ 6,7)

Due to the crisis and social tension the attention is drawn primarily to the global factors and there is no sufficient awareness of the risks at the specific workplace.

The factors indicated by the respondents can be generally classified in several groups:

1. Societal factors.
2. Personal factors.
3. Organizational factors.

3.1. Societal Factors

Under the conditions of transition generating poverty, unemployment and a high crime rate both among the health personnel and the patients the socio-economic situation in the country is mentioned as a factor generating physical violence by nearly 19% of all respondents. A significantly larger number - – 26.2 % indicate it as a factor contributing to the appearance of psychological violence. It is noted that the spiritual degradation in society, the changing system of values and the model of social relations during the period of transition contribute to the increase of the cases of violence. The nature and consequences of the health reform studied below could also be included in that group of factors.

The fear and insecurity related to the above mentioned factors generate a high level of **stress and social tension** both among health personnel and patients. According to every 9th respondent they may potentially lead to physical violence and according to every 5th – to psychological violence. Furthermore, part of the health personnel and particularly those working in the intensive and emergency units are subjected to permanent stress due to the numerous encounters with victims of violence on the street, at home or as a result of other incidents.

According to the respondents some supervisors use the economic dependence, absence of any legal protection and low social status of the health personnel due to their miserably low pay and continuous redundancies in the health sector to create an atmosphere of fear, insecurity and submission in a work setting of ongoing psychological harassment.

No less important factor for the occurrence of violence is the tolerance of violence in all its forms on the part of the public, the lack of concern on the part of the state authorities and the absence of any effective protective-punitive mechanisms and strategies to fight against violence.

3.2. Individual factors

Every third respondent perceives the patients' individual characteristics as a factor for physical or psychological violence at the workplace. An ever increasing aggressiveness in the patients' behavior is observed. Enraged, angry or distraught for one reason or another, ordinary or alcohol or drug affected patients are the chief cause of violence in the health institutions or facilities. According to the respondents in some cases such behavior is caused by the low level of education, upbringing and health culture as well as the lack of respect for the health personnel in the health sector. The patients' behavior is not tolerant, there is no patience and family problems are transferred to the health institutions; all that appears as a cause or precondition for physical and psychological violence.

The growing number of patients suffering from acute or chronic mental disorders who remain outside the mental institutions without any adequate follow-up treatment due

to the disastrous situation of the society, family and health care system constitutes a threat to the health personnel. According to 20.6% of the respondents, the very mental or senile condition of the patients in a number of health institutions, i.e. mental clinics and dispensaries and homes for the elderly poses a threat of predominantly physical violence. To a lesser extent these deviations have been mentioned as the cause of psychological violence - 9.1%.

3.3. Organizational Factors

The workplace itself has a considerable potential for violence based on the interactions between the personnel, the personnel and the management, the managers' personal characteristics and their style of management. **When the relationships in the health institutions are not good enough** they lead to conflicts at the workplace. The absence of any procedure for their resolution and the management style have been cited as a primary factor for psychological violence by 39.7% compared to 14.7% who think they lead to physical violence. The lack of mutual respect, tolerance and acceptance between colleagues and between health personnel at different hierarchical levels is the cause behind the emergence of different forms of violence. The tense relations between the GPs and the health specialists are increasingly cited as a factor stimulating violence. In a number of health institutions it is the supervisor who is the source of endless psychological and emotional harassment. As pointed out by the respondents its causes are his/her managerial incompetence, inability to communicate, lack of interest in the problems of the staff, conceit, megalomania and disrespect for the rights of the personnel.

About 15% of the respondents emphasize that in some degree the risk of violence is also to be found in **the inefficient organization and bad working conditions**. The following factors are among those cited: 12-hour working day, work intensification due to insufficient personnel, incomplete night work teams and the need to work alone at night because of that, excessive paper work that needs to be done in compliance with the requirements of the National Health Insurance Fund leading to long lines of waiting patients who become irritable and aggressive due to the long time they have to wait. The physical factors of the work setting, i.e. noise, lighting, temperature and others have not been indicated among the factors influencing the rise of violence. **The lack of security measures and the lower level of control** are cited mainly as a factor for the rise of physical violence. On the other hand the participants in the focus groups pointed out that if the measures for security and control over the access of patients are too strict, they might have a negative impact and give rise to violence.

The insufficient information about the reform and the fact that it is not understood by the patients, the non-availability of financial resources in the health institutions, including resources needed to maintain health and safety at work, the high level of hospital indebtedness, staff downsizing and low pay, the problems and difficulties in the interaction with the NHIF, especially in connection with the National Framework Contract, the accreditation procedures for health institutions, the introduction of paid health services etc. are cited by 16.1% of the participants in the survey among the factors generating physical violence and by 23 % - among the factors generating psychological violence at the workplace.

The summarized data concerning the answers to the open-ended question about the factors generating physical and psychological violence are given in the Table below. As

shown, according to the respondents **the key factors contributing to workplace violence are as follows:**

- The personality and behavior of the patients as well as the behavior of specific groups of patients;
- The social and economic situation in the country;
- The health care reform.

The more profound analysis of the data however points to some internal distinctions as regards the ranking and intensity of the factors being cited for the two types of violence.

Table 8
Factors contributing to the workplace violence - %

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 organisation 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	

The analysis of the data on the factors generating violence by professional status (Annex №№ 6,7) reveals the following more interesting tendencies:

Among the factors for physical violence the leading role of the personality and behavior of the patients is retained in nearly all professional groups: physicians, nurses, midwives, administrative staff, pharmacists. The support personnel rank first the behavior of specific groups of patients. Physicians rank second the socio-economic situation in the country while nurses stress on the behavior of specific groups of patients (primarily those of mentally handicapped). Physicians cite the organization and conditions of work and the absence of measures for security and control in the third place and nurses - the socio-economic situation and the health care reform. The supervisor's style of conduct and personality are ranked second and third by administrative and support personnel respectively.

The ranking of the specified factors for psychological violence is somewhat different. The personality and behavior of the patients retain their leading role according to the physicians, nurses and health personnel related to medicine while some other professional groups (pharmacists, administrative staff, technical staff) regard the supervisors' management style and qualities as most important. The socio-economic situation in the country is also ranked first by the physicians. The health care reform as a factor for psychological violence is ranked second by physicians, nurses and support personnel and the style of management – by midwives, support personnel and health

personnel. Stress in society and social tension are considered a key factor by physicians, midwives, administrative, technical and support personnel.

Certain distinctions in the ranking of factors depending on the type of health establishment have been observed (Annex №№ 8,9).

According to the respondents working in **hospitals** the factors that largely determine the likelihood of outbursts of **physical violence** are:

- Lack of security measures and control – 40%
- Personality and behavior of the patients – 39.6%
- The socio-economic situation in the country – 15,1%

The following factors have been identified as key factors for **psychological violence**:

- Personality and behavior of the patients – 37.3%
- Management style and qualities – 27.6%
- The socio-economic situation in the country – 25.4%

According to the respondents working in **health centers** the following factors appear as key determinants of physical **violence**:

- Personality and behavior of the patients – 42.6%
- The socio-economic situation in the country – 20.4%
- The lack of security measures and control – 18.5%

The factors contributing to **psychological violence** at the workplace have been ranked as follows:

- Personality of the patients – 26.3%
- The socio-economic situation in the country - 21.1% and the health care reform – 21.1%
- Management style and qualities – 15.8% and relations in the workplace – 15.8%

The participants in the survey working in **dispensaries** identify the following as key factors for physical **violence**:

- Specific groups of patients – 57.1%
- The socio-economic situation in the country – 30.8% and the health care reform – 30.8%
- Personality and behavior of the patients – 25.6%

The following major factors contributing to **psychological violence** have been indicated:

- The socio-economic situation in the country – 37.8%
- Stress and social tension – 32.4 and personality and behavior of the patients – 32.4%
- Work organization and working conditions– 18.9%

The individual GPs rank the health care reform in the first place as a factor for physical – 57.1% and psychological violence – 65.2%.

The factors commented so far were also mentioned during the discussions in the focus groups. However the accent in the focus groups of physicians, nurses and patients was on the impact of the health care reform, which had brought about some huge changes in the process of health care in general and turned the health personnel into a buffer between the populist policy of the government spreading the belief that all services

are free and accessible on the one hand and the patients who suffer from the defects of the reform. As one hospital managers noted, “The organizational and administrative changes in a society that is not healthy become a precondition for violence.”

The health care reform was carried out without any debate in society and consequently people **are not sufficiently informed and hence the sense of insecurity of both the health personnel and the patients**. Added to that is the lack of clarity concerning the frequent changes in the statutory regulations and the complicated relationships with the NHIF. The patients demand faster and better quality services but instead they receive less than they are even used to and on top of everything they have to go through considerable bureaucratic obstacles and trials before they can reach a specialist to examine them or before they can get their free medicines. As they have the habit **of receiving free medical aid** when they are asked to pay fees each time they enter the consulting room of their doctor or when they find out that the number of examinations by specialists is limited and they have to be put on the waiting list, the patients become tense and aggressive. According to the patients **the access to health care of the most vulnerable part of the population** – the unregistered long-term unemployed or those working in the gray economy without a contract and without any social security coverage from their employer – is difficult because they have no right to choose their own GP and have to pay for all medical services.

The outpatient health care is largely influenced by the relationships between GPs and nurses. The latter often have no employment contracts and their salaries are miserably low because they are paid by the GPs. The relationships between GPs and medical specialists are much similar since the former tend to refer ever fewer patients to the specialists and try to perform their functions thus reducing their remuneration. That is further complicated by the limits on the number of referrals to specialists to which each GP is entitled. All this may be a factor for an outburst of psychological violence. Added to that is the conflict of interests between the GPs and the patients due to the large number of patients the GPs have registered in their list and consequently the long waiting time to see the doctor, which further irritates both doctors and patients and may lead to violence.

The group of physicians also pointed out that **different factors of violence are determined by the specific nature of the individual health institutions and their geographical location**. The long lines of sick people and the hours of waiting in the hospitals, especially in the city hospitals due to staff cuts are a favorable setting for outbursts of patients aggressiveness. Another reason is the absence of exact regulations concerning the rights of both patients and health personnel. The dispensaries are a closed system but in some cases patients who suffer from mental disorders are prone to violence. At the university hospitals where students are taught the intensive stream of people is another condition for more serious cases of violence. Typical of them however is psychological violence **posing obstacles to professional development and hierarchical growth as well as imposing limits on the professional activities** of some individuals. Practical experience shows that in some university hospitals assistants become supervisors and professors perform the functions of interns.

The representatives of private **health institutions** share that serious cases of violence can also be observed, including physical violence. Some nouveau riche who go there are usually rude and arrogant and behave outrageously with the medical staff insisting that they want everything to be provided all at once with the argument that “I am paying!”

The participants in the focus groups think that violence is less likely in **small towns** because people know each other and the cases of violence spread about, while in big cities anonymity is more widespread and they are more prone to violence.

3.4. Reforms, Major Measures of Restructuring, Downsizing in the Health Sector and Their Impact on Violence in Health

The real reforms in Bulgaria were started in July 2000 following the adoption of fundamental legislation defining the objectives and mode of restructuring of the then existing health care system. The new legislation covered the following: the Health Insurance Act, the Health Institutions Act and the Physicians and Dentists Professional Associations Act. A transition was effected from a system of centralized planning and centrally run and financed universal insurance coverage and free access system to a social insurance system.

The reform started first in the field of outpatient establishments with a radical restructuring of the existing network of polyclinics, replacing them with Diagnostic-Consulting centers, Medical centers, Medical technical Laboratories and others. The main burden fell on GPs and specialists in outpatient units. The outpatient aid financing underwent a complete change, being taken over by the National Social Insurance Fund – a public institution under tripartite supervision. It collects the funds from the mandatory health insurance system introduced by law and spends them after concluding a National Framework Contract with the Physicians and Dentists' Professional Associations. The newly created outpatient health institutions and facilities were registered as commercial companies. **The restructuring** of the health sector was 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 cuts **affecting** mostly health personnel with a secondary level of education: nurses, midwives and others. The available hospital beds per 100 000 people fell from 1061 in 1995 to 749.5 in 1999. Against that background the health care services to the population continue to be underfunded and that is perceived by the population as reduction of health care quality. The expenditure on health care as percent of the GDP decreased from 4.1% in 1999 to 3.8% in 2000 and 2001. Indebtedness of hospitals to Electricity Company and to pharmacies continued to be very high.

That manner of implementing the health care reform generated a sense of insecurity among the health personnel on the one hand and lack of clarity and understanding of the new forms of relations on the part of the population. There are also distinctions and lack of equality in the quality of the health services provided in both bigger and smaller settlements. The reform in the hospital institutions started in July 2001 and some of them are already working with the National Health Insurance Fund.

Furthermore, according to the observations in the process of restructuring and reforms in the field of health the public sector **salaries** lag behind both versus the increases of the prices of goods and services and versus the payment in the private sector. In about 12 years since the start of the democratic changes in Bulgaria the average salary in the country has actually dropped by 49.1% and that in the public sector - by 51,4%. The average monthly gross salary in the budget-funded health sector is about 90 US\$; for the health personnel with a higher medical education it is about 120 US\$ and for the health personnel with a secondary-level education - about 75 US\$ while the average monthly salary level in the country is about 108 US\$ according to the data for 2001. In addition to

the low pay levels the payment of salaries is very often delayed, especially in municipally-funded health care establishments. * These data show that the remuneration of the health personnel is a permanent stress-generating factor for those employed in the sphere of health.

According to the respondents the following serious changes have taken place in the health institutions and facilities in Bulgaria in the past two years:

- restructuring/reorganization – 63.9 %;
- staff reduction – 60.7%;
- resources reduction – 23.2%;
- increased number of staff – 7.9%;
- additional resources – 6.0%.

The prevailing view is that most of these changes have led to negative consequences for the situation in health care. Nearly half of the respondents (48.1%) think that the work situation for staff has worsened and one fourth (25.1%) – that the situation for patients has worsened. Much fewer are those who believe that the work situation for staff and the situation for patients have improved - 23.2 и 18.6%. (Annex № 10). The deteriorated work situation for the staff is largely due to resource reduction according to 82.4% and to staff cuts according to 66.2% of the respondents. Though indicated by a lower number of respondents - 40.2%, restructuring heightens tension and has a negative impact on the functioning of the health institutions and facilities.

On the whole 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 are a real condition for rising tension and conflicts in the health establishments as a basis for the rise of different forms of violence between the individual groups of the health personnel and between the health personnel and the patients.

4. EFFECTS AND IMPACT OF VIOLENCE AT WORK IN THE HEALTH SECTOR

Aggression and violence at the workplace are indisputably a problem not only for the victims of violence but for society as a whole because the negative effects are manifested in different areas and their operation is both direct, indirect and continuous. That is an unexplored area in Bulgaria. The absence of any well-outlined dynamics and registration of this phenomenon accounts for the inability to make a comprehensive realistic assessment of the complex impact of violence in the health sector.

The relatively low level of physical violence registered in the survey – 38 cases (7.5 % of the respondents) does not permit an accurate assessment of the physical injuries, but we can still note that injuries have been mentioned only in 7 cases. Subsequent treatment being necessary is noted in 4 incidents and in three cases the victims had to take sick leave,

* To illustrate more clearly the incomes situation in the health sector we shall cite some data from the anonymous survey conducted by the ISTUR at CITUB and the Federation of Health Unions by the end of last year in 21 ex-district towns in the country. 675 employees from different health institutions and professions were surveyed. Responding to the question “Which category would you refer your household to?” 10.2% defined their household as extremely poor, 42.3% - on the brink of survival and 22.6% - as poor with no problems of survival. On the whole, 75.1% of all respondents defined themselves as poor to one degree or another.

i.e. in the serious physical injuries caused by violence are more of a rarity than a normal phenomenon in the health institutions included in the survey.

Because of the small number of registered incidents of physical violence, making any generally valid conclusions concerning the effect of violence in terms of financial losses incurred on the victim or health institutions is not possible.

However the price paid for violence exceeds by far any financial losses for the victims of workplace violence. **The psychological effects from violence have a lasting and multi-faceted effect.** They affect the emotional state, work and family life of the victims. Though not representative, the data obtained still enable us to outline some trends with regard to the differences in men and women's reactions (Annex № 11).

More than half of the victims of physical violence has unpleasant disturbing memories to an average or high degree (according to the 5-score evaluation scale). That phenomenon is more pronounced among men. Thus 44,4% men and 59,1% women share that they occasionally have repeated memories of the incident and feel anxiety and 33,3% men and 7,3% women experience that frequently and very frequently. Over 80% women and about 60% men try to overcome the memory of what happened by avoiding to think or talk about the incident. The experienced physical violence makes the victims become "super-alert" and watchful and on guard. That is more typical of men – over 70% and about 55% give answers within the range of occasionally – very often. Men more often than women have the sense that everything done has been an effort - 80% men and 52% women respectively.

Violence committed at the workplace obviously has a high price: a stronger feeling of anger and helplessness, impaired health, high level of stress and sometimes fear, problem transfer to the family. These findings have been confirmed during the discussions in the focus groups.

No less significant are the consequences and negative effects of psychological violence. Indeed its much broader scope and scales registered in the survey as well as its multi-faceted impact represent a very serious problem. **Verbal abuse** generates disturbing memories and thoughts to an average and high degree in 56% of the men 67% of the women subjected to that form of violence and over 60% of the women try not to think or talk about what happened. A significant number of respondents (about 60% of the men and nearly 70% of the women) have become "super-alert" and watchful. Nearly the same number of men and women find themselves in a dead-lock, feeling that what they have done is in vain; that feeling is stronger among women. (Annex № 12) These experiences of the victims of violence cannot but have a negative impact on the relations between patient and care-giver and between the staff members, both in terms of their relations as colleagues and in terms of their mutual trust and respect in the hierarchy. The level of stress and tension often becomes much higher as a result of the disrupted micro-climate and inner tranquility.

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 super-alert (Annex № 13).

All this points to what is known in psychiatry as **post-traumatic syndrome**, whose symptoms are incessant re-visiting of the traumatic event, avoidance of any occasions (people, situations, topics) that could remind of it or a sometimes selective amnesia, irritability, agitation, hostility towards the others.

As pointed out in the focus groups of nurses and physicians the effects from the different forms of psychological violence often lead to impaired health, distress and a number of socially significant diseases. As already noted, the very high negative effect of this type of violence sometimes manifested as a post-traumatic stress syndrome combined with the absence of any institutional support mechanisms leads to **low self-esteem, self-accusations and self-isolation**. These reactions however are very dangerous because they do not eliminate the prerequisites for the occurrence of violence at the workplace but disrupt the inner psychological and emotional comfort of the victims, do not allow them to perform as best they could at the workplace and that ultimately affects the work of the health institution as a whole.

The trade union representatives in the focus group pointed out that the atmosphere of psychological violence in the health institution arrests **the development of the individual concerned and has a depressing effect on all the rest**. One is compelled to engage in a continuous fight with the manifested harassment, as “someone warding off evil dogs” according to the figurative expression suggested in the group, and to lose time and effort instead of being active and investing all his/her energy in work and high quality professional work performance. Therefore the less violence, the freer and more motivated the individual will be and the more strength he will have for quality work and dedication in his profession.

In summing up we could say that regardless of **who is the perpetrator of violence – patient, supervisor, colleague or a chance person, its effect directly or indirectly concerns everybody linked in the system described by us as multi-layer system with many directions and areas of impact**.

The sexual harassment may have consequences that are even more dangerous both for the victims and for the other staff of the health establishment, even when it is only manifested as psychological and has never crossed the threshold of physical violence. The sexual harassment in all its forms is linked with humiliation, threats and exploitation. From the perspective of all individuals, even those who have never suffered directly from that type of violence, it is disruptive to the trust and mutual respect that underlie any free and open exchange of ideas. Such a behavior has a negative impact on the quality of work and creates a hostile, threatening or aggressive atmosphere at the workplace.

The focus groups emphasized that in order to avoid such conflicts what is important is not only for everyone to refrain from any behavior that may be defined as sexual harassment, but also to strongly oppose any such activities on the part of other colleagues or representatives of the management. That could happen even in the absence of any statutory regulations if there is a formal or informal procedure in the health institutions; however, in both cases it is advisable to adhere to the rules of complete confidentiality.

The discussions in the focus groups touched upon a rather important issue – **worker fluctuation** as the outcome of violence and bad workplace relationships in the health institution. It has not been covered by any statistics, i.e. the reasons for the frequent change of jobs both within and outside the different health institutions have not been registered. The role of the line managers and the top management was pointed out. A goal specific violence prevention policy should be followed to reduce the negative effects to the minimum and where violence has already occurred – more flexibility should be introduced in the personnel policy (referrals to new jobs, rotation etc.). **The culture of fear of violence established in the society as a result of its frequent manifestations should be opposed through creation of conditions that do not permit it to enter the workplace.**

Not only the victims of violence are affected by its effects; as already noted, **though indirectly, they influence the micro-climate in the health institution too** and generate tension and conflicts between the staff and between the management and the staff. In the final analysis **that is reflected in the quality of work, affecting not only the patients, but also the health sector and society as a whole.** Because of that both employers and health personnel are equally interested in reducing the cases of violence at the workplace.

In conclusion we would like to note that any realistic assessment of the direct and indirect consequences and impact of violence at the workplace in the health sector should rest on the empiric knowledge in that area while encompassing these phenomena in a streamlined system permitting adequate action against the conditions and factors conducive to incidents of violence. As already noted, at this stage such a system is not available; moreover, there are not even elementary statistics on the incidents of violence and no quantitative parameters of the consequences (number of lost working days, treatment costs in case of mental or physical trauma etc.).

5. INDIVIDUAL AND INSTITUTIONAL RESPONSE TO VIOLENCE

5.1. Coping Strategies of Victims

Physical violence as a rule carries the risk of injuries; the reaction cannot always be adequate to the situation and emotional stress leaps drastically. That does not happen every day, so it leaves a lasting imprint in the mind of the individual. Yet the rule “meet aggression with aggression” does not always work in sphere of health. Hence the specific nature of the “patient-doctor” conflict. The doctor always keeps the health of the patient in mind and is inclined to a more tolerant attitude. It was shared in the focus groups that with their manner and conduct the more experienced nurses and physicians try to divert the attention and calm the patients down, thus preventing the escalation of abuse. They are much more experienced in reading the warning signals of aggressive behavior.

Physical self-defense is needed in some cases; according to the survey data however it is relatively rarely resorted to (in 18,4 % the registered incidents involving both men and women). The “reactions of common sense” such as verbal persuasion predominate among women – 40%; while only 18,2% of the men follow this course. Such reactions as sharing with colleagues, seeking counseling and reporting to the line managers are all more typical of women (indicated respectively by 40,7%, 14,8% and 37% of the women who have answered that question), while men typically take no action (36.4%) or pretended it never happened (9,1%). As shown by the data, the different cases of psychological violence tend to be reported to the line manager to a lesser degree than sharing with colleagues and friends, which is most often the case.

Thus **women’s reactions** to verbal abuse and bullying/mobbing are as follows:

- Told a colleague – 47,5%, (54,8%)
- Told the person to stop – 38,0% , (37,3%)
- Told friends/family – 34,8%, (30,2%)

Men’s reaction to verbal abuse is somewhat different from that of women:

- Told the person to stop – 57,1%
- Told a colleague – 32,1%

- Told friends/family – 21.4%; reported it to management – 21.4%; took no action – 21,4%.

In case of bullying/mobbing 34,4% of the men prefer to tell a colleague, 31.3% choose ‘told the person to stop and told friends/family’ in the second place.

What makes impression is that no help is sought from the trade unions or from the professional organizations in the cases of both physical and psychological violence. That may be due to a number of reasons; one of them is certainly the fact that they have not put the prevention of violence at the workplace on the agenda of their activities.

5.2. Reporting Procedures, Investigation, Prosecution and Interventions. The Problem of Underreporting

As noted above, the problem of workplace violence and more specifically, workplace violence in the health sector is not on the agenda of society. There are no groups or institutions dealing specifically with that problem. The data from the survey point to **the absence of any special reporting procedures** for the cases of violence at the workplace as well as of any individual and institutional strategies and policies dealing with violence in most of the health institutions included in the survey. Nearly 50% of the respondents are explicit that no special reporting procedures exist for the cases of violence in the health institutions where they work and about 30% do not know if there are any such procedures. Only 23% of the respondents indicate that there is some type of reporting procedure and the reporting of violence is mainly encouraged by the management - 14.4% or by the colleagues – 10.5%. Such procedures are more developed in the public sector and primarily in the homes for the elderly (33.3%), dispensaries (30.2%) and private sector individual medical practices (28.6%).

To the extent it is done, such cases are reported in compliance with the general procedure of reporting violations of discipline or of the interior regulations and by submitting a complaint or informing the management of the health institutions or the Ethics Commissions set up at the Physicians’ Union and the other professional organizations. However, as shown by the discussions in the focus groups, mostly cases concerning employment issues or impaired relations in individual health institutions are reported that cannot be considered cases of violence. Some formal mechanisms of rights protection are said to exist, but they are not actually being used. In 2/3 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%) said that reporting **was useless**, and 14% -that they did not report because they **were afraid of negative consequences**.

The situation with verbal abuse and bullying/mobbing is much similar and the responses given by men and women do not differ substantially – thus about 61% did not report because they thought that was useless and nearly 30% were afraid of negative consequences. About 10% did not know who to report to and about 15% thought that the incident was not important.

Some action to investigate the causes of violence was taken only in several cases – between 1 and 6.5% indicated that action was taken to investigate the causes of the different types of violence.

As shown by the data from the survey and the discussions in the focus groups, apart from the causes already mentioned **the underreporting of the incidents of violence is also related to the Bulgarian mentality, the social tolerance of violence, and the absence of any organizational and institutional support to the victims** of violence. The feelings and

suffering of the victim are ignored. The message to the victims of violence is that they themselves are to be blamed for what happened to them because this attitude was caused by their own behavior. Therefore it is the norm in our culture to keep silent about the violence suffered, especially if it is sexual, because it is something shameful and disgraceful.

Furthermore it was pointed out that the underreporting of the incidents of violence is also largely due to **the lack of awareness of this phenomenon** and of the fact that such acts are violations of the human and labor rights of the individual concerned. There is no awareness that workplace violence is a priority problem whose solution may be a solution of some other problems both at the workplace and in the society at large.

Another reason for underreporting of the incidents of violence under the conditions of recession and mass unemployment typical for the country is the **economic compulsion** reducing the chances of choosing a workplace and of being protected by the law and creating a sense of impunity; the still insensitive public opinion. All this compels the victims of violence to conceal their problem for the sake of their survival because they do not see any support coming from their workplace or from the government and the public and have no trust in the latter. Most focus groups expressed the opinion that **the Bulgarian laws and law enforcement system offer no efficient protection** against violence at the workplace. The legal system does not “recognize” many forms of violence as unacceptable social behavior.

Nonetheless during the quality interview with lawyers and judges in the sphere of labor it was emphasized that although no special legislation exists concerning workplace violence, a number of laws provide opportunities to file a complaint against violence (Annex № 16), but because of the lack of knowledge or the long and sluggish court procedures and considerable financial costs involved, the victims of violence refrain from resorting to them.

In the situation thus outlined there are **two possible ways out** for the victims of violence, including those subjected to continuous psychological harassment: either to leave their job or to reconcile themselves and put up with the situation because they must provide incomes to their family.

In Bulgaria there are **no rehabilitation measures** for the victims of violence; no specialized counseling or medical centers providing psychological support in such cases, except a few non-governmental organizations, which, as already noted, deal mainly with the problems of women victims of domestic violence and some private psychotherapists. Besides that according to some leading psychiatrists it is still not customary in Bulgaria to seek help from a psychiatrist or psychologist and the victims of violence often “do not recognize” the psychological complaints generated by violence and are not aware that they need a suitable therapy and support; so to say, though sick, they are still “up and about”. There is a prejudice that only mentally deranged people seek psychiatric or psychological help or that it is the fashion in the West. However, even those who realize that they are in need of help often cannot afford it due to the lack of money.

6. ANTI-VIOLENCE STRATEGIES

It is reported by the respondents that employers resort to specific policies, which, though not directly addressing violence, still create some conditions for prevention and reduction of violence at the workplace. First among them is health and safety at work – 68.7% and the policies against psychological and physical violence – about 35%. About 1/3

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 health institutions managers agreed that the measures being undertaken are mainly within the framework of the disciplinary procedures and do not specify measures against violence. Violence at the workplace, especially psychological violence, has not been a subject of special discussions in the health sector.

The Safety At Work Act was adopted in 1997 under trade union pressure. Though it does not contain any specific provisions concerning violence, it may still be used as a basis for negotiations between the worker and employer representatives concerning the establishment of a work setting protecting against certain hazards.

Table 9

Employer Policy - %

Policies on	Yes	No	Don't know	No response
Health and safety	68.7	14.6	10.6	6.1
Physical workplace violence	35.2	24.0	27.4	13.4
Verbal abuse	35.2	24.0	27.4	13.4
Sexual harassment	28.8	28.9	29.5	13.6
Bullying/mobbing	28.3	26.8	29.1	15.7
Treat	27.4	28.1	28.5	15.9

Most widespread among the health institutions in Bulgaria **are the measures** for security and improvement of the surroundings of the health institutions reported by 70.8% and 48.8% of the respondents. Special equipment and clothing (31.0%) and restricted public access (27.3%) are the other more popular measures.

More than half of the respondents believes that **most effective in their work setting would be:**

- security measures – 77.5%;
- improved surroundings – 72.4%;
- reduced periods of working alone – 63.3%;
- restricted public access – 58.9% and
- staff training – 56.8%.

Despite the measures reported to exist, the participants in the survey think that **specific strategies are needed at all levels:** individual, at the workplace, in the system of public health and on a national level.

The long-term strategies to reduce the level of violence at the workplace need to provide for solution of the economic and social problems in all their variety and complexity – such problems as unemployment, poverty, crime, low educational level etc. The higher efficiency of the health reform is also believed to be an important factor for reduction of workplace violence. The proposals along these lines aim to improve the legal framework and the interactions with the National Health Insurance Fund, to reduce the paper work and documents to be filled in, to reduce the number of paid health services, simplify the specialists examination procedures and set up supplementary health insurance funds.

Along with the more general measures related to the improvement of the overall economic situation and the of the manner of conducting the reform, **the accent** in the

quantitative and qualitative part of the survey **is laid on the importance of undertaking and introducing such measures at the workplace as:** prevention measures, security measures and control; improved organization and working conditions; staff training to work with risk groups and to detect and cope with violent and aggressive behavior; reporting procedures, medical and psychological counseling and help to the victims of violence, improved relationships and introducing HRM practices; administrative measures for punishment and control.

Table 10

**PROPOSED MEASURES TO PREVENT THE
WORKPLACE VIOLENCE - %**

Measures	Per cent
Improvement of socio-economic situation	18.8
Improvement of health care reform	23.8
Preventive and security measures, control	41.3
Improvement of work organization and working conditions	26.3
Education and rising the level of culture	12.5
Improvement of collective relations, conflict resolution procedures	12.1
Training, development and HRM	22.5
Administrative measures – sanctions, control	15.4
Improvement of the effectiveness of the state bodies-police, etc.	8.3
Reporting procedures, special bodies, consulting	22.1
Others	20.8
Not necessary	4.2
No response	8.3

The data concerning the proposed measures according to professional status and type of health institution are given in Annexes №№ 14, 15.

The participants in the focus groups pointed out that currently there are no effective specific strategies and activities addressing violence at the workplace both in the health institutions and on an institutional and national level in Bulgaria. The trade unions and the professional organizations do not have their own strategies either. **It is however high time to admit the existence of violence at the workplace, the health sector included, and to propose effective short- and long-term strategies, involving all social actors on different levels in their development.**

SECTION C CONCLUSIONS

1. IDENTIFICATION OF CONTRIBUTING FACTORS

As shown by the survey, workplace violence is a fact in the health sector in Bulgaria. No doubt, in order to understand its essence, forms of manifestation and consequences and to undertake adequate measures for its prevention, it is important to define the causes and factors contributing to its existence and reproduction. The workplaces in the health sector have their own specific features making the health personnel more vulnerable and exposed to the risk of violence due to the complicated network of links and relationships and the activities performed in the health institutions, which may motivate and stimulate incidents of violence.

The major factors contributing to the appearance of different forms of physical and psychological violence have already been examined in Section B divided in three groups: Societal, personal and organizational. In summing up these factors with a view to developing prevention strategies and determining tasks at the different levels we will classify these factors as **internal and external**. Their interaction is presented on Diagram № 1. Depending on their content and strength these factors may contribute or prevent incidents of violence at the workplace (See Annexes №№ 17, 18).

A. EXTERNAL FACTORS - determining the characteristics of the setting outside the workplace contributing to workplace violence. They include:

❶ Societal or Contextual Factors:

☛ **The socio-economic situation in the country** as a factor contributing to violence through its characteristics as follows:

- spiritual and economic crisis;
- poverty and unemployment;
- high level of crime and impunity of criminals;
- stress and social tension.

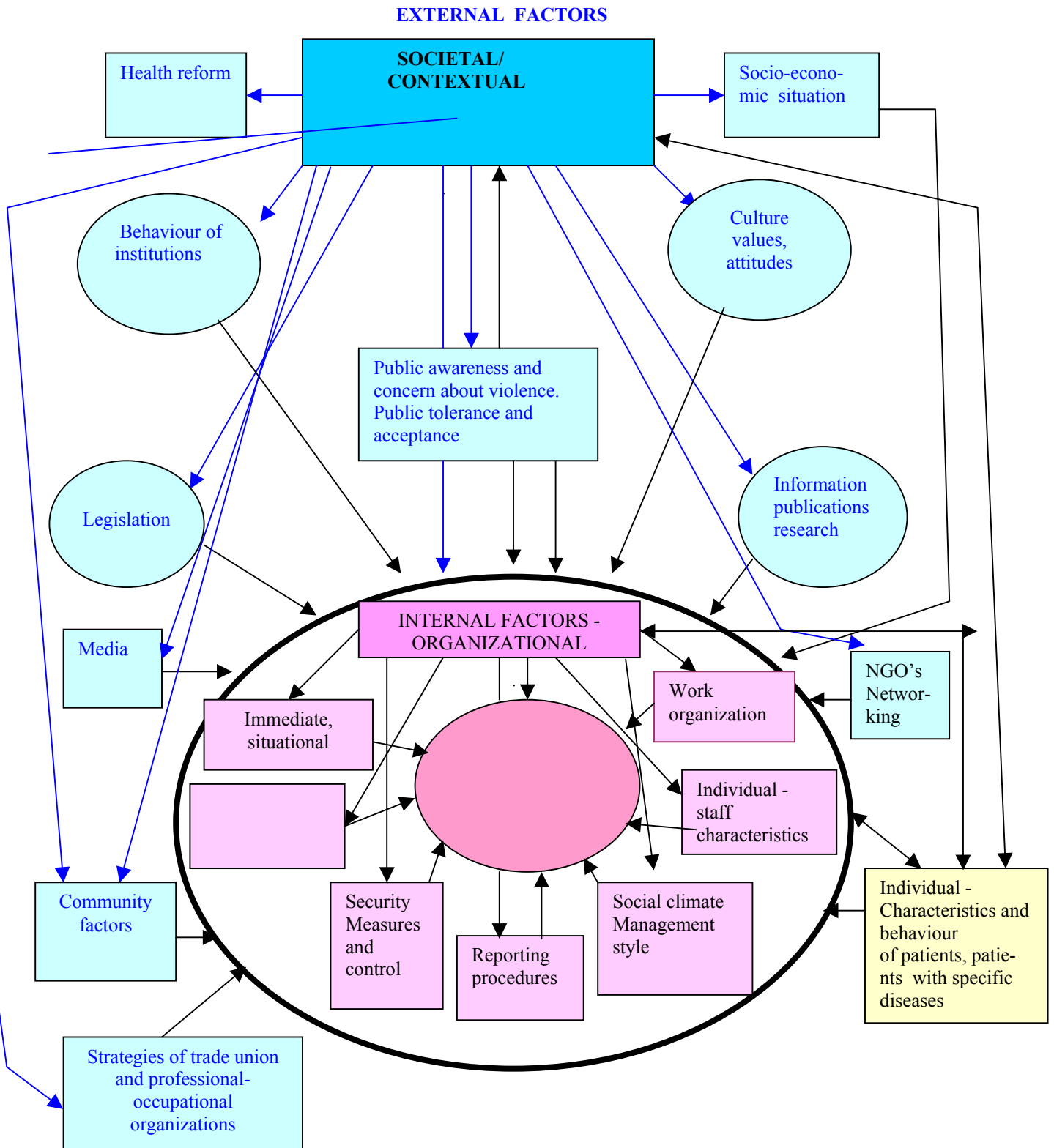
☛ **Health Reform:**

- restructuring; ongoing and impending privatization;
- staff reduction;
- reduced financing and resources;
- lack of information on the reform generating insecurity among patients and health personnel;
- changing legal and regulatory system, complicated relations with NHIF;
- introduction of paid health care services and higher health costs of the households;
- difficult access to health care services, especially to specialized ones;
- exclusion of some groups from health insurance and consequently from the chance to use services paid by the Health Insurance Fund;
- low pay of the health personnel in the public sector;
- low social status of the health workers and lack of respect for them;
- lower quality of patient treatment.

☛ **Lack of concern on the part of the government and passivity of the institutions**

- ✚ **Patriarchal culture and stereotypes** choosing the right of the stronger, macho culture (masculinity); victimization of the victims of violence
- ✚ **Lack of social awareness and concern** about violence; tolerance for the manifestations of violence
- ✚ **Lack of special legislation** concerning violence; insufficient use of the opportunities provided by the current legislation in defense of the victims of violence
- ✚ **Lack of publications in the media** revealing the scope of violence and condemning it; TV films spreading the culture and patterns of violence
- ✚ **Lack of scientific and empirical surveys, publications** and statistics on violence in its different forms
- ✚ **Lack of strategies of the trade union and professional-occupational organizations** in the health care sector for prevention of violence
- ✚ **Lack of networks of NGOs and other support organizations**, exerting pressure for actions to be taken against violence

Diagram 1
INFLUENCING FACTORS IN THE CONTEXT OF WORKPLACE VIOLENCE



☞ **Community Factors**

- high crime level;
- poverty and unemployment;
- alcohol and drug abuse;
- anti-social behavior;
- high level of domestic violence.

② Factors related to the personality and behavior of patients/clients, their relatives and visitors in the health institutions

☛ **Personality traits and unstable behavior**

- low culture and education;
- inclination to manifestations of aggressiveness ;
- hostility;
- transfer of family problems;
- drugs and alcohol dependency;

☛ **Patients with specific health complaints**

- mentally deranged;
- senile;
- terminally ill.

B. INTERNAL FACTORS – organizational – determine the characteristics of the workplace in the health sector and the organization of the activities and relationships which may contribute to incidents of violence

① Personal characteristics and behavior of the health personnel – they are similar to those listed for patients

② Direct/risk factors related to the specific characteristics of the workplace in the health sector

☛ **Daily, including direct physical contact** with patients and their friends and relatives

- ☛ Work with patients with specific health complaints
- ☛ Shift or night work
- ☛ Work alone
- ☛ Home care
- ☛ Feminized sector

③ Work organization

- ☛ Not enough staff available
- ☛ Work intensification
- ☛ Long waiting for medical examinations and procedures
- ☛ Pressure of time
- ☛ Bureaucratic procedures and lot of paper work

④ Socio-psychological – relating to the style of interaction in the health facility

☛ **Management style and qualities**

- incompetence and lack of professionalism;
- no respect of the rights of the health personnel.

☛ **Professional growth barriers**

☛ **Nature of the relations at the workplace**

- culture of fear;
- atmosphere of conflict;
- no cooperation;

- ineffective communication.

⑤ No programs for prevention of violence and reporting procedures

☛ **Underreporting of the incidents of violence**

☛ **No identification of the incidents of violence**

☛ **No support measures** for the victims of violence: counseling, treatment, support

⑥ No training in violent behavior symptom identification, prevention and control of aggressive behavior

⑦ No measures for security and control

☛ **Uncontrolled access** of patients

☛ **No special technical means** of security

☛ **Unfavorable characteristics of the physical environment** – no lighting etc.

2. IDENTIFICATION OF PREVENTION FACTORS

While adhering to the classification of internal and external factors and factors increasing the risk of violence at the workplace as well as factors and relationships shown on Diagram 1, let us briefly outline the factors that could prevent workplace violence and eventually transform it as a “violence-free zone”. (Annex № 18). Developed as actions against violence at the workplace following the “who-what” line, they will be studied in more detail in the Section below.

A. EXTERNAL FACTORS - defining the characteristics of the external work setting and contributing to the reduction and overcoming of workplace violence. They include:

① Societal or Contextual Factors:

☛ **Improvement of the socio-economic situation in the country**, lowering the level of unemployment and improvement of the living standards of the population

☛ **More efficient health care reform:**

- Approving the legal framework in the health care sector;

- Better quality work and better pay of the health personnel and better quality of the health care services being provided;

- Promoting the prestige of the medical profession in society.

☛ **Greater concern on the part of the government and more intensive activity of the institutions**, including the legislative and law enforcement systems

☛ **Changing the cultural and values stereotypes** concerning violence, relations between men and women, hierarchy and equality

☛ **Public awareness and concern** about violence, “zero tolerance” and non-acceptance of violence, especially at the workplace

☛ **Publications and media broadcasts against violence**

☛ **Scientific and empirical surveys and publications**, statistics and reliable information on the scope and types of violence

☛ **Development of strategies of the trade unions and professional organizations** in the health sector and building NGO Violence prevention networks

The biggest opportunities for prevention of workplace violence are to be found in the health institutions themselves. Naturally their management and personnel alone could

not overcome poverty or the low cultural and educational level of some patients and some other problems generating violence in society and at the workplace. However, they could improve the conditions and attack the very roots of the phenomena that may provoke violence. Therefore they should pay attention to the internal factors.

B. INTERNAL FACTORS – they define the characteristics of the workplace, the organization of work and the relationships in the health sector which if subjected to a positive change may contribute to the reduction or overcoming of workplace violence.

❶ **Development of a violence prevention strategy and program**, including a clear mechanism of reporting, investigating and taking action in support and assistance to victims of workplace violence.

❷ **Improvement of work organization**

❸ **Improvement of the socio-psychological climate** in the health institutions and at the workplace – development of an atmosphere of cooperation and support.

❹ **Training management and personnel** how to identify the symptoms of violent behavior; prevention and control of aggressive behavior

❺ **Take security, protection and control measures**

❻ **Personal characteristics and behavior of the health personnel** – application of HRM methods, personnel selection, training and retraining, promotion of professionalism

❼ **Direct/risk factors** related to the specific characteristics of the workplace in the health sector: some of them are not amenable to change but have to be considered and neutralized as much as possible by influencing other factors. The harmful effects of shift and night work and work alone can be overcome through rotation, hiring more people to work at critical workplaces and in providing home care and during transportation of sick people.

SECTION D

RECOMMENDATIONS

1. FURTHER ACTION ON NATIONAL AND ORGANIZATIONAL LEVEL

We have to admit with regret that while many countries are able to offer good practices that are already effective and direct efforts towards their improvement, the first steps are yet to be made in Bulgaria.

All indifference to and acceptance of violence will have to be overcome. Of course it cannot be expected that a program will make it vanish, no matter how good and widely supported it is. The democratic countries in Europe and the world are an example of that. However it is important to begin to talk about violence, to admit its existence at the workplace and to attack the limits of tolerance; to encourage the formation of a culture and morality of non-tolerance of violence, no matter where and how it is manifested. Our society should not continue to accept violence as part of the rules of the game and justify that acceptance with the problems of transition.

Violence in general and workplace violence in particular is a complex problem whose impact and influence are felt in many areas and therefore it should be opposed on many levels through the joint efforts of all parties concerned (Diagram 2)

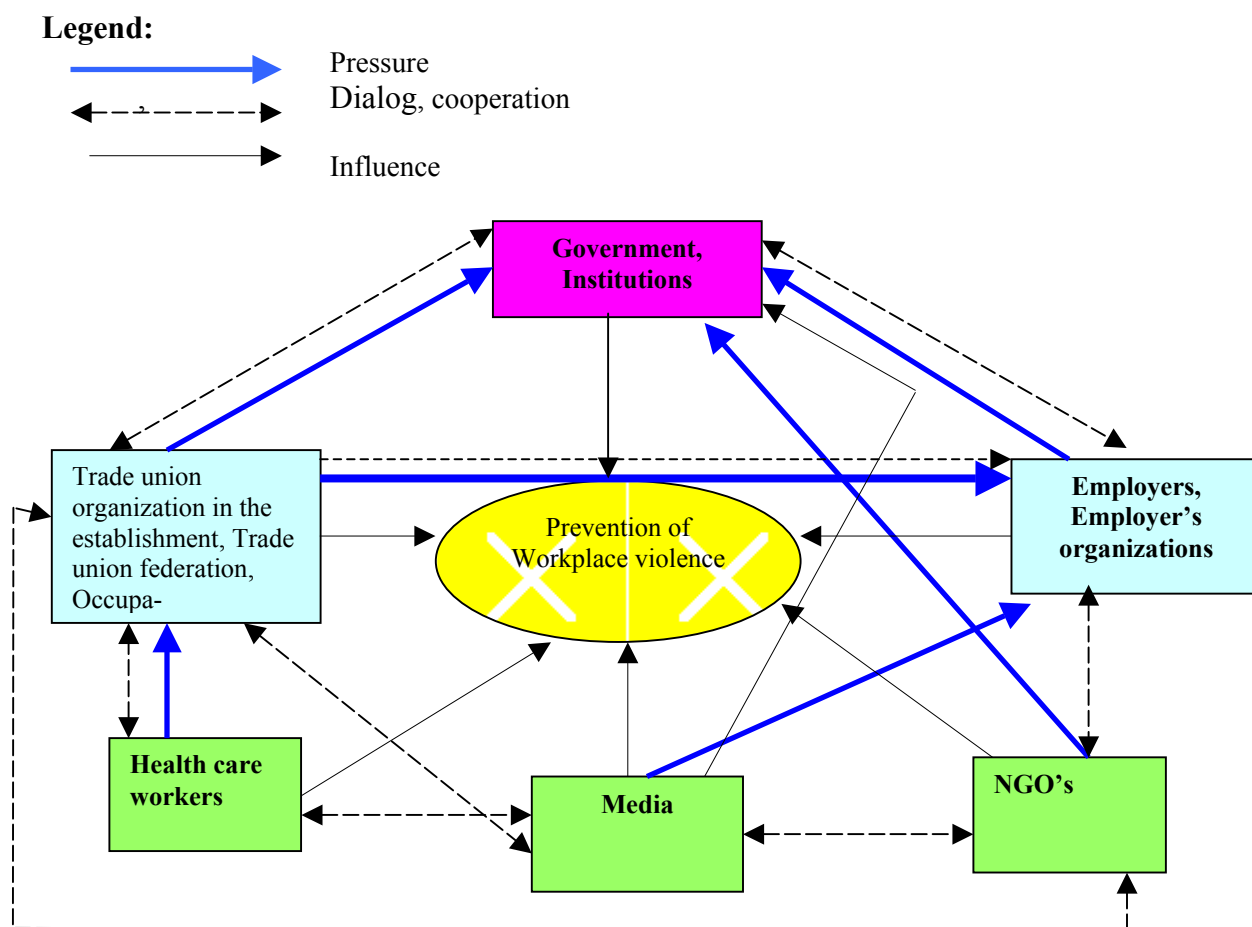
Keeping in mind the national context and the foreign experience studied by us, we could outline the initial landmarks of the strategy for future action. We expect the

aggregated results from this project to be particularly valuable in a long-term strategic perspective.

The violence elimination strategy should include measures on all levels: national, sectoral, at the work place and on an individual level.

Diagram 2

**BRINGING THE EFFORTS OF ALL STAKEHOLDERS TOGETHER IN THE DRIVE TO
ELIMINATE VIOLENCE AT THE WORKPLACE**



1.1. National level – Higher public awareness of this phenomenon and more active role of the institutions directly concerned with violence

The social and cultural context in the country points to a period of transition from lack of interest and use of mechanisms of pushing under the carpet, ignoring or denying the problem of violence to initial debates on this issue and first attempts to re-assess the situation in the country. An example for that is the issue of domestic violence which is now increasingly in the focus of public attention under the pressure on the part of a number of NGOs.

- **It is necessary to draw the attention of the public through active involvement of the trade unions and the professional-occupational organizations and promotion of understanding and recognition of the existence of the problem** “violence at the

workplace” and public awareness of that problem as a phenomenon that can no longer be underestimated and tolerated as “part of the work”. The violence at the workplace in the health sector deserves every attention due to its high price for the separate individuals, the health care sector and society as a whole. The awareness of the problem should be translated into specific strategies and actions to attack the causes giving rise to violence and allowing it to reproduce itself. That may prove to be a good foundation for the development of non-violence in society.

- **Also necessary are surveys and information** in order to gain a clear idea of the phenomenon, its spreading, its causes and consequences and the possible measures to counteract it at the respective stage. It is important to define the acts representing violence, but the definition should not be so broad as to cover all violations of rights at the workplace. Figuratively speaking, “to begin treatment, we have to know the disease”.

- Pressure on the part of the trade unions and all interested parties to define the problem of workplace violence as **a priority of the National Program of Mental Health**.

- **Legislative changes** – to amend and complement the current laws, i.e. the Labor Code, Safety at Work Act, the Penal and the Penal Procedures Code etc. and in a longer-term perspective – to develop specific legislation on violence at the workplace. To incriminate workplace violence in all its forms, to define it as crime and tie it up with specific sanctions.

- **Information and media campaigns** to increase the awareness of the problem and attack the roots of violence, break the silence and turn it into a social problem that cannot be accepted and tolerated in a democratic society.

- **To enhance the efficiency of the health care reform** and create conditions for high quality of the health care services.

- **To intensify the work of the institutions** concerned with violence – the court, the police and the prosecutors office and provide conditions for higher trust in them.

- **To unite the efforts of** the social partners on a national level and NGOs with those of the Ministry of Health, the Ministry of Labor and Social Policy, the Ministry of Education and Science, the Chief Labor Inspectorate etc. to counteract the incidents of violence at the health institutions, schools etc.

1.2. On the Level of the Health Sector

- **Awareness of the existence of the problem in the professional community.**

- **Development of a program** focused on actions against violence at the workplace with the participation of the trade unions, the employer structures, 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. This program may include:

- ☛ **training** of the health personnel in the problems of violence and the mechanisms to prevent and cope with violence;

- ☛ **surveys;**

- ☛ **designing materials, leaflets and picture folders** mobilizing for zero tolerance to violence at the workplace;

- ☛ **data collection procedures** for incidents of violence in the health sector;

- ☛ **mobilizing campaigns** to realize violence and the importance of opposing it at every workplace;

☛ **a follow-up actions procedure** in cases of violence: legal advice and defense, including in court, measures for treatment and support, including free time with a psychotherapist;

☛ **“a hot line”** set up to report incidents of violence at individual health institutions and facilities to the head offices of the trade union federations and professional organizations and creation of a data base as a basis to undertake actions.

- **Incorporation in the Articles of Association and programs** of the trade union and professional organizations of provisions to protect rights in the context of workplace violence. The Codes of Ethics for physicians and dentists should include clauses concerning the inadmissibility of any incidence of violence at the workplace.

- **Incorporation in the Health Sector Collective Agreement** of provisions aimed at elimination of violence at the workplace.

- **Incorporation in the Accreditation Procedures** for health institutions and facilities of a requirement of measures providing safety at work and aimed at prevention of violence at the workplace.

- Insistence on the part of the trade union federations to **include the problem of workplace violence in the Health Management Training Program** in Universities.

- **Involving and networking with NGOs.**

1.3.Workplace: Specific Measures and Programs to Combat Potential and Actual Violence at the Workplace

According to the labor law in Bulgaria workers are entitled to safety at work and employers are obliged to provide such conditions. At this stage the problems of violence at the workplace may be part of The **Program for Health and Safety at Work** and specific programs to combat violence at the workplace could be developed at a later stage.

- **Within the framework of the program the attention should be focused on::**

- ☛ A ban on violence at the workplace;

- ☛ Evaluation of the workplaces in terms of the risk of violence;

- ☛ Provision of security measures and technical means and higher administrative control;

- ☛ Staff training to cope with situations of violence, including how to identify potentially violent behavior and how to control it;

- ☛ Introduction of special procedures to report and encourage the personnel to report;

- ☛ Motivation of the personnel for active involvement in the implementation of the measures and the Program;

- **Involvement of the committees on working conditions** set up under the 1997 Act concerning actions to be undertaken concerning workplace violence.

- **Documentation and data collection** on workplace level on each incident of violence and its summarizing by the trade union and/or professional organizations obliged to protect the rights of their members and using this information to update actions and strategies.

- **Programs aimed at the victims of violence:** counseling, therapy, rehabilitation, support and other services.

- **Measures to improve the organization of work.**

- **Improvement of the climate** at the workplace in the health sector; overcoming fear and insecurity leading to stress that can potentially turn into violence. Introduction of clear rules and mechanisms of conflict resolution. Application of human resources management practices. Introduction of a conflict resolution procedure. Provision of opportunities for skill level enhancement and professional growth. Realistic evaluation of input and a corresponding pay level.
- **Incorporation of the problems of violence in the Interior regulations and the Collective Agreement** – thus ensuring the involvement of the health personnel and its representatives
- **Monitoring** of the measures introduced to combat violence
- **Higher level of information** of the health personnel concerning the measures taken.

SUMMARY

Violence is all-pervasive; it is present in the life of all nations, all social strata, occupations, age and ethnic groups. Its psychological foundation is to be found in people's dependence based on force and the hierarchy of power. Violence may be an element of human behavior and human relations at all levels and in all situations, manifested in different forms and resulting in the victims physical and mental injury and suffering.

All researchers of violence recognise that the violence is embedded in the cultural, social, economic and political conditions in society and in people's socio- psychological stereotypes and attitudes. Until recently the subject of violence at the workplace, including sexual harassment as one of its extreme forms was a "taboo" in the country. That type of phenomena were considered alien to the socialist realities and hence – non-existent. Today we find that they had been and continue to be part of our life. Yet even now in the conditions of democracy violence in the Bulgarian society is perceived with tolerance and is still shrouded in silence. The victim is blamed that she/he is responsible for what happened and subjected to victimisation. On the whole the violence is not on the society agenda. There is no transparency and public concern and no measures for violence prevention and adequate protection of the victims of violence. In Bulgaria at present there is no accurate and reliable **statistics** and research available neither on violence as such nor on workplace violence in its different forms. **The Bulgarian laws and law enforcement system offer no efficient protection** against violence at the workplace.* The legal system does not "recognize" many forms of violence as unacceptable social behavior.

The measuring of the spreading and scales of violence in the health sector as well as in all other sectors of employment is rendered especially difficult owing to the fact that for various reasons, the cases of violence at the workplace are very rarely reported to the management or to any other authorities. The public and particularly the staff employed in the health sector are still unaware of the problem of workplace violence. Its significance is largely underestimated and it is interpreted in the context of the hardships facing people in their daily life, the stress due to the negative consequences of the long painful reform and the violence and crime as part of the transition. Public health as a system with many actors (patients, physicians, nurses, auxiliary and support staff, hierarchical supervisors,

* See overview of Bulgarian legislation in Annex 16

institutions related to the functioning of the system, professional associations, trade unions) which form a complex multi-layer matrix of links and connections conceals potential possibilities for the rise of conflicts and violence. They may arise as a result of the direct contact between the individual actors or indirectly, for example in connection with the inadequate responses on the part of some institutions, lack of information concerning one's rights and obligations etc. In all cases however there is a specific subject and victim of violence. In particular, our survey is focused on the victim of violence with the aim of identifying the quantitative parameters (magnitude and scope) and eventually performing an in-depth quality analysis of the links, causes, consequences and effects.

The data from the survey show that physical violence is not typical for the health sector in Bulgaria. It generally occurs along the line of conflict between patient and doctor/nurse. Victims of physical violence in the health sector are both women and men. The higher relative share of women victims of physical violence is predetermined by the specific characteristics of the sample related to the feminization of health care. Physical violence is most widespread among nurses, physicians and support staff. Yet the midwife and medical transport professions can also be regarded as high-risk professions. Particularly risky in that regard are the dispensaries for mental disorders, the hospital emergency wards and intensive units.

The most widespread form of workplace violence is the verbal abuse. Second in scale is bullying/mobbing. The data show that psychological violence is much more frequent along the conflict line "subordinate-supervisor" than is the case with physical violence. Verbal abuse and bullying among peers and along the hierarchy has been growing. Negligible part of the respondents shares that they had been subjected to sexual harassment. The assessment of the actual scales of the phenomenon of workplace violence is rendered even more difficult by the fact that as already mentioned no statistics and no system of reporting cases are available. The main conclusion is that the incidences of violence at the workplace in the health sector are underreported and the phenomenon is largely undocumented.

Although all professional groups are affected by certain forms of violence, the **nurses are at highest risk** as they are in direct continuous contact with the patients and sometimes appear as a buffer between physician and patient. That situation is further complicated by their status in the hierarchy and official subordination to the physicians.

The survey results show that the factors generating violence are rooted in a broad social, economic, organizational and cultural context. At the same time some specific characteristics of the health care system are shown to heighten the risk for workplace violence: feminized sector, shift work, working alone during examinations and procedures, daily contact with patients suffering from different health complaints and with their relatives, work at night, pressures caused by the lack of time. Along with that the multi-faceted and complex nature of the factors and their interaction contributing to the cases of violence at the workplace was revealed in the questionnaires received and during the discussions in the focus groups.

Aggression and violence at the workplace are indisputably a problem not only for the victims of violence but for society as a whole because the negative effects are manifested in different areas and their operation is both direct, indirect and continuous. That is an unexplored area in Bulgaria. The absence of any well-outlined dynamics and registration of this phenomenon accounts for the inability to make a comprehensive realistic assessment of the complex impact of violence in the health sector. However the price paid

for violence exceeds by far any financial losses for the victim of the health institution. The psychological effects from violence have a lasting and multi-faceted effect. They affect the emotional state, work and family life of the victims of violence. In summing up we could say that regardless of who is the perpetrator of violence – patient, supervisor, colleague or a chance person, its effect directly or indirectly concerns everybody linked in the system described by us as multi-layer system with many directions and areas of impact.

The survey showed that currently there are no effective specific strategies and activities addressing violence at the workplace both in the health institutions and on an institutional and national level in Bulgaria. The trade unions and the professional organizations do not have their own strategies either. It is however high time to admit the existence of violence at the workplace, the health sector included, and to propose effective short- and long-term strategies, involving all social actors on different levels.

All indifference to and acceptance of violence will have to be overcome. Of course it cannot be expected that a program will make it vanish, no matter how good and widely supported it is. The democratic countries in Europe and the world are an example of that. However it is important to begin to talk about violence, to admit its existence at the workplace and to attack the limits of tolerance; to encourage the formation of a culture and morality of non-tolerance of violence, no matter where and how it is manifested. Our society should not continue to accept violence as part of the rules of the game and justify that acceptance with the problems of transition.

It is necessary to draw the attention of the public through active involvement of the trade unions and the professional-occupational organizations and promotion of understanding and recognition of the existence of the problem “violence at the workplace” and public awareness of that problem as a phenomenon that can no longer be underestimated and tolerated as “part of the work”. The violence at the workplace in the health sector deserves every attention due to its high price for the separate individuals, the health care sector and society as a whole. The awareness of the problem should be translated into specific strategies and actions to attack the causes giving rise to violence and allowing it to reproduce itself. That may prove to be a good foundation for the development of non-violence in society.

ANNEXES

ANNEX 1

REGISTERED CRIMINAL OFFENCES

Kind of offences	1996			1997			1998			1999			Discovery rate - %
	Registered offences – number	Discovered offences – number	Discovery rate - %	Registered offences - number	Discovered offences - number	Discovery rate - %	Registered offences - number	Discovered offences - number	Discovery rate - %	Registered offences - number	Discovered offences - number	Discovery rate - %	
Total	184975	83097	44,9	228218	104163	45,6	149532	85087	56,9	136838	82486	60,3	
Of which:													
Intentional homicide	742	614	82,7	715	560	78,3	945	667	70,6	599	528	88,1	
Assault and battery	1172	994	84,8	1335	1151	86,2	190	160	84,2	364	338	92,3	
Debauchery	358	337	94,1	389	351	90,2	427	404	94,6	412	389	94,4	
Rape	767	695	90,6	774	707	91,3	770	722	94,3	755	698	92,5	
Not paying of alimony	2387	2279	95,5	1300	1230	94,6	1570	1498	95,4	2495	2451	98,2	
Robbery	5880	2853	48,5	6706	3415	50,9	4494	2968	66,0	4309	2795	64,9	
Theft	136691	51052	37,4	177116	68597	38,7	98046	45534	46,4	83680	40670	48,6	
Fraud	3581	2760	77,1	4230	3281	77,6	4119	3428	83,2	5485	4792	87,4	
Extortion	690	581	84,2	602	505	83,9	506	459	90,7	424	390	92,0	
Arson	1108	278	25,1	1177	275	23,4	1339	445	33,2	1234	390	31,6	
Hooliganism	1215	1111	91,4	1553	1430	92,1	2092	2005	95,8	2216	2147	96,9	
Illegal production, possessing and use of weapon	1370	1294	94,5	1168	1114	95,4	1285	1265	98,4	1088	1062	97,6	
Theft of motor vehicles	9629	1698	17,6	7556	1092	14,5	8006	1705	21,3	7283	1244	17,1	

Source: Ministry of Interior

HEALT CARE ESTABLISHMENTS UN SOFIA - CITY

Type of health care establishments	Number	Personnel
1. Public health care establishments, incl.:	18	2148
1.1. University hospitals, incl.:		
1.1.1. Multi –profile	3	
1.1.2.Specialized	10	
1.2. National specialized	5	
2.Municipal health care establishments, incl.:	84	4761
2.1. Municipal hospitals, incl.:	11	
2.1.1. Multi - profile	4	
2.1.2. Specialized	7	
2.2. Specialized dispensaries	5	
2.3. Diagnostic–consultative centers	27	
2.4. Medical centers	5	
2.5. Dentists centers	21	
2.6. Medical-dentists centers	1	
2.7.Medical-technical laboratories	14	
3. Private hospitals and clinics	11	737
4. Social health care establishments, incl.:	14	322
4.1. Nursing homes	3	
4.2. Orphan homes	1	
4.3. Social house patronage	10	
5. Private practices, incl.:	-	935
5.1. Individual		312
5.2. Group		623
Total population for the sample composition:		8903

ANNEX 3

SAMPLE – NUMBER OF SURVEYED BY TYPES OF HEALTH CARE SETTINGS

Type of health care setting	Number of clusters	Number and share of surveyed	
		Number	Structure- %
Public health care establishments	8	157	30,9
Municipal health care establishments	7	179	35,2
Diagnostic-consultative centers	4	54	10,6
Medical centers	2	37	7,3
Dentists centers	1	12	2,4
Medical-technical laboratories	1	8	1,6
Private hospitals and clinics	2	22	4,3
Private pharmacy	1	10	2,0
Social health care establishments	1	15	3,0
Private individual practices (GPs)		14	2,7
TOTAL:	27	508	100,0

ANNEX 4

Total Table 7: Victim professional and ethnic profile for types of violence

	Physician		Nurse		Midwife		Pharmacist		Ambulance		Auxiliary	
	Ethnic maj	Ethnic min	Ethnic maj	Ethnic min	Ethnic maj	Ethnic min	Ethnic maj	Ethnic min	Ethnic maj	Ethnic min	Ethnic maj	Ethnic min
	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)
All types of violence	112 100,0	2 100,0	118 100,0	3 100,0	18 100,0	-	3 100,0	-	7 100,0	-	29 100,0	13 100,0
Physical violence (total)	7 6,2	-	9 7,6	-	2 11,1	-	-	-	3 42,9	-	4 13,8	3 23,1
Phys viol with weapon	-	-	-	-	-	-	-	-	-	-	1 25,0	-
Phys viol w/o weapon	7 100,0	-	9 100,0	-	2 100,0	-	-	-	3 100,0	-	3 75,0	3 100,0
Verbal abuse (total)	56 50,0	1 50,0	61 51,7	2 66,7	8 44,4	-	2 66,7	-	1 14,3	-	9 31,0	3 23,1
all the time	10 17,9	-	9 14,8	1 50,0	1 12,5	-	2 100,0	-	-	-	-	1 33,3
Sometimes	35 62,5	1 100,0	46 75,4	1 50,0	4 50,0	-	-	-	-	-	9 100,0	2 66,7
Once	11 19,6	-	6 9,8	-	3 37,5	-	-	-	1 100,0	-	-	-
Bullying (total)	45 40,2	1 50,0	45 38,1	1 33,3	8 44,4	-	1 3,33	-	3 42,9	-	15 51,7	-
all the time	5 11,1	-	4 8,9	-	-	-	-	-	1 33,3	-	1 6,7	-
Sometimes	30 66,7	1 100,0	37 82,2	1 100,0	4 50,0	-	1 100,0	-	2 66,7	-	12 80,0	-
Once	10 22,2	-	4 8,9	-	4 50,0	-	-	-	-	-	2 13,3	-
Sexual harassment (total)	3 2,7	-	3 2,5	-	-	-	-	-	-	-	1 3,4	-
all the time	-	-	-	-	-	-	-	-	-	-	-	-
Sometimes	2 66,7	-	-	-	-	-	-	-	-	-	1 100,0	-
Once	1 33,3	-	3 100,0	-	-	-	-	-	-	-	-	-
Racial harassment (total)	1 0,9	-	-	-	-	-	-	-	-	-	-	-
all the time	-	-	-	-	-	-	-	-	-	-	-	-
Sometimes	-	-	-	-	-	-	-	-	-	-	-	-
Once	1 100,0	-	-	-	-	-	-	-	-	-	-	-

(Continued and end)

Administration		Allied professions		Technical staff		Support staff		Other	
Ethnic maj	Ethnic min	Ethnic maj	Ethnic min	Ethnic maj	Ethnic min	Ethnic maj	Ethnic min	Ethnic maj	Ethnic min
N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)
29 100,0	-	18 100,0	-	3 100,0	1 100,0	26 100,0	-	9 100,0	-
1 3,4	-	1 5,6	-	-	-	1 3,8	-	-	-
-	-	-	-	-	-	-	-	-	-
1 100,0	-	1 100,0	-	-	-	1 100,0	-	-	-
18 62,1	-	10 55,5	-	2 66,7	-	12 46,2	-	4 44,4	-
3 16,7	-	1 10,0	-	-	-	1 8,3	-	-	-
14 77,8	-	6 60,0	-	2 100,0	-	10 83,3	-	2 50,0	-
1 5,6	-	3 30,0	-	-	-	1 8,3	-	2 50,0	-
9 31,0	-	6 33,3	-	1 33,3	1 100,0	12 46,2	-	4 44,4	-
3 33,3	-	-	-	-	-	-	-	-	-
6 66,7	-	4 66,7	-	1 100,0	1 100,0	12 100,0	-	3 75,0	-
-	-	2 33,3	-	-	-	-	-	1 25,0	-
1 3,4	-	1 5,6	-	-	-	1 3,8	-	1 11,1	-
1 100,0	-	-	-	-	-	-	-	-	-
-	-	-	-	-	-	-	-	-	-
-	-	1 100,0	-	-	-	1 100,0	-	1 100,0	-
-	-	-	-	-	-	-	-	-	-
-	-	-	-	-	-	-	-	-	-
-	-	-	-	-	-	-	-	-	-
-	-	-	-	-	-	-	-	-	-

ANNEX 5

Total Table 4: Demographic characteristics of victims by types of violence
(for ethnic group, calculate the percentages within each category (minority and majority)
and between each category (total majority and total minority)

	n																	
	Age																	
	19 or under	20-24		25-29		30-34		35-39		40-44		45-49		50-54		55-59		60+
	N (%)	N (%)		N (%)		N (%)		N (%)		N (%)		N (%)		N (%)		N (%)		
All types of violence (total)	-	13	3,3	38	9,7	55	14,1	53	13,6	78	19,9	70	7,9	66	16,9	17	4,3	1 0,3
Physical violence (total)	-	1	100,0	1	100,0	8	100,0	3	100,0	7	100,0	3	100,0	6	100,0	2	100,0	-
Phys viol with weapon	-	-		-		-		-		-						1	50,0	-
Phys viol w/o weapon	-	1	100,0	1	100,0	8	100,0	3	100,0	7	100,0	3	100,0	6	100,0	1	50,0	-
Verbal abuse (total)	-	5	100,0	17	100,0	24	100,0	24	100,0	41	100,0	35	100,0	35	100,0	7	100,0	1 100,0
all the time	-	-		1	5,9	4	16,7	6	25,0	6	14,6	5	14,3	7	20,0	7	100,0	-
sometimes	-	5	100,0	14	82,4	18	75,0	14	58,3	29	70,7	22	62,9	23	65,7	-		-
once	-	-		2	11,8	2	8,3	4	16,7	6	14,6	8	22,9	5	14,3	-		1 100,0
Bullying (total)	-	5	100,0	16	100,0	22	100,0	25	100,0	26	100,0	32	100,0	23	100,0	7	100,0	-
all the time	-	-		-		2	9,1	4	16,0	3	100,0	3	9,4	4	17,4	-		-
sometimes	-	4	80,0	15	93,8	16	72,7	17	68,0	19	73,1	25	78,1	16	69,6	4	57,1	-
once	-	1	20,0	1	6,3	4	18,2	4	16,0	4	15,4	4	12,5	3	13,0	3	42,9	-
Sexual harassment (total)	-	1	100,0	4	100,0	1	100,0	1	100,0	3	100,0	-		1	100,0	-		-
all the time	-	-		1	25,0	-		-		-		-		-		-		-
sometimes	-	1	100,0	-		-		-		1	33,3	-		1	100,0	-		-
once	-	-		3	75,0	1	100,0	1	100,0	2	66,7	-		-		-		-
Racial harassment (total)	-	1	100,0	-		-		-		1	100,0	-		1	100,0	1	100,0	-
all the time	-	-		-		-		-		-		-		-		1	100,0	-
sometimes	-	1	100,0	-		-		-		1	100,0	-		-		-		-
once	-	-		-		-		-		-		-		1	100,0	-		-

Continued and end)

Marital status					Majority group				Minority group				Sex	
Single	Married	Living with partner	separt/div	Widow	Total	in country	in community	in workpl	Total	in country	in community	in workplace	Males	F
N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	
49 17,8	136 49,5	11 4,0	34 12,4	17 6,2		372	365	366		19	19	19	69 17,6	32
2 100,0	25 100,0	2 100,0	2 100,0	-		28 100,0	26 100,0	26 100,0		3 100,0	3 100,0	3 100,0	9 100,0	22
-	24 96,0	-	-	-		27 96,5	25 96,2	25 96,2		-	-	-	8 88,9	
2 100,0	1 4,0	2 100,0	2 100,0	-		1 3,5	1 3,8	1 3,8		3 100,0	3 100,0	3 100,0	1 11,1	22
24 100,0	136 100,0	5 100,0	13 100,0	8 100,0		183 100,0	181 100,0	181 100,0		6 100,0	6 100,0	6 100,0	28 100,0	16
2 8,3	23 16,9	-	2 15,4	1 12,5		27 14,8	26 14,4	26 14,4		2 33,3	2 33,3	2 33,3	7 25,0	22
20 83,3	94 69,1	5 100,0	8 61,5	3 37,5		128 69,9	127 70,2	127 70,2		4 66,7	4 66,7	4 66,7	16 57,1	11
2 8,3	19 14,0	-	3 23,1	4 50,0		28 15,3	28 15,5	28 15,5		-	-	-	5 17,9	23
22 100,0	103 100,0	4 100,0	16 100,0	9 100,0		149 100,0	146 100,0	147 100,0		7 100,0	7 100,0	7 100,0	31 100,0	12
1 4,5	12 11,7	-	1 6,3	1 11,1		14 9,4	14 9,6	14 9,5		2 28,6	2 28,6	2 28,6	4 12,9	12
17 77,3	77 74,8	3 75,0	12 75,0	6 66,7		112 75,2	109 74,7	110 74,8		4 57,1	4 57,1	4 57,1	22 71,0	94
4 18,2	14 13,6	1 25,0	3 18,8	2 22,2		23 15,4	23 15,8	23 15,6		1 14,3	1 14,3	1 14,3	5 16,1	19
1 100,0	8 100,0	-	2 100,0	-		11 100,0	11 100,0	11 100,0		-	-	-	1 100,0	10
-	1 12,5	-	-	-		1 9,1	1 9,1	1 9,1		-	-	-	1 100,0	
1 100,0	1 12,5	-	1 50,0	-		3 27,3	3 27,3	3 27,3		-	-	-	-	3
-	6 75,0	-	1 50,0	-		7 63,6	7 63,6	7 63,6		-	-	-	-	7
-	3 100,0	-	1 100,0	-		1 100,0	1 100,0	1 100,0		3 100,0	3 100,0	3 100,0	-	4
-	1 33,3	-	-	-		-	-	-		1 33,3	1 33,3	1 33,3	-	1
-	2 66,7	-	1 100,0	-		-	-	-		2 66,7	2 66,7	2 66,7	-	2
-	-	-	-	-		1 100,0	1 100,0	1 100,0		-	-	-	-	1

AHEKC 6

FACTORS CONTRIBUTING TO PHYSICAL VIOLENCE IN WORKPLACE BY PROFESSIONAL STATUS

	Number / %											
Factors	Physician	Nurse	Mid-wafe	Phar-macist	Ambu-lance	Auxilia-ry/ancil-lary.	Admini-strative	Allied to medicine.	Technic-al staff	Support staff	Other	Total
Social and economic situation in the country	17 23,3	11 18,6	0 0,	1 20,0	1 50,0	0 0,	4 36,4	1 7,1	1 20,0	2 28,6	3 20,0	41 18,8
Health care reform	11 15,1	11 18,6	1 16,7	1 20,0	2 100,0	3 14,3	1 9,1	1 7,1	1 20,0	1 14,3	2 13,3	35 16,1
Stress and social tension	10 13,7	7 11,9	0 0,	0 0,	0 0,	2 9,5	0 0,	3 21,4	1 20,0	3 42,9	0 0	26 11,9
Personality and behaviour of patients	27 37,0	24 40,7	2 33,2	2 40,0	1 50,0	6 28,6	7 63,6	5 35,7	0 0,	0 0,	6 40,0	80 36,7
Specific groups patients	8 11,0	16 27,1	0 0,	0 0,	1 50,0	8 38,1	1 9,1	4 28,6	1 20,0	3 42,9	3 20,0	45 20,6
Management style	5 6,8	3 5,1	0 0,	0 0,	0 0,	3 14,3	4 36,4	0 0,	0 0,	1 14,3	1 6,7	17 7,8
Relations in the workplace	6 8,2	3 5,1	0 0,	0 0,	0 0,	2 9,5	0 0,	1 7,1	1 20,0	0 0,	2 13,3	15 6,9
Work organization and working conditions	13 17,8	7 11,9	0 0,	1 20,0	1 50,0	3 14,3	3 27,3	1 7,1	0 0,	1 14,3	2 13,3	32 14,7
Lack of security measures and control	13 17,8	9 15,3	0 0,	1 20,0	0 0,	3 14,3	4 36,4	0 0,	0 0,	0 0,	0 0,	30 13,8
Lack of special bodies and procedures	7 9,6	5 8,5	0 0,	1 20,0	0 0,	0 0,	0 0,	1 7,1	0 0,	1 14,3	1 6,7	16 7,3
Other	19 26,0	12 20,3	1 16,7	1 20,0	0 0,	3 14,3	4 36,4	2 14,3	2 40,0	3 42,9	3 20,0	50 22,9
No violence in workplace	14 19,2	6 10,2	3 50,0	1 20,0	0 0,	4 19,0	0 0,	3 21,4	2 40,0	1 14,3	4 26,7	38 17,4

ANNEX 7

FACTORS CONTRIBUTING TO PSYCHICAL VIOLENCE IN WORKPLACE BY PROFESSIONAL STATUS - number / %

Factors	Physician	Nurse	mid-wife	Pharmacist	Ambulance.	Auxiliary/ancillary.	Administrative	Allied to medicine	Technical staff	Support staff	other	Total
Social and economic situation in the country	25 29,1	18 26,5	4 33,3	2 25,0	2 100,0	2 11,8	1 6,3	5 26,3	2 50,0	2 25,0	3 25,0	66 26,2
Health care reform	22 25,6	20 29,4	3 25,0	1 12,5	0 0,	1 5,9	2 12,5	4 21,1	1 25,0	4 50,0	0 0,	58 23,0
Stress and social tension	16 18,6	8 11,8	6 50,0	0 0,	0 0,	3 17,6	6 37,5	3 15,8	2 50,0	2 25,0	2 16,7	49 19,4
Personality and behaviour of patients	25 29,1	30 44,1	4 33,3	1 12,5	1 50,0	4 23,5	3 18,8	7 36,8	0 0,	1 12,5	5 41,7	80 31,7
Specific groups patients	6 7,0	8 11,8	0 0,	0 0,	0 0,	7 41,2	0 0,	0 0,	0 0,	1 12,5	1 8,3	23 9,1
Management style	15 17,4	13 19,1	4 33,3	3 37,5	1 50,0	4 23,5	7 43,8	6 31,6	3 75,0	2 25,0	1 8,3	59 23,4
Relations in workplace	9 10,5	9 13,2	1 8,3	1 12,5	0 0,	3 17,6	4 25,0	7 36,8	2 50,0	1 12,5	4 33,3	41 16,3
Work organization and working conditions	14 16,3	12 17,6	2 16,7	1 12,5	0 0,	1 5,9	3 18,8	4 21,1	0 0,	3 37,5	1 8,3	41 16,3
Lack of security measures and control	8 9,3	7 10,3	0 0,	1 12,5	0 0,	2 11,8	0 0,	1 5,3	0 0,0	0 0,	0 0,	19 7,5
Lack of special bodies and procedures	6 7,0	5 7,4	1 8,3	1 12,5	0 0,	3 17,6	2 12,5	0 0,	0 0,	1 12,5	0 0,	19 7,5
Other	21 24,4	19 27,9	5 41,7	1 12,5	0 0,	2 11,8	8 50,0	7 36,8	1 25,0	1 12,5	2 16,7	67 26,6
No violence in	12 14,0	4 5,9	0 0,	0 0,	0 0,	1 5,9	0 0,	1 5,3	0 0,	1 12,5	3 25,0	22 8,7

ANNEX 8**FACTORS CONTRIBUTING TO PHYSICAL VIOLENCE IN WORKPLACE****BY TYPE OF HEALTH CARE SETTING – number/%**

Factors	Hospital	Medical center	Nursing house	Dispensaries	GP	Total
Social and economic situation in the country	16 15,1	11 20,4	2 16,7	12 30,8	0 0,	41 18,8
Health care reform	8 7,5	9 16,7	2 16,7	12 30,8	4 57,1	35 16,1
Stress and social tension	13 12,3	4 7,4	2 16,7	6 15,4	1 14,3	26 11,9
Personality and behaviour of patients	42 39,6	23 42,6	1 8,3	10 25,6	4 57,1	80 36,7
Specific groups patients	13 12,3	4 7,4	6 50,0	18 46,2	4 57,1	45 20,6
Management style	13 12,3	1 1,9	2 16,7	0 0,	1 14,3	17 7,8
Relations in the workplace	11 10,4	3 5,6	0 0,	1 2,6	0 0,	15 6,9
Work organization and working conditions	15 14,2	5 9,3	3 25,0	8 20,5	1 14,3	32 14,7
Lack of security measures and control	12 40,0	10 18,5	1 8,3	7 17,9	0 0,	30 13,8
Lack of special bodies and procedures	7 6,6	6 11,1	1 8,3	2 5,1	0,0	16 7,3
Other	25 23,6	13 24,1	3 25,0	7 17,9	2 28,6	50 22,9
No violence in workplace	23 21,7	10 26,3	2 16,7	3 7,7	0 0,	38 17,4

ANNEX 9 FACTORS CONTRIBUTING TO PSYCHICAL VIOLENCE IN THE WOKPLACE
BY TYPE OF HEALTH CARE ESTABLISHMENT - number /%

Factors	Hospital	Medical center	Nursing house	Dispensarie	GP		total
Social and economic situation in the country	34 25,4	12 21,1	5 38,5	14 37,8	1 12,5	0 0,	66 26,2
Health care reform	33 24,6	12 21,1	2 15,4	6 16,2	5 62,5	0 0,	58 23,0
Stress and social tension	26 19,4	7 12,3	3 23,1	12 32,4	1 12,5	0 0,	49 19,4
Personality and behaviour of patients	50 37,3	15 26,3	1 7,7	12 32,4	2 25,0	0 0,	80 31,7
Specific groups patients	7 5,2	2 3,5	4 30,8	6 16,2	4 50,0	0 0,	23 9,1
Management style	37 27,6	9 15,8	7 53,8	2 5,4	1 12,5	3 100,0	59 23,4
Relations in the workplace	25 18,7	9 15,8	3 23,1	3 8,1	1 12,5	0 0,	41 16,3
Work organization and working conditions	23 17,2	6 10,5	5 38,5	7 18,9	0 0,	0 0,	41 16,3
Lack of security measures and control	11 8,2	3 5,3	0 0,	4 10,8	1 12,5	0 0,	19 7,5
Lack of special bodies and procedures	10 7,5	4 7,0	2 15,4	2 5,4	1 12,5	0 0,	19 7,5
Other	41 30,6	12 21,1	0 0,	11 29,7	3 37,5	0 0,	67 26,6
No violence in workplace	10 7,5	9 15,8	0 0,	3 8,1	0 0,	0 0,	22 8,7

AHEKC № 10

IMPACT OF CHANGES IN THE WORKPLACE ON THE DAYILY WORK
 number/ %

Changes	Impact							
	None	Work situation for staff worsened	Situation for patient worsened	Work situation for staff improved	Situation for patients improved	other	Don't know	Total
Staff cuts	33 14,9	147 66,2	78 35,1	23 10,4	25 11,3	0 0,	10 4,5	222 60,7
Restriction of resources	8 9,4	70 82,4	46 54,1	3 3,5	3 3,5	0 0,	3 3,5	85 23,2
Restructuring	39 16,7	94 40,2	50 21,4	71 30,3	58 24,8	1 0,4	15 6,4	234 63,9
Increased staff numbers	5 17,2	6 20,7	2 6,9	14 48,3	10 34,5	1 3,4	0 0,	29 7,9
Additional resources	3 13,6	1 4,5	1 4,5	14 63,6	12 54,5	0 0,	1 4,5	22 6,0
Other	0 0,	2 22,2	3 33,3	5 55,6	3 33,3	1 11,1	0 0,	9 2,5

ANNEX 11

RESPONSE TO EXPERIENCED PHYSICAL VIOLENCE

	Number/ %																	
Since you were attacked , how bothered have you been by:	Not at all			A little bit			moderately			Quite a bit			Extremely					
	male	female	total	male	female	total	male	female	total	male	female	total	male	female	total			
Repeated disturbing memories, thoughts or images of the attack	1 11,1	1 4,5	2 6,5	1 11,1	2 9,1	3 9,7	4 44,4	13 59,1	17 54,8	2 6 22,2 19,4	4 18,2		1 11,1	2 9,1	3 9,7			
Avoiding thinking about or talking about the attack or avoiding having feelings related to it	1 11,1	2 11,1	3 11,1	2 22,2	1 5,6	3 11,1	4 44,4	8 44,4	12 44,4	2 5 22,2 18,5	3 16,7		-	4 22,2	4 14,8			
Being “super-alert” or watchful and on guard	1 11,1	6 26,1	7 21,9	1 11,1	4 17,4	5 15,6	3 33,3	1 4,3	4 12,5	2 6 22,2 18,8	4 17,4		2 22,2	8 34,8	10 31,3			
Feeling like everything you did was an effort	1 20,0	3 15,8	4 16,7	-	3 15,8	3 12,5	-	3 15,8	3 12,5	1 5 20,0 20,8	4 21,1		3 60,0	6 31,6	9 37,5			

ANNEX 12

PROBLEMS IN RESPONSE TO EXPERIENCED VERBAL ABUSE

Number/ %

Since you were ABUSED , how bothered have you been by:	Not at all			A little bit			moderately			Quite a bit			Extremely		
	male	female	total	male	female	total	male	female	total	male	female	total	male	female	total
Repeated disturbing memories, thoughts or images of the attack	6 24,0	15 10,9	21 13,0	5 20,0	29 21,2	34 21,0	4 16,0	43 31,4	47 29,0	6 24,0	35 25,5	41 25,3	4 16,0	15 10,9	19 11,7
Avoiding thinking about or talking about the attack or avoiding having feelings related to it	7 26,9	28 21,7	35 22,6	6 23,1	23 17,8	29 18,7	6 23,1	42 32,6	48 31,0	2 7,7	25 19,4	27 17,4	5 19,2	11 8,5	16 10,3
Being “super-alert” or watchful and on guard	9 36,0	32 23,7	41 25,6	1 4,0	13 9,6	14 8,8	2 8,0	29 21,5	31 19,4	4 16,0	38 28,1	42 26,3	9 36,0	23 17,0	32 20,0
Feeling like everything you did was an effort	8 38,1	25 21,2	33 23,7	3 14,3	16 13,6	19 13,7	4 19,0	32 27,1	36 25,9	2 9,5	19 16,1	21 15,1	4 19,0	26 22,0	30 21,6

ANNEX 13

RESPONSE TO EXPERIENCED BULLIED/MOBBED

Since you were bullied/mobbed, how bothered have you been by:	Number/ %																	
	Not at all			A little bit			moderately			Quite a bit			Extremely					
	male	female	total	male	female	total	Male	female	total	male	female	total	male	female	total			
Repeated disturbing memories, thoughts or images of the attack	5 17,2	14 12,8	19 13,8	9 31,0	27 24,8	36 26,1	6 20,7	38 34,9	44 31,9	7 24,1	19 17,4	26 18,8	2 6,9	11 10,1	13 9,4			
Avoiding thinking about or talking about the attack or avoiding having feelings related to it	5 17,9	18 17,0	23 17,2	6 21,4	22 20,8	28 20,9	10 35,7	35 33,0	45 33,6	5 17,9	21 19,8	26 19,4	2 7,1	10 9,4	12 9,0			
Being “super-alert” or watchful and on guard	8 29,6	20 19,0	28 21,2	1 3,7	16 15,2	17 12,9	5 18,5	32 30,5	37 28,0	6 22,2	26 24,8	32 24,2	7 25,9	11 10,5	18 13,6			
Feeling like everything you did was an effort	6 31,6	14 16,3	20 19,0	1 5,3	15 17,4	16 15,2	3 15,8	23 26,7	26 24,8	4 21,1	20 23,3	24 22,9	5 26,3	14 16,3	19 18,1			

ANNEX 14

PROPOSED MEASURES FOR REDUCING THE VIOLENCE IN WORKPLACE BY PROFESSIONAL STATUS- number / %

Measures	Physician	Nurse	mid-wife	Pharmacist	Ambulance.	Auxiliary/ancillary.	Administrative	Allied to medicine	Technical staff	Support staff	Other	Total
Improvement of socio-economic situation	20 24,7	11 16,9	0 0,	1 25,0	0 0,	4 22,2	3 23,1	4 21,1	0 0,	1 11,1	1 9,1	45 18,8
Improvement of health care reform.	24 29,6	13 20,0	2 20,0	1 25,0	1 25,0	3 16,7	1 7,7	4 21,1	1 16,7	5 55,6	2 18,2	57 23,8
Preventive and security measures, control	33 40,7	28 43,1	5 50,0	0 0,	2 50,0	6 33,3	7 53,8	7 36,8	2 33,3	6 66,7	3 27,3	99 41,3
Improvement of work organization and working conditions	22 27,2	17 26,2	2 20,0	0 0,	2 50,0	6 33,3	4 30,8	3 15,8	0 0,	2 22,2	5 45,5	63 26,3
Education and rising the level of culture	7 8,6	11 16,9	0 0,	1 25,0	2 50,0	4 22,2	1 7,7	2 10,5	1 16,7	1 11,1	0 0,	30 12,5
Improvement of collective relations, conflict resolution procedures	8 9,9	4 6,2	3 30,0	1 25,0	0 0,	5 27,8	1 7,7	4 21,1	1 16,7	0 0,	2 18,2	29 12,1
Training, development and HRM	16 19,8	19 29,2	2 20,0	1 25,0	0 0,	2 11,1	3 23,1	7 36,8	2 33,3	0 0,	2 18,2	54 22,5
Administrative measures, control	14 17,3	11 16,9	3 30,0	1 25,0	0 0,	2 11,1	0 0,	3 15,8	0 0,	2 22,2	1 9,1	37 15,4
Improvement of state bodies-police	9 11,1	5 7,7	1 10,0	1 25,0	1 25,0	2 11,1	0 0,	0 0,	0 0,	1 11,1	0 0,	20 8,3
Reporting procedures, special bodies. Counseling	19 23,5	17 26,2	2 20,0	1 25,0	0 0,	3 16,7	2 15,4	4 21,1	2 33,3	1 11,1	2 18,2	53 22,1
Other	17 21,0	15 23,1	2 20,0	1 25,0	0 0,	3 16,7	3 23,1	5 26,3	0 0,	2 22,2	2 18,2	50 20,8
Not necessary	4 1,7	1 1,5	0 0,	0 0,	0 0,	0 0,	1 7,7	1 5,3	0 0,	0 0,	3 27,3	10 4,2

AHEKC № 15

PROPOSED MEASURES BY TYPE OF THE HEALTH CARE SETTING - number/%

Measures	Hospital	Medical center	Nursing house	Dispensarie	GPs	total
Improvement of socio-economic situation	22 16,9	9 18,4	4 33,3	8 17,8	2 28,6	45 18,8
Improvement of health care reform.	32 24,6	11 22,4	5 41,7	7 16,7	2 26,6	57 23,8
Preventive and security measures, control	52 40,0	14 28,6	6 50,0	23 54,8	4 57,1	99 41,3
Improvement of work organization and working conditions	32 24,6	9 18,4	5 41,7	14 33,3	3 42,9	63 26,3
Education and rising the level of culture	16 12,3	3 6,1	1 8,3	9 21,4	1 14,3	30 12,5
Improvement of collective relations, conflict resolution procedures	21 16,2	4 8,2	1 8,3	2 4,8	1 14,3	29 12,1
Training, development and HRM	33 25,4	8 16,3	4 33	9 21,4	0 0,	54 22,5
Administrative measures, control	22 16,9	5 10,2	0 0,	9 21,4	1 14,3	37 15,4
Improvement of state bodies-police	7 5,4	5 10,2	0 0,	9 21,4	1 14,3	20 8,3
Reporting procedures, special bodies. Counseling	32 24,6	10 20,4	1 8,3	9 21,4	1 14,3	53 22,1
Other	24 18,5	15 30,6	2 16,7	8 19,0	1 14,3	50 20,8

Annex 16

OPPORTUNITIES PROVIDED BY BULGARIAN LEGISLATION FOR PROTECTION AGAINST WORKPLACE VIOLENCE

The paper was prepared on the basis of a review of Bulgarian legislation made by the authors and includes opinions and recommendations expressed during the quality interview of lawyers and judges practicing in the field of labor law

The legal framework of worker rights protection and protection against discrimination is contained in the texts of Art.6 of the **Constitution** of the Republic of Bulgaria and Art. 3 of the Labor Code (LC). Under Art. 5 of the Constitution the provision of safe and healthy conditions of work is a constitutional right of the workers and employees in the Republic of Bulgaria.

The general rights and obligations of the parties to the process of work relating to the formation, maintenance and observance of the rules for safe and healthy conditions of work are regulated in **the Labor Code**. (Art 127, 275, 276, 277, 281, 284, 288, 289.

The Labor Code does not include provisions protecting the worker from workplace violence. In case of violence at the workplace it is possible to use some clauses concerning illegal dismissal (Art. 344 – the persons dismissed because they have refused sexual relations with the employer may challenge the legitimacy of dismissal under that Article) and the material responsibility of the employer in case of worker demise or health injury during an employment accident (Art. 200). In the amended LC effective since 31 March 2001 a new paragraph 2 is added to Art. 127 specifying that the employer is obliged to protect the worker dignity during the performance of work activities.

Currently no provisions exist in the LC prohibiting sexual harassment at the workplace. Women victims of sexual harassment have to use the penal law and turn to the court. For criminal offenses however the requirements for evidence are stringer than those in the civil law and the penal law contains no provisions whatsoever providing protection against the employer in the most frequent cases of sexual harassment.

According to the **Health and Safety at Work Act** adopted in 1997 *“healthy and safe are those conditions of work that are not conducive to occupational diseases and accidents at work and provide prerequisites for complete physical, psychological and social well-being of the employees.”*

The Act contains a number of provisions (Art 3,4, 7, 14, 16, 23, 24, 25, 27, 28, 38, 39, 51, 54 etc.), which, though not directly addressing violence at the workplace, may be used or amended in a such a way as to refer to violence at the workplace as well.

- The employer is obliged to meet all requirements of the statutory acts concerning provision of safe conditions of work and protection of the worker health and life and to establish work organization that removes or limits all occupational hazards in the maximum degree possible.

- For the provision of safe and healthy conditions of work in compliance with the European practices the Act provides for the establishment of a developed system of social partnership through committees and groups set up at the enterprise with worker and employer representatives. The employer is obliged to provide annual training to the members of the committees for conditions of work.
- The employer is obliged to provide health services to his workers from the labor medical services.
- In the process of his actions to provide safe and healthy conditions of work the employer is obliged to make an assessment of the health and safety hazards and use it as a basis to plan and apply appropriate hazard prevention measures and whenever that is not possible, to provide protection to the workers and employees and all persons who find themselves in proximity to the site of the hazard. (the order, procedure and intervals of risk assessment performance are regulated in Ordinance № 5/11 May 1999 of the Ministry of Labor and Social Policy and the Ministry of Health).
- It is mandatory for the workers and employees to be insured against employment accidents and occupational diseases in accordance with the degree of occupational risk.
- The employer is obliged to insure the workers and employees, working at workplaces or occupations at risk as specified by the Council of Ministers, against the risk of occupational disease and employment accident and at his own expense.
- In case of non-observance or violation of the provisions of the Act the persons concerned shall be held responsible in conformity with the Labor Code and other specific statutory and regulatory acts.

Some of the provisions of the Mandatory **Social Security Code** could also be used to protect victims of violence:

- According to Art. 55 “Employment accident is any health injury that has happened during or in connection with the work done, as well as any work performed in the interests of the enterprise that has caused disability or death”;
- According to Art. 56 “An occupational disease is a disease that has exclusively or predominantly set in under the impact of harmful factors of the working environment or process on the body... and has caused permanent disability or death. All complications and subsequent consequences are considered occupational disease too.”
- The declaration, investigation and documentation of occupational diseases and employment accidents are regulated in Art. 57-60 and Art. 61-63 of the Mandatory Social Security Code and the relevant decrees respectively.

One of the forms of control over the observance of the above mentioned principles and obligations is the administrative control exercised by the Labor Inspectorate, which has the authority to impose sanctions on the employer in case of violation of the labor law at the enterprises.

In case of violation of the worker rights under the labor law and **labor dispute** arises. Labor disputes are settled in court as civil cases as there is no specialized labor courts in

Bulgaria. According to Art. 359 of the Labor Code the settlement of labor cases by the court is free for the workers. However the payment for the lawyers' services is entirely at the expense of the workers. To a number of them the lack of funds is an obstacle to refer the cases of violence to the court. There is an opportunity for worker rights to be defended by a lawyer free of charge through the Trade Union Bar Office set up by the Confederation of Independent Trade Unions in Bulgaria.

There are no special rules how to conduct court proceedings for cases involving violence or discrimination at the workplace. The difficulties proceed first and foremost from with the need to prove the case of violence or discrimination and eventually to determine the sanctions involved. If the court is benevolent, the sexual harassment and other manifestations of violence at the workplace can be interpreted as non-fulfillment on the part of the employer of his employment obligation to provide conditions corresponding to the nature of work. However, so far there has been no such court practice.

The present court practice does not include any encouraging signals that the judges would be flexible in case of claims filed on the ground of Art. 8, paragraph. 3 of LC providing that "in the implementation of the worker rights and obligation no discrimination, privileges or restrictions shall be allowed, directly or indirectly, on the basis of nationality, origin, sex, race, skills, color, age, political or religious beliefs, membership in trade union and other public organizations and movement, family, social and property status and disability."

The review of the provisions of the Civil procedures Code, the Penal Code and the Penal Procedures Code and of the court practice itself shows that though certain legal opportunities are currently provided, there is no comprehensive protection mechanism for the victims of violence at the workplace.

Whenever violence has resulted in injury which depending on its type can be classified as light, medium and serious, Art. 128 of the **Penal Code** can be invoked and Art. 144, paragraph makes it possible to institute penal proceedings for a threat to murder. According to Art. 143 "a claim shall be filed against a person who coerces another person to do, not to do or to suffer something against his/her will by resorting to force, threats or abuse of power to that end". Under Art. 146 a person can be punished with imprisonment or be fined if she / he "says or does anything that is derogatory to the honor and dignity of another person in his/her presence".. Under that Act sexual comments may be punishable as derogatory. The only measure against sexual harassment under the law is contained in Art. 150 dealing with acts of sexual violence but not rape and Art.153 envisaging "punishment of imprisonment for up to three years for a person who has sexual intercourse with a female person, forcing her to that by availing himself of her job dependence on him". This text is practically not being applied since the act is next to impossible to prove by the victim. Due to the complicated procedures in the Penal Procedures Code requiring observance of time periods, evidence of the guilt and provision of defense services that are very expensive and most people cannot afford them, only a few cases of violence reach the court

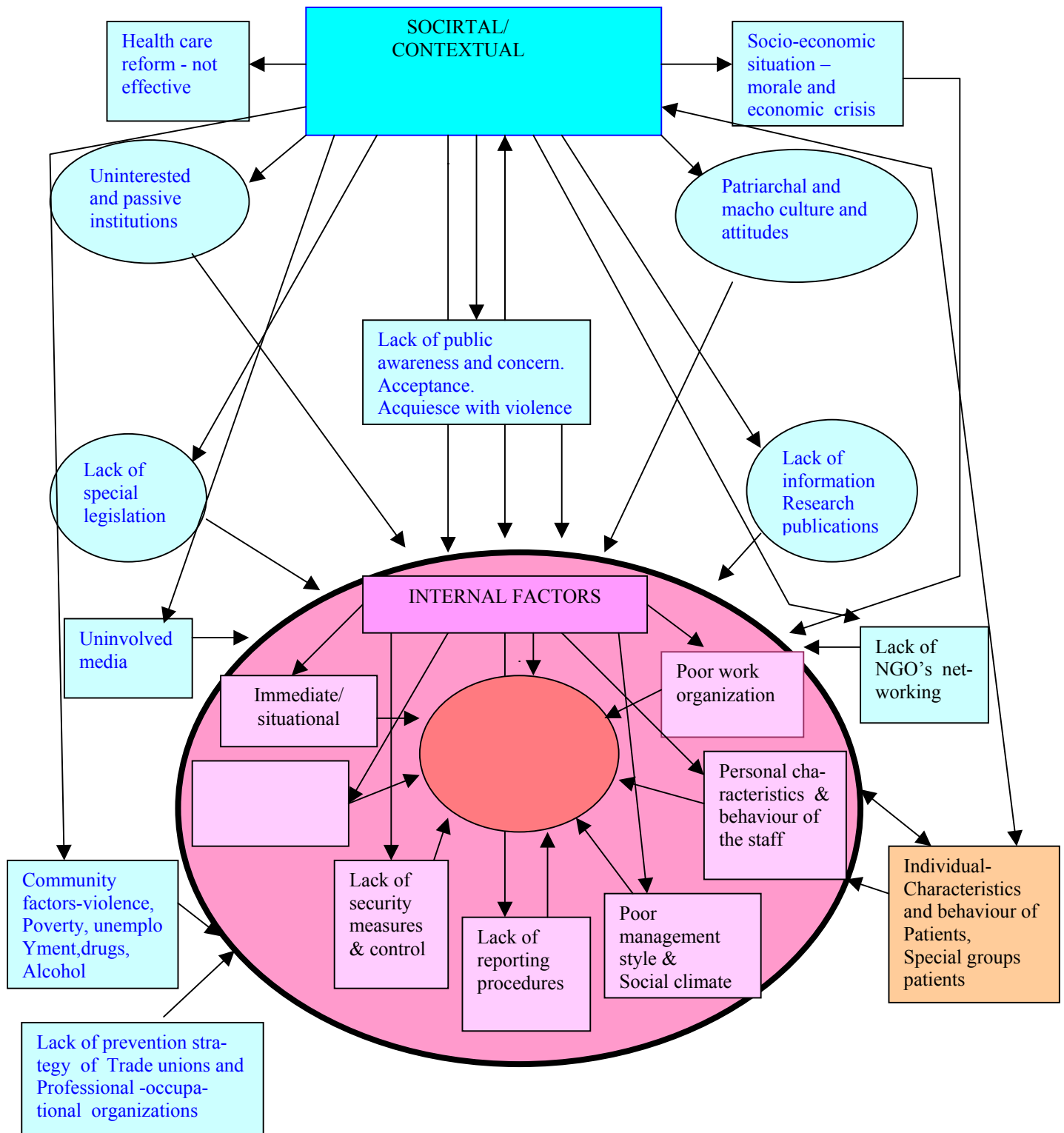
The victims may seek court protection to be indemnified for any moral and material damages suffered by them as a result of impermissible injury in accordance with the order and procedures of Art. 45 of the Liabilities and Contracts Act.

Some measures have been proposed in the Bill on Equal Opportunities of Men and Women submitted to the Parliament for debate, but no date of the debates has been fixed yet.

In summing up we can say in general that the current Bulgarian laws do not settle the specific problem of violence at the workplace in its different forms of manifestations and no adequate protection is provided to the victims of violence. They have to be modified and amended with the participation of the trade unions, the professional organizations and the non-governmental organizations acting in defense of the rights and dignity of the individual.

Annex 17

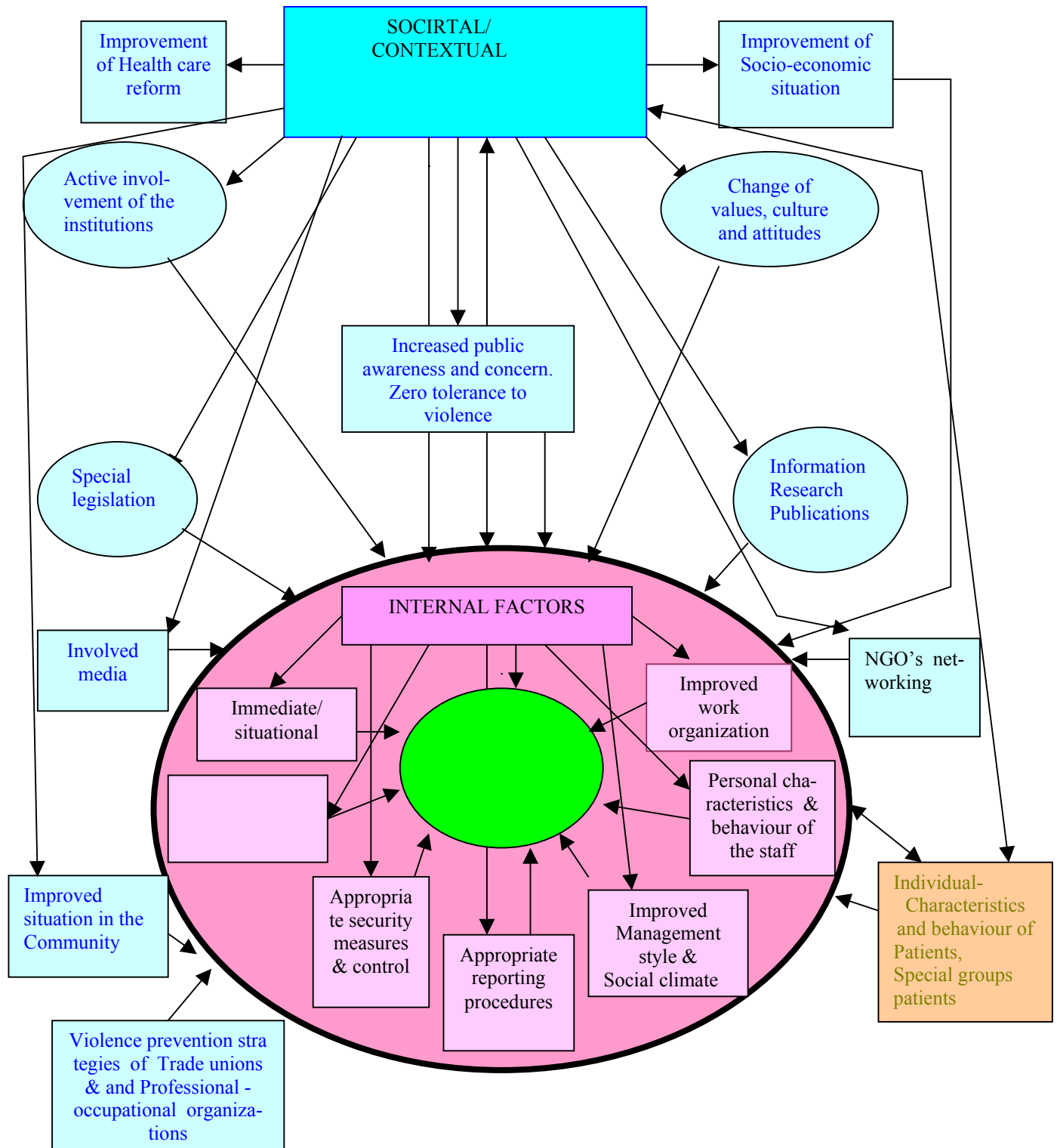
FACTORS CONTRIBUTING TO WORKPLACE VIOLENCE EXTERNAL FACTORS



Annex 18

FACTORS PREVENTING WORKPLACE VIOLENCE

EXTERNAL FACTORS



² American Nurses Association. Workplace violence: Can you close the door on it?, 1999

⁴ Chappell Duncan and Vittorio Di Martino. Violence at work. ILO, 1998 , p.9

⁵ Violence in the workplace, NIOSH

⁷ Chappell Duncan and Vittorio Di Martino. Violence at work. ILO, 1998 , pp.12; Cary Cooper, Naomi Swanson, Workplace Violence in the Health sector: STATE-OF –THE ART, 2 draft, 2001

⁸ Violence and its victims. Animus Association, 1996, p. 6 (in Bulgarian)

⁹ Violence and its victims. Animus Association, 1996, p. 11(in Bulgarian)

¹⁰ Tisheva, Genoveva. Monitor Daily, 8 March, p. 44. One of Every Seven Women is a Victim of Violence at the Workplace. (in Bulgarian)