Is workplace violence against health care workers in Mozambique gender related?

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Abstract

Letters to the editor do not require abstract

Background

Violence in specific contexts, including workplaces, is a major problem. It is also acknowledged that violence against health care workers (VHCW) tends to remain invisible in comparison to other forms of violence.[1]

In sub-Saharan Africa (SSA), VHCW has been reported from several countries, acknowledging its endemic dimension, the negative impact on health care workers (HCW) and services, a high level of tolerance to non-physical violence and absence of policies to deal with violence, contributing to the underreporting of the problem and its neglect in health workforce planning.[2,3]

However, gender aspects of violence have not been properly addressed, remaining the question as to what extent VHCW should be interpreted as gender-based violence (GBV), a global public health problem with a significant prevalence in developing countries.[4,5]

This letter revisits data reported previously in this Journal that describe the typology and the perceived impact of VHCW at the health services of the City of Lichinga in Mozambique during 2019.[3] In this letter we attempt to understand if our results on VHCW in Niassa can be considered as an example of GBV.

This was driven by the 2019 Centenary Conference of the International Labour Organization which adopted a Convention, accompanying Recommendations and a Declaration, to address, among other issues, violence and harassment in the workplace. These documents acknowledged that GBV and harassment disproportionately affect women and girls, and recognize "that an inclusive, integrated and gender-responsive approach, which tackles underlying causes and risk factors, including gender stereotypes, multiple and intersecting forms of discrimination, and unequal gender-based power relations, is essential to ending violence and harassment in the world of work" (https://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO::P12100_ILO_CODE:C190).

Population and methods

This was an observational, descriptive, cross-sectional study, carried out from March to May 2019 in all departments of the Lichinga Provincial Hospital and at the Lichinga City Health Centre in the Niassa Province of Mozambique.

The methodological details are described in other article.[3] This questionnaire survey collected self-reported information on VHCW in selected health care units in the 12 months preceding the survey date.

The study participants were recruited following a simple random sampling strategy. The study excluded HCW: who were on vacation or taking another type of leave; working at the study health unit for less than 12 months; who did not report any history of having suffered violence in the workplace in the past 12 months. Two hundred and sixty HCW were eligible to participate based on inclusion criteria.

The study was approved by the Institutional Committee on Bioethics in Health, Faculty of Medicine, Eduardo Mondlane University and Central Hospital of Maputo (registration number CIBS FM & HCM 097/2018).

Data were entered into SPSS 20.0. The analysis cross tabulated sex of the HCW with other categorical variables testing statistical significance with either Fisher Exact test, Pearson or likelihood ratio chi-square. Means were compared using ANOVA.

Results

Female victims of VHCW in Niassa are usually younger (63% of females were less than 35 years of age, compared to 45% of males, p=0.020) and more inexperienced than their male colleagues [men (11.3+ 7.5 years) had a longer working presence in the health sector than women (8.0+4.9)(Anova p=0.003)].

Our results indicate that the health center (HC) is a higher risk environment than the hospital and the percentage of female victims of VHCW working at the HC (n=14/65, 22%) is higher (n=6/75, 8%) than the percentage of male victims (Fisher exact test p=0.020). The relative percentage of women (n=39/65, 60%) doing night shifts (working from 18:00 hours to 07:00 hours) was higher than men (n=33/75, 44%)(Fisher exact test p=0.043).

Women (n=58/65, 89%) more than men (n=53/75, 71%) reported not knowing if the health services had any policies or procedures to deal with VHCW (likelihood ratio p=0.040). Females (n=42/64, 66%), more than males (n=34/74, 46%), were not encouraged to report VHCW (Fisher exact test p=0.016).

Women were more frequently threatened by different-sex aggressors than men (table 1).

Table 1. Sex of the aggressors cross-tabulated with sex of victims of workplace violence

			Sex of the victim of violence male	Sex of the victim of violence female
Sex of the verbal aggressor*	female	n	6/34	11/28
		%	18%	39%
	male	n	28/34	17/28
		%	82%	61%
Sex of the physical aggressor**	female	n	0/4	2/4
		%	0%	50%
	male	n	4/4	2/4
		%	100%	50%
Sex of the sexual harasser**	female	n	3/5	1/3
		%	60%	33%
	male	n	3/5	2/3
		%	60%	67%
Sex of the person discriminating**	female	n	3/12	2/4
		%	25%	50%
	male	n	10/12	2/4
		%	83%	50%
Sex of the person bullying**	female	n	5/28	6/26

		%	18%	23%
	male	n	24/28	2026
		%	86%	77%

*Fisher exact test p= 0.05 ** Fisher exact test not significant

Conclusions

If we seek to eliminate VHCW then quality research and theoretical work must substantiate its underpinnings. Our findings, although not conclusive, support the need to consider gender as a dimension when conducting research on VHCW. If we do not do so, gender will continue to be an invisible and ignored dimension of intervention strategies to prevent VHCW.[6]

This is particularly important in a context where there is a growing feminization of the health workforce in lower-middle- and upper-middle-income countries, as well as differences between male and female physicians' engagement with the profession, potentiating exposure to violence in the workplace.[7]

If research supports the hypothesis that VHCW can be construed as GBV, then the observed prevalence of VHCW might be the result, as referred above of the "stereotypes, multiple and intersecting forms of discrimination, and unequal gender-based power relations" associated to gender inequalities in society that underly such violence. This will indicate the need to frame policies and strategies against VHCW within a broader framework to tackle the social, cultural and political contexts that sanction this type of violence.[8-15]

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