



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 COUNTRY CASE STUDIES RESEARCH INSTRUMENTS

RESEARCH PROTOCOL

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Workplace Violence in the Health Sector Country Case Studies Research Protocol

Preface

This paper is addressed to potential researchers and research institutions interested in conducting one of the country case studies within the ILO/ICN/WHO/PSI project **Workplace Violence in the Health Sector**. It provides background information on the subject and the project as well as a methodological guideline, a study report outline and research instruments meant as support for the researchers.

Introduction

Violence at work has become an alarming phenomenon worldwide. The real size of the problem is largely unknown and recent surveys show that current figures represent only the tip of the iceberg.

Violence includes both physical and non-physical violence. It finds its expression in physical assault, homicide, verbal abuse, bullying/mobbing, sexual and racial harassment, threat and mental stress. Violence and workplace violence may be defined differently in different socio-cultural environments.

Violence is present in all work environments, however, health personnel are particularly exposed. Since this workforce is in its large majority female, the gender dimension of the problem is very evident. The consequences of violence at work have a significant impact on the efficiency and effectiveness of health systems at large. The equal access to primary health care is endangered if the scarce human resources, the health workers, feel under threat, e.g. certain geographical and social environments, situations of general conflict, work situations where transport to work, shift work and other health sector specific conditions make this work unacceptable.

Purpose of the project “Workplace Violence in the Health Sector”

The International Labour Office (ILO), International Council of Nurses (ICN), World Health Organization (WHO) and Public Services International (PSI) have launched a joint project to gain a better understanding of workplace violence in the health sector and minimize its negative impact on the victims and services.

Collecting data on the nature of workplace violence and on promising anti-violence interventions is a major element of the project. The project therefore includes several case studies in countries of different regions of the world and different economic development. In addition several cross cutting theme studies will be realised. The synthesis of all study findings will serve as a basis for the development of sound policies and practical approaches to address workplace violence in the health sector. The project's purpose is to identify and design effective strategies to eliminate workplace violence in the health sector.

The research results will be discussed at an international workshop in April 2002. The final outcome of the joint project will be practical and viable anti-violence guidelines and tools to support international, national and local efforts to eliminate violence from the health sector workplace.

Objective of the country case studies

The objective of the country case studies consists in showing country-specific evidence and practical solutions concerning workplace violence in the health sector. By summarizing existing information and analysing newly obtained information the study aims to identify risk

factors as well as best practices of anti-violence interventions in the given socio-cultural context. This work will serve as a basis for the formulation of guidelines for prevention and coping strategies targeting issues of workplace violence in the health sector.

Study results will be made available in 2002 for national / local action. Use of the questionnaire and interview guidelines for a wider target population is also possible for interested potential partners in future programmes.

Methodology

It is important that all major stakeholders be informed and involved in the study process, e.g. health authorities, management, unions, professional associations. Access to the workers and data will be greatly facilitated as a result.

A period of time should be considered to train local researchers on methodology and use of instruments if necessary.

The case studies combine three methodological approaches:

- 1) Review of research undertaken, existing and available information and literature in the country on the issue of violence at work in the health sector.
- 2) Field research – qualitative part:
Emphasis on focus group discussions, following the question - guidelines (Annex II, *will be provided as extra-document*).
Target groups should include the first six and if possible all eight categories:
 - Representative organisations (unions, associations, employers' organisations)
 - Private owners of health services
 - Health sector personnel
 - Health authorities (at central and decentralized levels of health care system)
 - Management (senior- and middle management)
 - Patients/clients
 - Occupational health and safety specialists
 - Labour lawyers

Each target group should constitute separate focus groups in order to promote frank discussion (i.e. a similar level of hierarchy is important). As for certain categories of target population it may be difficult or impossible to create focus groups. Having a number of qualitative interviews with individual representatives of these groups is an acceptable option. These interviews should follow the same guideline as for focus group discussion.

The general objective of the focus group discussions is to obtain in-depth information about personal opinions, perceptions, attitudes, experiences and recommendations concerning the subject workplace violence to complement the issues addressed in the survey questionnaire. One of objectives of the focus group discussions is to verify or revise definitions of violence, which are used for the survey (questionnaire, see Annex II). It is therefore recommended to conduct some of the focus group discussions before the distribution of the questionnaire whereas some of the focus groups can be conducted after distribution of questionnaire.

- 3) Field research – quantitative part

The quantitative element of the study consists in a confidential survey with a standardized questionnaire (Annex II). A certain amount of time will be required by staff to complete the

questionnaire. The allocation of work time for project participation may need to be negotiated with the employers.

In order to encourage health personnel to participate in the survey it is important to guarantee confidentiality to respondents. Therefore the modalities of questionnaire return should be considered in detail.

The target population of this survey is health sector personnel. The questionnaire should be distributed to staff in a minimum number of health facilities and work settings, at minimum within a major city in the country.

The emphasis will be placed on sampling the range of health care settings, professional groups and hierarchy levels as opposed to covering all health sector personnel in a major city of the country. A balanced representation of health sector personnel in the defined urban area should be included in the sample by designing a stratified random- sample (*for a detailed sample design frame, see Annex II*). The emphasis of the case studies is put on comparing major urban cities of different countries as a first step in filling information gaps. Focussing data collection to a major city area will facilitate the research process within the given time and resource constraints. If rural health care settings can be included in the sample, the additional data would be of great value.

Within the chosen urban area all major health care settings should be covered, representing the national health system . If there is an active public and private sector, please include an appropriate number of each in the sample for comparison.

- Major referral hospitals of a major city (Tertiary level)
- Regional and district hospitals (Secondary level)
- Health care centres, clinics, community health posts, outreach services (home care, ambulance) (Primary level should cover more facilities compared to hospital settings as one emphasis of research)
- Rehabilitation centres, convalescent homes, nursing homes, homes for the elderly:
- General practitioners offices, independent health care professionals (nurses, midwives)

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

Personnel categories to be covered include all professional groups (also support services):

- physician
- nurse / midwife
- pharmacists
- managers
- auxiliary/ancillary
- ambulance
- administration/clerical
- professions allied to medicine (therapists/radiographers/assistants)
- technical staff (laboratory/sterilisation)
- support services (security, catering, kitchen, maintenance, reception)

All hierarchy levels within institutions should be included.

As an orientation and support, the sample methodology is described in detail in an extra-document (Sample design frame, Annex II). The instructions for sampling demonstrate the ideal way. The described sample may not be possible to be realized in certain countries/ study sites. In case of changes within the sample design (e.g. selection certain health

facilities or professional groups ; other approach of sampling) researchers are requested to state the reason for their decisions.

Researchers are asked to send proposals on numbers and type of work settings to be included within the given time frame. In addition, researchers are asked to send the sample design to sponsors for review and approval before contracts will be issued. A cost estimate will also be submitted to the Steering Committee before research contracts are granted.

Instructions / Guidance for study process and report

As support for the researcher, a study outline is provided as well as study instruments (Annexes I and II). This is to facilitate a standard methodology for the case studies conducted in different regions worldwide and ensure better comparability of the results.

Please note:

Any changes to the study process, the research protocol and any change of instruments, including definitions, have to be approved by Steering Committee.

The outline (Annex I) addresses numerous aspects of the subject and should be used as follows:

- Keep length of section A short – providing a brief summary to describe the context.
- Put absolute emphasis on section B and give attention to C and D

Please note in general:

When no information is available concerning a given aspect, state its absence and if relevant the reasons for its absence. This statement is helpful to identify gaps of information and future research needs.

Details:

Section A

1. Concept of violence, literature review and comparison with field study results (max 3 pages)
2. Short review of existing research and statistics (who collects data in which way, do networks exist, is access easy or not) (max 3 pages)

Section B

Emphasis to be given to field study process (methodology, sample, etc) and results (quantitative and qualitative). Please use provided instruments. (max 20-25 pages)

Sections C and D

Crucial as basis for the further development of strategies, guidelines and tools (max 7 pages)

Executive Summary (2 pages)

Total length of text (not including annexes): 35 - 40 pages

Annexes:

- Data analysis table of core data (table format see Annex II)
- Statistical findings from questionnaire
- Relevant policies / regulations / legislation
- Bibliography of national studies and publications

Format of report

It is necessary to use compatible software programmes for the documents: preference is given to “Microsoft - Word”, Excel and PowerPoint. Use of other software should be cleared with the project sponsors (text, charts, figures, etc).

References should be indicated by a number in the text and details entered as endnotes. Brief footnotes providing clarification of the text are accepted (same page).

The report, including first draft, has to be submitted in English.

Time table

Contracting of external collaborator	15 July	2001
Interim report (results of literature review, section A of Outline, draft)	15 October	2001
First draft of study report	15 November	2001
Final draft country study report	20 December	2001

ATTACHED ANNEXES

Annex I

- Outline (see below)

Annex II

Study instruments:

1. Sample design frame (provided as extra document)
2. Types and sources of data (see below)
3. Survey questionnaire, violence definitions included (provided as extra document)
4. Focus group / interview guideline (provided as extra document)
5. For Report Annex: Analysis table of core data (*to be provided*)

Annex III

Background information for researchers:

- ILO/ICN/WHO/PSI Project Document (*has been provided with general information*)
- State of the art paper (*draft version, to be provided*)
- ICN: Guidelines: Coping with violence in the workplace : *please visit* http://www.icn.ch/guide_violence.pdf
- ICN: Toolkit International Nurses Day 2001: “Nurses always there for you: United Against Violence”, *please visit* <http://www.icn.ch/indkit.2001>
- Information on Workplace Violence in general : *please visit* <http://www.ilo.org/public/english/protection/safework/violence/index.htm>
- Hoel, et al: The Cost of Violence/Stress at Work and the Benefits of a Violence/Stress– Free Working Environment, ILO 2001; *please visit* <http://www.ilo.org/public/english/protection/safework/whpwb/econo/costs.pdf>

Annex I

Outline – Draft

A. Background

1. Concept of violence (literature and comparison with study definitions)
 - definition of violence in general, (physical, psychological, sexual violence; threshold for violence, acceptance of violent behaviour)
 - definition of workplace violence with focus on health sector; if possible comparison to other employment sectors
 - role of national, occupational, professional culture (e.g. impact of levels of acceptance on violent behaviour)
 - gender issues (e.g. discrimination)
2. Existing violence measurement mechanisms
 - definition of the health services sector and related social services and their workplaces
 - different approaches to illustrate, categorize and explain the phenomenon
 - indicators and categories of statistical data
 - data sources (who collects data)
 - problem of underreporting
3. Existing knowledge on workplace violence in the health sector in the country
 - summary of relevant research undertaken in the country

B. Country case study (results of field study)

1. Methodology
 - Description of methods used to collect and analyse data
 - description of sample
 - limits of the study (quality of data, representation of sample, etc)
2. Magnitude, characteristic and scope of workplace violence in the health sector
 - frequency of reported incidents concerning the different forms of violence at work (what/how)
 - perpetrators related to different forms of violence (who)
 - characteristics of victims : age, gender, race/ ethnic group (migrants?), professional group, professional experience (who)
 - work settings at risk / in cases of physical violence also place, time, day of the week (where / when)
3. Influencing factors in the context of workplace violence
 - Contributing factors (triggers) (why)
 - How does the relative importance of violence risk factors (incl. individual factors) vary across settings? Is there a common set of risk factors that can be identified?
 - Physical environment (noise, lighting, temperature, access to toilets, overcrowded rooms, building, etc)
 - Organizational culture
 - relationship between management practices and violence
 - relationship of Human Resource Management and violence
 - sources of distress/ discomfort in the workplace (eg job insecurity, long hours, environment/surrounding, work conditions (eg financial situation of service, atmosphere)

- Reforms, major measures of restructuring, downsizing in Public Service / Health Sector and their impact on violence in health
 - what is the impact of reorganization of health care on violence in the work place in the different settings
- 4. Effects and Impact of violence at work in the health sector
 - impact on the individual employee / worker
 - physical / psychological consequences (incl. private life)
 - consequences in relation to work (distress /burnout, transfer /quits, absenteeism, financial situation, career path)
 - impact on migrant health personnel
 - gender issues
 - impact on service delivery for patients and clients (quality of care)
 - impact on the health service / institution / enterprises (cost data, lost work days, staff fluctuation, staff shortage)
 - consequences for health sector and society at large (if possible)
 - burden of disease / injury
 - estimated cost of treatment
 - social impact of a climate of violence (e.g. culture of fear)
- 5. Individual, institutional and systematic responses to violence
 - Coping strategies of victims / witnesses (immediate reaction)
 - reporting procedures
 - existence, popularity, access
 - reasons for underreporting
 - activities (investigation, prosecution, interventions etc)
 - rehabilitation of victims (treatment, counselling, etc) & impact /evaluation of rehabilitation programs
 - initiating persons, groups, institutions, structures, networks
- 6. Anti-violence strategies
 - categories of anti-violence actions
 - existing promising prevention measures/ programs on institutional, organizational (unions / professional associations) and national level
 - prevention strategies recommended by interviewees (field study)
 - consultation between workers, employers and management
 - workers' priorities
 - employers' priorities
 - Perception of effectiveness: policies /strategies / interventions
- C. Conclusions
 - identification of contributing factors
 - Identification of prevention factors
- D. Recommendations
 - Promising interventions in terms of
 - prevention of workplace violence in the health sector
 - reporting procedures
 - rehabilitation of victims (and perpetrators)
 - post-violence response
 - Further action on national and organizational level

ILO/ICN/WHO/PSI Workplace Violence in the Health Sector –
Country Case Study, Research Protocol – ANNEX II, 2.**Type and sources of data for describing the magnitude and impact of violence and for understanding the etiology of violence**

Please note: this overview, written in regard to violence in general, is meant as a general orientation for researchers. Types and sources of data have to be adjusted to workplace violence (in the health sector).

Type of Data	Data Sources	Examples of the types of information collected
Mortality	Death certificates, vital statistics registries, coroner or mortuary reports	Characteristics of the decedent, cause of death, location, time, manner of death
Morbidity and other health data	Hospital, clinic, or other medical records	Diseases, injuries, as well as information on physical, mental, or reproductive health
Self-report	Surveys, special studies, focus groups	Attitudes, beliefs, behaviours, cultural practices; exposure to violence in the home or community
Community	Population records, local government, or other institutional records	Population counts and density; levels of income, education, unemployment; divorce rates
Crime	Police records, judiciary records, surveys	Type of offence, characteristics of offender, relationship between victim and offender, circumstances of event
Cost	Program, institutional or agency records, special studies	Expenditures on health, housing, social services; costs of treating violence-related injuries; utilization patterns
Policy or legislative	Government or legislative records	Laws, institutional policies and practices

Source: WHO: World Report on Violence and Health. Chapter 1 Violence as a Public Health Problem.; publication forthcoming 2002

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