Work Schedule and Client Characteristics Associated With Workplace Violence Experience Among Nurses and Midwives in Sub-Saharan Africa

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*Violence against health care workers perpetrated by clients and/or their friends and family (Type II) is a growing problem that can severely impact health care delivery. We examined the prevalence of Type II workplace violence among nurses and midwives in sub-Saharan Africa and its association with work status, schedule, and client characteristics. Nurses and midwives (*n = *712) completed an anonymous survey while attending nursing meetings. Generalized estimating equation models, accounting for clustering within residing countries, were employed. Participants who were exposed to risky client characteristics (*aOR = *1.39–1.78,* p < *.001), and those who worked more than 40 hours a week were more likely to have experienced Type II workplace violence (*aOR = *1.72–2.15,* p < *.05). Findings will inform policy and organization level interventions needed to minimize nurses' and midwives' exposure to Type II workplace violence by identifying risky clients and addressing long work hours.*

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Violence against health care workers is a growing problem worldwide and can severely impact health care delivery. *Workplace violence* is defined as "violent acts, including physical assaults and threats of assault, directed toward persons at work or on duty" (Centers for Disease Control and Prevention/National Institute for Occupational Safety and Health, 1996, p.1). Violence can be classified into four types: Type I (criminal intent), Type II (customer/client), Type III (worker on worker), and Type IV (personal relationship) (University of Iowa Injury Prevention Research Center [IPRC], 2001). In sub-Saharan Africa, *Type II workplace violence* among nurses and midwives, the focus of this paper, is defined as that which occurs when the person who commits the act of workplace violence is either the recipient or object of service (current or former client, patient, customer, criminal suspect, or prisoner, etc.) provided in the workplace by a health care worker or victim (IPRC, 2001).

Workplace violence is a common concern for both developed and developing countries. The economic burden of workplace violence associated with fatal

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or nonfatal assaults affects organizations as well as victims, costing billions of dollars in lost wages, medical costs, support costs, and lawsuits (Schmidtke, 2011). Moreover, workplace violence has tremendous psychological and physiological impact on the victims, their families, co-workers, and the organization as a whole, and elicits concerns about the organization's commitment to safety on the job (Beech & Leather, 2006). It is worth noting that in many places in sub-Saharan Africa, 50% or more of hospitalized patients are infected with HIV (Madhava, Burgess, & Druker, 2002), which adds another layer of risk within the work environment for nurses and midwives.

Despite the magnitude of the problem of workplace violence, research exploring the causes and evaluating interventions to reduce workplace violence is still limited. By contrast, numerous researchers representing various disciplines have described various conceptualizations of the problem, with a focus on both personal and workplace factors leading to violent behaviors and injury. Barling (1996) conceptualized workplace violence and included personal factors such as type A behavior, alcohol consumption, and history of aggression as predictors of workplace violence. Smith-Pittman and McKoy (1999) stated that every violent state involves "at least four elements: a perpetrator, causative factors, environment conducive to violence, and targets" (p. 6). Occupational health researchers, on the other hand, conceptualized workplace violence using a work organization framework (Centers for Disease Control and Prevention/National Institute for Occupational Safety and Health, 2002; McPhaul & Lipscomb, 2004; McPhaul, London, & Lipscomb, 2013) that is inclusive of a comprehensive health and safety program approach (U.S. Department of Labor, & Occupational Safety and Health Administration, 2004).

The literature provides limited data about the magnitude of Type II workplace violence in sub-Saharan Africa as well as other middle- and low-income, developing countries. The purpose of this paper was to assess the prevalence of Type II workplace violence in a sample of nurses and midwives primarily from three sub-Saharan African countries: Nigeria, Tanzania, and Kenya.

Prevalence of Workplace Violence Globally and in Sub-Saharan Africa

In addition to having 25% of the world's disease burden, sub-Saharan countries have a severe shortage of health care workers (Dovlo, 2007). Nurses constitute 45% to 60% of the health care workforce in sub-Saharan Africa, with high nurse-to-physician ratios, and one of the lowest nurse-to-patient ratios in the world (Dovlo, 2007). The nursing shortage in sub-Saharan countries can be attributed to a number of factors, including: economics, politics, education, the HIV pandemic, work organization, and bureaucracy, all of which potentially affect the work environment of nurses and midwives by causing them to work long hours in critically understaffed facilities (Dovlo, 2007). Consequences of these shortages include an increasingly stressful work environment, placing the nurses at risk for violence and stress-related diseases, ultimately compromising the quality of care.

In 2002, a report on workplace violence in Australia, Brazil, Bulgaria, Lebanon, Portugal, South Africa, and Thailand, sponsored by the International Labor Office, International Council of Nurses, World Health Organization, and Public Services International, acknowledged the extent and severity of the problem of workplace violence in the health care setting (Di Martino, 2002). The report indicated that a majority of health care workers in each country had experienced at least one incident of physical or psychological violence in the previous year (67.2% in Australia, 46.7% in Brazil, 75.8% in Bulgaria, 61% in South Africa, 54% in Thailand, and, in Portugal, 60% in a health center and 37% in a hospital; Di Martino, 2002).

In the United States, a high percentage of workplace incidents and deaths have been attributed to violence within health care settings (Centers for Disease Control and Prevention/National Institute for Occupational Safety and Health, 2002; Lipscomb, Silverstein, Slavin, Cody, & Jenkins, 2002; Peek-Asa, Cubbin, & Hubbell, 2002; Peek-Asa et al., 2009; U.S. Department of Labor, Bureau of Labor Statistics [BLS], 2006). In each year from 1993 to 1999, 1.7 million incidents of violence occurred in the workplace (Duhart, 2001). The BLS