


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 Study: South Africa

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Background

INTRODUCTION

There is growing concern worldwide about the increase in workplace violence. The purpose of the study is to obtain information on the level of workplace violence in the health sector in South Africa. In particular this study examines the extent of workplace violence, factors that may contribute to violence and explore the most suitable strategies and appropriate policies to prevent and address violence in the workplace.

1. THE CONCEPT OF WORKPLACE VIOLENCE

1.1 DEFINITION OF VIOLENCE

Introduction:

The term "workplace violence" is not commonly used in South Africa. Terms like "harassment", "discrimination", "abuse", "bullying" and "intimidation" are widely used, but "violence" as such is reserved almost exclusively to describe physical violence. This is the language of the media and the broad South African population, while violence is defined as being physical, psychological and structural in local and international academic literature and studies. It was therefore important for the researcher to establish if the term “workplace violence”, defined as being physical and/or emotional by the sponsors for the purposes of this study, would be understood and accepted by the subjects participating in survey.

The assumption that the subjects may not understand a term like “violence” as being physical and emotional violence, informed the study "The impact of Crime and Violence on the delivery of state health care services in the Western Cape" Sandra Marais, Elrena van der Spuy & Ricky Rontsch of the Medical Research Council earlier this year. Furthermore, the qualitative and quantitative survey included questions on verbal abuse and sexual harassment, but did not refer to these forms of psychological violence as “violence” because the researchers assumed that this word would confuse the subjects as it would be regarded as physical violence only.[1]

When the term "workplace violence" was tested in focus group discussions for the purpose of this study, the subjects surprisingly immediately conceptualised "workplace violence" as being both physical and psychological injury. Both forms of workplace violence were perceived to be evenly damaging to the victims' physical (referring to possible subsequent psychosomatic illnesses and not the physical injury), emotional, psychological and social development by participants in focus group discussions.

1.1.1 Definitions of Workplace Violence

There are many definitions for violence, locally and internationally. A definition that originated from South Africa in 1989 is that of Van Der Merwe: "Violence is the application of force, action, motive or thought in such a way (overt, covert, direct or indirect) that a person or group is injured, controlled or destroyed in a physical, psychological or spiritual sense".[2] This definition is inclusive of physical and psychological violence. Equally descriptive of the physical and psychological nature of violence is the definition agreed upon by the European Commission: "Incidents where persons are abused, threatened or assaulted in circumstances related to their work, involving an explicit or implicit challenge to their safety, well-being or health".[3]

The European Commission's definition had been adapted by ILO/ICN/WHO/PSI (Annex 1) as a definition for workplace violence for purposes of the study to read: "Incidents where staff is abused, threatened or assaulted in circumstances related to their work, including commuting to and from work, involving an explicit or implicit

[1] Medical Research Council. 2001. Draft paper "The impact of crime and violence on the delivery of State Health Care Services in the Western Cape" presented by Sandra Marais on 18/10/2001 at Unisa Institute in Lenasia.
[2] Van der Merwe, H W. 1989. *Pursuing Justice and Peace in South Africa*. New York: Routledge
[3] Wynne, R., Clarkin, N., Cox, T. & Griffiths, A. 1997. Guidance on the Prevention of Violence at Work. Luxemburg: European omission, DG-V.

challenge to their safety, well-being or health" as the overriding definition. The definition consists of sub-definitions describing physical and psychological workplace violence in terms of assault/attack, abuse, bullying/mobbing, harassment, sexual harassment, racial harassment and threats separately.

The definitions provided by the sponsors had been tested in focus group discussions and accepted with words added in some cases to make it more descriptive within the South African context. However, the basic definitions remained unchanged and clearly illustrated that South Africans identified with the international concept of violence and workplace violence. For example, focus groups suggested that "strangling" be added as an example of physical violence and the word "intimidation" be added to psychological workplace violence among others. The revised definitions approved by the ILO/ICN/WHO/PSI Steering Committee are dealt with elsewhere in this report. In later focus group discussions the new definitions were used and all participants had accepted these with no suggestions for changes.

The Council for Conciliation, Mediation and Arbitration (CCMA) was requested to comment on Annex 1. The CCMA contended that, to a large extent, the Labour Relations Act, Act 75 of 1997, cover these definitions, but that these definitions could be refined. Whatever the shortcomings in legal definitions, all legislation is subject to the South African constitution. Section 10 of the South African constitution states: "Everyone has inherent dignity and a right to have their dignity respected and protected." The CCMA comments are attached as Annex 4.

Following the study, the researcher subsequently invited the CCMA, trade unions in the health sector, trade union federations and other interested parties to several meetings to work out a definition of workplace violence for South Africa that would be applicable to all sectors. The definition used in this study with minor adjustments was preferred. The following definition emerged (for consideration by government, labour and business at the appropriate forum): *"Incidents where employee(s) are physically or emotionally abused, harassed, threatened or assaulted (overt, covert, direct, indirect) in circumstances related to their work, including commuting to and from work, involving an explicit or implicit challenge to their safety, well-being or health."*[4]

The World Health Organisation defines violence as "the intentional use of physical force or power, threatened or actual, against another person or against oneself or a group of people, that results in or has a high likelikhood of resulting in injury, death, psychological harm, maldevelopment or deprivation"[5] This definition clearly includes structural violence.

The inclusion of structural violence to identify acts of corporate violence like poor lighting, insufficient security and so on would be implicated in the definition of the sponsors without referring to "structural violence". It is also necessary to take note of the nutshell definition, complete with critical proviso in the Oxford companion to Philosophy: "Popularised by the Norwegian sociologist Johan Galtung, the idea of structural violence involves a wide construal of violence aimed at showing that its menace is present in institutional ways even where no literal or 'narrow' violence occurs. Structural violence does not involve agents inflicting damage by force, but is equivalent to social injustice. Apart from its potentiality for confusion, a key problem with the concept is its dubious suggestion that a variety of apparently quite different social problems are all essentially the same and will therefore yield to the one approach."[6] However, the definition provided by the sponsors is not confusing.

1.2 A THRESHOLD/ACCEPTABILITY LEVEL FOR WORKPLACE VIOLENCE

The word "threshold" suggests an "upper limit" a "verge" or "margin" and in the case of workplace violence an "acceptability level". Therefore a threshold suggests that a certain level of violence would be acceptable in some circumstances. But how much is acceptable or would that be up to the individual or a specific society? It can be argued for instance that, in some countries, like South Africa, reasonable corporal punishment for children by the parents (not schools), is totally acceptable while it would be regarded as abuse in a country like Sweden where there is legislation against corporal punishment for children. While parents may legally administer corporal

[4] Adapted from European Commission DG-V

[5] World Health Organization. 1995. Violence. A public health priority. Geneval: WHO, taken from the submission from World Health Organization to the Committee on the Rights of the Child for its Day of General Discussions, September 28, 2001 . http://www.crin.org/docs/resources/treaties/erc.28/WHO1.pdf visited on 9 March 2002.

[6] Oxford companion to philosophy. 1995. From http://www.xrefer.com/entry/553621 visited on 9 March 2002.

punishment, excessive punishment would be regarded as child abuse in South Africa. The legal sanction to parents to administer reasonable corporal punishment, does not imply that corporal punishment is acceptable in all communities or social groups. This "threshold" is dependent on legal, cultural, developmental, social, political, religious, emotional, resilience levels and other dispositions of individuals and the community. Within the scope of this study it is possible to explore a "threshold of violence'' on the philosophical level, as this would suggest a study in its own right.

It is clear from the foregoing discussion that a "threshold of violence" is dynamic and open-ended. "According to current literature, beliefs, expectations and assumptions about the world play a pivotal role in determining the effects of victimisation..."[7] This fact is evident in the manner in which health care workers distinguish between and react to violence from patients under different circumstances. In certain instances, when patients are confused from anaesthetics, they could become violent. Similarly patients suffering from diseases like Alzheimer's disease, psychiatric patients or patients on medication and so on, could also become violent. Health care workers understand this within the context of the patient's condition. Health care workers said in focus group discussions that although they understand "it still gets to you" and it is experienced as extremely unpleasant and even dangerous. Health sector staff is well aware of the fact that every patient must receive equal care. However it emerged in focus group discussions that, while psychopathology is mitigating when a patient behaves violently, substance abusing and criminal patients and their escorts' violence are not acceptable. It was observed in the focus group discussions that there is a bitterness or resentment by health care workers for having to attend to criminals, patients/patient escorts who are substance abusers and then abuse health care workers, while the system is overloaded with non-criminals and non-violent, sober citizens in need of medical care. It is especially the "gang wars" in hospitals that could be extremely dangerous and the trauma units in some hospitals in the country is either behind bars or bullet-proof windows. It is a matter of the violence in the streets spilling over in the hospitals, according to the focus group participants. While the public sector hospitals must serve all communities, health care workers in the private sector hospitals' trauma units are also exposed to criminals because the laws of the country require the authorities to provide medical care to criminals and when public hospitals cannot attend to the offenders in custody, these criminals are taken to private hospitals. These are the risks healthcare workers are exposed to. Beyond the bona fide condition of the patient causing him/her to be violent, workplace violence is unacceptable and a source of concern.

Society takes it for granted that healthcare workers are trained and have to cope with the patients' psychopathological conditions. However, it is not only the patients with psychopathological conditions, but also the violence "from the streets" and from colleagues that cause grief. Over the years South Africans had been traumatised by the brutality of violent crimes and the words "crime" and "violence" are often interchangeable. The violence is spilling over from the streets into the healthcare facilities and aggressive, violent and criminal patients often physically and verbally abuse health care workers. In a violently charged environment like Johannesburg there is constant fear and violence in all its forms are present.

According to Robert Thornton, head of the Anthropology Department of the University of the Witwatersrand, all views of violence are retrospective. "Violence has a very powerful role in human representations of power, and in attempts to wield power over others... it is not violence itself the act and its destructive consequences that is causally effective or the 'instrument of power'"[8], but rather our reaction to and the interpretation of violence we construct after the event of violence". This viewpoint is useful, not only to understand the enormous fear of violence health care workers expressed in focus group discussions, but also compliments the argument that "there is always a significant subjective component in an individual's response to violence" (Haber, Lewis, 1997) . Violence, according to Thornton activates new social patterns and processes because it disrupts social and cognitive patterns, but cannot yield direction or form. Therefore, Thornton argues that violence stands at the origin of new social forms, but does not cause them. The viewpoint that violence is symptomatic of a society undergoing change, is also expressed in other literature. According to Butchart, Hamber, Terre Blanche & Seedat in the chapter "Violence, power and mental health Policy in Twentieth Century South Africa, the sociological, demographic or public health approach "constructs violence as the product of a vast web of socio-ecological relationships and risk factors that impinge upon people to increase or decrease their proclivity for

[7] Hamber, B & Lewis, S. 1997. An Overview of the Consequences of Violence and Trauma in South Africa. *Occasional paper written for the Centre for the Study of Violence and Reconciliation*, Johannesburg.

[8] Thornton, R. 1995. The Peculiar Temporality of Violence. Paper delivered at the Centre for the Study of Violence and Reconciliation, Johannesburg. 29 March 1995. Web page: http://www.wits.ac.za/csvr/papers/papthorn.htm visited on 15 August 2001.

violence, and which through adequate identification by way of epidemiological and social research can be manipulated to prevent the problem"[9] The socio-ecological relationships impacts on the workplace and links workplace violence to the broader changes in modern society by comparing the natural ecosystem with that of society: "The relationships among species in an ecosystem are usually complex and finely balanced and every action, organism or specie has an impact on the system. This is called the Holoconotic Principle. Nothing is a singular phenomenon in an ecosystem.... You cannot view the 'Corporate Ecosystem' as a separate entity. It is part of society's ecosystem."[10] This implies that what is happening in society would reverberate in the workplace. The viewpoint that workplace violence is symptomatic of socio-economic changes in the country specific, but also worldwide, had been expressed in focus group discussions too. However if acceptance of this fact has a significant, if any influence on the individuals' threshold of violence is doubtful and was not expressed as such in focus group discussions.

Which form of violence has the greatest impact on the well-being of the individual? Physical or psychological violence? While the actual physical injury in the case of physical violence is absent in psychological violence, the secondary physical repercussions to physical and psychological violence are similar for both types of victims. The fact that emotional violence impact on the physical well-being of the victim too cannot be overlooked. In a recent study among Norwegian victims of workplace bullying, a comprehensive measure of personality called the MMPI-2 revealed that victims of bullying (in this context "bullying" would include verbal abuse and harassment) presented a 3-2-1 profile on the MMPI-2, indicating a personality with serious psychosomatic problems resulting from stress and anxiety and a tendency to convert psychological stress into physical symptoms[11]. The analysis of the focus group discussions will indicate that the reactions of the subjects to both forms of workplace violence are similar - it impacts on their physical (psychosomatic illnesses) and psychological well-being, their productivity and performance. Significant relationships were found between experienced bullying and psychological, psychosomatic and muscle-skeletal health complaints (Einarsen, Matthiesen, 2002.) while 75% of victims portrayed stress symptoms indicating Post Traumatic Stress Disorder (PTSD). Even 5 years after the bullying has ceased, as many as 65% reported symptoms indicating PTSD.[12]

A threshold of violence exists only on a uniquely individual level, is changeable and subject to a variety of factors. It can also be argued that, in the case of psychopathology, a synthetic threshold exists where health care staff conditioned themselves to understand the source of the violence as the patient's condition, but they admit to having difficulty to cope with this type of violence too. Individuals' levels of resilience and sense of coherence (soc) differ. Each person has an unpredictable threshold and capacity to deal with violence and other traumatic events in life. Health care workers don't get "used to" abuse of a physical or psychological nature, even when patients' conditions are of a psychopathological nature or when a patient escort, manager or colleague could be stressed. Health care workers claim that it is commitment to the profession that help to work through condition-related patient violence, but it does not render them immune. However, violence unrelated to psychopathology from any source is extremely disturbing and unacceptable.

2. EXISTING VIOLENCE MEASUREMENT MECHANISMS

2.1 DEFINITION OF THE HEALTH SERVICES SECTOR AND RELATED SOCIAL SERVICES AND THEIR WORKPLACES

To determine the magnitude of this sector is fraught with problems. Does one include "new age", herbal and "alternative medicine" health care workers too? Neither the South African Health Review 2000 nor the SA Hospital and Nursing Handbook 2000 provided adequate information of the study population and facilities and in most cases the study population had to be estimated from the universum. South Africa is currently developing a

[9] Butchart, A., Hamber, B., Terre Blanche, M & Seedat, M. 1998. Violence, power and mental health Policy in Twentieth Century South Africa in Foster, D., freeman, M. & Pillay, Y (eds), Mental Health Policy Issues in South Africa, pp. 236-262, Cape Town: Medical Association Multimedia Publications, 1998. Obtained from CSVR website http://www.org.za/papers/papbh&ab.htm visited 09/03/2002.
[10] Marais (now Steinman), S and Herman, M. 1997. Corporate Hyenas at Work. Kagiso Publishers.
[11] Einarsen, S. & Matthiesen, B. 2002. Workplace Bullying: Learning from a decade of research. Proceedings from the Adelaide International Conference on Workplace Bullying, 20-22 February 2002.
[12] Einarsen, S., Matthiesen, S.B. & mikkelsen, E.G. 1999. Tiden leger alle sár? Senvirkniger af mobbing I arbeidslive *(Is time a great healer? Long term effects of workplace bullying).* Universiteitet j Bergen: Institutt for Samfunnspykologi.

District Health System (DHS) and a sophisticated Health Information System (HIS), but at the time of the study, neither the DHS nor the HIS was implemented and/or operational but in the process of transformation.

For the purpose of this study only health care workers registered with South Africa's Health Professional Council were included and provision was made for administrative and support staff accounting for a percentage of the population. But exactly how big is the health sector and where do we draw the line? The workplaces could also be difficult to define. Imagine describing a tree as a workplace? In rural South Africa the mobile clinics would choose a tree in the village to park the mobile clinic and serve the patients from there. The workplace would in this instance be defined as the mobile clinic, just as for paramedics it is the ambulance rather than 'roadside' or 'shebeen'. For the purposes of this study public and private hospitals, clinics, day clinics, satellite clinics, offices of physicians/dentists/health practitioners, paramedical staff on duty in ambulances, offices of professions allied to medicine, nursing and personal care facilities, home care services, laboratories and facilities for long-term care were defined as workplaces.

2.2 DIFFERENT APPROACHES TO ILLUSTRATE, CATEGORIZE AND EXPLAIN THE PHENOMENON

While the recording of incidents of workplace violence for health care workers is very important, data on workplace violence simply do not exist or is unavailable. The only measurement or indication of the problem of workplace violence is vaguely indicated in the total number of disputes (the nature of the disputes were not specified and more than 80% of cases relate to unfair dismissals of a substantial and procedural nature) in the public and private health referred to the Council for Conciliation, Mediation and Arbitration (CCMA) for the period 1 June 2000 - 31 May 2001. While these figures do not reflect the scope or magnitude of the problem of workplace violence in the health sector, the information reflects on the labour relations and efficiency of problem-solving mechanisms and interventions in both sectors, which would also be relevant to workplace violence. The number of cases in the private health care sector (PRIHCS) amounted to 1578 and the public health care sector (PUBHCS) amounted to 23; 1601 in total. The PUBHCS established a The Public Health and Social Services Bargaining Council in July 2000 and disputes are directly referred to this body for conciliation and arbitration. According to an official at the Public Health Services Bargaining Council, they handled approximately 600 cases country-wide in the first year, of which 200 was in respect of the Gauteng Province. Therefore the number of cases in respect of the study population for the Johannesburg Metropolitan Region could not, by any statistical means exceeds 75 for the period 1 July 2000 to 30 June 2001.

It is disturbing to note that 8,6% of health care workers in the PRIHCS take their disputes with employers to the CCMA and this could be the tip of the iceberg because a large number of employees do not report or declare a dispute with the employer. Only 37% of these cases are settled at conciliation hearings. It emerged from focus group discussions that, for some unknown reason, the Labour Relations Act was not implemented until late 2000 and therefore public sector employers could not take action against staff members who committed serious dismissible offences. This may have influenced the number of declared disputes for the PUBHCS. However, these figures were the first indication that there would certainly be enormous problems in labour relations and workplace violence in the health care sector.

During interviews with Human Resources Managers at private healthcare facilities and at public hospitals, none held any statistics on reported incidents of workplace violence. The crime statistics on homicides from the South African Police do not indicate whether a person was killed at work, home, or on the streets and therefore no reliable statistics on homicides and/or attacks at the workplace are available. The National Injury Mortality Surveillance System (NIMSS) are making excellent progress in upgrading mortality records in the country and significantly, 15 mortuaries in the Eastern Cape, Northern Cape, KwaZulu-Natal, Gauteng and the Western Cape participated in 2000. It is expected that the number of participating mortuaries would increase dramatically in the next few years and to provide accurate information on deaths at the workplace and the victim-perpetrator relationship. The NIMSS Data Collection Form could however provide more explicitly for the workplace as there could be some confusion or underreporting of such deaths in the form's present format. With some adjustment the NIMSS Data Collection Form could provide South Africa with more accurate statistics specifically on workplace homicides, accidental deaths and the sectors it occurred in.

Workplace violence is under reported and recorded, or like a large number of subjects responded in answering the questionnaires being viewed "useless" to report at all. This compares with the tendency in society not to

report violent crimes because it is perceived to be "useless".

3. EXISTING KNOWLEDGE ON WORKPLACE VIOLENCE IN THE HEALTH SECTOR IN THE COUNTRY

There is an increasing awareness and concern about workplace bullying in South Africa, yet this country is lacking behind the developed or first world countries in research. The awareness about workplace bullying was reported in the regional newspaper "The EastRander" in July 1994 featuring the researcher's work. The "Corporate Hyena" or bully was coined and a typology of office denizens described. The book "Corporate Hyenas at Work"[13] was published in 1997. The Foundation for the Study of Work Trauma held the first International Conference on Workplace Trauma on 8 and 9 November 2000 in Johannesburg, which raised interest from the public and private sectors about the topic.

There had been a few research projects prior to 2001 partially dedicated to the phenomenon of workplace violence in the health sector. One of these is the doctoral thesis (Psychology) of Dr Arthur Ngwezi at the University of Pretoria in 1997 titled "Work Stress in a group of black nurses"[14]. Of particular interest for this study is Ngwezi's analysis of working conditions and in particular the "interaction in the medical team as stressors" and "Dealing with patients" of stressors, but not necessarily indicative of workplace violence. The important findings from Ngwezi's research are listed below:

Interactions in the medical team as stressors:

- Poor interpersonal relationships with doctors and other superiors - 61,6% *(one can accept that workplace violence will take place within this context)*
- Low "team-spirit" between nurses, superiors and medical staff - 56,6%
- Unreasonable behaviour of superiors (e.g. being rude, favouritism) - 36,6% *(this is also indicative of workplace violence)*

Dealing with patients as stressors:

- Dealing with impatient and angry patients - 36,6%
- Dealing with drunken and over-demanding patients - 36,6% *(workplace violence would be present in such circumstances)*

This study is not representative of the health sector population but significantly indicates high levels of stress that could result in workplace violence.

The first research on workplace violence per se in the health care services is that of the Medical Research Council: "The impact of crime and violence on the delivery of State Health Care Services in the Western Cape." While the focus of the MRC research is not the same as this research project, it allows for a reasonable comparison. The MRC research found that 60% of all respondents have to deal with workplace crime and violence frequently, verbal abuse is frequent and commonplace and 92,3% of respondents reported being verbally abused in the last two years, 36,4% of interviewees had occasionally been threatened with assault while crime concerns and incidents are rife.

The Ethics Institute of South Africa conduct an ethics audit on the Chris Hani Baragwanath Hospital (report released on 3 November 2001) with one of the objects being to assess the general working environment at Chris Hani Baragwanath Hospital (CHBH) and the possible effects that actors in that environment might have on the personal and interpersonal conduct of the employees. CHBH is not the most problematic public hospital in South Africa, but trends in this hospital would also be indicative of the situation experienced at other public hospitals. As expected, the ethical audit also encountered workplace violence being a problem as two-thirds of the staff agreed that the number of security staff was inadequate and 76% felt that they were poorly equipped to do their job.

[13] Marais (now Steinman) and Herman, M. 1997. Corporate Hyenas at Work, Kagiso Publishers, Cape Town..
[14] Ngwezi, A. A. 1997. Work stress in a group of black nurses. University of Pretoria.

57% believed that the screening of visitors was problematic and in general there is a huge lack of confidence in the capacity and ability of security staff to ensure a safe environment.[15].

When the findings of these studies in the public health sector (the research excluded private health care sector participants) are compared with the findings of this study on the incidence of workplace violence in the PRIHCS, workplace violence is much higher in the PUBHCS, despite the CCMA data suggesting that 8,6% of all private health care sector declaring disputes with their employers at the CCMA because if, for instance, the 8,6% is added to the percentage of PRIHCS staff who reported at least one incident of workplace violence in the study the frequency of incidents in the PRIHCS is still lower than in the PUBHCS, however there are important factors that influence the PRIHCS statistics, like the many self-employed service providers who are not so much at risk for violence as those working in formal settings.

In both sectors, the nursing sector is at great risk of workplace violence and the nursing profession has been singled out in many local and international studies for its propensity for stress and violence: "Although there is a high risk of workplace violence across all healthcare occupations, most commentators now agree that it is members of the nursing profession who are most at risk. While emergency departments and psychiatric settings still constitute particular 'hot spots' of violence, the rationalisation of healthcare services, leading to large numbers of disgruntled clients, and the advent of 'care in the community programmes', with their consequent early discharge from healthcare agencies, have both resulted in an increased risk of violence across many healthcare settings"[16].

An article in Health SA Gesondheid, Vol. 3 No. 2, 1998, does not deal with workplace violence as such, but explore attitudes of management, the exhibition of a paternalistic management style as having a negative impact on non-formal relationships. A strong argument is made in respect of the impact of leadership and management philosophy on labour relations: "Nurse managers and subordinates agreed that the leadership style exhibited by managers is the way in which the management philosophy of the organisation manifests itself in practice, and that management's leadership style has a definite effect on the level of the employee's performance inclination"[17]

Another study into the enhancement of positive working relationships among the role players within the managed healthcare context in Gauteng (Mahlo & Muller: 2000) found that role players (in this case private hospitals and general medical practitioners) and medical aid schemes indicated problems in the areas of communication, inadequate staff competence, procedural complexity, cost saving versus quality care, perceived loss of power by doctors and patients and the system of accounts payment. While this study did not explore workplace violence within managed healthcare, indications are that inadequate communication and power play (the doctors vs. the funders/hospital staff) could at the very least, be the cause of some workplace violence. The study recommended the empowerment of role-players, staff development, and standardisation, use of advanced information technology, recruitment and selection as solutions to improve these working relationships.

In an article (Health SA Gesondheid Vol 1 No. 2 1996) on the promotion of nurses mental health, the article fails to identify workplace violence as an obstacle influencing the mental health of nurses, but suggests supportive supervision, support workshops, assertiveness and stress management training and creating opportunities to cherish self in relationships with God, self and others as a solution to the interpersonal relationship, self-esteem and stress management problems experienced by nurses (Poggenpoel: 1996). While these life skills programmes could be useful, the root cause of the problem and a structural and strategic approach to solve it had been overlooked

It can be accepted that workplace violence is present in all economic sectors. "During 1998-1999 an Internet communication survey was conducted by the researcher simultaneously with the same survey with clients' employees as participants when presenting workshops on site. 78% of respondents reported that they had been victimised at least once during their careers.... During 2001 limited research on workplace violence was conducted at a large employer (the name cannot be mentioned for purposes of confidentiality). The organisation

[15] Ethics Institute of South Africa. 2001. Chris Hani Baragwanath Hospital Ethics Audit.
[16] Cooper, Cary L; Swanson N. 2001. Forthcoming Working paper: Workplace Violence in the Health Sector: State-of-the-Art.
[17] Bezuidenhout, M. 1998. The contribution of the Nurse Manager to healthy labour relations, Part 2. Health SA Gesondheid Vol. 3 No. 2 (1998) quoted from Gerber, P.D., Nel, P.S. and Van Dyk, P.S. 1992. Human resources management: 2nd edition. Halfway house: Southern.

was undergoing major changes and the workers were uncertain of their positions. Significantly: 25% affirmed "often" and "way too much" dreading to go to work because if interpersonal relationships with their peers and supervisors being less than pleasant; 30% of respondents experience "not too often" bullying; 10% of respondents experience physical threats on a daily basis and 2.5% are physically attacked on a daily basis."[18]

In a study about violence against domestic workers, Mmatshilo Motsei found that psychological violence against domestic workers had been document, but that physical and sexual harassment has been a "best kept" secret . This is partly attributed to the "social inequalities of power and rights between individuals of different races, sexes and classes"[19]. Therefore the solutions must be sought both within and outside the domestic environment.

Notwithstanding the impact of societal violence on the workplace, sweeping change in most organisations seems to be associated with abnormally high levels of workplace violence. In view of the restructuring in all sectors, the shortages of manpower and equipment in the PUBHCS, the drain of healthcare workers from South Africa, the high levels of workplace violence in the health sector as a whole require immediate intervention.

[18] Marais-Steinman, S. 2001. Challenging workplace bullying in a developing country: the example of South Africa. Forthcoming publication. Extract from Chapter 19 for a book to be edited by Proff. Cary Cooper, Stale Einarsen, Dieter Zapf and Helge Hoel for 2002.
[19] Motsei, M. 1990. The best kept secret: violence against domestic workers. Seminar No. 5, 1990. 25 July 1990 at the University of the Witwatersrand, Johannesburg, South Africa. http://www.csvr.org.za/papers/papmmots.htm visited on 9 March 2002.

SECTION B
Country Case Study(Results Of Field Study)

1
METHODOLOGY

1 DESCRIPTION OF METHODS USED TO COLLECT AND ANALYSE DATA

The study involved both qualitative and quantitative surveys. First and foremost it was necessary to determine the area where the study was to be conducted. For practical purposes, the Greater Johannesburg Metropolitan region was ideal as this area is fairly representative of urban South Africa. The Greater Johannesburg Metropolitan area is inclusive of areas like Krugersdorp and Roodepoort with lower crime rates than Johannesburg proper. But every South African city is unique. The frequencies for violent crimes are not uniform across the country. For example, provincial crime statistics indicate that homicide and assault rates are highest in the Western Cape, then the Northern Cape and then only Gauteng (Hamber & Lewis, 1997), but as a city Johannesburg proper remains the "crime" capitol.

The full range of health care facilities and health workers in the different health care settings were identified. The sampling design included the following multiple steps in order to reduce response bias:

- Listing and description of all facilities and service providers with available statistics
- The stratification of the sample for focus group discussions and the survey, determined by the total numbers of staff in the different categories of registered health care workers in South Africa as a whole to ensure a representative sample.
- Focus group discussions took place during 5-21 September 2001, also with the view to test definitions and make adjustments before administering the questionnaires.
- Questionnaires were administered from 24 September to 21 October.
- Other focus group discussion took place from 1 to 24 October to test the revised definitions and obtain further perspectives.

1.1 FOCUS GROUP DISCUSSIONS

The qualitative survey involved focus group discussions with health care workers, stakeholders and patients. Fieldworkers were identified and trained as note takers and moderators simultaneously as well as in the administering of questionnaires. Focus group discussion during the period 5-21 September 2001 tested the definitions provided by the ILO/ICN/WHO/PSI Annex 1 before the administering of the questionnaires for country-specific input. Accordingly, the Steering Committee of the ILO/ICN/WHO/PSI approved the definitions for workplace violence, physical and emotional as per Annex 2. Afterwards, between 1 and 24 October, perspectives were obtained from further focus group discussions and the revised definitions were tested and in all instances received favourably.

Full details of the moderator and note taker as well as the minutes of discussions are attached as Annex 3 in the form of a schedule. Focus Groups were, in as much as it was practically possible, homogeneous (for examples nurses on the same level, but working in different settings, pharmacists, professions allied to medicine and so on) in both the private and public sectors. The discussions were semi-structured as the sponsors had provided three different sets of interviewing questions for stakeholders, health care workers and patients.

Availability, safety concerns and the location of facilities, time and budget constrains played in role in determining the facilities and health care worker groups whom participated in these discussions.

1.2 QUESTIONNAIRE SURVEY

To ensure the best response rate possible and given the general tendency in this country that, sending out questionnaires would result in a 1-15% return, it was decided that the questionnaires be administered by field

workers where possible at the premises of the facility. However, in some cases, especially in the PRIHCS, the facility management was adamant that too much time would be lost through administering the questionnaires with a field worker and they suggested that they take a number of questionnaires and administer and collect it themselves through the human resources departments and that respondents be given a choice to either mail it back to the researcher themselves or to hand it in at the human resources department. While the last option could not be regarded as ideal, it nevertheless proved useful in obtaining the number of responses required. While it is possible for the management of a private setting to pressure staff to answer the questionnaire in a certain manner, it is extremely hard to establish this beyond reasonable doubt. There is reason to believe that such manipulation had been dealt with or had been minimised (see discussion of problems with survey later in this report). Table 13 of this report deals with frequencies (at least one incident) at the different facilities. Some of the private facilities, like Tshebo-Themba Hospital in Soweto, are likely to report a relatively lower frequencies as a very caring and enthusiastic management team and staff were encountered. In some instances, where management took partly or full responsibility for the administering of the questionnaires for example Witwatersrandse Tuiste vir Bejaardes, Park Lane Clinic, Lesedi Clinic, the frequencies indicated high levels of workplace violence and therefore no manipulation is expected. Further comments are made later in the report regarding the method of distribution and the possible impact on the responses.

All facilities were given a total numbers of nurses, technicians, support, administrative staff and management required from that specific facility to ensure broad presentation and in most cases these facilities provided the numbers requested. In other cases the questionnaires were distributed via e-mail through alumni societies at the Health Development Council, hand-delivered at the premises of health care workers in the PRIHCS with a return envelope and stamp, or mailed with a stamped return envelope. In cases where the targeted sample could not be obtained at study units, there was an ongoing contingency plan to ensure that another facility could be approached in a short space of time. This happened in a few instances, or there were instances where the responses were poor or unreliable due to interference from management and until the researcher exhausted all avenues, but obtained the required minimum number of questionnaires. The distribution realised as follows:

TABLE 1 : DISTRIBUTION OF QUESTIONNAIRES

The

Method of Distribution	Public Health Care Sector	Private Health Care Sector
Field worker administered	84%	45%
Other	16%	65%

"Other" means of distribution were where the facility distributed the questionnaires and the fieldworkers delivered/collected, delivered or mailed with a stamped envelope and returned by mail, or sent and/or received electronically (fax and e-mail).

The difference in the methods of distribution reflects the difference in attitudes towards the study between the PUBHCS and the PRIHCS. While the political and provincial head of the department for the Gauteng Province requested all health care facilities and providers in the Johannesburg Metropolitan Area to cooperate with the researcher in a circular letter, cooperation with the private health care facilities and service providers depended on the group and the hospital managers who, in some cases when participating, mainly viewed the process as a sacrifice and time-consuming and therefore alternative methods of distribution had to be resorted to.

The alternative methods of distribution proved very useful to enable the researcher to accommodate the fears of some the PRIHCS facilities that too much time will be wasted. Furthermore it enabled the researcher to engage independent providers through electronic means or the mail. Where the questionnaires were delivered and collected the PRIHCS facilities by a field worker, it could have technically been possible for management to manipulated responses and where there was suspicion that this in fact did occur (e.g. a whole section's questionnaires filled in one handwriting), the questionnaires were rejected. However, at these facilities staff were also approached to send in their questionnaires via mail as a confidentiality measure and to ensure that staff that felt intimidated, could participate. There are no guarantees, but it can be accepted that obstacles to avoid response bias through alternative methods of distributions had been minimised.

Once the questionnaires were collated, it became necessary to prepare the questionnaires for analysis. Firstly, the open-ended questions of the questionnaires O1, O2 and O3 had to be categorised so that it could form part of the data. For this purpose the remarks were listed and categorised and a guide was compiled to indicate the variable in the margin for the data capturers. The guide for questions 01, 02 and 03 of the questionnaire is attached as Annex 6.

Each questionnaire was then labelled in the right corner indicating the questionnaire number, public or private health care sector, a number for the name of the facility, the service level of the facility/provider and a number indicating the method of distribution.

After all questionnaires had been received back completed, these were prepared and labelled, 1018 questionnaires were packaged and taken to Statkom of the Rand Academic University for further preparation, data capturing, analysis and cross tabulation. The cross tabulations were chi-squared to establish significant differences between the public and private health care sectors.

2. DESCRIPTION OF SAMPLE

The meticulous planning to obtain a representative sample the study design delivered the desired results in that there the difference in what emerged from the survey and the initial planning still delivered a representative sample, more so with the questionnaire survey than with focus group discussions. The reason for the difference in planning and what materialised with the questionnaire survey, was the fact that private health care facilities did not deliver the "quota" per facility. Other facilities had to be approached and ultimately alternative ways of distribution had to be improvised to obtain a representative sample in the PRIHCS.

A discussion of the focus groups and questionnaire survey follows:

2.1 FOCUS GROUPS

Eighteen focus group interviews took place involving a representative cross-section of all health care workers in the PUBHCS and PRIHCS with the exception of medical doctors who could not, because of their schedules in the PUBHCS and for monetary reasons on the case of the PRIHCS, participate in such a interview..
Furthermore, a workshop attended by 38 hospital representatives, managers, commissioners of the Council for Conciliation, Mediation and Arbitration, labour advocates, fieldworkers, trade unions and other human rights organisations to discuss the survey results and work towards solutions was held on 9 November and served as a focus group too.

TABLE 2: CATEGORIES INCLUDED IN FOCUS GROUP DISCUSSIONS

QUALITATIVE RESEARCH : FOCUS GROUP DISCUSSIONS 179 SUBJECTS INTERVIEWED		
Public Health Sector	Private Health Sector	Stakeholders
Nurses *(all categories, 26 participants)* Professions allied to medicine *(9 participants)*	Nurses *(all categories, 24 participants)* Manager and therapists *(9 participants)*	Trade Unions *(11 participants)* CCMA *(11 participants, drew up document re definitions)* Individual interviews *(4 interviews,*

QUALITATIVE RESEARCH : FOCUS GROUP DISCUSSIONS *179 SUBJECTS INTERVIEWED*		
Public Health Sector	Private Health Sector	Stakeholders
Pharmacists *(5 participants)* Support Staff *(9 participants)* Admin Staff *(6 participants)* Parameds *(10 participants)*	HR Managers *(4 managers, not structured interviews, individual visits)* Admin Staff *(8 participants)*	*not structured)* Patients *(5 participants)* Joint Workshop/Brain-storming all stakeholders *(38 participants)*

The information obtained from the Focus Groups interviews were refined in a report on each question in a cross tabulation (Annex 3) and the strengthening of the findings in the questionnaire survey would be indicated in the discussion of the results and the conclusions further on in this report.

2.2 QUESTIONNAIRE SURVEY

The health care facilities were listed and for this purpose the 2000 Hospital and Nursing Year Book and available statistics from the Health Systems Trust, Gauteng provincial government, StatsSA (Department of Statistics) were used. The facilities were described and categorised according to the level of care attached as Annex 7.

While an initial selection of facilities delivered some obstacles, especially with the PRIHCS facilities and providers and the researcher had to depend on stratified availability sampling and not stratified random sampling. It is likely that those sites, which cooperated, are aware of the important impact of workplace violence in the health care sector (for example the Netcare group) and have already limited interventions in place. These would use the findings of this study to improve existing interventions and to monitor the effectiveness of their policies. It follows that those health care groups who refused to participate may very well expected their sites to show up with high frequencies. Because of various reasons these sites would regard the study as a time-consuming or there may well be no awareness and therefore an indifference to the importance of the study. The exclusion of some health care provider groups from the study could have had an influence on the findings, however it is not possible to determine if and to what extent.

The following facilities and service providers participated in focus group discussions and the questionnaire survey:

TABLE 3 : PARTICIPATING FACILITIES

PUBLIC HEALTH CARE SECTOR	PRIVATE HEALTH CARE SECTOR
➢ Johannesburg General Hospital ➢ Chris Hani Baragwanath Hospital (Soweto) ➢ Edenvale Hospital ➢ Yussaf Dadoo Hospital (Krugersdorp) ➢ 11 districts of Primary Health Care Clinics (covers whole area, provincial and local government) ➢ The Johannesburg Metropolitan Council Emergency Services ➢ Tara Psychiatric Hospital ➢ Avril Elizabeth Home for the mentally and physically disabled[20] ➢ Witwatersrandse Home for the Aged[21]	➢ Milpark Hospital ➢ Parklane Clinic ➢ Kenridge Hospital ➢ Krugersdorp Hospital ➢ Lesedi Private Hospital (Soweto) ➢ Tshebo-Themba Private Clinic (Soweto) ➢ Africure Ambulance Service ➢ Netcare Rehabilitation Hospital ➢ Roodepoort Centre for the Aged ➢ Sandringham Nursing Home ➢ Professions Allied to the Medicine ➢ Homecare Nurses ➢ Physicians & private professional service providers.

[20] This facility does not fall under the control of the health department, but is subsidised by the state and for the purposes of the study, classified as "public health sector".
[21] Ibid.

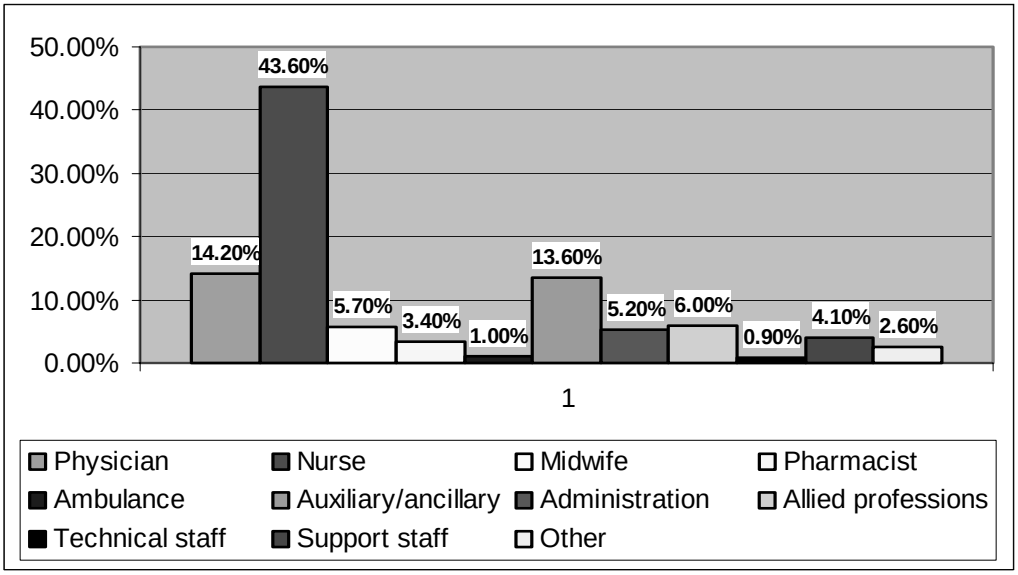
South Africa is a developing country where wealth and poverty exist side by side. As there is a vast discrepancy between the public and private health care, it was decided to sample equally from both sectors and where possible and applicable, equally in all the levels to make a meaningful comparison.

The researcher obtained the full cooperation of the government health care authorities and participating health care providers in the PRIHCS. The head of the Department of Health of the Gauteng Province requested all hospitals, clinics and healthcare facilities in the Johannesburg Metropolitan Area through a circular letter to give their full participation and that staff be informed that the survey is voluntary and confidential and that participants would not be identified.

The participation from private health care providers however depended on the goodwill of the hospital or group and the cooperation of the management of the hospital or clinic group head office indicated which hospitals could be approached. In all cases, a personal visit was paid to the management of the facility beforehand, requesting their cooperation. Stakeholders like unions, the statutory bodies involved in labour disputes and professionals were also involved and gave their cooperation.

It was then necessary to determine how many of each category of health care workers needs to be collected and for this purpose Health Professionals Council of South Africa's 1998 statistics were used. The stratifying and categorising of health care workers are attached as Annex 8. This is how the different professionals categories of health care workers realised in the questionnaire survey:

FIGURE 1 : CATEGORIES HEALTH CARE WORKERS PRESENTED IN THE SAMPLE



The next step was to determine the size of the levels of service levels defined as follows:

Level 1: Major referral hospital. (Tertiary level). This category of facility has the most specialised staff and technical equipment.
Level 2: Regional and district hospitals (Secondary level). This category of facility has fewer specialities than referral hospitals, but still has differentiated care and services.
Level 3: Clinics, mobile clinics, satellite clinics, community health care centres, with a variety of services like oral health, curative care, chronic care, child health, immunisation, family planning, STD, TB, HIV counselling, home visits, mental health, school health, primary health care clinical services, geriatric care, podiatry, psychiatry counselling, ANC. This category also include ambulance services (if independent from hospitals)
Level 4: Rehabilitation centres, long-term care facilities.
Level 5: General practitioners' offices, specialists and other independent health care professionals.

The number of health care workers working in each level and then the number of questionnaires to be administered in each service level was determined. The working plan is attached as Annex 8. This is how the services levels are presented in the sample:

54.9% - Level 1: Major referral hospitals
11.7% - Level 2: Regional/district hospitals
7.2% - Level 3: Clinics and ambulance services
14.5% - Level 4: Long term care
11.5% - Level 5: Independent service providers

It is evident that the sample is representative of the different service levels. The Pre-Survey Sampling Logistics (see table below) was compiled to serve as a logistics guide to accurately determine where/how/which categories and the totals to be sampled at each site/category service provider. This proved to be extremely valuable in contacts with the facilities and providers. In all cases the available facilities/providers selected from the volunteers who participated in the survey, with the result that from the researcher's point of view it was a truly availability sample. Initially the facilities were stratified and randomly selected. However, as the project progressed, availability played the dominant role in the selection of the facilities, more so in the PRIHCS than in the PUBHCS.

TABLE 4: PRE-SURVEY SAMPLING LOGISTICS

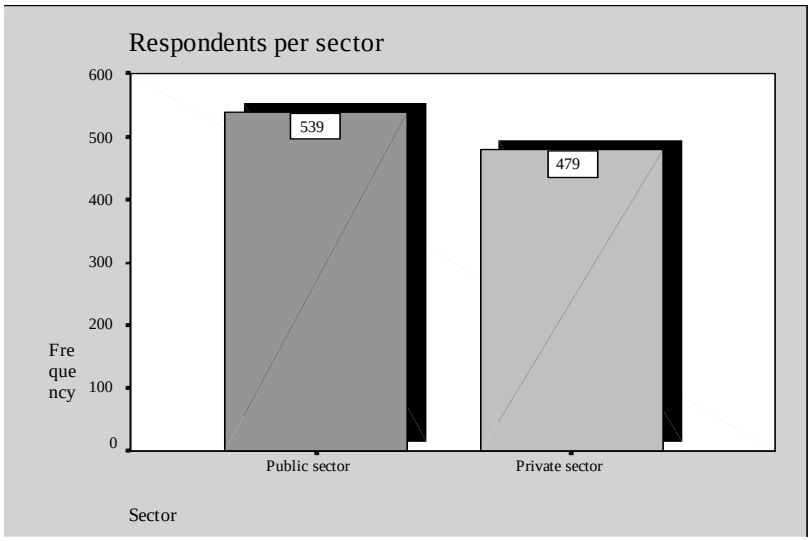
Public Health Care Sector										
Catego-ry/Facil.	**Joh.Gen andCHBaragwa Jhb - CHBa 55%**		**SoutRand 16%**	**Tara 6%**	**PHC Lgov 11%**	**Avri Eliza 6%**	**Wit-watR 6%**	**No. for pub/priv**		
Physic.	**22**	**43**	**2**	**1**	**2**			***70***		
Nurses	**55**	**111**	**46**	**19**	**36**	**18**	**18**	***303***		
Prof.	*32*	*65*	*27*	*11*	*21*	*10*	*10*	*178*		
Staff	*7*	*15*	*6*	*3*	*5*	*2*	*3*	*41*		
Ass/Aux	*16*	*30*	*13*	*5*	*10*	*5*	*5*	*84*		
Pharma	**5**	**10**	**1**	**1**	**2**			***19***		
Manage	**4**	**4**	**2**	**1**	**3**		**1**	***15***		
Ancil.		**5**			**5**			***10***		
Opt.		*5*						*5*		
Environ					*5*			*5*		
Ambul.					**5**			***5***		
Admin	**5**	**10**	**4**	**2**	**2**	**1**	**1**	***25***		
Prof.	**10**	**18**		**1**				***29***		
Radiog	*3*	*4*						*7*		
Sph/Au	*1*	*2*						*3*		
Physio	*3*	*4*						*7*		
Psy	*3*	*4*		*1*				*8*		
OccThe	*2*	*2*						*4*		
Support	**5**	**11**	**4**	**1**	**1**	**1**	**1**	***24***		
Techno	**3**	**4**						***7***		
TOTALS	**109**	**216**	**59**	**26**	**56**	**20**	**21**	***507***		
Private Health Care Sector										
Catego-ry/Facil.	Roo **Tuist 6%**	**Netc Reha 6%**	**Sandham 6%**	**Mil-park 23%**	**Park-lane 16%**	**Kenridge 16%**	**Lesedi 11%**	**Kru/dorp 16%**	**Priv. Pro-vider**	**Total**
Physic.									**70**	**140**
Nurses	**14**	**14**	**14**	**70**	**48**	**48**	**34**	**48**	**13**	**606**
Prof.	*8*	*8*	*8*	*41*	*29*	*29*	*20*	*29*	*8*	*356*

Staff	*2*	*2*	*2*	*9*	*6*	*6*	*4*	*6*	*2*	*82*
Ass/Aux	*4*	*4*	*4*	*20*	*13*	*13*	*10*	*13*	*3*	*168*
Pharma		**1**	**1**	**1**	**1**	**1**		**1**	**13**	**38**
Manage	**1**	**1**	**1**	**3**	**3**	**2**	**1**	**3**		**30**
Ancil.									**10**	**20**
Opt.									***5***	*10*
Environ									***5***	*10*
Ambul.									**5**	**10**
Admin	**1**	**2**	**2**	**6**	**4**	**4**	**1**	**4**	**1**	**50**
Prof.		**4**							**25**	**58**
Radiog									***7***	*14*
Sph/Au		*1*							***2***	*6*
Physio		*1*							***6***	*14*
Psy									***8***	*16*
OccThe		*2*							***2***	*8*
Support	**3**	**4**	**3**	**2**	**2**	**2**	**2**	**6**		**48**
Techno				**1**	**1**			**1**	**4**	**14**
TOTALS	**19**	**26**	**21**	**83**	**59**	**57**	**38**	**63**	**141**	**507**
TOTAL PUBLIC AND PRIVATE HEALTH CARE SECTOR WORKERS										1014

The actual sample (see Figure 1) differed from Pre-Survey Sample Logistics because organisations and the exact quantities per category per facility depended on availability and had to be changed. However, this logistical planning served as an excellent guide. What actually emerged from the questionnaire survey could be regarded as a representative sample of the health care sector. The researcher tried to sample the exact same totals in the PUBHCS and PRIHCS. Even though it was expected that it would not be practicably possible. This approach kept the researcher on tract to obtain the most representative sample possible, as specified.

This is how the distribution of the sample in the public and private health care sectors realised in the questionnaire survey:

FIGURE 2: PUBLIC AND PRIVATE HEALTH SECTOR SAMPLE



Public Health Care Sector: 52.9%
Private Health Care Sector: 47.1%

2.2.1 Respondent Demographic Data

2.2.1.1 Sex Distribution

Respondents were predominantly female (74,5%), with 21% male while 4,5% respondents did not indicate their sex. There was no significant difference between the gender distribution in the PUBHCS and PRIHCS.

2.2.1.2 Age Distribution

TABLE 5: AGE GROUP AND PERCENTAGES

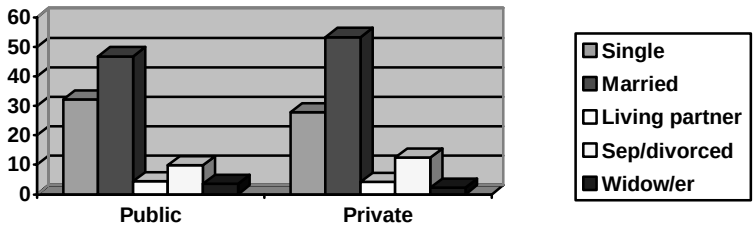
AGE GROUP	COUNT	PERCENTAGE
20-24	44	4.3
25-29	132	13.0
30-34	176	17.3
35-39	160	15.7
40-44	195	19.2
45-49	127	12.5
50-54	95	9.3
55-59	53	5.2
60+	32	3.1
Missing (didn't fill in)	4	.4
TOTAL	*1018*	*100%*

There are no significant differences in the age group distribution in the private and the PUBHCS in general, except for the age group 20-24 with 5.8% of the study population in the PRIHCS and only 3% in the PUBHCS.

2.2.1.3 Marital Status

The majority of health care workers (49,9%) are married. There are interesting differences between the marital status of health care workers in the public and PRIHCS although the similarities are more striking. It is evident that the public sector draws more single, living with partner and widowed employees, while there are higher percentages of married and divorced people working in the PRIHCS:

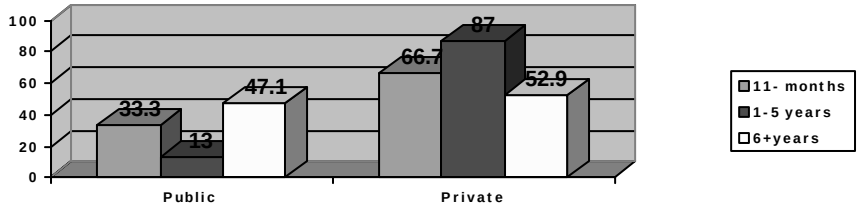
FIGURE 3: MARITAL STATUS OF RESPONDENTS



2.2.1.4 Foreign/Immigrant Workers

10,5% of health care workers came from other countries. Of these migrant workers, 38% work in the PUBHCS and 62% work in the PRIHCS. Younger immigrant health care workers predominantly work in the PRIHCS in the first five years as illustrated below.

FIGURE 4: FOREIGN AND IMMIGRANT WORKERS - PERIOD IN COUNTRY



2.2.1.5 Ethnic Groups

The question was "How do you see yourself in the country, community and workplace" which delivered interesting responses:

TABLE 6: ETHNIC GROUPS - HOW DO YOU SEE YOURSELF IN THE COUNTRY, COMMUNITY AND WORKPLACE?

How do you see yourself	Public Health Sector		Private Health Sector	
	Majority	Minority	Majority	Minority
in the country	334	157	202	223
% in group	62,3%	41.3%	37.7%	58.7%
% in sector	68%	32%	47.5%	52.5%
in community	357	122	308	103
% in group	53,7%	54,2%	46,3%	45,8%
% in sector	74,5%	25,5%	74,9%	25.1%
in workplace	325	161	257	157
% in group	55,8%	50,6%	44.2%	49.4%
% in sector	66.9%	33.1%	62.1%	37.9%

This question was problematic for some respondents and some respondents asked for clarification from fieldworkers present. To avoid misunderstanding in cases where a fieldworker did not administer the questionnaire,, the questions were discussed when handing over the questionnaires for distribution. For instance, the majority ethnic group would be at the workplace, but the person working in a specific section may be a minority in that section and the respondents could have interpreted it differently if a fieldworker was not present to answer a question or explain when administering the questionnaire. In general it was taken as the workplace as a whole. It is evident from the counts that some respondents left ignored parts of the question and 118 respondents did not answer the question at all. However, there is a significant difference in the number of respondents in the public sector viewing themselves as the majority ethnic group (68%) as opposed to those viewing themselves as the majority ethnic group in the country in the PRIHCS (47,5%).

2.2.2 Workplace Data of Respondents

The Personal and Workplace Data and other data are attached as Annex 9 and cross-tabulations in respect of data is attached as Annex 10. However the following salient points indicate significant differences between the private and public sectors and/or significant information obtained from the dataset:

☞ 11,5% (n=58) respondents indicated that they are "senior managers" in the PUBHCS as opposed to 7,9% (n=36) in the PRIHCS. It appears as if the public health care sector would then present with more hierarchies as opposed to the rather “slim” management structure in the PRIHCS. While one would expect better accessibility and therefore a higher level of satisfaction by respondents expressed in focus group discussions, it was not the case and there were more references to incompetent management by the PUBHCS focus groups than the PRIHCS participants. This could be an indication that the PUBHCS could be “top heavy” with senior managers while there are staff shortages on other levels. This could contribute to the higher levels of workplace violence experienced in the PUBHCS.

☞ 4,6% (n=22) of health care workers in the PRIHCS work part-time and 1,9% (n=10) in the PUBHCS. It appears as if the PRIHCS is more flexible in employing part-time health care workers as and when the need arise. It is for instance a well-known fact that private hospitals employ part-time staff between certain hours when there is a higher patient-intake to prevent long cues. The PUBHCS could certainly benefit from employing more part-time workers to cope with long cues at pharmacies or during peak periods.

☞ The patient profile significantly differs between the two sectors: 67,4% (n=147) of the respondents who work with newborns are in the PUBHCS; similarly 56,6% (n=175) work with children, 59,1% (n=185) work with adolescents, 53,5% (n=404) work with adults. It can be assumed that health care workers in the public sector would have a broader range of experience. This is also evident in the significant differences of the gender profile of patients in the two sectors: : 22,1% (n=105) work with female patients only, 2.5% (n=12) work with male patients only and 75.4%

(n=358) work with male and female patients in the PUBHCS while 7% (n=28) work with female patients only, 4.2% (n=17) with male patients only and 88.8% (n=355) work with male and female patients in the PRIHCS.

The above biographic and workplace data are examples and illustrate how the sample captured the broad range of health care workers in their different settings with significant differences already emerging from this specific data between the private and public health care sectors of South Africa. Their demographic details differ, their work settings, their patients and their anxiety about workplace violence represents two worlds in one study.

3 LIMITS OF THE STUDY

3.1 WHAT THE STUDY COULDN'T CAPTURE/EXPLORE

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

3.1.1.1 The Greater Johannesburg Metropolitan region is, as explained earlier in the study, fairly representative of urban South Africa and therefore the study is in part representative of urban South Africa and not the rural areas.

3.2 PROBLEMS EXPERIENCED WITH FIELD WORK

3.2.1 The health sector in South Africa is under immense strain because of staff shortages - and it was extremely difficult to make the necessary arrangements.

3.2.2 The high rate of crime and violence in the Greater Johannesburg Metropolitan was a problem. It is felt that the safety of fieldworkers should be top priority. The planning and study design necessarily took cognisance of this very real threat.

3.2.3 Unavailability of and/or slackness to deliver statistics and comply with deadlines to make the necessary arrangement compounded the difficulties experienced. Availability of facilities and workers influenced the sampling, for example, the largest provider of private hospitals and clinics would only make a few facilities of their choice available, while other groups chose not to participate in the research project. It was extremely difficult to get cooperation in the PRIHCS with the exception of one group. In general the PUBHCS felt that participation in the research project is a sacrifice.

3.2.4 The extent of workplace violence in the health sector became evident when, in a few instances, field workers were subjected to abuse behaviour from health care managers, couldn't approach facilities because of labour related problems and threatening behaviour from criminals outside the facilities. There was also an instance when a manager attended a focus group discussion uninvited and prevented the participants to engage in an open and honest discussion.

3.2 PROBLEMS EXPERIENCED WITH QUESTIONNAIRES

3.3.1 Questionnaires of this length is normally a problem, but in a highly pressurised environment like the health care sector some respondents were under pressure to get back to their work stations.

3.3.2 The questionnaire created the following problems in the SA context:
Question PD 6: Which category best describes your present professional group? *Many respondents marked more than one category. The problem was rectified manually as follows: if the respondent marked both ancillary & nurse, ancillary took precedence. If the respondent marked both other and another category, the latter took precedence.*

3.3.2.2 Question PD 13: Work most frequently with... newborns, infants, children, and adolescents (10-18 years of age, adults, and elderly.
Many respondents marked more than one category and these were thus viewed as separate variables.

3.3.2.3 Question PD 14: Spend more than 50% of time working with... physically disabled, mentally disabled, home care, terminally ill. HIV/AIDS, psychiatric patients, mother/child care, geriatric patients, occupational health and safety, school health, other....
Although it is impossible to spend more than 50% of your time on more than one activity, many SA respondents marked more than one category and hence, in order to eliminate any bias, these were recorded as separate variables.

3.3.2.4 Question PD 19: Is there encouragement to report workplace violence? By whom: Manager/employer, Colleagues, Union, Association, Own family / friends, Other,
Since one can be encouraged by more than one person / group, the questions in pd 19.1 were viewed as separate variables.

3.3.2.5 Question PV 1.3: Who attacked you?: patient/client, relatives of patient / client, staff member, management / supervisor, external colleague / worker, general public, other
Respondents clearly did not understand that these questions apply only to the last time you were attacked and thus often marked more than one option. To avoid bias, these were considered as separate variables.

3.3.2.6 The latter comment (1.3.3.3.5) also applies to Questions PV 1.7, PV 1.12 and PV 1.13 as well the equivalent questions relating to verbal abuse, mobbing/bullying, sexual- and racial harassment.

3.3.2.7 In many cases respondents failed to fill in all the questions and a large percentage of respondents did not fill in the open-ended questions O1, O2 and O3 are did not give the three variables required.

3.3.2.8 Every possible care had been taken to ensure that all respondents feel safe to express themselves in the questionnaires. In one case, where a batch of questionnaires from a section from one of the facilities obviously had been filled in the same handwriting, the batch (21 questionnaires) was rejected.

3.3.2.9 In cases where the first page of the questionnaires had been completed by the respondent, and the rest left blank, had also been rejected. There were 28 such cases from various facilities.

3.3.2.10 Question PD 9 "Which category of employment sectors represents best your employment for your main job?" was also open to double interpretation e.g. the Sandringham Nursing Home. While it could be classified under "religious" (Jewish community) but it is also private - non profit sector. Therefore the additional labelling of questionnaires classifying them as either PRIHCS or PUBHCS was useful in rectifying such misunderstandings.

3.3.2.11 Question PV 1.1 It emerged quite late in the administering of the questionnaires that not everybody understood the same thing under a weapon. "Weapon" could have meant "gun" to some and therefore it could be accepted that violence with a weapon could indeed be much higher than the frequencies indicate in this report.

3.3.2.12 Some questions, also towards the end of the questionnaire weren't well answered or the respondents got tired, were in a hurry.

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

Respondents from both the private and public health care sectors reported high incidents of workplace violence in the respective sectors. However, the levels of workplace violence reported in the public health sector were abnormally high.

1. FREQUENCY OF REPORTED INCIDENTS CONCERNING THE DIFFERENT FORMS OF VIOLENCE AT WORK

61,9% of all health care workers in South Africa experienced at least one incident of physical or psychological workplace violence (verbal abuse, bullying/mobbing, racial harassment, sexual harassment) the past twelve months as illustrated in the figure below:

There is a marked difference between the violence (physical and psychological) in the PUBHCS when compared to the PRIHCS and a number of respondents experienced more than one incident of physical and psychological violence as illustrated below:

TABLE 7: NUMBER WORKPLACE VIOLENCE INCIDENTS PER RESPONDENT

Number of different types of violence experienced per respondent	PUBHCS Count	PUBHCS %	PRIHCS Count	PRIHCS %	Total Percentage
One type only	183	34.0	120	25.1	29.8
Two types per respondent	194	19.3	81	16.9	18.2
Three types per respondent	63	11.7	34	7.1	9.5
Four types per respondent	27	5.0	19	2.1	3.6
Five types (ALL) per respondent	6	1.1	2	.4	.8
TOTALS	383	71.1	247	51.6	61.6

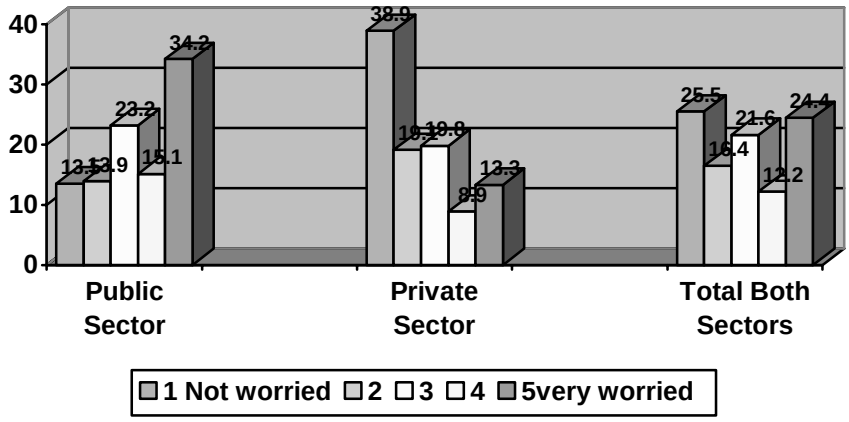
Although the PRIHCS's incidents of workplace violence is also very high, the PUBHCS's frequency are much higher and this is indeed a shocking picture. It should also be noted that 17.8% of respondents experienced three to five types of violence in the PUBHCS while 9.6% of respondents reported the same in the PRIHCS. These figures are alarming and healthcare workers are worried about the situation, more so in the PUBHCS than in the PRIHCS as illustrated in the table below:

TABLE 8: WORRIED ABOUT THE LEVEL OF VIOLENCE

Level of being worried		PUBHCS	PRIHCS	TOTAL
1 not worried at all	Count	70	179	249
	%	13.5	38.9	25.5
2	Count	72	88	160
	%	13.9	19.1	16.4
3	Count	120	91	211
	%	23.2	19.8	21.6
4	Count	78	41	119
	%	15.1	8.9	12.2
5 very worried	Count	177	61	238
	%	34.2	13.3	24.4

From the above it is evident that health care sector staff in the PUBHCS are more anxious than those in the PRIHCS. This is reflected in the higher incidence of workplace violence in the PUBHCS but factors (for example policies, post-violence reactions and so on) that will be discussed later on in this report significantly impact on the level of anxiety experienced by the health care workers.

FIGURE 5: LEVEL OF BEING WORRIED ABOUT WORKPLACE VIOLENCE



While 72,5% of health care workers in the PUBHCS is moderately to very worried (3-5) about workplace violence only 42,2% of health care workers in the PRIHCS share this level of worriedness. This is a significant difference. In both sectors there is no significant difference between male and female respondent's level of anxiety or worry about workplace violence.

BOX 1: QUALITATIVE SURVEY THEME
Frequency of Violence in both health care sectors

Focus group discussions suggested that health care workers in the PUBHCS were subjected to more workplace violence than their counterparts in the PRIHCS. Those in the PUBHCS listed more physical violence of an aggressive nature (e.g. gang wars) than those in the PRIHCS who would experience physical violence from confused or psychiatric patients. They understood this in terms of the patients' conditions. Psychological workplace violence was also more frequent in the PUBHCS with more examples listed than in the PRIHCS. The results pertaining to the sector frequencies of incidents of the various forms of workplace violence of the questionnaire survey is therefore no surprise. The level of concern about the violence in the workplace was also expressed in focus groups discussions. The large majority of participants expressed concern about the levels of workplace violence and said that it is worse than a year ago, in few instances groups felt that it stabilised, but not one focus groups were more at ease than a year ago. It is a growing problem.

1.2 PHYSICAL WORKPLACE VIOLENCE

Physical workplace violence seems to be extremely high in the PUBHCS and also high, but significantly lower in the PRIHCS. 135 respondents reported having been physically attacked in the workplace. Of this total 67,4% work in the PUBHCS and 32,6% in the PRIHCS. The result is that 17% (n=91) of health care workers in the PUBHCS had been physically attacked in the last twelve months while 9.1% (n=44) of health care workers in the PRIHCS reported at least one physical attack. Of these, 11,3% (n= 13) had been with a weapon. However, the percentage incidents involving weapons are slightly higher in the PRIHCS: 13,5% of incidents of physical violence involved weapons in the PRIHCS and 10,3% in the PRIHICS.

What is most disturbing is that 73.6% (n=64) of those who had been physically attacked in the PUBHCS perceived the incident to be typical and commonplace while, in the case of the PRIHCS 61.5% (n=24) perceived this to be a typical incident. When asked if the incident could have been prevented 70.3% (N=52) of the respondents in the PUBHCS who had suffered a physical attack answered affirmative while only 29.7% (n=22) of respondents in the PRIHCS believes the same. While one could presume that in the private sector most attacks were related to perpetrators psychopathology whereas in the public sector they were due to interpersonal and societal factors a major factor would relate to security in and around the hospitals where security is more efficient because of the high priority it receives and the risk of a facility getting a bad reputation and subsequently losing money as a result of inadequate security. The security guards in the PUBHCS were also perceived to be "incompetent" by the participants in focus groups discussions groups. In as far as the commonality of physical violence incidents and the avoidability of the incidents are concerned there, is a very significant difference between the public and private health care sectors.

Equally disturbing is the total of participants who witnessed incidents of physical violence in the workplace. Witness trauma is accepted by psychologists and as defined in the DSM-IV (the fourth edition of the American Psychiatric Association's Diagnostic and Statistical Manual), equally traumatic to the actual experience. The DSM-IV's international equivalent is the World Health Organization's ICD-10. In the PUBHCS 25.5% (n= 131) and in the PRIHCS 10.1% (n= 44) respondents reported to have witnessed incidents of physical violence. Once again, significant differences between the PUBHCS and the PRIHCS and reason for concern.

The combined percentages for health care workers who had been exposed as either direct or witness victims to physical workplace violence in both health care sectors are 30,9% but within the PUBHCS only this figure is 42,5% and PRIHCS only, 19,2%. These are alarming figures and more alarming, the huge discrepancy between the two sectors.

BOX 2: QUALITATIVE SURVEY THEME
Physical Violence

In focus groups discussions a number of PUBHCS groups requested that the word "strangling" be added to the original definition as an example of physical attacks. Although this is an assault without a weapon, it is a severe life-threatening incident and accounts of strangling as a cause of death in general violent crimes in the country is also commonplace in the killing of women and young children. The larger majority of health care workers are women and therefore the issue of strangling would receive attention. The issue of group violence was also mentioned and violence between rival unions..

While physical violence is a concern to both PUBHCS and the PRIHCS, the biggest concern came from the PUBHCS because these incidents are more crime-related, while the physical violence experienced in the PRIHCS would focus more on patients. The focus groups also mentioned car hijackings, robberies, certain places in public hospitals (e.g. the "bridge" at Chris Hani Baragwanath Hospital), the fact that criminals hide in big hospitals, gang wars being continued in the hospital, patients with fire-arms, attacks in the car parks, convicted criminals have no respect for staff and slap, bite and spit staff. It has recently been reported that a nurse lost her finger due to an HIV-infected patient biting off her finger and now fear contracting the disease.

The extent of physical attacks with a weapon may be greater than the questionnaire survey figures reflect. The account given here must be regarded as the minimum figure. As mentioned earlier in this report, some understood "weapon" to mean fire-arm while there are incidents where staff had been threatened with knives or a piece of glass being held to a worker's throat.

Patients are often the perpetrators and patients who had been stabbed, for example, is reported experience immense anger and attack health care workers. Health care workers explained that the anger appears to be related to feelings towards the perpetrators and that “a stab” (name for stabbed patients) may also abuse substance. Similarly psychiatric patients, patients with diseases like Alzheimer and confused patients could get violent, but there is understanding for their condition. Patients under the influence of drugs or alcohol physically attacking health care workers. Theft is a problem in the PUBHCS and health care workers and their families are threatened and/or being stalked by crime syndicates operating in the hospitals, should they dare report theft or unauthorised requests for stock. Fear, and being worried about physical violence was observed and related in the focus group discussions.

Physical violence seems to be a far greater concern in the PUBHCS than in the PRIHCS and focus groups observations strengthens the results of the questionnaire survey.

1.3 PSYCHOLOGICAL VIOLENCE

On average psychological violence is very high, with verbal abuse topping the list. Health care workers reported 49,5 having experienced incidents of verbal abuse, bullying/mobbing 20,4%, racial harassment at 22,3% and sexual harassment at 4,6%. There is a significant higher incidence of verbal abuse, bullying/mobbing, and racial harassment in the PUBHCS than in the PRIHCS. The only exception is on the incidence of sexual harassment, where there is no significant difference between the two sectors. The figures are reflected below:

TABLE 9: PSYCHOLOGICAL VIOLENCE INCIDENTS AND INTENSITY

Description	Percentage Both Sectors	Public Health Care Sector		Private Health Care Sector	
		Count	%	Count	%
Answered "yes" to verbal abuse	52	323	60.1	204	42.8
How often: all the time	13.8	40	13.1	29	14.9
How often: sometimes	68.5	207	67.6	136	69.7
How often: once	17.8	59	19.3	30	15.4
Answered "yes" to bullying/ mobbing	20.6	131	24.4	78	16.3
How often: all the time	15.1	17	13.4	14	17.9
How often: sometimes	63.4	83	65.4	47	60.3
How often: once	21.5	27	21.3	17	21.8
Answered "yes" to racial harassment	22.5	145	27.1	82	17.4
How often: all the time	18.5	19	14.1	21	25.9
How often: sometimes	63.4	92	68.1	45	55.6
How often: once	18.1	24	17.8	45	18.5
Answered "yes" to sexual harassment	4.6	26	4.8	21	4.4
How often: all the time	13.2	3	13.6	2	12.5
How often: sometimes	55.3	13	61.9	8	50.0
How often: once	31.6	6	27.3	6	37.5

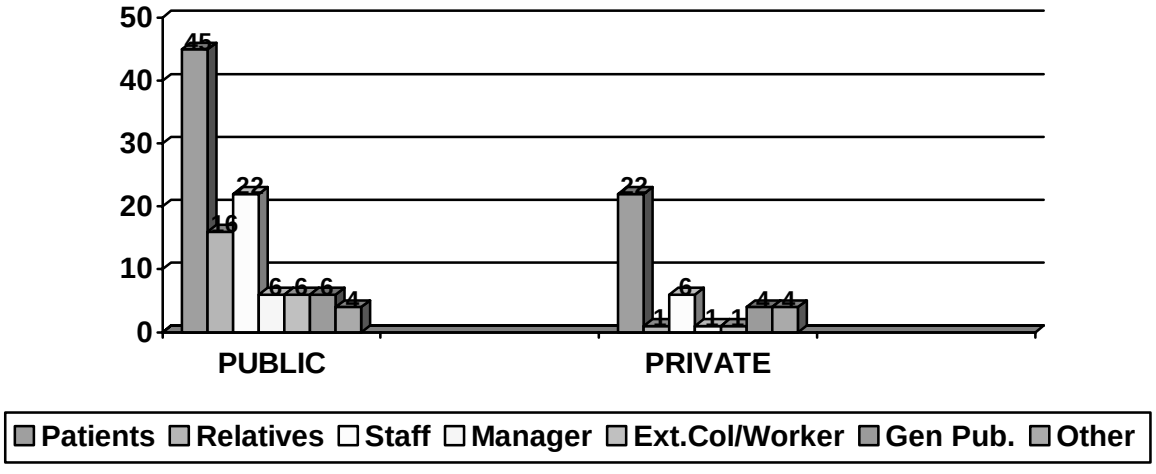
On average the majority (60%-70%) of both sectors' respondents who reported psychological violence, experienced the frequency in all forms of psychological violence happening to them "sometimes". But there are sector differences in the intensity of incidents of those reporting it to happen "all the time". Those who reported being bullied/mobbed in the PRIHCS experience it "all the time" 17,9% as opposed to the PUBHCS's 13,4%. The incidence of racial harassment happening "all the time" is also higher in the PRIHCS - 25,9% as opposed the PUBHCS's 14,1%.

The most salient feature is that in the PUBHCS the incidence of psychological violence is extremely high.

2. PERPETRATORS OF VIOLENCE

The respondents listed more than one perpetrator in some instances, for example the patient and the patient's relatives. Therefore the counts would exceed the actual number of respondent.

FIGURE 6: COUNTS FOR TYPES OF PERPETRATORS PHYSICAL VIOLENCE



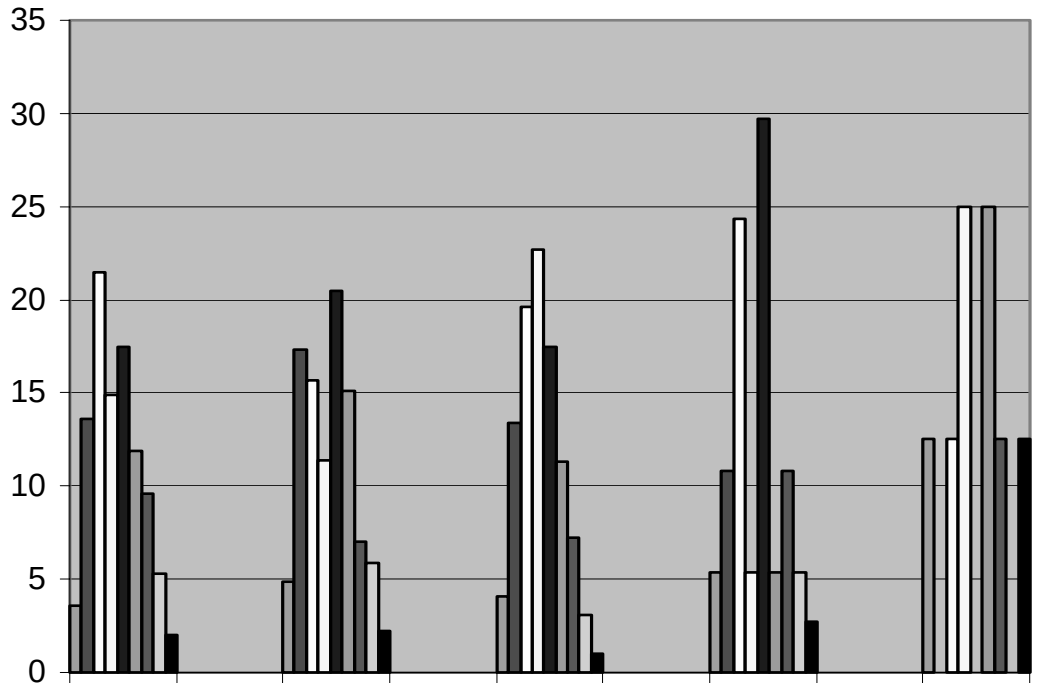
It is evident that in both the PUBHCS and the PRIHCS, patients are the perpetrators, while relatives of the patients and staff members are a much larger problem in the PUBHCS than in the PRIHCS. While percentages are small for Manager/Supervisors as perpetrators, it is still disturbing that they are the perpetrators in 5,7% of PUBHCS cases and 2,5% cases in the PRIHCS.

TABLE 10: COUNTS FOR TYPES OF PERPETRATORS OF PSYCHOLOGICAL VIOLENCE

	Verbal Abuse		Bullying/Mobbing		Sexual Harassment		Racial Harassment	
Perpetrator	Public	Private	Public	Private	Public	Private	Public	Private
Patients	140	75	32	7	6	6	53	37
%	33.4	27.7	18.9	7.8	20.7	30.0	26.0	30.6
Relatives	75	47	22	3	2	2	37	17
%	17.9	17.3	13.0	3.3	6.9	10.0	18.1	14.0
Staff	121	82	60	38	8	4	64	38
%	28.9	30.3	35.5	4.2	27.6	20.0	31.4	31.4
Man/Super	50	36	28	26	2	1	22	17
%	11.9	13.3	16.6	28.9	6.9	5.0	10.8	14.0
ExtCol/Wor	8	8	7	5	5	4	13	3
%	1.9	3.0	4.1	5.6	17.2	20.0	6.4	2.5
Gen.Public	13	8	4	4	3	2	10	8
%	3.1	3.0	2.4	4.4	10.3	10.0	4.9	6.6
Other	12	21	8	7	3	1	5	1
%	2.9	7.7	4.7	7.8	10.3	5.0	2.5	0.8
TOTALS	419	271	169	90	29	20	204	121

It is interesting to note that, although it may appear as if patients and patient relatives are the biggest culprits in psychological violence, when the incidents are counted across, it seems as if staff members had been involved in more incidents of psychological violence than the health care workers had been receiving from patients. The following diagram illustrate the point. The perpetrators of psychological numbers only differ in numbers in the two sectors, but the patterns are the same. However the frequencies for staff and management/supervisors and "other" involved in psychological violence is proportionately higher in the PRIHCS.

FIGURE 7: PERPETRATOR PROFILE - ALL FORMS OF PSYCHOLOGICAL VIOLENCE



	1 Violence		2 Violence		3 Violence		4 Violence		5 Violence
20-24	3.6		4.9		4.1		5.4		12.5
25-29	13.6		17.3		13.4		10.8		0
30-34	21.5		15.7		19.6		24.3		12.5
35-39	14.9		11.4		22.7		5.4		25
40-44	17.5		20.5		17.5		29.7		0
45-49	11.9		15.1		11.3		5.4		25
50-54	9.6		7		7.2		10.8		12.5
55-59	5.3		5.9		3.1		5.4		0
60+	2		2.2		1		2.7		12.5

BOX 3: QUALITATIVE SURVEY THEMES

Psychological Violence

The results of the questionnaire survey is no surprise when one compares it to what had been related in focus group discussions and interviews. Psychological violence, especially verbal abuse had been singled out as the most common form of abuse by all focus groups - in the public as well as the private health care sector. The list of examples are endless:

- Colleagues screaming on each other, shouting, threats, cliques, undermining of colleagues, gossip/slander, abuse, racial slurs and harassment, sexual harassment.
- Pharmacists experience hostility and aggression from patients waiting for hours in long queues at public hospitals.
- Patients and relatives can be very abuse and aggressive towards health care workers.
- Rudeness experienced from other colleagues and patients
- Physicians are guilty of psychological violence, especially with nurses, because they "are always right" and can, in the PRIHCS even cause a staff member to be dismissed or request managers to "get rid" of a certain staff members. To a large extent arrogance and sarcasm of some physicians, humiliating staff and their qualifications.
- The moneylenders are official staff members who lend money to colleagues and cause a lot of problems at one particular public hospital - they intimidate and abuse staff when they want

their money. Absenteeism increase at the end of the month. They are staff members.

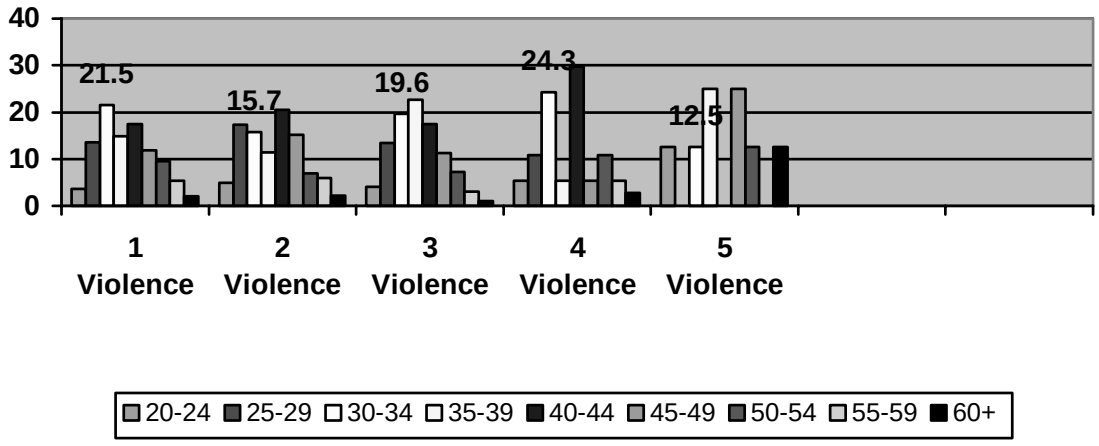
- At homes for the elderly there is sometimes verbal abuse by the elderly person and their children.
- .Abuse of power by senior staff members or being inconsiderate and overloading more junior staff members. Senior staff would also favour some juniors more than others.
- Some colleagues regard themselves as more efficient and try to score points by making negative remarks about others ' work.
- Sexual harassment like bum pinching from patients and doctors touching nursing staff, sometimes very indecently.
- Humiliation and disrespect from patients and public.
- Threats to healthcare workers from families and friends of the patients.
- Threats from crime syndicates operating in hospitals.
- Patients and relatives under the influence of alcohol or using drugs are guilty of verbal abuse, sexual harassment and racial harassment
- Black nursing staff experience prejudice against them and their qualifications by all ethnic groups, including their own. There is still disbelief that a black person can excel. They find this behaviour humiliating and demotivating.
- Throwing around of objects - management would do that occasionally when they do spot-checks on wards.
- Unions can sometimes be at loggerheads and they would attack each other or intimidate staff not participating in their activities.
- Malpractices: at one private hospital administrative staff are expected to make the patient's beds - this is also an unfair labour practise.

3. CHARACTERISTICS OF VICTIMS

3.1 AGE

Age do not seem to be a deterrent to the perpetrators of violence of violence. Certain age groups are more vulnerable as illustrated with percentages and number of types (physical and psychological) of violence below: The age group 40-44 appears to be particularly vulnerable, followed by 30-34 to high incidences of different types of violence.

FIGURE 8: AGE GROUP AND NR. INCIDENTS OF VIOLENCE



3.2 SEX There is no significant difference between the percentage within male and female health care workers subjected to workplace violence. There is also no difference in the frequency in different incidents encountered by both genders. 3% of males experienced sexual harassment while 5% of females were subjected to sexual harassment. These figures seem abnormally low when the high incidence of rape in South Africa is taken into

account. One would also expect the frequency with females to be much higher. The fact is - level of awareness of sexual harassment in South Africa is very low indeed. In mixed focus groups discussions male participants stated that there is no such a thing as sexual harassment, it is "male nature" and female participants laughed while it did not receive priority in most other groups, it was mentioned as a matter of fact. This is part of the problem and need to be stopped in the workplace.

3.3 MARITAL STATUS

There are differences in the level of violence as far as the marital status of the victims are concerned. 58,6% of those respondents who reported being married experienced at least one of the types of violence, while 66,9% of single health care workers experienced the same, followed by 63,6% of those living with a partner. Single workers, those living with partners and widow(er)s are more vulnerable than their married colleagues. "single" workers reported 49,5% of cases, which involved 3 different types of violence .

3.4 RACE/ETHNIC GROUP AND PROFESSIONAL GROUP

Under majority, South Africans understand "black". For the purposes of definitions in the labour laws (affirmative action) of the country, everybody is "black" excluding heterosexual males with no social, physical or mental impediments. All other members are, to a certain degree, "previously disadvantaged" groups. Depending on the social and political orientation, "coloured" (black and white mix) and Asian respondents could have viewed themselves as "black" and thus "majority" ethnic group. It is accepted that the overwhelming majority of respondents classified themselves as "majority" because of their race and skin colour and "minority" would be white South Africans.

The differences in the different forms of harassment experienced by the majority and minority ethnic groups in the country are illustrated below:

TABLE 11: ETHNIC GROUPS IN THE COUNTRY AND WORKPLACE VIOLENCE

FORM OF ABUSE	MAJORITY IN COUNTRY		MINORITY IN COUNTRY	
	Count	*% of incidents*	*Count*	*% of incidents*
Physical Violence: without a weapon	50	52.6%	45	47.4%
Physical Violence: with a weapon	9	75%	3	25%
Verbal Abuse	281	58,8%	197	41.2%
Bullying/Mobbing	128	67.4%	82	32.6%
Sexual Harassment	23	54.8%	19	45.2%
Racial Harassment	128	61.2%	81	38.8%
AVERAGE IN INCIDENTS		60,6%		39,4%

In the case of physical violence without a weapon the minority ethnic group is proportionately more at the receiving end of this form of violence, while the majority ethnic group experience more proportionately more physical violence with a weapon. Proportionately the majority ethnic group in the country also experience slightly more Bullying/Mobbing in the workplace, while the minority ethnic group report more incidents of sexual harassment. Workplace violence is cross gender and racial divides. It is clear that both the majority ethnic group and the minority ethnic group equally experience workplace violence proportionately to their representation in the health sector with some differences in the type of violence metered out to them. Significantly, when respondents reported being a minority in the workplace there is a dramatic increase in the incidence of violence. However, please note that this is not race-related, because a majority in the country could well be a minority in a specific work setting. This is illustrated below:

TABLE 12: COMPARISON BETWEEN INCIDENCE OF VIOLENCE OF MAJORITY AND MINORITY IN WORKPLACE

TYPE OF VIOLENCE	Freq. Majority workplace	Freq. Minority workplace
Physical violence	13.7%	14.2%
Verbal Abuse	47.8%	61.9%
Bullying/Mobbing	18.7%	24.6%
Sexual Harassment	4.5%	4.1%
Racial Harassment	17.4%	30.5%

Disturbing is the extremely steep increase in racial harassment when people are minorities in the workplace. Although it is common knowledge that there are discrimination against minorities in all countries, these figures calls for greater sensitivity and the protection of minorities, irrespective of colour, in the workplace settings.

TABLE 13: WORKPLACE VIOLENCE BY PROFESSION

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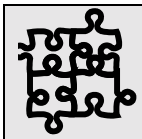
PROFESSIONS	All Violence	Physical Violence	Verbal Abuse	Bullying/ Mobbing	Sexual Harassm.	Racial Harassm.
Physicians	15.8	9.8%	40.6%	12.6%	2.1%	14%
Nurse	26.3	14.1%	58%	26.1%	4.3%	28.9%
Midwife	22.9	12%	51.8%	20.5%	3.6%	26.5%
Pharmacists	15.3	2.9%	41.2%	8.8%	2.9%	20.6%
Ambulance	48.0	50%	70%	50%	30%	40%
Auxiliary/Ancillary	23.1	18.9%	52%	18.2%	4.7%	21.6%
Admin/Clerical	13.0	5.6%	37%	13%	3.7%	5.6%
Professions Allied	18.4	3.2%	43.5%	17.7%	9.7%	18.1%
Technical Staff	37.8	22.2%	55.6%	44.4%	22.2%	44.4%
Support Staff	24.9	29.3%	56.1%	26.8%	2.4%	9.8%
Other	23.8	7.7%	69.2%	11.6%	3.8%	26.9%

It is evident that ambulance staff experience the highest frequency of all forms of workplace violence, followed by technical staff. All category nurses (nurse, midwife, auxiliary) are most vulnerable and with other categories reporting very high frequencies. Of interest is that 40,6% of physicians experienced verbal abuse and 14% were victims of racial harassment - these were mainly in the PUBHCS as private providers/professionals of medical services had relatively low incidents of workplace violence.

3.4 STATUS

The large majority of victims belongs to "staff" and "other" group while managers, line managers and senior managers are less likely to be victims of workplace violence. The power and status of those in the more senior positions render them less vulnerable, but definitely not immune to physical and psychological violence.



BOX 4: QUALITATIVE SURVEY THEME
Characteristics of Victims

When asked who would be the most vulnerable to workplace violence, most groups thought of themselves being the most vulnerable. However after more objective consideration the focus groups said that all staff is vulnerable, but staff working with psychiatric patients, those working in trauma or casualty units and with patients that had been stabbed experiencing immense anger, those in direct contact with the public like nurses, therapists, doctors. Staff in the lower hierarchies is more vulnerable. In emergency services and trauma units males in focus group discussions said that female staff members are more vulnerable.

4. WORK SETTINGS AT RISK

In most cases, incidents took place inside facilities. 80% of incidents took place at the patient's home in the case of ambulatory staff. Physical attacks happened 36,5% between 07:00 and 13:00; 19.8% between 13:00 and 18:00 and 16.7% between 18:00 - 24:00. 19% of respondents could not remember when it happened. Fridays delivered more physical violence than other days at 13,7%, followed by 12,1% on Saturdays. Almost 40% of respondents could not remember the day of the incident.

3.6.1 Public Health Care Sector

The incidents of workplace violence are spread over a wide range of settings at facilities. Hospitals risk sections for physical attacks (more than 10%) are general medicine, psychiatric wards, specialised units and "other", while surgeries, primary health care facilities and homes for the elderly are also risk units. Incidents of psychological violence (more than 10%) is, in the case of verbal abuse higher in frequency in specialised units, general medicine, health care centres and homes for the elderly. Bullying/Mobbing incidents are higher in psychiatric care, specialised units, health centres, primary health care and home for the elderly. The risk of sexual harassment is highest in psychiatric and specialised units following close behind are general medicine, surgery, emergency, ambulatory, homes for the elderly and primary health care units. Racial harassment is highest at health centres, followed by general medicine, then specialised units and homes for the elderly.

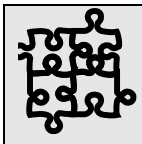
3.6.2 Private Health Care Sector

The incidents of workplace violence are spread over a wide range of settings at facilities. When more than 10% of incidents are reported in a section, it is deemed to be significant. Hospital risk sections for physical attacks are general medicine and operating room while those spending most of their time at ambulatory service, general surgery, the operating room, management and specialised units are more at risk. Psychological workplace violence (more than 10%) is recorded as highest in general medicine, followed by specialised units, operating room, intensive care and management. Bullying/Mobbing is highest in general surgery and in the operating room followed by general medicine, intensive care and ambulatory services. Sexual harassment takes place more in general surgery than any other setting, followed by intensive care units, ambulatory services, health care centres and homes for the elderly. Racial harassment incidents are highest in general medicine, followed by specialised unites and general surgery.

3.6.3 Service Levels

The service level (as defined earlier in the report) of the facility plays a significant role in the level of workplace violence (all sorts) experienced. 59.1% of physical attacks take place at Level 1 facilities (the largest hospitals) while only 13,1% of these attacks happen at Level 2 facilities. Level 4 facilities are report higher frequencies than Level 2 hospitals. Witnessing workplace violence are also very high at Level 1 hospitals with 57.1% of respondents reporting to have witnessed workplace violence and 20% of respondents at Level 4 hospitals reporting the same. Significantly 68.9% Level 5 respondents reported no forms of violence, while 32.4% suffered at least one incident are from Level 1 hospitals. The most cases of at least 2 incidents of workplace violence was on Level 2 (25.2%) while at least 4 incidents reported was 5,9% on Level 2 too. The highest incidents of three to five types of violence were reported at Level 4 facilities.

It is clear that the incidence of workplace violence relates to the size of the facility and service levels.



BOX 5: QUALITATIVE SURVEY THEME

Work settings at risk

Weekends could be dangerous and direct contact with the public. The location of the facilities, especially the public hospitals is also seen by the focus group as a safety risk. Administrative staff working with the public and accounts is also in a risky situation. Where there are long queues like at pharmacies in the PUBHCS, there is a danger of patients getting out of control.

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3.
INFLUENCING FACTORS IN THE CONTEXT OF WORKPLACE VIOLENCE

1. Contributing factors

1.1 Violence risk factors across settings

The incidence and risks are much higher in public health care settings than private health care settings. One can only look at the incidence of violence (at least one incident) at each setting as reflected in the table below.

TABLE 14: FREQUENCY VIOLENCE AT THE FACILITIES (AT LEAST ONE INCIDENT)

Facility		At least one incident of wpv per respondent					
		No		Yes		Total	
Service Level & Sector	Facility Nr.	Count	%	Count	%	Count	%
01 PUBHCS	01 Jhb Gen	21	18.9%	90	81.1%	111	100.0%
01 PUBHCS	02 CHBara	75	34.1%	145	65.9%	220	100.0%
02 PUBHCS	03 Y Dadoo	9	30.0%	21	70.0%	30	100.0%
02 PUBHCS	04 Edenvale	8	29.6%	19	70.4%	27	100.0%
03 PUBHCS	05 PHC	24	38.1%	39	61.9%	63	100.0%
03 PUBHCS	06 Ambulance			5	100.0%	5	100.0%
04 PUBHCS	07 Tara	7	16.7%	35	83.3%	42	100.0%
04 PUBHCS	08 Avril	7	35.0%	13	65.0%	20	100.0%
04 PUBHCS	09 Wits	5	23.8%	16	76.2%	21	100.0%
01 PRIHCS	10 Milpark	18	26.1%	51	73.9%	69	100.0%
01 PRIHCS	11 Parklane	12	25.0%	36	75.0%	48	100.0%
01 PRIHCS	12 Kenridge	40	70.2%	17	29.8%	57	100.0%
01 PRIHCS	13 Krugersdorp	24	43.6%	31	56.4%	55	100.0%
02 PRIHCS	14 Lesedi	9	25.0%	27	75.0%	36	100.0%
04 PRIHCS	15 Tshebo	13	52.0%	12	48.0%	25	100.0%
04 PRIHCS	16 Netcare	13	54.2%	11	45.8%	24	100.0%
03 PRIHCS	17 Africure	2	40.0%	3	60.0%	5	100.0%
04 PRIHCS	18 Roodepoort	7	58.3%	5	41.7%	12	100.0%
04 PRIHCS	19 Sandringham	12	41.4%	17	58.6%	29	100.0%
05 PRIHCS	20 Private	82	68.9%	37	31.1%	119	100.0%

The differences in the frequency of incidents at the different settings could be attributed to and influenced by a number of factors listed below:

- The location of public facilities. The large facilities in the study were all close to densely populated and high crime areas. When a facility is in or near a high crime area, the risk of violence would be much higher. The surprise in this research project is that the Johannesburg General Hospital's (01) incidence of violence is much higher than Chris Hani Baragwanath Hospital. The incidences recorded at CHBaragwanath Hospital (02) correlates with the findings of Ethics Institute of South Africa's recent research too. The Johannesburg General Hospital is nearby the densely populated, impoverished and high crime area (drugs, gangs, prostitution) of Hillbrow and Yeoville and also close to central Johannesburg.

  Another contributing factor is that Johannesburg General Hospital was, in the apartheid era a prestigious “white" hospital and is therefore still favoured as the "best". This perception results in

overcrowding and increasing pressure on health care workers.

Milpark Hospital, known as South Africa's top trauma private trauma hospital also presents with a high incidence of workplace violence, so does Parklane Clinic. Both hospitals are close to Hillbrow and Yeoville and their casualty sections serving these areas would also have high levels of violence. Criminals are also taken to these hospitals when public hospitals cannot attend to the injured person in custody.

Tshebo-Themba, a private hospital in Dobsonville, Greater Soweto has a relatively low incidence of workplace violence. However, this is one of the smaller, most luxurious private hospitals in South Africa and seems not to be influenced by its location. Some private hospitals in Johannesburg and elsewhere - like Garden City Clinic (not included in the sample) have separated their casualty section from the hospital and the two are in different locations. Johannesburg General Hospital and other huge public hospitals protect their staff in casualty (trauma unit) with bullet-proof glass or bars, preventing non-patients to have access. It can be accepted that the presence of a casualty/trauma unit influences the level of violence at a facility, but the fact that some hospitals in perceived less desirable areas have significantly lower incidences of violence can not only be attributed to preventative measures and policies. The most likely explanation however might be that such hospitals draw on a wealthy client base and do not deal with groups at high risk for violence.

- Public hospitals are overcrowded and short-staffed.
- When an individual is a legal owner of a firearm (the person must be granted a licence by the relevant authority), then it is not constitutionally possible for a hospital to take the firearm away, but it is possible for the security to take a firearm away from an unlicensed owner. They request the licensed person to hand in the firearm, but nothing can prevent the person to take the firearm into the hospital. This is a great risk factor.
- Long waiting periods. The Citizen[22] newspaper reported that chaos reigned at the Helen Joseph public hospital in Johannesburg where patients had been queuing at the hospital pharmacy for days. Toilets were in a bad condition and only one toilet was working. There was only one pharmacist to serve a large number of outpatients. Staff had been reported to say that the situation was out of control and patients were noisy and uncontrollable. This is typical of most outpatient departments at public hospitals and definitely a contributing risk factor to workplace violence.
- Level 5 (Private providers of services like physicians, radiologists, pharmacists, physiotherapists, podiatrists, speech and audio therapists, occupational therapists and so on) presents with low frequencies of violence in their settings, while incidences of violence are much higher in formal private health care facilities. This strengthens the lower incidence of wpv the in the PRIHCS.
- Those working with psychiatric patients, in the case of TARA Hospital with mainly psychiatric patients, the incidence of workplace violence are much higher than at other facilities, mainly due to the condition of the patients.

- Contributing to violence - open question opinions from questionnaire survey:
  (a) Respondents in the PUBHCS cited staff related problems such as incompetent staff, staff shortages, overload, poor quality staff, rankism (abuse of power), lack of teamwork, poor staff communication, working shifts and general staff dissatisfaction being the most important contributor to physical violence and psychological violence.
  (b) From both sectors, but more so in the PUBHCS the opinion is that security issues play an important role in physical violence - and poor or inadequate security, unsafe surroundings and the location of the facility are contributing factors.
  (c) Respondents from both sectors cited stress, frustrated, "entitled", demanding and psychiatric patients and relatives of patients as main contributors to physical and psychological workplace violence.
  (d) Interpersonal issues, image problems with the public and relationships with the public is viewed as a main contributor to all forms of workplace violence - by both the public and private sector respondents - rudeness, disrespect, intolerance, failed or inadequate communication, failed conflict resolution, bad attitudes, tempers, power battles, nepotism and staff undermining each other is also given as reasons.

[22] Venter, Liesl. 21 September 2001. The Citizen, page 7. "Hell in Jo'burg hospital where chaos reigns"/

(e) Verbal abuse, bullying/mobbing, racial harassment and sexual harassment can go over into physical violence.
(f)Racial issues and cultural differences/misunderstandings are factors playing a role in both physical and psychological violence. "Too much hatred, too little tolerance" one respondent wrote.
(g) Economic issues like the poor financing of the facility, the high levels of poverty and unemployment, lack of equipment and finances, shortage of beds and overcrowding, poor remuneration and the presence of "moneylenders" (staff who lends staff money and then pressurise them to pay back - an illegal practice in hospitals) triggers all forms of violence in the workplace.
(h)Poor management is viewed by respondents in the PUBHCS to be a problem contributing to both physical and emotional violence.
(i) Alcohol and drug abuse is an important trigger for both forms of workplace violence.
(j) Lack of patient screening and patient protocols.

Individual or personality factors contributing to workplace violence were not measured in the survey, but would only be of significant importance for the individual's reaction to workplace violence, in that the individual level of resilience could speed up recovery from trauma.

- When the importance respondents attach to security measures, improved surroundings, the restricting of public access, patient screening and patient protocols, the restricting of exchange of money at the workplace, increase in staff-numbers, check-in procedures for staff, reduced periods of working alone, training, human resources development, changed shifts or rotas and special clothing - as "very helpful" and smaller percentages "moderately helpful" - the lack of these measures could be regarded as risk factors or contributing factors to workplace violence.

1.2 PHYSICAL ENVIRONMENTAL RISK FACTORS

Some of the physical factors influencing the levels of workplace violence had been dealt with in 1.1 (above) and in the qualitative survey theme below. However, the location of the facility is one of the most important contributing factors as well as the presence of a casualty or trauma unit. In large facilities certain areas are viewed to be dangerous and health care workers are well aware that crime syndicates operate there. A physician told a field worker that it is dangerous to walk in the passages at night because of inadequate lighting and criminals that hide out in the facilities.

According to one of the matrons of the larger hospitals, one of the biggest problems is the many entrances to the facility. It is difficult if not impossible to control and to safeguard. Too many entrances would pose a safety threat to health care staff.

While some public hospitals are notably clean, some are dirty. This is not due to lack of performance by cleaners but by vandalism by the public using the facilities. Toilets for example at public hospitals are ever so often "uprooted", toilet paper is stolen and taps are left open with water running on the floors. It is difficult for health care workers and other patients to be positive under these circumstances. The environment would have an influence on psychological violence. 56% of respondents viewed improved surroundings as very helpful in combating violence.

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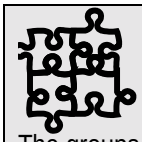

BOX 6: QUALITATIVE SURVEY THEME

Triggers of workplace violence

The groups differed in the emphasis on the types of violence but overall agreed that frustrated patients and patients and visitors abusing substances, psychiatric and confused patients, post-operation patients, criminals and gangs account for most of the physical violence. Bad management, rankism, pressure, overload, insufficient or broken equipment, unreasonable demands and expectation, ambitious and opportunistic colleagues, finances, stress, long hours, inconsiderate staff, personality clashes, bad communication, feelings of entitlement from the public and patients, colleagues disloyal to each other, no protection against unreasonable patients/visitors (they are always right), the mental state of patients, the HIV/AIDS pandemic and fears to contract the disease, disrespect, misunderstandings, cultural differences and ignorance from the public triggers psychological violence.

2. ORGANISATIONAL CULTURE

The high levels of workplace violence is not surprising when one consider that only 61.2% of respondents in the PUBHCS confirm that their employers have specific policies on health and safety while 80.5% in the PRIHCS confirms the same. This is a significant difference. Significantly 27.7% of respondents in the PUBHCS don't know and 14.5% in the PRIHCS. Only 25.1% of respondents in the PUBHCS confirmed that their employees do have policies in place against physical violence while 50.6% don't know if there are policies in place. Again a significant difference between the PUBHCS and the PRIHCS when 43.7% of respondents in that sector confirmed that there are specific policies in place against physical violence while 38.2% don't know. There seems to be a lack of communicating policies to health care workers in both sectors, more so in the PUBHCS.

The situation seems worse as far as psychological violence is concerned.

TABLE 15: SPECIFIC POLICIES ON PSYCHOLOGICAL VIOLENCE

Employer has specific policies in place for.....	Verbal Abuse		Bullying/Mobbing		Sexual Harassment		Racial Harassment	
	Pub	Pri	Pub	Pri	Pub	Pri	Pub	Pri
Yes	15.9%	34.5%	12.4%	21.8%	22.3%	35.7%	16.9%	30.4%
No	29%	24.6%	27.8%	26.5%	22.3%	21%	26.6%	23.9%
Don't know	55%	40.8%	59.8%	51.7%	55.3%	43.4%	56.6%	45.8%

In the PUBHCS 15.2% confirmed that their employer has specific policies on threats and 25.6% confirmed in the PRIHCS, 26.7% and 25.4% respectively reported "no" and 58.2% of PUBHCS staff did not know while 49% in the PRIHCS didn't know either.

It appears that management have either not set policies in place or they did not communicate these policies to health care workers. There is a lack of communication and workers are not aware of their rights. The underreporting of workplace violence is therefore no surprise. Communication and transparency is the basis of a healthy corporate culture and this seems to be absent, more so in the PUBHCS.

The measures as reflected in table 16 is by no means sufficient. These figures merely reflect counts and it is evident that the inadequacy of measures taken by management at most facilities could in part be responsible for the high levels of violence.

TABLE 16: COUNTS - MEASURES TAKEN BY MANAGEMENT

MEASURES TAKEN TO REDUCE WORKPLACE VIOLENCE	NR. ANSWER "YES"
Security measures (e.g. guards, alarms, portable telephones)	695
Improving surroundings (e.g. lighting, noise, heat, access to food, cleanliness, privacy)	470
Restrict public access	377
Patient screening (to record and be aware of previous aggressive behaviour)	234
Patient protocols (e.g. control and restraint procedures, transport, medication, activities, programming, access to information)	295
Restrict exchange of money at the workplace (e.g. patient fees)	230]
Increased staff numbers	174
Check-in procedures for staff (especially for home care)	107
Special equipment or clothing (e.g. uniform or absence of uniform)	285
Changed shifts or rotas (i.e. working times)	231
Reduced periods of working alone	171

Training (e.g. workplace violence, coping strategies, communication skills, conflict resolution, self-defence)	289
Investment in human resource development (training for career advancement, retreats, rewards for achievement, promotion of healthy environment	92
None of these	92
Other	35

Security is a major concern for South Africans and it is not surprising that the majority of respondents affirmed that steps had been taken to improve security at facilities. But in focus group discussions it became clear that these are not adequate. According to the majority of participants, the situation is worse than a year ago. The measures fail to make workers feel more secure. It is evident from the above figures that not enough has been done by the management of the various facilities to reduce the risk of workplace violence for health care workers and give them a greater feeling of security. In addition, major changes, staff cuts and restriction of resources took place, which could only have compounded the growing level of workplace violence in the health sector. It is interesting to note that over 50% of the respondents from the PUBHCS answered yes to the steps taken to improve their safety, but on the question of human resources development, training and career advancement only 87 of the 194 respondents are from the PUBHCS and it can therefore be said that the PRIHCS made a more concerted effort to develop staff from a Human Resources Management point of view.

In the PUBHCS the Netcare group contracted the services of ICAS (Independent Counselling Services) to counsel staff members that had been exposed to physical violence. Staff can phone the organisation's hotline and arrange appointments if necessary or receive telephonic counselling. This is especially useful when car hijackings occur or when there is death or divorce in the family. While these steps need to be commended, it is an anonymous service and as such outside the organisation. This service fails to reduce the levels of workplace violence. Management recognised a need but they are treating the symptoms rather than the problem.

TABLE 16: COUNTS - SOURCES OF DISCOMFORT - CHANGES/SHORTAGES

IMPACT OF WORK CHANGES ON DAILY WORK						
	None	Staff worse	Staff better	Clients worse	Clients better	Other
Changes in work setting	158(8.8)	684(38.1)	210(11.7)	521(29.1)	188(10.5)	32(1.8)
None	92(59.0)	39(25.0)	9(5.8)	7(4.5)	6(3.8)	3(1.9)
Restructuring	18(5.3)	125(36.5)	50(14.6)	100(29.2)	46(13.5)	3(0.9)
Staff cuts	28(5.1)	269(49.0)	23(4.2)	205(37.3)	18(3.3)	7(1.3)
Increased staff numbers	14(6.8)	30(14.5)	68(32.9)	24(11.6)	56(27.1)	15(7.2)
Restriction of resources	0	184(48.7)	18(4.8)	158(41.8)	5(4.0)	3(0.8)
Additional resources	6(4.7)	19(15.2)	40(32.0)	16(12.8)	44(35.2)	0
Other	0	18(51.4)	2(5.7)	11(31.4)	3(8.6)	1(2.9)

It is evident from table 18 that changes impact dramatically on the well-being of staff and patients alike. The effects of major restructuring exercises, downsizing and staff cuts together with risk factors in the broader social environment do have an impact on workplace violence.. In section A of this report reference was made to the higher levels of workplace violence encountered at organisation undergoing major restructuring. The moment a person no longer feel that his/her job is secure, interpersonal relationships and group coherence fades. It is therefore not surprising that one of the major complaints in the focus groups discussions were that colleagues don't stand together and they don't trust one another.

With workplace and societal violence on the increase, staff and equipment cuts, the loss of a sense of security and permanency, the massive drain of health care workers to foreign countries, the reorganisation and restructuring of the health care sector cannot come at a worse time and a considerable number of respondents reported staff cuts. The situation is such that there is already a shortage of health care workers in this country and if workplace violence and other factors undermining employee safety and satisfaction are not addressed

immediately, South Africa may well find itself in the same situation as Zimbabwe where the health services in that neighbouring state had collapsed.

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

The impact of the different forms of workplace violence is most visible in the individual's reaction to these forms of violence: There is a difference between the reactions of health care workers in the public and private health workers.

TABLE 19: PHYSICAL VIOLENCE REACTION

For the purposes of identifying moderate to severe symptoms of trauma and/or Post Traumatic Stress Disorder "moderately", "quite a bit" and "extremely" are considered as a total. In all types of workplace violence the incidence of symptoms of trauma/PTSD experienced by the victims are very high.

Since you were attacked, how BOTHERED have you been by:	Not at All		A Little Bit		Modera-tely		Quite a Bit		Extreme-ly	
% Sector	**Pu**	**Pri**	**Pu**	**Pri**	**Pu**	**Pri**	**Pu**	**Pri**	**Pu**	**Pri**
(a) Repeated, disturbing memories, thoughts, or images of the attack?	19,8	36,6	23,5	26,8	22,2	9,8	19,8	24,4	14,8	2,4
(b) Avoiding thinking about or talking about the attack or avoiding having feelings related to it?	24,1	46,2	20,3	12,8	24,1	20.5	25.3	12,8	6,3	7.7
(c) Being "super-alert" or watchful and on guard?	8,8	15,0	17,5	27,5	11,3	10	23,8	30	38,8	17,5
(d) Feeling like everything you did was an effort?	30,4	52,6	10,1	13,2	20,3	13,2	20,3	7,9	19	13,2

It is obvious that health care workers in the PRIHCS experienced significantly less uncomfortable reactions in the case of physical violence, but a more severe reaction than workers in the PUBHCS in being "super-alert", watchful and on guard after the incident. However, significant numbers of victims display trauma-reactions.

TABLE 20: VERBAL ABUSE REACTION

Since the incident(s), how BOTHERED have you been by:	Not at All		A Little Bit		Modera-tely		Quite a Bit		Extreme-ly	
% Sector	**Pu**	**Pri**	**Pu**	**Pri**	**Pu**	**Pri**	**Pu**	**Pri**	**Pu**	**Pri**
(a) Repeated, disturbing memories, thoughts, or images of the abuse?	22,6	29,4	26,1	26	20,7	21,1	18,2	14,2	12,4	9,3
(b) Avoiding thinking about or talking about the abuse or avoiding having feelings related to it?	27,5	29,4	27,5	34	21,9	20,3	15,4	10,2	7,8	6,1
(c) Being "super-alert" or watchful and on guard?	22,1	23,5	18,2	25,5	18,2	18,9	18,5	15,8	22,4	16,3

Since the incident(s), how BOTHERED have you been by:	Not at All		A Little Bit		Modera-tely		Quite a Bit		Extreme-ly	
(d) Feeling like everything you did was an effort?	25,8	37,8	19,2	25,5	19,5	13,3	16,6	9,7	18,9	13,8

It is obvious that health care workers in the PRIHCS experienced moderate to significantly less uncomfortable reactions in the case of verbal abuse. Notably the impact of verbal abuse with a lesser trauma reaction than physical violence, but compared to the consequences of physical violence and dangers involved, the reaction to verbal abuse is severe.

TABLE 21: BULLYING/MOBBING REACTION

Since the bullying/mobbing incident(s), how BOTHERED have you been by:	Not at All		A Little Bit		Modera-tely		Quite a Bit		Extreme-ly	
% Sector	**Pu**	**Pri**	**Pu**	**Pri**	**Pu**	**Pri**	**Pu**	**Pri**	**Pu**	**Pri**
(a) Repeated, disturbing memories, thoughts, or images of the bullying/mobbing?	16,6	23,7	33,1	15,8	14,9	14,5	14,9	18,4	20,7	27,6
(b) Avoiding thinking about or talking about the bullying/mobbing or avoiding having feelings related to it?	24	31,3	24,8	16,4	27,2	22,4	12,2	22,4	11,2	7,5
(c) Being "super-alert" or watchful and on guard?	16	17,9	15,1	10,4	22,7	15,3	21	9	25,2	37,3
(d) Feeling like everything you did was an effort?	23,1	22,7	19,8	24,2	17,4	24,2	19,8	15,2	19,8	13,6

Health care workers in the PRIHCS present with slightly less uncomfortable reactions than those in the PUBHCS in the case of bullying, but this is the a form of violence where trauma reactions do not differ so very significantly as in other types of violence.. However the reactions to bullying are as severe in reactions to physical violence for both sections. Once again the significantly higher state of alertness in the PRIHCS as opposed to the PUBHCS as a trauma reaction is surprising.

TABLE 22: SEXUAL HARASSMENT REACTION

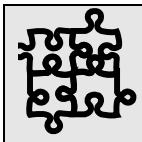
Since the sexual harassment, how BOTHERED have you been by:	Not at All		A Little Bit		Modera-tely		Quite a Bit		Extreme-ly	
% Sector	**Pu**	**Pri**	**Pu**	**Pri**	**Pu**	**Pri**	**Pu**	**Pri**	**Pu**	**Pri**
(a) Repeated, disturbing memories, thoughts, or images of the sexual harassment?	21,7	42,9	39,1	19	8,7	23,8	8,7	9,5	21,7	4,8
(b) Avoiding thinking about or talking about the sexual harassment or avoiding having feelings related to it?	37,5	36,4	20,8	27,3	8,3	13,6	12,5	18,2	20,8	4,5
(c) Being "super-alert" or watchful and on guard?	8,7	28,6	13	28,6	4,3	0	39,1	9,5	34,8	33,3
(d) Feeling like everything you did was an effort?	22,7	60	13,6	15	4,5	5	27,3	10	31,8	10

Once again the trauma reaction to sexual harassment in the PRIHCS is significantly less unpleasant in some instances than in the PUBHCS, but the sharp difference in being “super-alert” in the PUBHCS as opposed to the PRIHCS victims of SH is surprising.

TABLE 23: RACIAL HARASSMENT REACTION

Since the racial harassment, how BOTHERED have you been by:	Not at All		A Little Bit		Modera-tely		Quite a Bit		Extreme-ly	
% Sector	**Pu**	**Pri**	**Pu**	**Pri**	**Pu**	**Pri**	**Pu**	**Pri**	**Pu**	**Pri**
(a) Repeated, disturbing memories, thoughts, or images of the racial harassment?	25,2	26,2	25,2	16,7	15,8	20,2	15,1	16,7	18,7	20,2
(b) Avoiding thinking about or talking about the racial harassment or avoiding having feelings related to it?	32,4	33,8	20,1	26	22,3	14,3	13,7	13	11,5	13
(c) Being "super-alert" or watchful and on guard?	27,5	24	13,8	17,3	14,5	16	12,3	14,7	31,9	28
(d) Feeling like everything you did was an effort?	34,8	34,2	10,9	15,1	11,6	15,1	15,9	20,5	26,8	15,1

Although victims of racial harassment in the PRIHCS experience once again less traumatic reactions, the reactions in both sections are closer to each other than with other violent events.



BOX 7: QUALITATIVE SURVEY THEME

Impact of Workplace Violence on the Health Sector

Focus groups related that there was a general feeling of unhappiness and after an incident of physical violence the quality of service drops. Psychological violence causes tension, withdrawal by victims, absenteeism, less caring attitude towards patients. Staff turnover increases, workers just stay away or resign and departments cannot run smoothly because they have to train new people frequently. Staff become less sensitive or densitised, they call patients a "head" or a "stomach" or a stab. It is a detrimental influence on the patient/health care worker-relationship. Communication between staff is influenced and everyone just take care of him- or herself and they may not notice when a staff member is on the brink of a nervous breakdown. Staff say they become negative and wouldn't go the extra mile. Psychosomatic illnesses and unproductivity is the order of the day. Burnout is a result of workplace violence and workers fear coming to work and going home - some need to force themselves mentally to go to work. Absenteeism and staff resignations. The high level of workplace violence make staff leave for other countries. The work atmosphere is morbid and unpleasant and a few members in the focus group said that it would not affect the care they give to patients, but that it remains difficult re survive the atmosphere. Workplace violence has a numbing effect on the workers - you start to care less about everything and everybody.

The above tables and information related to fieldworkers in the focus group discussions clearly illustrate the impact of workplace violence on the individual. The 4 questions on levels of trauma intrusion, dissociative amnesia, hyper-vigilance and energy level (or chronic fatigue syndrome) indicates that a large number of the respondents answered "moderately, "quite a bit" and "extremely" which could be associated with symptoms of post traumatic stress disorder (PTSD).

The impact of workplace violence on the individual's social development is far-reaching. Depressed, anxious (and after prolonged exposure this could develop into PTSD) all report that it affects their relationships with friends and family. They have a need to talk about incidents at the workplace or as one therapist put it in a focus group discussion: "I feel like telling my family members - "don't be such hypochondriacs complaining about headaches, my work is the worst. I don't want to hear about yours." In most focus group discussions participants related how the workplace violence influenced their family lives. Social problems may arise like resorting to alcohol. At Chris Hani Baragwanath Hospital focus group participants said that they go to the shebeen (African pub) on the other side of the "bridge" (a pedestrian bridge giving entrance to CHBaragwanath Hospital and viewed by everybody as dangerous).

In the workplace the victim's interpersonal relationships are affected. They are suspicious, hyper-vigilant, appear to outsiders to obsessive about the situation, easily irritated, suffer from a lack of concentration (with a resultant increase in mistakes) to name a few. The effects are behaviourally as well as in the victim's affectivity to the organisation with negative affectivity and less commitment to the job featuring strongly.

Workplace violence also poses a threat to the career ambitions of health care workers. They are often disillusioned about the high levels of workplace violence and in the case of South African health care workers, leave for greener pastures. In focus groups discussions where were remarks like: "I am in this job because I must earn a living, I don't see it as mission anymore".

While the Ethics Institute of South Africa's report on unethical behaviour of health care workers at CHBaragwanath shocked South Africa, but the high levels of workplace violence as the root cause of patient abuse had not been put into context. In fact, health care workers are so threatened by the high levels of abuse, that they could resort to exercising some form of power over the patients to protect themselves. Newspaper reports on chaotic conditions in public hospitals emphasise the plight of health care workers, whose primary function is to serve and protect life.

Workplace violence negatively effects the dignity, happiness and well-being of the victim. Aggressive behaviour is used as a struggle tactic in interpersonal conflict. Einarsen wrote in the International Journal of Manpower "Bullying[23] seems to contain at least four phases: aggressive behaviour, bullying, stigmatisation and severe trauma[24]." In most corporate environments the victim is often treated as the problem. When stepping into the case, upper management, union representatives, or personnel administration tend to accept the prejudices produced by the offenders, thus blaming the victim for his/her misfortune. Third parties or managers may see the situation no more than fair treatment of a difficult and neurotic person.[25] This is the denial and shame by which abuse thrives. Like one manager said in a focus group discussion - offering the explanation to a difficult phenomenon like workplace violence - "it is people bringing their problems to the workplace". Although very few managers hold sentiments like these, the reality is that knowledge about workplace violence and its effects on the individual is not unknown and more awareness is necessary. This is to the detriment of the victim who seeks, more than anything else, validation of the experience.

The Foundation for the Study of Work Trauma found that ALL victims of workplace violence tested[26] for mental health disorders suffered from depression, anxiety, PTSD and in one case dissociative amnesia was also present. While it is wide accepted that PTSD is a likely outcome of physical violence "in cases of the most severe incidents of bullying, victims have frequently been diagnosed with PTSD (Leymann and Gustafsson, 1996). In a Norwegian study which compared victims of severe bullying with individuals who had been involved in traumatic disasters, a large proportion of the bullying victims were found to suffer from symptoms of PTSD at a higher level than those involved in disasters (Einarsen et al, 1999)[27]

. Kivimake found in a Finnish study of hospital employees that targets of bullying had on average a 50% higher certified sickness absenteeism than those who were not bullied. Even when adjusted for possible impact on previous state of health, targets' absenteeism rates were still 26% higher. It was mentioned in focus group discussions that at the end of the month absenteeism figures would rise as a result of the physical and emotional violence of "moneylenders" who then wants payments.

According to Hoel[28] there is no substantial evidence to prove that bullying influences productivity. However, workplace violence significantly affects turnover rates (something South Africa can hardly afford with the drain of health care workers to foreign countries) as was illustrated in the UNISON trade union (UK) study of 1997 where

[23] Here the word "bullying" is used to describe all forms of workplace violence excluding sexual harassment.
[24] Einarsen, S. 1999. The nature and causes of bullying at work. International Journal of Manpower. Volume 20 Number 1 Page 16-27.
[25] Ibid.
[26] Tested with the following instruments: Prime Care Evaluation Mental Disorders, Trauma Recovery Scale (TRS), Impact of Events Scale (IES) Symptom Checklist-45 (SCL/45), Dissociative Experiences Scale (DES), Dissociative Regression Scale (DRS), Toronto Alexithymia Scale (TAS) were used by the International Traumatology Institute.
[27] Hoel, H; Sparks K.; Cooper, C.L. 2000. The cost of violence/stress at work and the benefits of a violence/stress-free working environment. Report commissioned by the International Labour Organization (ILO) Geneva.
[28] Ibid.

26,4% indicated that they had left the job because of workplace violence (called "bullying" in the UK). 20% of those who witnessed workplace violence left their jobs too. Hoel and Cooper found in a study in the UK that people who were currently bullied had the worst mental and physical health, the highest sickness absenteeism and intention to leave, lowest productivity - workplace violence have long term effects.

When the negative impact of workplace violence on the employee's performance, health, turnover, absenteeism and so on is considered, the cost of workplace violence is astronomically high. The cost to replace a professional person in South Africa is estimated to be anything between R25000 - R45000 per person. Then exit packages because of ill-health, early retirement, legal costs (the cost to the private sector with their 1578 conciliation hearings and compensation costs, just the past year could run into millions of rands). The effects workplace violence on the family of the victim could be far-reaching with additional financial burden to society, medical services and other family members.

In the cases of physical attacks 19,3% of the respondents required formal treatment. 47,6% of those who had been physically attacked had to take one day's leave, 23,8% were absent for 2-3 days, 14,3% for one week, 4,8% for 2-3 weeks, 4,8% for a month and a further 4,8% for 2-6 months. The absenteeism figures for those who were victims of psychological violence were not measured in the questionnaire survey. The impact of absenteeism and treatment for physical violence in the workplace can run into hundreds of thousands if not millions of rands already.

Levels of violence are very high in South Africa already - the workplace was always regarded as being free from the violence from the streets, but not anymore. The violence in society has spilled over in the workplace and to an extent in the homes (increase in domestic violence) of South Africa and the best way to address violence in this country is to address it, starting with the workplace. The workplace are perceived to have the structures and have a track record of success in dealing with complicated issues. The issue of HIV/AIDS awareness addressed by employers is an example.

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5.
INDIVIDUAL, INSTITUTIONAL AND SYSTEMATIC RESPONSES TO VIOLENCE

1. Coping, Reporting, Taking Steps and Rehabilitation

1.1 PHYSICAL WORKPLACE VIOLENCE

As far as physical attacks are concerned, 54 victims responded by reporting it to a senior staff member, 51 told the person to stop. 35 told a colleague about the incident, 21 told friends and family, 16 tried to defend themselves physically. 8 respondents completed an incident/accident form and 7 completed a compensation form, 6 responded by pursuing prosecution, 3 sought help from an association, 4 sought help from the union, 6 responded by transferring to another position and only 3 sought counselling. Significantly 28 took no action. In only 26,2% (n=33) of cases were action taken to investigate the causes of the incident. Of this 26,2% (n=26) action was taken by the management and employer in 68,4% (n=26) of the cases, followed by the police taking 15,8%(n=6) of the cases, "other" took action 13,2% (n=5) of the cases and unions in 2,6% (n=1) of the cases. 34 respondents reported no consequences for the perpetrator, in 21 cases a verbal warning was issued, in 3 cases care was discontinued, 7 cases were reported to the police and 3 instances were prosecuted. In 7 incidents "other" consequences played a role while 8 respondents said they do not know if there were any consequences to the perpetrator.

Victims of physical violence report that only in 17,8% of cases the employer offered counselling, in 44.7% of cases the supervisor or employer offered the victim an opportunity to speak about it or report the incident and in 26% of incidents the employer or supervisor offered to provide the victim with other support. On a scale of 1 to 5, 1 being very dissatisfied, 26,2% of victims were very dissatisfied, 20.5% are dissatisfied (2), while 30.3% rated

their level of satisfaction at (3), 3.3% were satisfied while 19.7% of respondents were very satisfied with the manner in which the incident was handled.

Some victims preferred not report or tell about the incident. 38 said that it was not important, 4 felt ashamed, 2 felt guilty, 31 was afraid of negative consequences, 8 reported it to be useless, 5 did not know who report to and 4 had other reasons for not reporting. Only 8,1% of those who witnessed an incident(s) of physical attack reported it and 4.1% were disciplined for reporting an incident of workplace violence.

When 25,1% of respondents could say with certainty that the employer has policies in place against physical violence while the rest report "no" or "don't know", the frequency of reporting incidents come as no surprise. There are no significant number of victims of physical violence who were offered counseling services, reporting of the incidents, actions taken and perpetrators brought to book are very low - a very unsatisfactory state of affairs indeed.

2.1 PSYCHOLOGICAL VIOLENCE

Gauging from Table 24 it is evident that in the case of verbal abuse the health sector staff prefer to assert their right to tell the person to stop the abuse, followed by reporting it to a snr staff member or telling a colleague about it. In a relatively large number of cases action is taken when the abuse is reported to a snr staff member (170 report to senior staff member, 101 take action, 92 of these management) but nothing is done in the majority of cases while a verbal warning is issued in over 40% of the cases. The smaller percentage of respondents who answered this question indicated that their employer gave them an opportunity to report the matter or to speak about it while insignificant numbers were referred for counseling. The overwhelming majority of those who reported the abuse are dissatisfied with the outcome while the majority who did not report the matter did so because they feared negative consequences and viewed it as “useless” to report.

Sexual Harassment: Gauging from Table 24 it is evident that in the case of bullying/mobbing the health sector staff prefer to assert their right to tell the person to stop the bullying/mobbing, followed by reporting it to colleagues, friends and to a snr staff member. Once again the victims don’t know what steps were taken when management took up the case and verbal warnings seems to suffice in approximately of the cases where action had been taken. The smaller percentage of respondents who answered this question indicated that their employer gave them an opportunity to report the matter or to speak about it while insignificant numbers were referred for counseling. The overwhelming majority of those who reported the abuse are dissatisfied with the outcome while the majority who did not report the matter did so because they feared negative consequences and viewed it as “useless” to report.

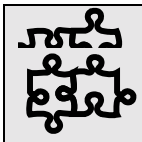
Bullying/Mobbing: Gauging from Table 24 it is evident that in the case of bullying/mobbing the health sector staff prefer to tell a colleague, tell the person to stop and thirdly take no action. Compared to verbal abuse where victims report the matter to a senior staff member, it can be assumed that, because of the power relationship in bullying/mobbing the perpetrator could involve a senior staff member. The overwhelming majority took no action and where action is taken, most victims don’t know what happened. The smaller percentage of respondents who answered this question indicated that their employer gave them an opportunity to report the matter or to speak about it while insignificant numbers were referred for counseling. The overwhelming majority of those who reported the abuse are dissatisfied with the outcome while the majority who did not report the matter did so because they feared negative consequences and viewed it as “useless” to report.

Racial Harassment: In most cases the victim told the person to stop or took no action. Those who could talk about it told friends, families and a colleague but only in 3 cases was this matter referred to a snr staff member. The majority of victims took no action and where action was taken a verbal warning was issued or the victim “don’t know” what happened. The smaller percentage of respondents who answered this question indicated that their employer gave them an opportunity to report the matter or to speak about it while insignificant numbers were referred for counseling. The overwhelming majority of those who reported the abuse are dissatisfied with the outcome while the majority who did not report the matter did so because they feared negative consequences and viewed it as “useless” to report.

TABLE 24: REACTION TO PSYCHOLOGICAL VIOLENCE

Strategies, Reporting, Taking Steps and Rehabilitation				
	Verbal Abu.	*Bullying/Mob*	*Sexual Hara.*	*Racial Haras.*
No. victims Counts	528	211	47	229
VICTIM REACTION				
Took no action	124	48	6	67
Pretend it never happened	81	28	6	31
Told the person to stop	204	61	19	74
Told friends/family	114	49	12	53
Told a colleague	146	70	13	59
Reported to snr staff member	170	46	12	3
Sought counseling	7	2	0	3
Sought help from the union	12	11	0	8
Sought help from association	6	2	0	3
Transferred to other position	11	6	1	4
Completed incident form	9	2	2	1
Pursued prosecution	3	2	1	2
Compensation claim	2	1	0	0
Other	24	6	1	10
EMPLOYER ACTION – INVESTIGATION				
Yes - action taken	101	34	10	30
No action	325	134	26	164
Don't know	66	31	3	26
WHO TOOK ACTION				
Management/employer	92	28	9	21
Union	5	4	0	1
Association	5	0	0	1
Community group	7	4	0	0
Police	1	2	2	0
Other	16	8	5	7
CONSEQUENCES TO PERPETRATOR/ABUSER				
None	56	11	2	11
Verbal warning issued	40	20	4	17
Care discontinued	2	0	0	1
Reported to police	4	0	3	1
Aggressor prosecuted	2	0	1	0
Other	12	6	0	3
Do not know	15	13	5	4
SUPPORT/REHABILITATION OF VICTIM				
Counseling offered	28	8	2	11
Employer give opp. to speak	132	58	11	42
Other support offered by employer	53	23	5	28
VICTIM SATISFACTION WITH HANDLING OF INCIDENT81				
1 Very dissatisfied	134	71	9	81
2	107	36	9	44
3	97	36	6	30
4	39	23	1	17
5 Very Satisfied	65	23	9	24
REASONS FOR UNDERREPORTING				
It was not important	79	33	16	27
Felt ashamed	15	8	5	5
Felt guilty	10	5	2	8

Strategies, Reporting, Taking Steps and Rehabilitation				
	Verbal Abu.	*Bullying/Mob*	*Sexual Hara.*	*Racial Haras.*
No. victims Counts	528	211	47	229
Afraid of negative consequences	94	50	8	57
Did not know who to report to	32	16	0	15
Useless	108	34	13	48
Other	51	17	4	20



BOX 8: QUALITATIVE SURVEY THEME

Victim and Institutional Responses

In the case of a physical attack there is emergency treatment available. In a focus group of auxiliary nurses the fieldworker was told that, to complain would be like signing your own death warrant - especially if a senior staff member is involved. While there is counselling available for staff at some private hospitals, staff in public hospitals speaks highly of the social workers that took it upon themselves to help staff members cope by counselling them and giving them an opportunity to "ventilate". In other focus group, staff complained that social workers run to management with confidential information and that they could not use that avenue. The institutional mindset that the patient or the doctor is "always right" is a barrier to open communication and staff coming forward with their problems. Some facilities hold it against the staff member when they complain. Professional Nurses at a public hospital said that the response mechanisms are inadequate. Professional counsellors are appointed to debrief and counsel nursing victims of violence but these are too few and the counsellors cannot cope with the need. It was clear from the focus group discussions that the institutional responses to workplace violence is deemed to be totally inadequate and as far as some of the participants were concerned, might as well be non-existent.

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

This is an area where large-scale intervention is needed. Unions and staff associations can cooperate with government, management and the community to drive a massive campaign against workplace violence to raise awareness. Unions have the flexibility and commitment to arrange anti-violence activities and they can play a meaningful role in educating and training their members and give support and assistance where needed. But members of the community (chaplains fulfill a meaningful role in the case of ambulatory staff) and support groups within the health care community should be mobilised too to address this problem effectively and immediately. Interdepartmental teams would be extremely useful. Health care workers found the focus group discussions very useful and discovered that they all have similar problems. Communication, networking and unleashing the energies of committed people could prove valuable and effective. The levels of workplace violence in the health care sector of South Africa justify that it be treated as an emergency and a national priority.

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6.
ANTI-VIOLENCE STRATEGIES

1. CATEGORIES OF ANTI-VIOLENCE ACTIONS

Anti-violence strategies are preventative measures against workplace violence. Within the South African context this country can definitely benefit from looking at other systems, however within the available resources, given that the HIV/AIDS pandemic would ruin the health care budget, it is realistic to approach the problem within a developing world context. In the forthcoming working paper 'Workplace Violence in the Health Sector: State-of-the-Art" compiled by Cooper, Cary L. and Naomi Swanson of the National Institute of Occupational Safety and Health of the USA, a differentiation is made between anti-violence strategies for patient/outsider violence and prevention actions for co-worker violence.

1.1 ANTI-VIOLENCE STRATEGIES FOR PATIENT/OUTSIDER VIOLENCE

1.1.1 Commitment

Words look nice on paper, but commitment does the job. Commitment by the South African government on national and provincial level, commitment by trade union federations and unions, commitment by hospital management, commitment by health care workers themselves are necessary. When people are committed they find the necessary resources to improve security and monitor risk situations, they would redirect their funds to training on all levels in workplace violence prevention and they will allocate enough funds and energy into assisting the victims of workplace violence. Commitment is an attitude and can only be brought about by realising the serious threat workplace violence poses to the South African health care system.

1.1.2 Reduce the security risk of crime syndicates operating in public hospitals

With the assistance of the relevant state departments like the police force, metropolitan police force and even the SA Defense force, hospitals could negotiate practical and innovative solutions, tapping from the knowledge of these units. For instance, a mobile police station could easily be accommodated in large hospitals like CHBaragwanath, Johannesburg General and Katlehong. These would bring about a better sense of security to health care workers and professional intervention in the case of assaults and threatening situations. Furthermore this would discourage crime syndicates operating in public hospitals responsible for theft and stalking health care workers. In networking with relevant state departments, the health care sector could also lobby for legislation against the carrying of fire-arms, cultural and other dangerous weapons by members of the public at these facilities and give healthcare workers the right to refuse treatment if these are not handed in on arrival. Metal detectors at entrances and scanners recording fingerprints of patients and visitors to the hospital could be a further deterrent to criminals. Carrying mobile panic buttons connected to a central control room could protect health care staff.

1.1.3 Reduce the number of entrances to hospitals

One of the reasons for the high incidence of theft (and crime syndicates) at public hospitals is the multiple entrances. These multiple entrances does not only render health care workers vulnerable to criminals hiding out in the PUBHCS facilities, but it is relatively easy for criminals to get away with stolen goods like medicines, linen, food etc. The structure of some buildings make it less practical and for this reason public hospitals should network with private hospitals and state departments and use their expertise. Fewer entrances would also lead to the better utilisation of security staff.

1.1.4 Policies, Codes and Programmes against Workplace Violence

While programmes and policies on security, safety and workplace violence should be drawn up, displayed with equal prominence as the posters advocating patients' rights. Policies should be clearly communicated to staff on a regular basis. A Code of Good Practice Dealing with Workplace Violence had been drawn up by the Foundation for the Study of Work Trauma and attached to this document as Annex 11 and while this Code is at present being discussed with the trade unions, private hospitals, labour law advocates, the CCMA and other

interested parties, this code would define workplace violence and creates the culture and mechanisms to deal with such incidents within the context of the South African laws. The Code will be finalised at a meeting between interested parties on 14 December 2001 where after it will be presented to NEDLAC as a blueprint for the development of a Code of Good Practice Dealing with Workplace Violence for South Africa.

The Code of Good Practice as well as an anti-violence programme with a protocol for patients included should form part of the visible zero-tolerance for violence policy. The patient protocol should also be displayed with the same prominence as the patients' rights. Consultation and involvement from employees should drive the programme and should contain the following:

- The programme should be translated in all the official languages of the country so that everybody understands it. Staff must be briefed on the policy in training sessions where they could ask questions and make suggestions.
- A system of reporting of incidents of workplace violence (both physical and emotional) should be put in place to monitor progress and identify "hot spots" needing more urgent intervention.
- An anti-violence suggestion box should be prominently displayed in a central place in the hospital so that staff can make suggestions and assist with the monitoring of workplace violence.
- There are staff members who have basic literary skills and extra attention should be given in training sessions to accommodate those staff members and acquaint them with the anti-violence policy.
- Interdepartmental teams to monitor workplace violence and resolve conflicts would drive the programme to all sections and department of the facility.
- While the interdepartmental teams would monitor all levels of workplace violence an Risk Team would liaise with the interdepartmental teams and management concerning high risk areas as well as processes and procedures that renders staff more vulnerable to workplace violence and recommend and implement the necessary steps.
- Periodic surveys would also be useful in developing a hands-on approach to workplace violence.
- Electronic and Administrative controls would prove in useful in preventing workplace violence and ongoing training should be given to staff on how to secure themselves from workplace violence and how and what to do in such instances. The Guidelines for Preventing Workplace Violence for health Care and Social Services Workers, US Department of Labor, Occupational Safety and Health Administration, 1998 is an extremely useful document. This document also deals with general safety measures that would be applicable to more sectors than the health care sector and could be incorporated in a policy document.
- Health care workers should receive specific training in managing conflict and aggression as such training could be very useful in altercations with psychiatric drugged or confused patients and members of the public.
- All incidents should be investigated and analysed.

1.1.5 Establish a Culture of Caring for Carerers

This should not be a public relations drive, but rather building a culture of caring for health care workers. First from within the hospital. This culture should also be taken to the public and their levels of awareness about workplace violence in the health sector should be raised. This would bring about more understanding and respect for nursing staff. Such a programme could be introduced on a national level by the national health department.

1.2 PREVENTION ACTIONS FOR CO-WORKER VIOLENCE

Workplace violence is multi-causal and the abuse of power plays an important role in workplace violence and especially psychological workplace violence. It is said that bad management needs bullies. Poor job design, limited scope for upward mobility, over-controlling or bad supervisors, low morale, poor communication, lack of leadership, highly competitive work environments, work overload, the need for a scapegoat, the social status of the victim, restructuring, changes and factors like globalisation (which translates in the high number of South African health care workers being recruited to work in foreign countries), staff shortage, lack of proper appraisal systems, role ambiguity and other managerial factors are mainly responsible for co-worker violence.

1.2.1 The role of conflict resolution

One effective way to stop workplace violence between co-workers is to prevent it by committing to an anti-violence policy and clearly communicate to staff that such behaviour is unacceptable. A good policy is a deterrent for a perpetrator. This is one component of a prevention programme – other elements should address the root causes through positive practices, such as environmental modification, financial and social support, education, etc.

Workplace violence is also said to happen because people get away with it. Disciplinary actions against perpetrators on any level in the hierarchy should be a reality and not just a threat. Conflict resolution is sometimes handled by outside consultants with good results as they are deemed to be neutral. However, there is also "shame" and "silence" surrounding abuse, it is most likely to happen in the absence of witnesses or the perpetrator could be a senior which, according to focus groups, are often the case in the health sector. In some cases it could be more difficult for an outsider to understand the situation. Therefore people who could be helpful and are trained in conflict inside the organisation could be helpful.

1.2.2 A culture of dignity and respect

Together with sound policies against workplace violence, a culture of dignity and respect which cascades from managerial level to all levels of employment and which is also expected from outside contractors is the answer. Those in the lower hierarchies of the health care sector (auxiliary nurses) often feel that they are treated without consideration and dignity.

1.2.3 Team building

There are still strict hierarchical levels within the health sector, which, in itself would be account for workplace violence. Team building workshops would be very helpful to heal the interpersonal interaction in the health care sector.

1.2.4 Training in cultural diversity and life skills

It is evident that racial harassment remains an issue within the South African context. Racial harassment is based on prejudices and training in cultural diversity could defuse some of the conflicts and painful experiences workers are subject to. Training in life skills is important and needed on all levels. Similarly training in ethical behaviour is very important and often neglected in the training of health care workers.

1.2.5 Training awareness of workplace violence

Training in workplace violence is important. Once staff is aware of it, they assert themselves better and keep their behaviour in check. Management and supervisors should also be trained in leadership and communication skills.

1.2.6 Transparency and open communication

Transparency, regular staff meetings and open and honest communication leads to positive attitudes as staff experience the withholding of information as a severe form of bullying.

1.2.7 Revitalisation programme

This is a programme developed by the Foundation for the Study of Work Trauma and the Commonwealth Open University called "Rewrite your Story" helping individuals to unbond with traumatic incidents and to revitalise themselves by "rewriting the story" and become the authors of their own story. Underpinned by narrative therapy this programme is helpful for the rehabilitation of perpetrators and victims.

2. EXISTING PROMISING PREVENTION MEASURES/PROGRAMMES

Some health care facilities like the Johannesburg General Hospital have introduced measures to improve security like installing closed circuit television in areas known to be dangerous. Casualty and trauma units work behind bars to protect staff against violence from people outside the hospital. The culture of fear and

despondency is still prevalent and the security at Johannesburg General Hospital and all the other public hospitals are still viewed by the staff as seriously inadequate.

In May 1999 President Mbeki visited the CHBara hospital with the then minister of Safety and Security, Minister Sydney Mufamadi . Staff at Bara told the President that they feared their safety and that they are afraid to report incidents - the minister then said that steps would be taken within a week. While these shows of solidarity boost staff morale, it is worthless when it is not followed up by concrete measures.

A promising intervention is that of the Netcare group but the impact and success of these measures needs to monitored against the levels of violence in these work settings. The independent counseling service with an emergency telephone counseling service can be commended. In focus group discussions staff knew about the service, but didn't use it. The service is confidential and paid for by the group. Those whose cars had been hijacked found it to be useful. One of the shortcomings of this service is that it does not provide a one-on-one critical incident debriefing because they need 48 hours, while the telephone hotline is a 24-hour service. From the data it is clear that the service is underutilised and staff should be trained in using the service.

However it is important to note that it emerged from this study that the Post Traumatic Stress Disorder (PTSD) symptoms are dramatically reduced FIRSTLY when the staff members had an opportunity to talk about the incident or report it and THEN counseling. While the value of counseling is not underestimated, the value of good management cannot be over-emphasized. It is also interesting to note from the cross tabulation in Annex 12 that the anxiety levels of staff who had been victimized are reduced considerably when there are policies in place, even though it has no significant influence on the preventability of the event.

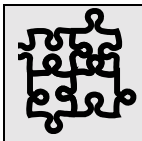
Furthermore, the Netcare group started with training programmes in literacy, life skills and cultural diversity at Milpark and other hospitals. The Human Resources departments are enthusiastic to address the problem of violence. There are induction programmes for new staff members and emergency treatment for physical injuries are available. There is visible security in parking areas and at hospital entrances. The hospitals are also equipped with closed circuit television. The group is trying to introduce a code of conduct for outside contractors like doctors, but progress is still slow and sensitive. At hospitals there are safety teams to monitor problem areas. These should definitely decrease the levels of violence and create an atmosphere in which workplace violence could be addressed. But there are no anti-violence programmes and the levels of workplace violence are still too high.

3. PREVENTION STRATEGIES RECOMMENDED BY INTERVIEWEES

The open-ended question O3 of the Questionnaire Survey requested respondents to identify measures that would reduce workplace violence. While a large number of respondents did not comment, responses were classified and grouped together. There were twice as many comments from the PUBHCS than the PRIHCS.

- PUBHCS workers made 144 comments that security be improved by restricting public access, taking fire-weapons off patients, introducing a mobile police station and employing more male staff members. Only 32 made comments to this effect were received from PRIHCS respondents.
- The PUBHCS workers made 126 comments that staff numbers must be increased in order to reduce waiting periods for patients at clinics within the facilities and pharmacies. PRIHCS respondents made only 21 comments to this effect.
- The improvement of interpersonal relationships and the image of health care workers is a concern for respondents from both sectors. 95 made comments from the PUBHCS and 48 respondents made comments from the PRIHCS said that there should be more open and honest communication, that staff should respect each other and that there must be more respect towards health care workers, more honesty and openness, team spirit should be enhanced and health care workers should be more loyal to each other. There should be more equality . The dignity of staff must be acknowledge and there should be more community participation in building the image of health care workers.

To a lesser degree other issues such as the importance of human resources, management supervision, distribution of resources, planning, discipline and accountability and transparency as a policy was mentioned.



BOX 9: QUALITATIVE SURVEY THEME
Preventative measures

Focus group participants had many ideas. One focus group declined to comment and said that it was a "sinking ship" and that nothing could be done to improve the situation. Others were optimistic and said that training in life skills, stress management, communication, conflict management, would be very useful. More communication, better orientation of new staff members, refresher courses, a culture of dignity and respect and regular meetings to "ventilate" and get to know staff members from other sections. Staff who had been physically attacked in the workplace should be treated with more care and understanding. Management should become more involved with staff members. Health care providers should act against outsiders including doctors who violate the rights of their staff members. Certain minority groups like auxiliaries should have the opportunity to get together and discuss their problems with a senior staff member. Team building is essential and there shouldn't be such a strict demarcation of tasks because it prevents teamwork. A patient focus group said that more staff, equipment and for example air-conditioning in over-crowded areas would go a long way to calm down tempers and the staff and patients need it. The patient group said that soothing music played in waiting areas and in fact all over the hospital could also ease tempers and would be helpful. Most groups emphasised that more security is needed, they should be better trained, parking areas should be adequately safeguarded and lighted at night time and that management should get down to the business of managing.

4. CONSULTATION BETWEEN WORKERS, EMPLOYERS AND MANAGEMENT

A start had been made with the consultation between workers, employers and management to reduce the risk of workplace violence with a meeting workshop on 9 November.

This workshop attended by managers, trainers, health and safety officers and matrons of the different hospitals, trade unions, stakeholders like the CCMA and human rights bodies, labour advocates, fieldworkers, advisors to the project and all interested parties to discuss some of the results of the survey and field work and to give input in preventative measures. The Edenvale Hospital provided the venue.

The workshop started with an introduction to the survey, a discussion of the methodology and sampling and main findings of the research project. Then the meeting split into three sections. One section lead by the CCMA representative draw the most attention - namely to look at a Code of Good Practise to Deal with Workplace Violence and the draft code compiled by the researcher was used as the working document. In general it was felt that the document is valuable and that definitions had to be refined further for the South African context and to be used as a generic code for all sectors. Certain minor changes were suggested for further discussion at a further meeting with all parties before the end of November.

Another section dealt with suitable interventions. This group singled out management training as a solution (and this was also raised as an issue in the open ended questions in the survey) - in South Africa hospital administrators are often matrons or doctors. This mindset need to change and the health department need to appoint people who are managers, rather than have qualifications in health related fields. Secondly, this group felt that Employee Assistance Programmes should cater for counselling and destressing of nurses and monitoring the levels of workplace violence at the facilities and offer appropriate interventions. Inadequate staffing and poor salaries are also cited as a contributing factor and health authorities should pay urgent attention to this matter and appoint more and better qualified staff and utilise existing staff better and encourage the improvement of qualifications and give more in-service training. In a developing country health sector staff often have to listen and assist with personal problems of patients and need training in this field. Training in cultural

diversity is essential. Students must be trained for the reality of working in a developing country. There is a need for enrichment programmes and also to provide for more leave for nurses, preferably twice a year. Orientation of new staff i n the ethics, rules and procedures at the different facilities. Unions must become part of the solution, help individual members and present programmes. Staff and patient rights must receive equal exposure and attention. General public must be made aware of the importance of health care workers. Training and recruitment for the next generation of health care workers must start now. Human Resources development must centre on teamwork and communication as part of on-going training and implemented as a planned and co-ordinated system. The security at hospitals should receive top priority, was the theme at the third group. They suggested that staff receive mobile panic buttons linked to a central control room, that weapons not be allowed at hospitals and that a scanner be used to deter criminals from the hospitals. Working alone as a risk factor and the safety of staff must receive top priority. Adequate lighting and general safety measures that would be applicable to all sectors must be adhered too - NOSA, the national safety institute should also be consulted as they could make valuable contributions.

The ongoing recording of incidents of workplace violence as a means of informing interventions and evaluating their effects should receive urgent attention and ways and means to introduce such systems could form part of the agenda for an urgent summit on this matter.

It was recommended that health care providers and interested parties get together on a regular basis and NEHAWU suggested that a national health summit be organised on the issue of workplace violence. The participants at the workshop would form the core group to arrange for more and better consultation between all the stakeholders and to engage everybody in preventative measures.

5. PERCEPTION OF EFFECTIVENESS: POLICIES/INTERVENTIONS

In the questionnaire survey, respondents rated helpfulness the policies, strategies and interventions as "very", "moderate", "little" and "not at all" as follows.

TABLE 25: PERCEPTIONS OF EFFECTIVE MEASURES

MEASURE	% Very	% Moderate	% Little	% Not at all
Security measures	66.2	17.5	13.8	2.5
Improve surroundings	56.2	23	16.8	4
Restrict public access	52.9	23.7	19.6	3.8
Patient screening	47.1	27.9	20.9	4.2
Patient protocols	45.4	26.9	23.1	4.6
Restrict exchange of money in the workplace	45.2	19.6	25.2	9.9
Increased staff numbers	55.1	17.8	18.4	8.8
Check-in procedures to staff	40.2	24.6	25.1	10.2
Special equipment and clothing	38.4	21.3	29.5	10.8
Changed shifts or rotas	33.5	24.3	27.5	14.8
Reduced periods of working alone	47.7	20.4	22.9	9
Training	58.9	20.6	17.1	3.5
Human Resource development	55.1	19.7	20.6	4.6

It is evident that security, training, improved surroundings, human resources development, increasing staff numbers, restricting public access are the priorities identified by the respondents while all other measures are viewed as high priorities.

It is also clear that respondents feel that present policies, strategies and preventative measures are totally inadequate to protect them against workplace violence and that the above measures, together with those recommended elsewhere in the report must be used as a basis to devise a comprehensive anti-violence programme.

SECTION C
CONCLUSIONS

The extremely high levels of workplace violence in the health sector of South Africa are shocking. Although it is accepted that there is a risk of workplace violence attached to work with psychiatric patients, confused patients or patients on medication it is unacceptable that health care workers should endure violence from the patient escorts, the public, criminals and outside contractors and high levels among staff members.

1. IDENTIFICATION OF CONTRIBUTION FACTORS

It is clear from the report that the following factors contribute to the extremely high levels of workplace violence in South Africa:

- The high levels of crime and violence in society are spilling over to the health care facilities.
- The levels of physical and psychological violence are much higher in the public health care sector than in the private health care sector due to the fact, that:
  (a) The public health care facilities are, in most cases, serving areas where crime rates are high and various socio-economic conditions prevail in those areas;
  (b) Patients and patient escorts at public health care facilities are sometimes members of gangs, criminals or substance abusers and pose a threat to the safety of health care workers;
  (c) Financial constraints, budget cuts, inadequate or old equipment, shortages of medicines, linen and other necessities to deliver services place the public health sector under immense pressure;
  (d) The impact of HIV/AIDS on the health budget is considerable. 50% of most public health care facilities' patients are there because of HIV/AIDS-related diseases causing a shortage of beds and resources;
  (e) Overcrowding in public hospitals;
  (f) Staff shortages and long queues for example at pharmacies or out-patient clinics in the hospital further exacerbate the potential for violence and conflict;
  (g) Public health care facilities have less resources for training and human resources development;
  (h) It is against policy to identify patient files indicating that the patient is potentially dangerous or even HIV-positive;
  (i) There are too many entrances to most public health care facilities, endangering the health care workers;
  (j) Public health care facilities must serve all the people of the country - also the criminals and therefore the clientele exercise their right to health care, but disregard the rights of health care workers.
  (k) Criminals hide in the hospitals when the police chase them and some criminals live in the hospital in places where they cannot be found.
- Workplace violence cuts through racial and gender divides, but minorities in the workplace - whether white or black - are more vulnerable to workplace violence, specifically verbal abuse and racial harassment.
- Certain professional groups like emergency staff, nurses, staff working in trauma and specialised units, technical staff and midwives are more exposed to workplace violence.
- Because of the patient profile health care workers in emergency and specialised services, general medicine, psychiatric wards experience more incidents of workplace violence in the public health sector while health care workers in ambulance/emergency services, general medicine, operating room experience higher incidences of workplace violence in the private health care sector.
- The size of the facility and service level plays a role in the incidence of workplace violence.

- Security staff at health care facilities is not armed. Respondents view security staff to be poorly trained and incompetent. The security staff cannot remove the firearm if the person is licensed and can only request that the person hand in the firearm.
- Trauma units inside most public hospitals and there is always a risk of violence at such units.
- Lack of teamwork and a sense of loyalty among staff members.
- Medical doctors abuse their status and could be very abusive to nursing staff - it is a well-known fact that a doctor can "get rid" of a staff member he/she doesn't like because of their special relationship with the private hospitals in particular.
- Stress related to health care work.
- Frustrated, "entitled" and demanding public with very little respect for health care workers.
- Rudeness, disrespect, intolerance, failed or inadequate communication, failed conflict resolution, bad attitudes, tempers, power battles, nepotism and staff undermining each other.
- Racial issues and cultural differences/misunderstandings
- Perceived poor management.
- Lack of patient screening and patient protocols.
- Lack of policies against workplace violence.
- Poor support for victims of workplace violence at facilities, inadequate responses and inadequate or no investigation into the matter.
- Perpetrators of workplace violence get away with it.
- Inadequate debriefing of victims of workplace violence.
- Lack of trust among staff members.
- Poor communication between staff, staff and management.
- Lack of training and intervention.
- Lack of commitment against workplace violence.
- Restructuring and staff cuts.

2. IDENTIFICATION OF PREVENTION FACTORS

- Commitment to a policy of zero-tolerance against workplace violence.
- A programme against workplace violence and vigilant monitoring of the programme, identifying areas that are unsafe or situations that may lead to conflict and timeously introducing measures.
- Adequate security measures and visible security.
- Screening of patients, patient protocols and restricting public access, especially in the case of patient escorts. Health care workers should have adequate access to records that could indicate a patient as potentially dangerous.
- Improved surroundings - lighting in parking areas, air-conditioning in places where there are many patients, reduction of noise, access to food and water for patients; soothing music.
- Increase in staff numbers.
- Caring attitude towards staff and an investment in training in workplace violence, coping strategies, communication skills, conflict resolution, self-defense.
- Better regulation and protection of staff through check-in procedures, mobile phones, panic buttons, special equipment or clothing, changed shifts or rotas, reduce periods for staff members working alone.
- Investment in human resource development - career advancements, good appraisal systems, rewards for achievement, promotion of healthy environment, encouragement to further qualifications and incentives.
- Training in cultural diversity.

SECTION D
RECOMMENDATIONS

1. PROMISING INTERVENTIONS

1.1 PREVENTION OF WORKPLACE VIOLENCE IN THE HEALTH SECTOR

1.1.1 Recommendation 1: Safety and Security

The issue of safety and security is of utmost importance at public and private hospitals. The hospital management, unions, staff members and in the case of public hospitals - government officials should arrange for a forum to network on these issues. Both health sectors should serve on this forum and the expertise of the police force, bodies like NOSA, security companies, legal and constitutional advisors, defense force and all other stakeholders must be brought together in this forum to draw up a comprehensive plan addressing security issues at hospitals.

In the interim:

- immediate attention must be paid to reduce the number of entrances at health care facilities,
- all health care workers should be issued with mobile panic buttons which is linked to a central control room
- all entrances should have security gates with metal detectors with trained staff in place to take appropriate action when a weapon is discovered.
- a scanner taking finger prints should be installed at entrances to deter criminals from entering the facility without good cause or for purposes of treatment
- security staff must receive ongoing training

1.1.2 Recommendation 2: Policing

Mobile police stations at large or high risk health care facilities would be serve as a deterrent for criminals and police would also be helpful in the case of crisis or where staff is threatened with a fire-arm and or robbery.

1.1.3 Recommendation 3: Recruit and employ more staff

There are staff shortages in all hospitals and vacancies should be filled immediately.

1.1.4 Recommendation 4 : Improve surroundings

Inadequate ventilation when there are a large number of patients in one location leads to workplace violence. Lighting should be improved in all areas, soothing music played to calm large crowds, access to food and water and facilities should be kept hygienic all the time.

1.1.5 Recommendation 5: Screening of patients

Potentially dangerous patients should be screened and health care workers alerted to the fact that the patient has a record of violence.

1.1.6 Recommendation 6: Patient Protocols

Patient protocols or a code of conduct must be compiled and distributed and displayed with the same vigour as the pamphlet on patients' rights.

1.1.7 Recommendation 7: Restrict the exchange of money

Although it is not always possible at public hospitals, money exchange should be restricted to at least a central area. Credit or debit card processors should be available so that "moneyless" payments would be possible.

1.1.8 Recommendation 8: Better controls over staff movement

Check-in procedures for staff should be monitored and it should be known where a staff member is at any given time. Changing shifts of staff members should also be more frequent, but in consultation with the staff member. The periods of staff members working alone should be reduced.

1.1.9 Recommendation 9: Protective clothing and equipment

The risk of nursing staff and other workers contracting HIV/AIDS is very real and protective clothing and equipment should be available at all facilities as this is a major source of stress and concern to all health care workers.

1.1.10 Recommendation 10: Training in Cultural Diversity

South Africa has a history of racial intolerance. Staff members on all levels should be trained in cultural diversity and respect for each other's cultures and habits.

1.1.11 Recommendation 11: Training in Sexual Harassment

South Africans do not have a high awareness of sexual harassment, yet this country has the highest incidence of rape in the world. A comprehensive programme about what sexual harassment is, should be a high priority.

1.1.12 Recommendation 12: Training in Workplace Violence

Training in what workplace violence is, the impact of workplace violence and its negative impact on staff and what to do when experiencing or witnessing workplace violence.

1.1.13 Recommendation 13: Training in self-defense

Staff needs to know how to handle perpetrators of emotional violence physically , underpinned with psychological knowledge to defuse the altercation.

1.1.14 Recommendation 14: Training in interpersonal communication and relationships

Training in interpersonal communication, lifeskills, conflict resolution, the concepts of dignity and respect, stress management, for interaction between colleagues and staff and patients/outsiders.

1.1.15 Recommendation 15: Training in Teamwork

Training in teamwork for better loyalty between staff members and improved relationships between the different hierarchies.

1.1.16 Recommendation 16: More latitude in the scope of assignments on different levels

More latitude should be allowed for health care workers to take decisions or to exercise initiative and the strict demarcation of tasks should not suppress initiative of rendering assistance with tasks below or above the worker's status.

1.1.17 Recommendation 17: Code of Good Practice to Deal with Workplace Violence

The Foundation for the Study of Work Trauma's Code of Good Practice to Deal with Workplace Violence should form the basis of a code to be introduced at the facility.

1.1.18 Recommendation 18: Physicians and Outside Contractors

Staff should be protected against the abuse of power by physicians and outside contractors. A Code of Good Practice to deal with Workplace Violence should not only be applicable to staff members but to everybody who deals with the particular facility.

1.1.19 Recommendation 19: Suggestion Box

A suggestion box should be placed in a central place in the facility and the Human Resources Departments should consider all contributions carefully.

1.1.20 Recommendation 20: Revitalisation of Staff

Narrative therapy and trauma unbonding is particularly useful to sensitise the health care workers who reported that they have become desensitised and numb. It is also useful for an organisation wants to revitalise the workforce and change the corporate culture.

1.1.21 Recommendation 21: Leave

The practice to "buy out" leave should be done away with and staff should be encouraged to take leave twice a year to prevent burnout.

1.2 REPORTING PROCEDURES

1.2.1 Recommendation 22: Commitment to an Anti-violence policy

The facility must develop an anti-violence policy and show zero-tolerance for any form of workplace violence. Staff must adhere to the policy and also feel protected by such a policy. There should be no exceptions.

1.2.2 Recommendation 23: Commitment to an Anti-violence programme and reporting procedures

A programme must be drawn up in consultation with staff members to reduce and alleviate workplace violence by identifying interdepartmental teams, ombudspersons and involving all staff members in actively driving the programme, introducing reporting procedures and meticulous records to monitor the situation and device timeous interventions.

REMARK: The Guidelines for Preventing Workplace violence for Health Care and Social Service Workers of the U.S. Department of Labor (Occupational Safety and Health Administration) 1998, guidelines by the International Council of Nurses and other bodies could be very useful in this regard.

1.3 REHABILITATION OF VICTIMS AND PERPETRATORS (intervention for all parties involved in incidents of violence: medium and long term)

1.3.1 Recommendation 24: Debriefing and Counseling of Victims

Staff who had been subjected to physical and prolonged psychological violence needs to be counseled and the necessary arrangement with either outside consultants or internal staff for such intervention should be available. Where it is suspected that a staff member may suffer from Post Traumatic Stress Disorder, professional intervention of a medical and counseling nature may be necessary.

1.3.2 Recommendation 25: Rehabilitation of Perpetrators

Perpetrators would also need assistance and training in Emotional Intelligence, lifeskills and management of aggression and anger would be helpful where applicable.

1.4 POST-VIOLENCE RESPONSE (short term, strategic and awareness interventions)

1.4.1 Recommendation 26: Special Care for Victims

Mindful that victims of workplace violence could develop Post Traumatic Stress Disorder, victims that had been exposed to severe physical and/or psychological violence must be monitored in an atmosphere of care and critical incident debriefing must follow as soon as the incident had been reported.

1.4.2 Recommendation 27: There must be an investigation, action and feedback

When workplace violence occur and is reported, there must be a thorough investigation, transparency and feedback to the victim of the appropriate steps taken to remedy the situation as well as steps to prevent further violence.

1.4.3 Recommendation 28: Discussion/Support Groups

The introduction of discussion and support groups for victims could be useful to validate their experiences with other victims and to ventilate their anger and fear in a safe environment.

1.4.4 Recommendation 29: Discussion Groups on Workplace Violence

Discussion groups, facilitated by someone who is familiar with the phenomenon and who could focus a group to support individuals who had been victimised would be very useful. This could form part of renewal or post-violence intervention.

2. FURTHER ACTION ON NATIONAL AND ORGANISATIONAL LEVEL

2.1 Recommendation 30: National Health Summit on Workplace Violence

A national summit on Workplace Violence arranged by the trade unions and involving all stakeholders where this report could be presented would be ideal. There could then be workshops and discussion groups afterwards to take the ideas further and making it their own by giving input.

2.2 Recommendation 31: Establishment of a Health Forum Against Workplace Violence

The establishment of a national forum against workplace violence for the health sector could be driven on local, provincial and national level with exchanging best practices, information and expertise as the object.

BIBLIOGRAPHY

REFERENCES

1. Bezuidenhout, M. 1998. The contribution of the Nurse Manager to healthy labour relations, Part 2. Health SA Gesondheid Vol. 3 No. 2 (1998) quoted from *Gerber, P.D., Nel, P.S. and Van Dyk, P.S. 1992. Human resources management: 2nd edition. Halfway House: Southern.*
2. Butchart, A., Hamber B., Terre Blanche, M & Seedat, M. 1998. Violence, power and mental health Policy in Twentieth Century South Africa in foster, D., Freeman, M & Pillay, Y (eds), Mental health Policy issues in South Africa, pp. 236-262, Cape Town: Medical Association Multimedia Publications, 1998. Obtained from CSVR website http://www.csvr.org.za/papers/paperbh&ab.htm visited 09/03/2002.
3. Cooper, Cary L; Swanson N. 2001. Forthcoming Working paper : Workplace Violence in the Health Sector : State-of-Art.
4. Einarsen, S. & Matthiesen, B. 2002. Workplace bullying: Learning from a decade of research. Proceedings from the Adelaide International Conference on Workplace Bullying, 20-22 February 2002.
5. Einarsen, S. 1999. The nature and causes of bullying at work. International Journal of Manpower. Volume 20 Number 1 Page 16 – 27.
6. Einarsen, S., Matthiesen, S.B. & mikkelsen, E.G. 1999. Tiden leger alle sár? Senvirkniger af mobbing I arbeidslive *(Is time a great healer? Long term effects of workplace bullying).* Universiteitet j Bergen: Institutt for Samfunnspykologi.
7. Ethics Institute of South Africa. 2001. Chris Hani Baragwanath Hospital Ethics Audit.
8. Hamber, B & Lewis, S. 1997. An Overview of the consequences of Violence and Trauma in South Africa. Occasional paper written for the Centre for the Study of Violence and Reconciliation, Johannesburg.
9. Hoel, H; Sparks K.; Cooper, C.L. 2000. The cost of violence/stress at work and the benefits of a violence/stress-free working environment. Report commissioned by the International Labour Organization (ILO) Geneva.
10. Mahlo, M & Muller, M. 2000. A strategy to enhance positive working relationships among the role players within the managed healthcare context in Gauteng. Health SA Gesondheid. Vol. 5 No. 3 (2000).
11. Marais (now Steinman), S and Herman, M., 1997. Corporate Hyenas at Work. Kagiso Publishers.
12. Marais-Steinman, S. 2001. Challenging workplace bullying in a developing country : the example of South Africa. Forthcoming publication. Extract from Chapter 19 for a book to be edited by Proff. Cary Cooper, Stale Einarsen, Dieter Zapf and Helge Hoel for 2002.
13. Medical Research Council. 2001. Draft paper “The impact of crime and violence on the delivery of State Health Care Services in the Western Cape” presented by Sandra Marais on 18/10/2001 at Unisa Institute in Lenasia.

14. Motsei, M. 1990. The best kept secret: violence against domestic workers. Seminar No. 5, 1990. 25 July 1990 at the University of the Witwatersrand.

15. Ngwezi, A. A. 1997. Work stress in a group of black nurses. University of Pretoria.

16. Oxford companion to Philosophy. From http://www.xrefer.com/entry/553621 visited on 9 March 2002.

17. Poggenpoel, M. Promoting Nurses Mental Health. Health SA Gesondheid Vol. 1 No. 2 1996.

18. Thornton, R. 1995. The peculiar Temporality of Violence. Paper delivered at the Centre for the Study of Violence and Reconcilliation, Johannesburg. 29 March 1995.. Web page : http//www.wits.ac.za/csvr/papers/ papthorn.htm visited on 15 August 2991.

19. U.S. Department of Labor. 1998. Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers.

20. Van der Merwe, H W. 1989. Pursuing Justice and Peace in South Africa. New York : Routledge.

21. Venter, Liesl. 21 September 2001. The Citizen, page 7. "Hell in Jo'burg hospital where chaos reigns".

22. World health Organization. 1995. Violence. A public health priority. Geneva: WHO, taken from the submission from World Health organization to the Committee of the Rights of the Child for its Day of General Discussions, September 28, 2001. http://www.crin.org/docs/resources/treaties/erc.28/WHO1.pdf visited on 9 March 2002.

23. Wynne, R., Clarkin, N., Cox, T. & Griffiths, A. 1997. Guidance on the Prevention of Violence at Work. Luxemburg: European omission, DG-V.