DISSERTATION

EXPLORATION OF WORKPLACE VIOLENCE EXPERIENCE AMONG NURSES AT A SELECTED UNIVERSITY TEACHING HOSPITAL IN RWANDA

By

MUSENGAMANA Valens

College of Medicine and Health Sciences

School of Nursing and Midwifery

Master of Science in Nursing (Education, Leadership and Management Track)

2019

DISSERTATION

EXPLORATION OF WORKPLACE VIOLENCE EXPERIENCE AMONG NURSES AT A SELECTED UNIVERSITY TEACHING HOSPITAL IN RWANDA

By

MUSENGAMANA Valens

Student Registration Number: 216338034

A dissertation submitted in partial fulfilment of the requirements for the degree of Master of Science Nursing (Education, Leadership and Management Track)

In College of Medicine and Health Sciences

School of nursing and Midwifery

Supervisor: Mr Gilbert Banamwana

CO-Supervisor: Prof. Oluyinka Adejumo

June 2019

DECLARATION

I, VALENS MUSENGAMANA, declare that this dissertation is the result of my own original work and has not been presented for any other degree at the University of Rwanda or any other institution**.**

Signature ------------------------------

Date--------------------------------------

DEDICATION

I would like to dedicate this dissertation to:

My beloved wife, Lea NYIRANGIRIMANA

My mother,

My sons and my daughter,

My classmates and my friends

All nurses who participated in this study

ACKNOWLEDGEMENTS

Praise is the Almighty God kept me alive, healthy and energetic and gave me ability to develop and successfully this dissertation.

I am profoundly thankful for those who provided me with the occasion to afford this master's program: The Government of Rwanda for education support, the Ministry of Health, Ministry of Education and the University of Rwanda.

I would like to thank International Labor Organization Library who gave the permission to use copyrighted instrument.

I would like to express my sincere gratitude to my supervisor Prof. Oluyinka Adejumo and my co-supervisor Mr Gilbert Banamwana for the continuous support and guidance while writing up this dissertation.

I would like to thank nurses working at a selected University Teaching Hospital in Rwanda for participating in this study.

Special thanks go to my wife, Lea NYIRANGIRIMANA for moral and material support along the journey of my studies.

I thank my co-workers in quality Management Directorate especially the Director of the unit, dear classmates, friends and all who participated in the accomplishment of my studies.

ABSTRACT

Title: Exploration of workplace violence experience among nurses at a selected University Teaching Hospital in Rwanda.

Background: Workplace violence (WPV) is a global problem in the health sector especially in the hospitals affecting healthcare works' job satisfaction and performance. Healthcare workers are affected especially nurses, WPV is present in different forms associated with various factors.

The aim of this study was to explore WPV experience among nurses working at a selected University Teaching Hospital in Rwanda

Method: The research approach used were descriptive cross-sectional design and quantitative. The stratified random sampling was used to recruit 195 participants among 379 nurses. The data was collected using a structured, validated, and self-administered questionnaire that was adapted from the ILO, ICN, WHO, and PSI. Frequencies and percentages were used for analyzing descriptive data. Chi-square test was used for evaluating association between variables.

Results: The findings revealed that (58.5%, n=114) of nurses have experienced some types of WPV in the 12 months preceding this study, among them (44.6%, n=108) of nurses were verbally abused when working with the patients/clients. The nurses providing emergency care, the nurses working at the emergency department and nurses working with vulnerable patients like HIV/AIDS patients were associated with WPV Chi^2 (1, n=195), $P=<0.001$). The psychological concerns are the most consequences of WPV among nurses working at a selected University Teaching hospital in Rwanda.

Conclusions: Based on the findings of this study, it was concluded that the hospital management needs to be aware of the WPV, develop and implement appropriate policies and strategies, and avoid WPV. These strategies could enable nurses to be concentrated psychologically to their job resulting in improvement of service delivery.

Recommendations: The researcher suggested that the hospital leaders and managers in nursing should be aware and understand WPV in the healthcare settings. The future cross-country study using both quantitative and qualitative approaches is suggested to explore all information regarding WPV in Rwanda hospital settings.

Keywords: Workplace, workplace violence, Nurses

TABLE OF CONTENTS

DECLARATION iii

DEDICATION iv

ACKNOWLEDGEMENTS v

ABSTRACT vi

LIST OF SYMBOLS AND ACRONYMS/ABBREVIATION x

LIST OF TABLES xii

LIST OF FIGURES xiii

CHAPTER ONE: INTRODUCTION 1

1.1 Introduction to the study 1

1.2 Background to the study 2

1.3 Problem statement 3

1.4 The aim of the study 4

1.5 Research objectives 5

1.6 Research questions 5

1.7 Rationale/ significance of the study 5

1.8 Definition of Concepts 5

1.9 Structure/Organization of the study 6

1.10 Summary of Chapter one 7

CHAPTER TWO: LITERATURE REVIEW 8

2.1. Introduction 8

2.2 Theoretical framework of the study 8

2.2.1. Types of workplace violence 8

2.2.2 Factors allied with WPV in healthcare system 9

2.2.3 Strategies to overcome workplace violence in healthcare system 10

2.3 Empirical Literature 11

2.3.1 Introduction 11

2.3.2 Types of workplace violence 11
2.3.3 Factors associated to workplace violence 12
2.3.4 Consequences of workplace violence 13
2.4 Critical review and research gap identification 14
2.5 The conceptual of framework 15
2.5.1 Application the model to the healthcare settings 16
2.6. Summary of chapter two 17
CHAPTER THREE: RESEARCH METHODOLOGY 18
3.1. Introduction 18
3.2. Research design 18
3.3. Research approach 18
3.4. Research setting 18
3.5 Population 20
3.5.1 The inclusion criteria 20
3.5.1 Exclusion criteria 21
3.6 Sampling strategy 21
3.6.1 Sample size 21
3.6.2 Sampling strategy 21
3.7. Instrument (Including reliability and validity) 23
3.7.1 Reliability 23
3.7.2 Validity 24
3.8. Data Collection 27
3.9. Data analysis 27
3.10 Ethical consideration 27
3.11 Data management 29
3.12 Data dissemination 29
3.13. Limitations and challenges 30

3.14. Summary of chapter three 30
CHAPTER FOUR: PRESENTATION OF THE FINDINGS OF THE STUDY 31
4.1 Introduction 31
4.2. Personal and workplace data of the sample 31
4.2.1. Gender, age, marital status and nursing work experience 31
4.2.2. The category of patients/ Clients and the sex of patients, nurses most frequently work with 32
4.2.3 Specialties where nurses spend more than 50% of working time 33
4.2.5 The amount of staff present in the same work setting with nurses more than 50% 35
4.3 Presentation of findings as aligned with the objectives 35
4.3.1 Types of WPV in the last 12 months 35
4.3.2 Factors associated with WPV 36
4.3.3 Consequences of WPV 39
4.4. Summary of the chapter 40
CHAPTER FIVE: DISCUSSION 42
5.1. Introduction 42
5.2. Demographic data 42
5.3 Types of WPV in the last 12 months 43
5.4 Factors associated with WPV 45
5.5 Consequences of WPV 45
CHAPTER SIX: CONCLUSION AND RECOMMENDATIONS 47
6.1 Introduction 47
6.2 Recommendations 47
6.2.2 Nursing education 48
6.2.3 Nursing practice 48
6.2.4 Nursing research 48

REFERENCES 49
APPENDIX II: INSTRUMENT 55
APPENDIX III: TIMEFRAME 59
APPENDIX IV: IRB ETHICAL CLEARANCE 61
APPENDIX VI: CONSENT INFORMED CONSENT FORM 63

LIST OF SYMBOLS AND ACRONYMS/ABBREVIATION

BLS: The Bureau of Labor Statistics

CHUK: Centre Hospitalière Universitaire de Kigali (Kigali University Teaching Hospital)

HDU: High Dependent Unit

HIV/AIDS: Human Immunosuppressed Virus/Acquired Immuno-Deficiency Syndrome

CMHS: College of Medicine and Health sciences

COHSASA: Council of Healthcare Service Accreditation of Southern Africa

ENT: Ear, Nose and Throat.

ICU: Intensive Care Unit

IRB: Institutional Review Board

ILO: International Labor Organization

ICN: International Council of Nurses

PSI: Public Services International

%: Percentage

OPD: Out Patient Department

RN: Registered Nurse

SPSS: Statistical Package for the Social Sciences.

UN: United Nations

UR: University of Rwanda

USA: United States of America

UTH: University Teaching Hospital

WHO: World Health Organization

WPV: Workplace violence

LIST OF TABLES

Table 3.1 Study participants in each stratum 22

Table 3.2 Content validity 26

Table 4.1Gender, age, marital status and nursing work experience of the study participants 32

Table 4.2 The category of patients/ Clients and the sex of patients, nurses most frequently work with 33

Table 4.3 Specialties where nurses spend more than 50% of working time 33

Table 4.4 Table Department or service where nurses spend more than 50% of working time 34

Table 4.5 The number of staff present in the same work setting with nurses more than 50% of work time 35

Table 4.6 Types of WPV in the last 12 months 36

Table 4.7 Factors associated with WPV 38

Table 4.8 Consequences of WPV 40

LIST OF FIGURES

Figure 2. 1: Chappel-Di Martino model adapted for this study (Di Martino, 2003b, p. 6) 16

Figure3.2 Location of Kigali University Teaching Hospital on map of Rwanda........................ 20

CHAPT
ER ONE: INTRODUCTION

1.1 Introduction to the study

WPV in the healthcare system is a worldwide work concern (Hamdan and Abu Hamra, 2015, p. 1). According to the World Health Organization (WHO), WPV is an incident where employees are abused, threatened, or assaulted in conditions linked to their work and at what time travelling to and after work resulting in the physical and psychological negatives effects on their health. The phenomenon affects all types of healthcare workers (Fute *et al.*, 2015, p. 1). Actually, WPV is a general problem in the healthcare locales and all healthcare workers are concerned (Tiruneh *et al.*, 2016, p. 1). In 2013, the Bureau of Labor Statistics (BLS) in the USA testified that WPV each year attacks between 23,540 and 25,630, most of them were in healthcare settings and welfare service. Healthcare and employees in welfare service are the most hurt as a consequence of WPV compared to the other sector of employees (Occupational Safety and Health Administration, 2016, p. 2).

The most common causes of WPV are overcrowding of patients and nurses' workload, nursing staff shortages, the patients suffering of dementia or Alzheimer's illness are more violent than others (Darawad *et al.*, 2015, p. 11). Long waiting time, lack of prevention measures, patients and family's needs not met are also the causes of WPV (Hamdan and Abu Hamra, 2015, p. 1). Patients' status such as disorientated and confused patients, patients with head injuries, patients using drugs abuse and patients with developmental delay are likely to be perpetrators, giving some frustrating nursing care in presence of relatives like nasogastric tube insertion, staff not having sufficient time for the patients, application of some hospital policies like limiting the numbers of visitors, visiting hours (Banda, Mayers and Duma, 2016, p. 416).

Vittorio di Martino, in 2003, have explained psycho-social and organizational causes of WPV like work organization and work capacity such as uncertainty, work excess, insufficient supervision, caring patients at the end of their life; also, team working with unresolved conflict, nurses' misunderstanding, interactions with patients and their relatives such as insufficient psychological preparation and counseling, job planning and job organization such as insufficient nurses' support, staff turnover, problems with

management and supervision, lack of means and employees' scarcity, invasive nursing care and incompetent personnel generate WPV (Di Martino, 2003a, p. 11).

The consequences of WPV in health sector were injuries with cost associated with treatment and indemnity among nurses (Speroni *et al.*, 2014, p. 2018), reduction of work performance (Al-Turki, Afify and Alateeq, 2016, p. 262), the attainment of institutions productions (Tiruneh *et al.*, 2016, p. 1), leaving nursing job (Boafo and Hancock, 2017, pp. 10&28), psychological concerns (Ferri *et al.*, 2016, p. 272), like having high levels of emotional exhaustion and depersonalization (Alameddine, Mourad and Dimassi, 2015, pp. 5;6 & 7), significant effects for well-being of employees, care of patient as well as having sensation of culpability (Hamdan and Abu Hamra, 2015, pp. 3;4&6).

Some interventions to address the WPV are healthcare workers training, restricted access, reducing overcrowding of patients and exists strategies to escape violence (Boafo and Hancock, 2017, p. 19). The evidence based strategies to manage WPV involve having laws, occupational health and safety legislation, offering in service training and education and reporting them to the relevant authority (Huston, 2014, p. 206).

1.2 Background to the study

Worldwide, about 36% of nurses were physically violated, 67% have experienced non-physical violence, 40% for bullying/mobbing, and 25% were sexually harassed , with around 33% of nurses reported to have physical wounded in an attack with the top rates of overall (61.3 %) in the Middle East (Spector, Zhou and Che, 2014, p. 77). In USA the studies have shown that in the mid-Atlantic region WPV among nurses was at high level to such an extent that 76% have experienced verbal and/or physical WPV (Boafo and Hancock, 2017, p. 10). In Europe, although nursing was the most healthcare professional affected by WPV (Vidal-martí and Pérez, 2017, p. 85) but, in general, the WPV is relatively low in European regions with the rate of 38.3% (Spector, Zhou and Che, 2014, p. 78). In Italian general hospital various health professionals are violated, most frequently were nurses (67%) for physical and sexual assault (Ferri *et al.*, 2016, p. 263). In Asia, Jordan's emergency nurses were the most affected by WPV, where, 91.4% of nurses working at emergency reported experiencing WPV (Darawad *et al.*, 2015, p. 9). In China, the prevalence of WPV was around 66%; of this, 65% was violated verbally, around 12% were violated physically and about 4% harassed sexually, (Shi *et al.*, 2017, p. 1). In Saudi Arabia in family medicine centers, 36% of nurses have been

affected by WPV (Al-Turki, Afify and Alateeq, 2016, p. 261). In Lebanon 62% of nurses have experienced verbal violence, 10% violated of physically (Alameddine, Mourad and Dimassi, 2015, p. 5). In Palestinian hospitals emergency, 72% of nurses reported non-physical violence against 40.2% for physical violence (Hamdan and Abu Hamra, 2015, p. 3).

In Africa, WPV was identified in different countries; Ethiopia, in South of the country, WPV among nurses at public health facilities was around 30%, (Fute *et al.*, 2015, p. 4). In North West of the country, 26.7% of nurses working in the referral hospital experienced WPV, among them physical violence was 60.2% against 39.8% of psychological violence. (Tiruneh *et al.*, 2016, p. 3). In Gambia, WPV among nurses was 62.1%, the types of WPV identified were verbal abuse at 59.8%, physical violence at 17.2%, and sexual harassment at 10% (Sisawo, Ouédraogo and Huang, 2017, p. 4). In Ghana, types of WPV found among nurses were sexual harassment at (12, 2%) and verbal abuse (52.7%) (Boafo, Hancock and Gringart, 2015, p. 99). In Malawi, the study conducted in the South region in five hospitals have shown that 70.54% of nurses experienced WPV among them 95% were abused verbally verbal, 73% threatened, 22% assaulted physically, 16% sexually harassed and other (3%) (Banda, Mayers and Duma, 2016, pp. 418& 419). In the Democratic Republic of Congo, nurses were the most affected by WPV among other healthcare workers, 59% were verbally aggressed, and 53.6% were physically violated and 63.3% sexually harassed (Uzembo *et al.*, 2015, p. 72). In Rwanda, one study found conducted in 2007-2008 and published in 2011 on WPV among healthcare workers in districts hospitals has shown that 39.4% (Newman *et al.*, 2011, p. 5) (Newman *et al.*, 2011, p. 9).

1.3 Problem statement

WPV among nurses has become a worldwide problem in the nursing profession (Liu *et al.*, 2015, p. 3). It is appalling to underline that WPV rates are tremendous in that 36.4% of nurses have been physically violated, over non-physical violence (70%), bullying (39.7%), and 25% reported sexually harassed, with 32.7% of nurses testified physically injured in an attack and the highest rate was observed in the Middle East of 61.3% (Spector, Zhou and Che, 2014, pp. 72&78). It is estimated that the negative impact of WPV was psychological concerns (Ferri *et al.*, 2016, p. 272); Injuries, (Speroni *et al.*, 2014, p. 218) , reduction of work performance (Al-Turki, Afify and Alateeq, 2016, p. 262) and thinking leaving their job, (Alameddine, Mourad and Dimassi, 2015, p. 7). The

most factors associated to WPV are overcrowding of patients and nurses' workload, nursing staff shortages (Darawad *et al.*, 2015, p. 11), short work experience and long waiting time (Hamdan and Abu Hamra, 2015, p. 3), few nurses per shift (Tiruneh *et al.*, 2016, p. 3), working night shift alone (Xing *et al.*, 2016, p. 7), few infrastructures, low-quality service and patient dissatisfaction (Boafo, Hancock and Gringart, 2015, pp. 105&106). Evidence based strategies to manage WPV involve having laws, occupational health and safety legislation, offer training sessions and a program of education and reporting them to the relevant authority (Huston, 2014, p. 206).

WPV in the Rwandan healthcare system is a worrying situation. Conferring to Kigali University Teaching Hospital report (2017), a survey conducted from July to December 2017 documented an incidence of relative who was about to knife a nurse after his wife's death while another case was the patient' relative who harassed verbally a nurse by telling her that she will pay for the death of his father. Furthermore, in the researcher's clinical experience, the issue of WPV has been plaguing nurses working at referral hospitals but due to poor documentation culture among healthcare professionals, this phenomenon seems to be not regularly reported.

Although, Rwanda adopted some strategies to address WPV like being in accreditation process in order to meet safety standards (MoH Rwanda, 2014, p. 5) and elaboration of policies and procedures related to security and safety (Cohsasa, 2015, p. 8), this situation is still threatening nurses in nursing practice environment. In addition, some referral hospital in Rwanda it comes up in vain with admission consent for a clause of staff respect with a view of tackling the WPV among health professionals. To the finest of our information, the sole study carried out in district hospitals was exploring the WPV in the context of gender discrimination but did not delve into WPV among nurses working in referral hospitals (Newman *et al.*, 2011, p. 1). Considering the paucity of research in district hospitals in Rwanda, it is believed that conducting this study could unearth different types, risk factors and consequences of WPV among nurses at a selected University Teaching Hospital (UTH) in Rwanda and may contribute to the existing improvement evidence-based strategies for its management.

1.4 The aim of the study

The aim of this study was to explore WPV experience among nurses at a selected UTH.

1.5 Research objectives

To assess the types of WPV among nurses at a selected UTH.

To identify the factors associated with WPV among nurses at a selected UTH

To explore the consequences of WPV among nurses at a selected UTH

1.6 Research questions

1. What are the types of WPV experienced by nurses at a selected UTH?
2. What are the factors associated with WPV among nurses at a selected UTH?
3. What are the consequences of WPV among nurses at a selected UTH?

1.7 Rationale/ significance of the study

Understanding WPV types, factors, and consequences associated with nurses at a selected UTH may serve enhancement in a different component of nursing education, nursing management, nursing practice and nursing research.

In nursing education, the study could offer essential information that can serve as a call to prevent WPV in order to enhance knowledge and skills of healthcare workers regarding WPV and providing healthcare and safety environment in the hospital.

The hospital nursing management may be aware of the WPV, develop and implement appropriate policies and strategies, and avoid staff turnover.

In nursing practice, the findings may be used to practice nursing in a safe environment without violence, nurses could concentrate psychologically to the job and improve nursing productivity, without absenteeism and nurses' turnover.

In nursing research, the findings from the present research may further contribute to the existing literature on WPV. In addition, the results from this study should offer the baseline information for future research related to WPV among nurses in the Rwanda University Teaching hospitals.

1.8 Definition of Concepts

Workplace: Any healthcare facility, whatever the size, location (urban or rural) and the type of service(s) provided, counting major referral hospitals of large cities, regional and district hospitals, healthcare centers, clinics, community health posts, rehabilitation centers, long-term care facilities, general practitioners' offices, other independent

healthcare professionals. In the case of services executed outside the healthcare facility, such as ambulance services or home care, any place where such services are performed will be considered a workplace (ILO *et al.*, 2002, p. 3). In this study, workplace is University Teaching Hospital of Kigali.

Workplace violence: The ILO/ICN/WHO/PSI Joint programme on WPV in the health sector defined as "Incidents where staff are abused, threatened or assaulted in conditions linked to their work, including commuting to and from work, involving an explicit or implicit challenge to their safety, well-being or health (ILO *et al.*, 2002, p. 3).

Nurses: A nurse is a person who has completed a program of basic, generalized nursing education and is authorized by the appropriate regulatory authority to practice nursing in his/her country (ICN, 2018). In this study, nurses are used to denote nurses /midwives with an advanced diploma in nursing/midwifery (A1), Bachelor's in nursing/midwifery and master's in nursing/midwifery.

1.9 Structure/Organization of the study

The chapters of this study were outlined as follows:

Chapter one introduces the topic, designates the background and significance of the research. It includes the problem statement, aim of the study, research objectives, and research questions and definitions of terms were also discussed in this chapter. Chapter two demonstrates the theoretical component of WPV, previous researches related to WPV and end by addressing the conceptual framework to lead the present study. Chapter three designates the study setting, the study approach as well as study design, and then it describes the study population, sample size as well as sampling techniques. It also designates data collection methods including research instrument with tool reliability and validity as well as data collection procedures. It also describes the data analysis methods, data management and ethical considerations, to be closed with study limitations and challenges. Chapter four describes from different tests used to analyze data. Chapter five discusses the study results with other previous studies data analysis and results presentation according to the study objectives. It shows in detail results in relation to our objectives. It shows also study limitations.

Lastly, chapter six gives the conclusion to the study as well as the recommendations to hospital and to future researches.

1.10 Summary of Chapter one

WPV in hospital settings is a common problem concern global. Hospital leaders and managers, healthcare providers are challenged to improve safety health environment outcomes. Working conditions, overcrowding of patients/ clients, absence occupational health and safety measures and patients conditions leads to WPV. Workplace safety environment, safety measures are wanted to avoid the violence and when the situation occurred the escaping technique is desired.

In this chapter, we offered the background and the problem related to WPV and how this research is significant. The study objectives, as well as study questions, were also presented, and finally how the work is subdivided.

CHAPTER TWO: LITERATURE REVIEW

2.1. Introduction

This chapter appraises the pertinent literature to this study articulated on the following themes: theoretical component of WPV, preceding studies that have been done in related to WPV based on critical review, research gap identification and conceptual framework. The purpose of the literature review was to understand what is currently known about WPV.

2.2 Theoretical framework of the study

The concept of workplace violence is increasing concerns above 30 years**,** the risk of WPV high among healthcare providers, this risk is estimated to 16 times comparing to other services (Cooper and Swanson, 2002, p. 15). It was defined as "The intentional use of power, threatened or actual, against another person or against a group, in work-related circumstances, that either results in or has a high degree of likelihood of resulting in injury, death, psychological harm or deprivation" (Cooper and Swanson, 2002, pp. 8–9).Violence in the workplace, including violence experience among healthcare workers has come to be a severe safety problem for hospitals worldwide (Chappell, 2015, p. 358), the WPV could be avoided because a safe and healthy working conditions is fundamental human right (UN High Commissioner for Human Rights and World Health Organization (WHO), 2008, p. 20).

The hospital setting is more disposed to WPV than other settings (Tiruneh *et al.*, 2016, p. 1). Working at the emergency department and psychiatric wards are most associated with WPV; meanwhile, rates of violence relate with the patient contact time, the nurses are at all time in contact with the patients and are more abused at the maximum rates (James P. Phillips, 2016, p. 1663).

2.2.1. Types of workplace violence

According to ICN, ILO and WHO joint program, they are two main types of workplace violence including physical violence and psychological violence. For long years ago the presence of physical violence at the place of work has always been documented, the existence of psychological violence has been neglected and this time requires attention.

Psychological violence is presently appearing as a urgency alarm at the place of work (Di Martino, 2003a, p. 3).

Physical violence mentions the use of physical force exerted to another person or group that give results of harming physically, sexually or psychologically. It can include beating, kicking, slapping, stabbing, shooting, pushing, biting, and/or pinching, among others. Although psychological violence is defined as intentional use of force, including threat of physical force, experience another person or group, which can result in harm to physical, mental, spiritual, moral or social development. Psychological violence covers verbal abuse, bullying/mobbing, sexual harassment, and threats (International Labour Office, 2003, p. 4).

Sexual harassment and bullying/mobbing are the components of psychological violence. Sexual harassment are expressed as unwelcome behavior that is observed by the victims as engaging situations of a sexual nature on their occupation, or that might, on reasonable grounds, be perceived by the offended person as an disobedience, a shame or a threat to their comfort. While Bullying/mobbing is defined as a practice of psychological harassment concerning of oppression through hurtful, painful, or spiteful attempts to humble or demoralize a person or groups of workers, including unfounded, continuous negative blames or reproaches causing social isolation to the individual from another contacts and dissemination wrong information (International Labour Office, 2003, p. 4).

2.2.2 Factors allied with WPV in healthcare system

Factors linked with WPV; healthcare providers experience a bigger risk of WPV triggering principally from violent comportment of their patients and patients relatives; whereas no precise diagnosis or type of patient guesses future WPV, but main researches suggested that hospitalized patients and critical mental health services, elderly patients, working at emergency are associated with present the highest risks (Occupational Safety and Health Administration, 2016, p. 3).

There are also the individual influences like; being in contact with clients violated in the past, being in contact with the patient for a long time, working alone, poor working conditions like poor lighting, insufficient communication means, having firearms or other arms like knives within the hospital premises (Occupational Safety and Health

Administration, 2016, p. 4).The Organizational risk factors are absence of policies and procedures related to WPV and lack of healthcare workers training associated with WPV, understaff and high volume work and insufficient security on site, patients long waiting times or patients overcrowded, impunity and tolerance of violence (Occupational Safety and Health Administration, 2016, p. 5).Victims of WPV could suffer a variety of consequences among them we can cite injuries, psychological concerns, absenteeism, leaving their job, feelings of incompetent, guilt, powerlessness; and at longtime the victims can lead to high blood pressure, therefore to the development of heart attack, cerebral vascular illness and gastric ulcers (Di Martino, 2003b, p. 15).

In the current years, WPV in the healthcare system has increased, and it affects healthcare workers and patients. Relationship Model of Chapell and Di Martino of WPV is a valuable tool for studies of WPV in the healthcare system (Rodríguez and Paravic, 2013, p. 200).

2.2.3 Strategies to overcome workplace violence in healthcare system

The strategies to address WPV can be are divided in two categories. The prevention actions related to patients' violence and prevention actions between staffs violence, even though there is intersection between the two. The prevention of workplace violence needs inter professional collaboration and strong participation from hospital leaders and managers.

All staffs must be communicated to clear written program/policies and procedures for safety, health and environment risk management. Supplementary preventive measures target the security environment like eliminating all weapons, correct lighting, surveillance cameras, alarm buttons, and so on. The security staffs must emphasize administrative controls. The hospital leaders must avail the training/education programs for employees concerning safety on workplace. The hospital administration must also manage the stressors job, such as over clawing of the clients/patients, insufficient communication between coworkers and job restructure to reduce all sources of WPV. All incidents related to WPV must report, analyzed and monitored. Therefore, draw the correctives measures within the institution in order to evaluate the effectiveness of the prevention program (Stark and Patterson, 1994, pp. 185–186).

2.3 Empirical Literature

2.3.1 Introduction

According to the Guardians website on 23 April 2019 a nurse was injured with a knife in Pakistan by a perpetrator denying to permit his child to be vaccinated (Guardian, 2019). On 3 June 2017, in United Kingdom, London Bridge a terrorist killed a nurse when she hurried to help a victim (Guardian, 2019). According to the Economist on line newspaper in the Republic Democratic of Congo, in East of the country, on February 27th 2019 a group armed attacked the Ebola clinic and killed healthcare workers including nurses and medical doctors in order to discourage humanitarian action (Economist, 2019). For unknown reason, the three International Rescue Committee (IRC) staff caught up in attack that led to tragic loss of life of an Ebola Response staff member, there after they were released with psychological concerns. (IRC, Report 19, April, 2019).

2.3.2 Types of workplace violence

Different studies were conducted on this topic; a study led in USA among nurses showed that 76% have experienced WPV (Speroni *et al.*, 2014, p. 218). Also a research steered in the USA, Texas State showed that WPV among nurses was 40.5% (Boafo and Hancock, 2017, p. 2). In Italy 67% of nurses were reported having assaulted (physical and sexual harassment) (Ferri *et al.*, 2016, p. 263).

The research conducted in Palestine hospitals on WPV among healthcare workers at emergency departments; a study revealed a high frequency of WPV (76%) among them physical violence was 35.5% and 71% of non-physical violence in the past twelve months prior the study (Hamdan and Abu Hamra, 2015, p. 1); this study is similar like other studies conducted in different countries; in China 12.6% of nurses and general practitioners suffered of physical violence among the 56.6% leaded to injuries and 45.4% took 2 or 3 days of sick leave (Xing *et al.*, 2015, p. 1). In Jordan, emergency department 91.4% of nurses reported experiencing WPV (Darawad *et al.*, 2015, p. 9). In Saudi Arabia, 36.0% of nurses reported WPV experience among healthcare workers (Al-Turki, Afify and Alateeq, 2016, p. 262).

In Southern Ethiopia, WPV among nurses at public health facilities was 29.9% among them 18% were physically violated, verbal violence was around 90% and about 13% harassed sexually (Fute *et al.*, 2015, p. 3). In Gambia, WPV among nurses was (62.1%)

(Sisawo, Ouédraogo and Huang, 2017, p. 4). A study conducted in Ghanaian nurses showed that sexual harassment was (12, 2%) and verbal abuse was (52.7%) (Boafo, Hancock and Gringart, 2015, p. 99). In Rwanda, a current study found was published in 2011 on WPV experience among healthcare workers showed that 39% were faced WPV, 26.9% verbally abused, 3.7% for physical violence, 15.8% for psychological violence, 7.1% sexually harassment, 2% for sexual assault (Newman *et al.*, 2011, p. 5).

2.3.3 Factors associated to workplace violence

In USA the studies have shown that in the mid-Atlantic region the factors associated with WPV were working at emergency department (Boafo and Hancock, 2017, p. 28). In Italian general hospital various health professionals are violated, working at the emergency department was associated with WPV because of overcrowding of patients in need of emergency care (71%) (Ferri *et al.*, 2016, p. 272). In Jordan, 91.4% of nurses working at emergency reported experiencing WPV (Darawad *et al.*, 2015, p. 9). In China, working night shift was associated with WPV (Xing *et al.*, 2016, p. 7) because of decreased number of nurses with limited support from management. In Saudi Arabia in family medicine centers, the factors associated with WPV were absence of punishment for the criminal around (50%), lack of collaboration (40.7%), not meeting required requests (36.6%), overcrowding of patients (33.3%), waiting for a long time (32.5%), and responses to hurt (0.8%) (Al-Turki, Afify and Alateeq, 2016, p. 262). In Lebanon being young healthcare workers were the most associated with violence as they are still developing nursing skills with few experiences of conflict management (Alameddine, Mourad and Dimassi, 2015, p. 7). In Palestinian hospitals emergency, the most factors associated with WPV were short work experience and being young nurse (Hamdan and Abu Hamra, 2015, p. 3). Abilities to manage phenomenon leading to WPV are associated with age and experience in nursing practice and should allow nurses to respond more intelligently than nurses with short experience when are in contact with perpetrators (Di Martino, 2003b, p. 18).

Ethiopia, in South of the country, the factors associated with WPV are the same found in Asia but, being a female is more associated with WPV because of gender discrimination (Fute *et al.*, 2015, p. 4). In North West of the Ethiopia the factors associated to WPV were; being young nurse between 18 to 39 ages, few nurses per team, working in men ward, antecedents of WPV, being single and separated/ widowed (Tiruneh *et al.*, 2016, p.

3). In Ghana, the factors associated to WPV were overcapacity of the hospitals, few nurses and infrastructure, long waiting times and inefficiency of quality service and patient dissatisfaction (Boafo, Hancock and Gringart, 2015, pp. 105&106). In the Democratic Republic of Congo, the factors associated with WPV were being married were more associated to verbal aggression (34.1%), being male nurses were more associated with physical violence (56.6%) and being female nurses were more associated with sexual harassment (64.5%) (Uzembo *et al.*, 2015, p. 72). In Rwanda, one study found conducted in 2007-2008 and published in 2011 on WPV the most factors linked with WPV in the health environment were gender inequality and the absence of reciprocal respect (Newman *et al.*, 2011, p. 10).

2.3.4 Consequences of workplace violence

The consequences of WPV are numerous, in Italian general hospital were psychological concerns at a rate of 73% (Ferri *et al.*, 2016, pp. 263&272). In Palestinian hospitals emergency, the WPV has revealed significant effects for the well-being of employees, care of patient; well-being of employees in terms of psychological concerns at rate of 9.3% as well as feelings of guilt 1.3%) and more than three times half likely to leave their job (Hamdan and Abu Hamra, 2015, pp. 3;4&6). In Saudi Arabia, the consequences of WPV were decreasing in job productivity (31.1%), feeling embarrassed (4.9%), feeling worried (2.5%), and other concerns about (5%) (Al-Turki, Afify and Alateeq, 2016, p. 262). In Lebanon, the consequences of WPV were thinking of leaving their job, having high levels of emotional exhaustion and depersonalization (Alameddine, Mourad and Dimassi, 2015, pp. 5;6 & 7). In Ghana, the consequences of WPV among nurses were roughly 12.2% complaining of disturbed memories and remembering the event or images of the abuse; 14,4% have disturbed by escaping sharing their violence experience; 21,5% have experienced hyper-vigilant and being on guard (Boafo, Hancock and Gringart, 2015, pp. 99;105&106). In Malawi, the main consequences of WPV were; poor work performance 29%, demoralization 23%, fearful when working 7%, emotional trouble 15% and lack of awareness in nursing career 12% (Banda, Mayers and Duma, 2016, pp. 418& 419). In Rwanda, one study found was conducted in 2007-2008 and published in 2011 on WPV among healthcare workers in districts hospitals shown the consequences of WPV were thought of withdrawal from the

nursing career after violence, personal traumatic, absenteeism and lower productivity (Newman *et al.*, 2011, pp. 9&10).

Strategies to address WPV were adopted across the world in many countries are having laws, occupational health and safety legislation, offer in service training and education and demanding reports involving WPV to address the problem (Huston, 2014, p. 206). In the USA, reporting the incidents are the strategies adopted (Speroni *et al.*, 2014, p. 4) and in Jordan (Darawad *et al.*, 2015, p. 2). In China, the strategies adopted was to improve nurse-patients communication and look solutions together in case of dispute and encouraging for respect for healthcare workers via the mass media (Xing *et al.*, 2016, p. 1). In the USA (Texas), healthcare workers training, restricted access, reducing overcrowding of patients and exists strategies are the strategies adopted (Boafo and Hancock, 2017, p. 19).

2.4 Critical review and research gap identification

A cross-sectional survey conducted in China Township Hospitals: 990 nurses have been recruited to complete questionnaires. However, these findings should not be generalized because the study focused only on physical WPV among nurses and general practitioners; further studies on others types of WPV are needed among nurses and General Practitioners (Xing *et al.*, 2016, p. 5).

A research conducted in Italian general hospital WPV among healthcare workers; 745 nurses and physicians have recruited. The purposes of this research were; to explore the prevalence and features of WPV and to find the factors associated with WPV. The results were restricted to one hospital, cannot be generalized to the rest of the hospitals (Ferri *et al.*, 2016, p. 266).

In Rwanda, one study conducted in 2007-2008 and published in 2011 using qualitative and quantitative approach on WPV among healthcare workers in districts hospitals, 15 out of 30 districts hospitals were selected randomly; 44 health settings at all levels were randomly selected. 450 healthcare workers have been recruited randomly, only 297 (66%) health workers responded to the study, of whom 205 were women and 92 were men. Around 20% of participants were managers; this could possibly influence the findings. The results should be considered with some attention, as an answer bias is likely to have particular impact on the study and also considering the low response rate (66%), and the study limitation to the district hospitals (Newman *et al.*, 2011, p. 5).

In selected University Teaching Hospital in Rwanda from July 2017 to December 2017 among the incidents done; two major incidents has been occurred; a relative tried to knife a nurse after his wife died, another major case found was at patient relative talked to the nurse that she will have negative consequences after death of his father, many cases related to WPV are not reported (CHUK, incidents report, 2017).

2.5 The conceptual of framework

In this study adopted the conceptual framework of the Chappell – Di Martino model. This model is constructed on a relationship examination of all the components producing stress, connecting together individual, work-related and environment surroundings influences. On the side of the individual considers the aggressor and the abused. The committer of WPV is probably to be in one of three main groups – a customer of an organization, a coworker, or a spectator. The abused is probably to be a worker or a spectator, such as a client or a worker of another organization unintentionally present when WPV occurs. The personal features of both the perpetrator and the abused play a significant part in the apparition of WPV. The model proposes that WPV is further probably to come when persons with "conflicting" individual features are in contact. Nevertheless, assumed the variety of such features, it is almost not possible to forecast the incidence of WPV based on this. An additional problem is the circumstance that persons work in diverse working situations that might calm or produce WPV.

The model emphases consequently on the interaction between individual and situational influences at work, stressing their shared role in producing or calming WPV.

Lastly, the model classifies the probable influence of all pertinent aspects and circumstances on the victim and the organization, and evaluates the "feedback" of this influence as a creator of WPV. It is a model that powerfully highlights the difficulty of eradicating WPV when it happens and the complete requirement of fighting violence to prevent WPV use those elements in combined mode (Di Martino, 2003b, p. 6).

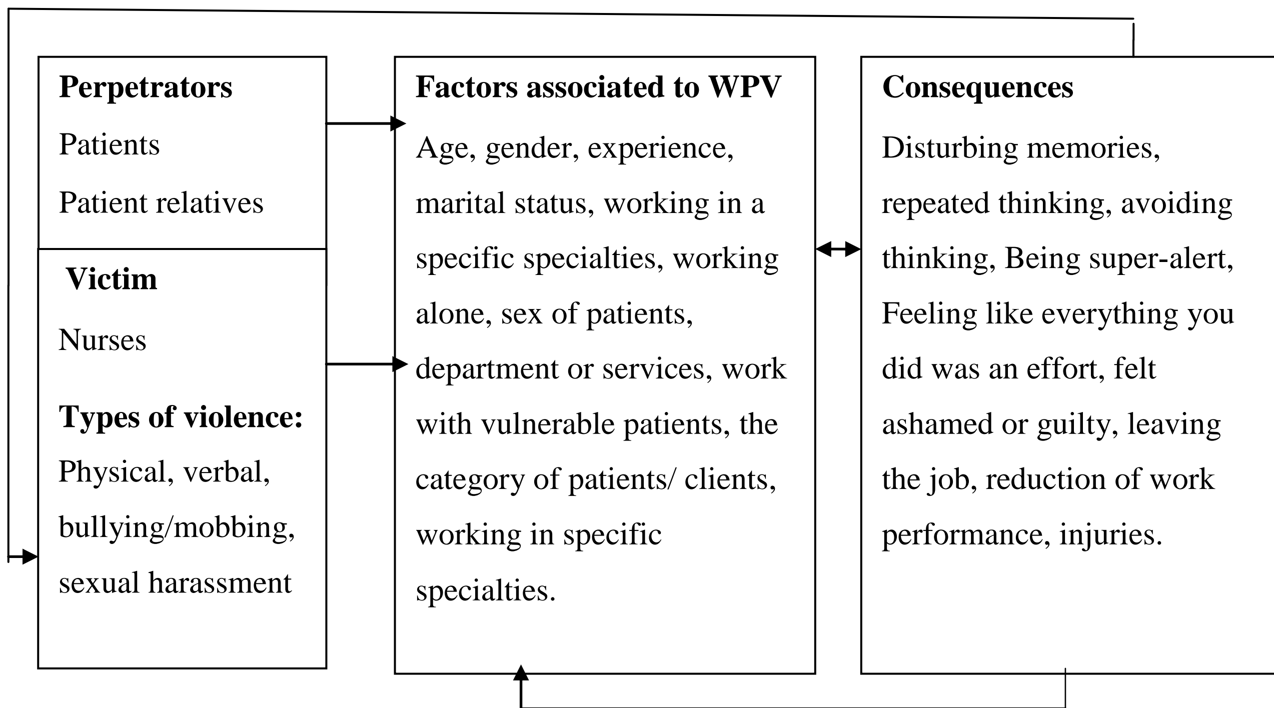

Figure 2. 1: Chappel-Di Martino model adapted for this study (Di Martino, 2003b, p. 6)

2.5.1 Application the model to the healthcare settings

The application of the model to the healthcare settings suggests that, inside the Chappell Martino model an amount of work-related conditions have been recognized where the risks factors of experiencing WPV and producing stress are mainly important.

Working unaccompanied; persons working unaccompanied are at superior risk to get physical and sexual harassment. Numerous healthcare employees, such as nurses working during night, do work unaccompanied or in isolated area and are consequently high danger of WPV.

Working in interaction with the open public**;** a large diversity of professions, as well as numerous in the healthcare settings, consist of having contact with the clients. Whereas, in greatest conditions this type of job does not produce exceptional issues, there are circumstances where contact to the clients can produce a greater menace of WPV.

Working with money and managing valuables ; when “valuables” like medicines are, or appear to be, can reached easily, there is a menace that criminality, and progressively violent crime, may be produced. Employees in healthcare settings are at risk to this kind of exposure. Working in a situation progressively exposed to WPV; working situations

which were prior without WPV and become increasingly affected. The proliferation of WPV in education settings, but also in healthcare settings, is part of this condition.

Working in settings of special vulnerability**;** growing amounts of employees are becoming involved in this situation and risky occupation, working to the poor conditions, reducing and work loss as well as WPV. Those in the healthcare settings are susceptible from this situation.

Employed with suffering persons; the suffering persons frustrated and irritated because of their illness and pain, difficulties of elderly person, mental diseases, consummation of alcohol and drugs can influence behavior and make people to become aggressive. WPV is, therefore, shared amongst employees in interaction with suffering persons that it is frequently considered an unavoidable part of the occupation (Di Martino, 2003b, pp. 7–8).

2.6. Summary of chapter two

The unknown information about WPV in the healthcare system has widely debated in this chapter, both theoretical and empirical, and perceptions of WPV in relation to the healthcare setting. A critical review and research gap were identified and finally, the chapter ended by providing the conceptual framework. The next chapter is dedicated to the research methodology of this work.

CHAPTER THREE: RESEARCH METHODOLOGY

3.1. Introduction

Chapter three of this dissertation offers a thorough explanation of the methods used in the study, the study settings, research approach, study design, population, sampling methods, ethical considerations, data collection process, data analysis, data management and dissemination were explained. It concludes with study limitations.

3.2. Research design

Referring to research design is the plan, structure and tactic of investigation considered so as to get solutions to research questions and to governor variance. In this present research, a descriptive cross-sectional design was used. Descriptive research determines the frequency of variables without any intervention and explains cause and effect relationship. The phenomenon of WPV experience among nurses at a selected UTH was described. Prospective, cross-sectional design comprises the collection of data at one point in time; the data was collected at point of time by reflecting the WPV experience among nurses, by recalling events that happened at a selected University Teaching Hospital in Rwanda in the previous twelve months prior to study.

3.3. Research approach

The present study used a quantitative research approach, this approach uses data that are numbers, tests, counting and measuring (Pandey, 2015, p. 11); the WPV experience among nurses was collected and quantified.

3.4. Research setting

This study was steered at CHUK; the Vision is that the Hospital will be the leader in providing quality Healthcare Services, education and conducting research; striving for excellence in Africa. The mission statement is that the Hospital is committed to provide quality healthcare according to international standards, train health professionals, contribute to the development of human resources, conduct outstanding research and provide technical support to the health system and this will be achieved with competent and motivated staff in collaboration with all stakeholders within available resources. Its Value Statement are; accountability, integrity, professionalism and excellence. The

CHUK is the largest hospital located in District of Nyarugenge at KN 4 Ave, Kigali City. It is the biggest healthcare setting in Rwanda with a capacity of 519 beds and monthly receive in average 1472 new patients in hospitalization, 9505 in Out patients Department. Annually, Kigali University Teaching Hospital received an average of 17 986 new patients in hospitalization and 114 060 in outpatients department.

Kigali University Teaching Hospital has 812 staff including 97 physicians, 446 nurses and midwives, 128 paramedical staff and 141 administration Support staff. The main departments present are; accident and emergency, surgical, internal medicine, pediatrics, gynecology and obstetrics, out patients, and theater plus critical care. Kigali University Teaching Hospital provides quality healthcare to the population, training, conducting research and supporting technically the north district hospitals, some part of western districts hospitals (Gisenyi, Kabaya, Muhororo, Shyira), some part of south districts hospitals (Kabgayi, Kibuye, Murunda, Mugonero), Muhima Hospital and Kibagabaga located to Kigali city. It started in 1918 working as health center. In 1965, it became the hospital of Kigali. CHUK was awarded the status of a referral and teaching hospital on 7/12/2000.

Figure 3.2 Location of CHUK on map of Rwanda

3.5 Population

A population is all the persons or items that have collective features that are the interest of the researcher (Pandey, 2015, p. 41). In this study, the population were all registered nurses interacting with the patients and clients during their work (N= 406), and working at the selected University Teaching Hospital; among them master's Degree (n=1), bachelors (n=24), advanced diplomas in general nursing (n=381).

3.5.1 The inclusion criteria

The inclusion criteria are:

- Nurses registered in the nursing council,
- Nurses interacting with the patients and clients during their work
- Having more than one year of working experience at a selected University Teaching Hospital in Rwanda,
- Willing to contribute in the study and being on duty throughout the data collection time.

3.5.1 Exclusion criteria

Exclusion criteria are:

- Nurses who have not been working at a selected University teaching hospital in Rwanda during past 12 months preceding data collection period because the study reflects the events happening in this period,
- The participants utilized for the pilot study,
- Nurses who declined to consent for this study.

For that reasons, 27 nurses were excluded in this study among them 20 nurses participated in the pilot study and 7 nurses not interacting with the patients and clients (working in Central Sterilization and Supply Department and the Director of Nursing). The population of this study is 406 minus 27 which make an N= 379.

3.6 Sampling strategy

3.6.1 Sample size

The study sample size was obtained by using Yamane's formula as mentioned in (Puszczak, Fronczyk and Urbański, 2013, p. 8). This formula is used to calculate the sample sizes; it was chosen to be used in calculating the sample size for the present study because the researcher needed an adequate sample size. The formula is shown below with a 95% confidence level and P=5 are presumed for Yamane's formula.

$$n = \frac{N}{1+N(e)^2}$$

Here n is the sample size, N is the population size, and e is the level of precision or sampling error which is 5%.

Application of the formula in sample size calculation in this study:

$\mathrm{n} = \frac{379}{1+379\,(0.05)^2} = \frac{379}{1+379\,(0.0025)} = 194{,}6$; The sample size of this study equal to 195 nurses.

3.6.2 Sampling strategy

The probability sampling technique called stratified random sampling was used in this present study. Stratified sampling is a method of determining a sample from a population. In stratified random sampling, the first stage consists of dividing the

population into strata and then the second stage consists of taking randomly a sample in each stratum constructing on percentage of each stratum compared to the population. In statistical study, when subpopulations within an general population vary, it is beneficial to sample each subpopulation (stratum) independently by stratifying them (Igwenagu, 2017, p. 37).

For the purpose of the current study, the selected University Teaching Hospital in Rwanda nurses population were divided into 8 departments (strata) including surgical, accident and emergency, internal medicine, critical care (ICU and HDU), pediatrics (including neonatology), OPD, maternity and theater. After that, the proportion was calculated based on the number of nurses in each department divided (N= 379) multiplied by 100. The sample in each department was obtained by using obtained sample size of 195 multiplied by the proportion.

To get the participants of this study the researcher was used simple random sampling technic, where by an alphabetical list was used to sort out in each department or service, then after one interval was used to get study participants.

Table 3:1 Study participants in each stratum

Department/Service	Number of nurses	Proportion	Sample
Critical care	28	7.4%	14
Maternity	60	15.8%	31
Pediatrics	70	18.5%	36
Medical	56	14.8%	29
Surgical	67	17.7%	35
Accident and emergency	37	9.8%	19
OPD	31	8.2%	16
Theater	30	7.9%	15
Total number	379	100%	195

3.7. Instrument (Including reliability and validity)

The data was collected by using a organized, pretested, and self-administered questionnaire that was adapted from the ILO, ICN, WHO, and PSI (World Health Organisation, 2003). The tool has four main parts (A, B, C and D). Section (A) contains individual and workplace data, Section (B) Contains physical WPV, Section (C) Psychological WPV including verbal abuse, bullying/mobbing and sexual harassment and Section (D) consequences of WPV. The types of measurement are: Types of WPV experience among nurses at a selected UTH, the factors associated to WPV among nurses at a selected UTH and the consequences of WPV at a selected UTH. Permission to use this instrument was granted from ILO Library by email correspondence (Appendix I, p. 51). It was reviewed to fit the local situation (Appendix II, p. 52).

3.7.1 Reliability

Reliability refers to the ability of a research behold to obtain constantly the similar results over-repeated testing periods which means that reliability is the grade to which a variable has closely the similar value when measured at different times. The very reliable measurement is one that has approximately the similar results each time it is measured. A scale can measure body weight with great exactness, while an interview designed to measure quality of life is more likely to produce errors that differ from one occasion to another. The more reliable dimension, the greater the statistical power at a given sample size to guess mean values and to test hypotheses. In quantitative research reliability essentially focuses on consistency and stability. The tool is reliable if Cronbach's Alpha test varies between 0. 7 to 1 (Heale and Twycross, 2015, p. 66).

The pilot study consisted of 10% of total population, if the aim is to establish intervention effectiveness in moderate group 20-25, participants are enough (Chapman, 2012, pp. 180 &190). In this study n=20 nurses at a selected UTH in ENT/OPD, surgical burn unit and ward 8 for orthopedic cases were used in pilot study to establish the reliability of the questionnaires in the Rwandan health context. The pilot study used convenience sampling method to get 20 participants. The participants, who were recruited in the pilot study, were also excluded from the list of population. The objective of the pilot study was to detect possible technical problems in data collection techniques comprising instructions and period bounds and to find indistinct or unclear items in a research instrument. The findings from this pilot study were useful in determining the

clarity of questions and some minor changes of the instrument were done. In the section (A) item PD5 asking years of working experience in CHUK, was removed because the researcher needs only years of experience in health sector. In the item PD 6; PD 6.1 asking interaction with the patients, these questions were removed because the nurses not interaction with the patients/clients were excluded in the study. In the item PD 6.2 category of elderly patients were removed because this category is not available at study setting. In the item PD 7 the types of specialties, chronic disease care was added because is present at study setting. However, in section D the items related to the consequences of WPV like reduction of work performance, thinking leaving the job and felt ashamed or guilty were added.

Finally, taking into account those changes, while adapting these instruments, the reliability was determined by using Cronbach's alpha test and the results revealed Cronbach's alpha of .834.

3.7.2 Validity

Validity of questionnaire has been defined as the degree of accuracy of the instrument; validity is whether the measuring instrument accurately measures what it is supposed to measure. The degree to which the instruments actually reflects the concept being measured. A valid measurement has to be reliable also, while a reliable measurement may not be valid (Heale and Twycross, 2015, p. 66). To ensure validity of this tool adoption was used by remaining with the questions measuring each objective, contextualization was used by corresponding each research question to the conceptual framework. The items of instrument removed are; in the section (A) item PD 4 asking 'Which category best defines your present professional group?" because this study concerns one category of healthcare worker (nurses), PD 6 "Do you work anytime between 18h00 (6 PM) and 07h00 (7 AM)?" this question was removed because it doesn't respond to any research objectives.

PD 12 Are there violence in your current workplace? This question has been removed because the presence of violence will be known in the results of the study. PD 13 was asking the procedure of reporting to WPV and PD 14 encouragement to report WPV were removed because, they don't respond to any research objectives. In the section (B) items PV 1.2 asking "Do you consider this to be a typical incident of violence in your

workplace?" This item was removed because this physical violence was well defined before.

The following questions were removed because they don't respond to any study objectives; PV1.3 "Who attack you? PD1.4 Where did the incident take place?, PD 1.5 asking the time of WPV, PD 1.6 Asking the day of WPV, PD 1.7 "How did you respond to the violence?", PD 1.8 "Do you think the violence could have been prevented?", PD 1.9.1 "Did you require formal treatment for the injuries?", PD 1.11 and 11.1.1 asking medical leave after attack and its duration.

PD 1.12 "Was any action taken to investigate the causes of the incident?" PD 1.13 "Did your employer or supervisor offer to provide you with counseling? PD 1.14 "Are you satisfied with the way in which the incident was controlled? PD 1.15 "If you did not report or tell about the incident to others, why not?" PD 2 "Have you witnessed incidents of physical violence in your workplace?" PD 3 "Have you reported an incident of workplace violence in the last 12 months?" VA 2 "How often have you been verbally abused in the last 12 months?" VA 3 Please thinks of the last time you were abused verbally in your place of work. Who verbally abused you? , VA 4 "Do you consider this to be a typical violence of verbal abuse in your workplace?" VA 5 "Where did the incident take place?" VA 6 "How did you respond to the verbal abuse?" VA 8 Do you think the incident could have been prevented, VA 9 "Was any action taken to investigate the causes of the verbal abuse?", VA 10 Did your employer or supervisor offer to provide you a counseling? , VA 11 "Are you satisfied you with the manner in which the incident was handled"? , VA 12 the reason of not reporting incident to others, BM 2 "How often have you been bullied / mobbed in the last 12 months?", BM 3 questions asking perpetrator of bullying and mobbing , BM 4 "Do you consider this to be a typical incident of bullying / mobbing in your workplace?", BM 5 "Where did the bullying / mobbing take place?" , BM 6 response to bullying and mobbing, BM 8 "Prevention of bullying / mobbing ", BM 9 action taken to inspect the causes of the bullying/mobbing, BM 10 providing counseling or another support, BM 11 "Are you satisfied you with the manner in which the incident was handled", BM 12 the reason of not reporting incident to others. SH 2 "How many have you been sexually harassed in the last 12 months? , SH 3 questions asking perpetrator of sexual harassment, SH 4 "Do you consider this to be a typical incident of sexual harassment in your workplace?", SH 5 Where did the sexual harassment take place, SH 6 Response to sexual harassment, SH 8 prevention of sexual

harassment, SH 9 action taken to inspect the causes of the sexual harassment, SH 10 providing counseling or another support, SH 11 “How satisfied are you with the manner in which the incident was handled?” , SH 12 the reason of not reporting incident to others. In the section C items HE 1 concerning the development of policies to address WPV and HE 2 concerning the measures to deal with WPV.

The table below displays the content validity which showing items of measurement matching to the research objectives and theoretical reviewed.

Table 3: 2. Content validity

Study objectives	Concept framework	Content validity	Questionnaire items
To assess types of WPV among nurses at a selected UTH.	Types: Types of WPV: Physical, verbal, bullying/mobbing, sexual harassment.	(Rodríguez and Paravic, 2013, p. 198)	Section B: PV1, PV1.1. Section C: VA1, BM1, SH1, WPV 1.
To identify the factors associated with WPV among nurses at a selected UTH	Factors associated to WPV: Age, gender, marital status, working experience, the category of patients/ clients, working in a specific specialties, working in some departments/services, working alone, work with vulnerable patients	(Di Martino, 2003b, pp. 7–8).	Section A: PD1, PD2, PD3, PD4, PD5, PD6, PD7, PD8, PD9
To identify the consequences of WPV among nurses at a selected UTH	Consequences: psychological concerns (disturbing memories, repeated thinking, feeling ashamed or guilty..), injuries, leaving the job, reduction of work performance	(Di Martino, 2003b, p. 15).	Section D: D1 PV 1.2,

3.8. Data Collection

After obtaining the required permission (Appendix V, p. 59) the researcher met every matrons and unit managers in order to request for assistance in retrieving nurses in their meetings and discuss an appropriate time of data collection, this period covered 3 weeks starting in March 2019. The researcher was present in nurses' staff meeting and clarifies the important information such as the aim of the study, the significance of the study and the estimated contribution of the participants as well as the right of them to not participate in the study (Appendix VI, p. 60). The chosen participants were provided with the directives, requested to sign a consent form previously permitting them to reply the survey and self-administered questionnaire in English version (Appendix II, p. 52) was distributed to respondents because it was a working language at a selected UTH. The researcher waited for the participants to complete the questionnaire, which improves the response rate by giving clarification if any. After completing the questionnaire the participants gave back the completed questionnaire immediately to the investigator. Respondents were requested to not reveal the content of the instrument to co-workers during 3 weeks of data collection period, from 11 March 2019 to 31 March 2019, in an effort to avoid participants to influence others in responding.

3.9. Data analysis

Data were analyzed by using Statistical Package for the Social Sciences (SPSS) version 21. Descriptive statistics were used to define the features of respondents and exposure to all types of WPV and to find out the consequences of WPV. To identify the factors related with WPV, inferential statistic such us Chi-square test were used to assess relationship between factors (age groups, sex, working experience, types of patients, sex of patients, working in a specific specialties, work with vulnerable patients, working alone) and WPV.

3.10 Ethical consideration

Ethical clearance for data collection was acquired from the Institutional Review Board (IRB) of the University in Rwanda (Appendix IV, p. 58) and the permission to collect data was acquired from a selected University Teaching Hospital in Rwanda ethics and research committee (Appendix V, p. 59) before the beginning of the data collection. The

authorization to adapt the instrument was obtained from the authors. The ethical principles of research were respected.

3.10.1 Autonomy

Autonomy is the capability for self-determination in action conferring to an individual plan. It is at this time that a participant can make a choice to contribute in a study if he/she appreciates the advantage and risks of the study leading to new knowledge. This factor also addresses how to respond to any form of physical harm or discomfort, violation of dignity and privacy and reparation (Akaranga and Makau, 2016, p. 7). Autonomy in the present study was respected by explaining to the respondents the aim of the study and expected outcome of their participation in order to decide themselves whether they would participate in the research after understanding the meaning of the work. The researcher also provided an information letter that mentioned the aim of the study so that they could read before completion of the questionnaire. Respondents completed the questionnaire on their own will, this means that they were not forced to complete the questionnaire and they signed informed consent form previously the completion of the instrument.

3.10.2 Confidentiality and anonymity

Anonymity denotes to keeping secret by not disclosing the ethnic or cultural background of respondents, refrain from referring to them by their names or revealing any other delicate information about a respondent (Akaranga and Makau, 2016, p. 6). In this study, the research instruments were identified by using coded number, no names or addresses were collected to protect the anonymity and participant privacy.

3.10.3 Beneficence/non-maleficence

Beneficence: Beneficence means, “doing good”(Akaranga and Makau, 2016, p. 7). During the present study, beneficence was respected, the researcher explained to the participants the aim of the study and the benefits that will come from it and the benefits were not overstated or even minimized. The benefits in this study are to inform hospital leaders/managers about WPV experience among nurses at a selected UTH.

Non-maleficence: This term expresses the probable risks of respondents. It highlights on what creates harm which could be physiological, emotional, social or even financial in nature (Akaranga and Makau, 2016, p. 7). During the study physically or psychologically harm was avoided. The researcher was not asked questions which are humiliating, being dissatisfied or obliging individuals to reveal info which could result in anxiety or even fear among the participants. The exact aim of the study was explained.

3.10.3 Justice

In the present study, justice principle was respected by treating all participants fairly and equally during and after the research study; the benefits from this study were equally distributed to all nurses at a selected UTH by knowing the types, factors associated to WPV and the consequences of WPV in order to take preventive measures.

3.10.4 Risks and benefits

The present study did not expose to participants any risks and there were no immediate benefits to the respondents. However, they will benefit from the results as the findings will inform hospital leaders/managers about WPV experience among nurses- so that future strategy can be carried out to address the problem. For that reason, the explanation and informed consent were given.

3.11 Data management

In this study data are descriptive and were obtained by using a self-administered questionnaire. Completed questionnaires were kept in closed-cupboard located in the research house and the coded data was stowed using standard SPSS file formats in a password-protected laptop, only the investigator and supervisor were accountable for storage, security and backup of the data. The data will be reserved until five years following the end of the research then after they will be discarded.

3.12 Data dissemination

The results of this study will be presented at UR/ College of Medicine and Health sciences/ School of Nursing and Midwifery to be awarded. The final report will be submitted the UR/CMHS in the library. A final copy will be also submitted to the IRB and at a selected University Teaching Hospital in Rwanda division of training and

research. In partnership with the supervisor, this work study will be published in an accredited nursing journal for public access.

3.13. Limitations and challenges

It is usually recognized that any research has its limits, strengths, weakness and challenges. Therefore, this study confronted methodological concerns enunciated as follows; initially, this study was steered in one of the University Teaching Hospital in the entire country, and as it was not illustrative of the estimated four Universities Teaching Hospitals and 42 districts Hospitals in Rwanda, and it was also limited to one category of healthcare workers (nurses) and to WPV done by patients and patients' relatives. Consequently, these findings may not be generalized to the whole hospital settings in Rwanda. Furthermore, the study was used a prospective self-reporting approach in data gathering, by recalling events in the last twelve months prior to study which might have possible biases.

The strength of this study was that the researchers could publish the updated findings on WPV in Rwanda Hospital context.

The weakness of this study, most study exploring WPV use together quantitative and qualitative approaches to explore the feelings expressed by the participants, this study used quantitative approach only, is suggested to be completed by qualitative approach. Future studies are recommended using both quantitative and qualitative approaches that explore all information regarding WPV including all categories of healthcare workers at different hospital settings.

The study was also limited to three objectives; further objectives could be discovered like the causes of WPV, strategies adopted to address WPV.

3.14. Summary of chapter three

This chapter three included the research methodology to apply in this study, the study design and approach. Population and sampling used for this research were presented as well as how participants were recruited. The data collection tool has been defined and the degree to which the measurement is trustworthy was presented through validity and reliability. Finally, the discussion of the data collection, data analysis, and data management was done. Ethical considerations, data dissemination, limitations and challenges ended this chapter.

CHAPTER FOUR: PRESENTATION OF THE FINDINGS OF THE STUDY

4.1 Introduction

The details of the data analysis and the results are displayed in tables. The aim of the study was to explore WPV experience among nurses at a UTH in Rwanda in order to inform the hospital leaders/managers about WPV experience among nurses- so that future strategies can be carried out to address the problem.

A total population of 379 nurses working at a selected UTH was targeted to participate in the study. Therefore, the researcher circulated the self-report questionnaires to 195 nurses who represent the sample size of this study, all participants responded to the questionnaires.

The results from this research are offered in agreement to the study objectives. Descriptive statistics are used to illustrate the frequencies and percentages of the study variables. Chi-square test for independence results showing whether there are associations between variables and WPV are presented.

4.2. Personal and workplace data of the sample

The demographic variables of this study included age, gender, marital status, nursing work experience of the participants, the category of patients/ clients, the sex of patients, specialties where nurses devote more than 50% of working time, department or service where nurses spend more than 50% of working time and the number of staff present in the same work setting with nurses more than 50% of work time.

4.2.1. Gender, age, marital status and nursing work experience

The results of the variables within the sample demographics as related to age, gender, marital status and nursing work experience of the participants are presented in Table 4.1. It showed that the majority of the respondents were more females 84.6%, (n=165) than males 15.4, (n=30). The ages ranged from 25 to 64 years, 23.6% fell into a group of 30-34 years; 26.7% fell into a group of 35-39 years old and 24.1% fell into a group of 40-44 years old. The majority of participants were married 83.6%, (n= 163). The majority of respondents had more than 6 years of experience 31.8%, (n=62) of 6-10 years, 20.5%, (n=40) had experience of 11-15 years; 13.3%, (n=26) had experience of 16-20 years and 19.5%, (n=38) had experience of more than 20 years.

Table 4.1 Gender, age, marital status and nursing work experience of the study participants

Variables	Categories	Frequency	Percent
Gender	Female	165	84.6
	Male	30	15.4
Age	25-29 years	12	6.2
	30-34 years	46	23.6
	35-39 years	52	26.7
	40-44years	47	24.1
	45-49 years	26	13.3
	50-54 years	6	3.1
	55-59 years	4	2.1
	60 -64 years	2	1.0
Marital status	Single	25	12.8
	Married	163	83.6
	Living with partner	1	.5
	Separated or Divorced	3	1.5
	Widow or Widower	3	1.5
Experience	1-5 Years	29	14.9
	6-10 Years	62	31.8
	11-15 Years	40	20.5
	16-20 years	26	13.3
	Over 20 years	38	19.5

4.2.2. The category of patients/ Clients and the sex of patients, nurses most frequently work with

The participants were invited to show the category of patients/ clients and the sex of patients, nurses most frequently work with. The table below was indicating that the

majority of patients/ clients that nurses were caring for were adults 77.9%, (n=152). Others category of patients/ clients cared by the nurses were children 16, 9%, (n=33); and newborns 5.1%, (n=10). The sex of patients, nurses most frequently work with were both males and females 78.5%, (n=153), the females only were 17.9%, (n=35) and males 3.6%, (n=7).

Table 4.2 The category of patients/ Clients and the sex of patients, nurses most frequently work with

Variables	Categories	Frequency	Per cent
The category of patients/ clients	Newborns	10	5.1
	Children	33	16.9
	Adults	152	77.9
The sex of patients	Female	35	17.9
	Male	7	3.6
	Male and female	153	78.5

4.2.3 Specialties where nurses spend more than 50% of working time

The participants in this study work in different specialties; the nurses mostly work in mother/ child care specialty 34, 4%,(n=67), nurses work in physical disabled specialty 21.5%, (n=42), terminally ill specialty 13.3%, (n= 26), emergency care 12.3%, (n=24), chronic diseases care 10.3%, (n=20), HIV/AIDS 3.1%, (n=6), others specialties represented 5.1%, (n=10).

Table 4:3 Specialties where nurses spend more than 50% of working time

Variable	Categories	Frequency	Per cent
Specialties	Physical disabled	42	21.5
	Mother/child care	67	34.4
	Terminally ill	26	13.3
	HIV/AIDS	6	3.1
	Emergency care	24	12.3
	Chronic disease care	20	10.3
	Others	10	5.1

4.2.4 Department or service where nurses pass more than 50% of working time

Table 4.4 displays the departments or services where nurses spend more than 50% of working time. The 8.2%, (n=16) of nurses work in Outpatients Departments (OPD), the 14.9%, (n=29) of nurses work in internal medicine, the 17.9%, (n=35) of nurses work in surgical, the (15.9%, (n=31) of nurses work in maternity, the 18.5%, (n=36) of nurses work in pediatrics, the 9.7%, (n=19) of nurses work in accident and emergency department, the 7.7%, (n=15) of nurses work in theater and 7.2%, (n=14) of nurses work in critical care unit.

Table 4.4 Department or service where nurses pass more than 50% of working time

Variables	Categories	Frequency	Per cent
Department or service	OPD	16	8.2
	Internal medicine	29	14.9
	surgical	35	17.9
	Maternity	31	15.9
	Pediatrics	36	18.5
	Accident & Emergency	19	9.7
	Theater	15	7.7
	Critical care	14	7.2

4.2.5 The amount of staff present in the same work setting with nurses more than 50%

The table below indicates that the amount of staff present in the same workplace with nurses more than 50% of work time. The 5.1%, (n=10) of nurses work alone, the 64.6%, (n=126) of nurses work in the team of 1 to 5 of staff, the 16.9, (n= 33) of nurses work in the team of the 6 to 10 of nurses, the 8.2%, (n=16) of nurses work in the team of 11 to 15 of staff, the 5.1%, (n=10) of nurses work in the team of more than 15 of staff.

Table 4. 5. The number of staff present in the same work setting with nurses more than 50% of work time

Variable	Categories	Frequency	Per cent
The number of staff	None	10	5.1
	1-5	126	64.6
	6-10	33	16.9
	11-15	16	8.2
	Over 15	10	5.1

4.3 Presentation of findings as aligned with the objectives

The findings of the study aligned with the objectives are presented, the study objectives are: to assess types of WPV among nurses working at a selected University Teaching Hospital in Rwanda, to identify the factors associated with WPV among nurses working at a selected University Teaching Hospital in Rwanda and to explore the consequences of WPV among nurses at a selected University Teaching Hospital in Rwanda. The results of descriptive and inferential statistics are displayed in the tables and the comprehensible explanations are given.

4.3.1 Types of WPV in the last 12 months

Table 4.6 shows that 58.5%, (n=114) of nurses have experienced some types of WPV in the 12 months preceding this study 6.7%, (n=13) have experienced physical violence when working with the patients/ clients among them 6.2% (n=12) experienced physical

violence without a weapon and 0.5%, (n=1) experienced physical violence with a weapon. The 44.6%, (n=108) of nurses were verbally abused when working with the patients/clients. The 15.4%, (n=30) of nurses were bullied/mobbed when working with the patients/clients. The 2.1%, (n=4) of nurses have experienced sexual harassment.

Table 4.6 Types of WPV in the last 12 months

Variables	Categories	Frequency	Percent
Some types of WPV	No	81	41.5
	Yes	114	58.5
Physical violence	No	182	93.3
	Yes	13	6.7
	Physical violence without a weapon	12	6.2
	Physical violence with a weapon	1	.5
Verbal abuse	No	87	44.6
	Yes	108	55.4
Bullying/Mobbing	No	165	84.6
	Yes	30	15.4
Sexual harassment	No	191	97.9
	Yes	4	2.1

4.3.2 Factors associated with WPV

Table 4.7 summarizes results from Chi-square test used to assess the relationship between personal and workplace data factors (age, gender, marital status, working experience, the category of patients/clients, and working in a specific specialty, working in some departments/services, working alone) and WPV. Therefore, a Chi-square for independence was used as they are proposed to be appropriate for indicating the association between one categorical independent variables (age, gender, marital status, working experience, the category of patients / clients, and working in a specific

specialties, working in some departments/services, working alone) and categorical dependent variable (WPV) (Pallant, 2016, p. 118).

A Chi-square for independence showed a significant association between working in specific specialties and WPV, Chi^2 (1, n=195), P=<0.001, with a high WPV for nurses working in emergency care specialty (mean=1.50), and HIV/AIDS (mean=1.11). Further, the results revealed a significant association between working in some department and WPV, Chi^2 (1, n=195), P=<0.001, with high WPV at accident and emergency department (mean=1.68), internal medicine (mean=1.03), and outpatient department (mean=1.00).

Therefore, there was no association between gender and WPV, Chi^2 (1, n=195), P=0.289, no association between nurses' ages and WPV,Chi^2 (1, n=195), P=0.143, no association between nurses' marital status and WPV, Chi^2 (1, n=195), P=0.997, no association between nursing working experience and WPV, Chi^2 (1, n=195), P=0.387, no association between the categories of patients/clients and WPV, Chi^2 (1, n=195), P=0.511, no association between the sex of patients and WPV, Chi^2 (1, n=195), P=0.278, no association between nurses' marital status and WPV, Chi^2 (1, n=195), P=0.997 and no association between the number of staff present in the workplace and WPV, Chi^2 (1, n=195), P=0.123.

Table 4.7 Factors associated with WPV

Variables	Categories	Mean	N	df	Value	P-Value
Gender	Female	0.79	165	3	0.38	0.287
	Male	0.87	30			
Age	25-29 years	0.75	12	21	27.91	0.143
	30-34 years	0.74	46			
	35-39 years	1.06	52			
	40-44years	0.70	47			
	45-49 years	0.80	26			
	50-54 years	0.17	6			
	55-59 years	0.25	4			
	60-64 years	1.00	2			
Marital status	Single	0.80	25	12	3.55	0.997
	Married	0.81	163			
	Living with partner	0.00	1			
	Separated or Divorced	1.00	3			
Nursing work experience	1-5 Years	0.73	29	12	12.75	0.387
	6-10 Years	0.90	62			
	11-15 Years	0.80	40			
	16-20 years	0.88	26			
	Over 20 years	0.63	38			
The category of patients/ clients	Newborns	0.70	10	6	5.26	0.511
	Children	0.61	33			
	Adults	0.85	152			
The sex of patients	Female	1.03	35	6	7.49	0.278
	Male	0.71	7			
	Male and female	0.75	153			

Specialties	Physical disabled	0.38	42	18	58.96	<0.001
	Mother/child care	0.79	67			
	Terminally ill	0.73	26			
	HIV/AIDS	1.11	6			
	Emergency care	1.50	24			
	Chronic disease care	0.85	20			
	Others	0.80	10			
Departments/Services	OPD	1.00	16	21	78.9	<0.001
	Internal medicine	1.03	29			
	surgical	0.34	35			
	Maternity	0.96	31			
	Pediatrics	0.63	36			
	Emergency	1.68	19			
	Theater	0.53	15			
	Critical care	0.35	14			
The number of staff present	None	0.90	10	12	17.77	0.123
	1-5	0.84	126			
	6-10	0.57	33			
	11-15	1.00	16			
	Over 15	0.60	10			

4.3.3 Consequences of WPV

The table below shows the consequences of WPV among nurses. The most consequences of WPV experienced by the nurses were psychological concerns like avoiding thinking about or talking about the attack or avoiding having feelings interrelated to it 43.6%, (n=85), repeated, worrying memories, thoughts, or images of the attack at rate of 35.9%, (n=70), being super-alert or watchful and on guard 11.8%, (n=23), feeling like

everything you did was an effort 11.3%, (n=22). Thinking of leaving the job 10.8%, (n=27), reduction of work performance 11.8%, (n=21) and nurses felt ashamed or guilty after being violated 9.7%, (n=19). 1 (0.5 %) nurse have injured as results of the violence.

Table 4.8 Consequences of WPV

Variables	Frequency	Percent
Repeated, disturbing memories, thoughts, or images of the attack	70	35.9
Avoiding thinking about or talking about the attack or avoiding having feelings related to it	85	43.6
Being super-alert or watchful and on guard	23	11.8
Feeling like everything you did was an effort	22	11.3
Reduction of work performance	21	10.8
Thinking of leaving the job	27	13.8
Felt ashamed or guilty	19	9.7
Injured as a result of the violence	1	0.5

4.4. Summary of the chapter

It is apparent from this study that there are more female respondents 84.6%, (n=165) than males 15.4, (n=30). Most nurses participants 50.3%, (n=98) fell into the 30-39 years old category, whereas 83.6%, (n=163) were married and 53.1% (n=104) had nursing experience more than 10 years. The majority of patients/clients nurses caring for were adults 77.9%, (n=152), the sex of patients, nurses most frequently work with were both males and females 78.5%, (n=153). The most nurses work in mother/ child care specialty 34, 4%, (n=67) and the 64.6%, (n=126) of nurses work in the team of 1 to 5 of staff.

The findings revealed that 58.5%, (n=114) of nurses have experienced some types of WPV in the 12 months preceding this study, among them 44.6%, (n=108) of nurses were verbally abused when working with the patients/clients. The findings shows also a significant association between working in a specific specialties and WPV, Chi^2 (1, n=195), P=<0.001, with a high WPV for nurses working in emergency care specialty

(mean=1.50), and HIV/AIDS (mean=1.11), an association between working in some department and WPV, Chi^2 (1, n=195), P=<0.001, with high WPV at accident and emergency department (mean=1.68). The most consequences of WPV experienced by the nurses were psychological concerns like avoiding thinking about or talking about the attack or avoiding having feelings related to it 43.6%, (n=85), repeated, worrying memories, thoughts, or images of the attack at rate of 35.9%, (n=70). The next chapter is dedicated to the discussion of the results.

CHAPTER FIVE: DISCUSSION

5.1. Introduction

This chapter offers the debate of findings. The aim of this study was to explore WPV experience among nurses working at a UTH. The significant findings was be discussed based on the aim, specific objectives and conceptual framework of the study in relation of research literature allied to WPV, which is strengthened by types of WPV, the factors associated with WPV and the consequences of WPV among nurses at a selected UTH. The chapter was closed with a summary.

5.2. Demographic data

The results from the present study showed that most of the participants were female 84.6%, (n=165) than males 15.4, (n=30). This gender distribution is in harmony with a similar study conducted in China about exploration of risk factors of WPV showed inequality between male (27.9%) and female (72.9%) in the nursing profession (Liu *et al.*, 2015, p. 6807). This female-dominance in the nursing profession is associated with the history perceived globally as a female-dominated vocation. Many participants (93.8%) aged above 30 years, and 83.6% were married, this study is comparable to a study led in Gambia on WPV against nurses where (64.4%) had above 31years old and (82.2%) were married (Sisawo, Ouédraogo and Huang, 2017, p. 4). However, this age is contrasted to the study conducted in the North Ethiopia where (68.9%) of respondents had age category between 18-29 years old and 78.6% were single (Tiruneh *et al.*, 2016, p. 3). 53.1% (n=104) had nursing experience of more than 10 years, this is similar to a study done in teaching hospital in Iran where 45% of respondents had more than 10 years of experience (Teymourzadeh *et al.*, 2014, p. 302). The 1-5 of the staff were present in the same work setting with nurses in (64.6%), this is in accordance with the study done in North Ethiopia where 1-5 of staff present with nurses in (71.8%) (Tiruneh *et al.*, 2016, p. 3).

5.3 Types of WPV in the last 12 months

The results of this research indicated that participants 58.5%, (n=114) of nurses have experienced some types of WPV in the 12 months preceding this study. The WPV at a selected University Teaching Hospital in Rwanda is in agreement with different studies conducted in different countries, in some there is a bit difference, in others countries is high or low. For instance, a study conducted in Gambia among nurses was shown that 62.1% have experienced WPV (Sisawo, Ouédraogo and Huang, 2017, p. 4). In China; the frequency of WPV was around 66% (Shi *et al.*, 2017, p. 1). In USA, a study led in the mid-Atlantic region among nurses showed that 76% have experienced WPV (Speroni *et al.*, 2014, p. 220). In Malawi, the study conducted in the South region in five hospitals has shown that 70.54% of nurses experienced WPV (Banda, Mayers and Duma, 2016, p. 418). In Italy, 45% of healthcare workers reported having suffered from WPV (Ferri *et al.*, 2016, p. 263). A study conducted in the USA, Texas state showed that WPV was 40.5% (Boafo and Hancock, 2017, p. 2). In Saudi Arabia in family medicine centers, 36% of nurses have been affected by WPV, (Al-Turki, Afify and Alateeq, 2016, p. 262).

However, concerning different types of WPV, 6.7% of nurses experienced physical violence. Comparing physical violence worldwide and in some countries, this rate is low. A quantitative data review of 136 articles revealed that physical violence among nurses was 36.4% worldwide (Spector, Zhou and Che, 2014, p. 72). In North West of Ethiopia, among them physical violence was 60.2% (Tiruneh *et al.*, 2016, p. 3). In Democratic Republic of Congo, nurses were the most affected by WPV among other healthcare workers including physical violence at 53.6% (Uzembo *et al.*, 2015, p. 72). A study called WPV against nurses in Texas State (USA) showed that 49.8% experienced physical violence within their nursing carrier (Boafo and Hancock, 2017). In Malawi, the study conducted in the South region in five hospitals has 22% of the nurses assaulted physically (Banda, Mayers and Duma, 2016, p. 418). Ethiopia, in South of the country, physical violence was for 18%, (Fute *et al.*, 2015, p. 4). In Gambia, physical violence at 17.2% (Sisawo, Ouédraogo and Huang, 2017, p. 4). In China; around 12% of nurses were violated physically (Shi *et al.*, 2017, p. 1). In Lebanon, 10% of nurses were violated physically (Alameddine, Mourad and Dimassi, 2015, p. 5).

The findings of the present study revealed that 44.6%, (n=108) of nurses were verbally abused when working with the patients/clients.

These results are low comparing with those found in the studies conducted in different countries. Worldwide, a quantitative data review of 136 articles revealed that physical violence among nurses was 66.9% (Spector, Zhou and Che, 2014, p. 72). In Malawi, the study conducted in the South region in five hospitals 95% abused verbally verbal (Banda, Mayers and Duma, 2016, p. 418). In Ethiopia, in South of the country verbal violence was around 90% (Fute *et al.*, 2015, p. 4). In China; 65% was violated verbally (Shi *et al.*, 2017, p. 1). In Lebanon, 62% of nurses have experienced verbal violence, (Alameddine, Mourad and Dimassi, 2015, p. 5). In Gambia Verbal abuse among nurses was at 59.8% (Sisawo, Ouédraogo and Huang, 2017, p. 4). In the Democratic Republic of Congo, nurses were the most affected by WPV among other healthcare workers including verbal aggression 59.0%, (Uzembo *et al.*, 2015, p. 72). In Ghana, verbal abuse (52.7%) (Boafo, Hancock and Gringart, 2015, p. 99).

Concerning bullying/mobbing, the results of this study showed that 15.4%, (n=30) of nurses were bullied/mobbed when working with the patients/clients. These findings are also low comparing with different studies. Worldwide, a quantitative data review of 136 articles revealed that 39.7% of nurses were physically abused (Spector, Zhou and Che, 2014, p. 72). In Malawi, the study conducted in the South region in five hospitals has shown 73% of the nurses threatened, (Banda, Mayers and Duma, 2016, p. 418). In the North West of Ethiopia where 39.8% of nurses experienced psychological violence (Tiruneh *et al.*, 2016, p. 3).

Finally, sexual harassment was also present, in this study, (2.1%, n=4) of nurses have experienced sexual harassment, this frequency is again low. In line with this, Worldwide, a quantitative data review of 136 articles indicated that physical violence among nurses was 25% (Spector, Zhou and Che, 2014, p. 72). In the Democratic Republic of Congo, nurses were the most affected by WPV among others healthcare workers where the nurses experience a high sexual harassment 63.3% (Uzembo *et al.*, 2015, p. 76). A study called WPV against nurses in Texas State (USA) showed that 32.5% of nurses have been sexually abused during their carrier in twelve past months (Boafo and Hancock, 2017). In Malawi, 16% of nurses have been sexually harassed (Banda, Mayers and Duma, 2016, p. 418). In Ethiopia, in South of the country about 13% of nurses harassed sexually (Fute *et al.*, 2015, p. 4). In Ghana, sexual harassment among nurses was at (12, 2%) (Boafo, Hancock and Gringart, 2015, p. 99). In Gambia sexual harassment among nurses

was at 10% (Sisawo, Ouédraogo and Huang, 2017, p. 4). In China about 4% was harassed sexually, (Shi *et al.*, 2017, p. 1).

5.4 Factors associated with WPV

The findings of this study shows a significant association between working in a specific specialties and WPV, Chi^2 (1, n=195), P=<0.001, with a high WPV for nurses working in emergency care specialty (mean=1.50), and HIV/AIDS (mean=1.11), an association between working in some department and WPV, Chi^2 (1, n=195), P=<0.001, with high WPV at accident and emergency department (mean=1.68). The results of this study are similar to those found in the USA, nurses working the in emergency department were the most concerned by occurrences (Speroni *et al.*, 2014). In 2017, another study conducted in the USA the studies have shown that in the mid-Atlantic region WPV was associated with nurses working at the emergency department (Boafo and Hancock, 2017, p. 28). In an Italian general hospital, various health professionals working at the emergency department was associated with WPV because of overcrowding of patients in need of emergency care (Ferri *et al.*, 2016, p. 272). In South Ethiopia, working at the emergency department (Fute *et al.*, 2015).

Therefore, working with suffering persons generate WPV, suffering persons are frustrated and irritated because of their illness and pain. Violence is therefore common amongst workers in contact with them and it is frequently reflected an unavoidable part of the occupation (Di Martino, 2003b, pp. 7–8). This is the case of the nurses giving emergency care or working at accident and emergency and for nurses working with the patients with HIV/AIDS.

5.5 Consequences of WPV

Based on the findings from this study, the consequences of WPV experienced by the nurses were psychological concerns like avoiding thinking about or talking about the attack or avoiding having feelings related to it 43.6%, (n=85), repeated, disturbing memories, thoughts, or images of the attack at rate of 35.9%,(n=70), being super-alert or watchful and on guard 11.8%, (n=23), feeling like everything you did was an effort 11.3%, (n=22), reduction of work performance 11.8%, (n=21) and nurses felt ashamed or guilty after being violated 9.7%, (n=19). 0.5 (n=1 nurse have been injured.

In support of these findings, the consequences of WPV found in Italian general hospital were psychological concerns at rate of 73% (Ferri *et al.*, 2016, p. 272). In Ghana, the

consequences of WPV among nurses were roughly 12.2% complaining of disturbed memories and having feelings or images of the abuse; 14,4% have been disturbed by avoiding sharing their violence experience; 21,5% have experienced hyper-vigilant and being on guard (Boafo, Hancock and Gringart, 2015, pp. 99;105&106). In Saudi Arabia the consequences of WPV were decreasing in job productivity (31.1%), feeling embarrassed (4.9%), feeling worried (2.5%) (Al-Turki, Afify and Alateeq, 2016, pp. 261&262). In Palestine, psychological concerns at a rate of 9.3% as well as feelings of guilt 1.3%) (Hamdan and Abu Hamra, 2015, p. 4). In Lebanon, the consequences of WPV were having high levels of emotional exhaustion and depersonalization (Alameddine, Mourad and Dimassi, 2015, p. 7).

The results from this study discovered that 10.8%, (n=27) of nurses think of leaving their job. the frequency of this study is few comparing to the studies conducted; in the USA in the mid-Atlantic region, where 63.3% nurses considered leaving nursing job (Boafo and Hancock, 2017, p. 28). In Lebanon, 31.7% of nurses think to leave their job because they have been harassed (Alameddine, Mourad and Dimassi, 2015, p. 6). In Palestine, most healthcare workers exposed to WPV thought to leave their job (Hamdan and Abu Hamra, 2015, p. 5), the attainment of institutions productions in North of Ethiopia (Tiruneh *et al.*, 2016, p. 1). This study showed that one nurse (0.5%, n=1) have injured, this frequency is low comparing to a retrospective data review conducted in the USA showed that 2.1% of nurses reported WPV injuries (Speroni *et al.*, 2014, p. 224). Worldwide, a quantitative data review of 136 articles showed that 32.7% of nurses reported being physically injured during WPV (Spector, Zhou and Che, 2014, p. 72).

5.5. Summary of the chapter

This part has discussed the finding of this study in relations with other studies conducted in different countries. The discussion was conducted according to the aim, conceptual framework and the objectives of the study. After, discussion on demographic data, the researcher passes through all objectives highlighting the similarities and the contrasts. The objectives covered were to assess the types of WPV, to identify the factors associated with WPV and the consequences of WPV among nurses working at a selected University Teaching Hospital in Rwanda. The following chapter is dedicated to the conclusion and recommendation.

CHAPTER SIX: CONCLUSION AND RECOMMENDATIONS

6.1 Introduction

The conclusion of all study given highlighting the phenomenon of WPV at a selected University Teaching Hospital in Rwanda in term of types of WPV, factors associated with WPV and the consequences of WPV. All objectives of the study have achieved. After that, the recommendations were given to the concerns level in relation to this study.

6.1 Conclusion

The purpose of this study was to explore WPV experience among nurses at a selected UTH in order to inform the hospital leaders/managers about WPV experience among nurses- so that future strategy can be carried out to address the problem. The findings from this study indicated that WPV is present in hospital under of their all types, as proved that participants 58.5%, (n=114) of nurses have met some types of WPV in the twelve months before this study. The 44.6%, (n=108) of nurses were verbally abused when working with the patients/clients. The 15.4%, (n=30) of nurses were bullied/mobbed when working with the patients/clients. The 2.1%, (n=4) of nurses have experienced sexual harassment. Furthermore, the nurses providing emergency care, the nurses working at the emergency department and nurses working with vulnerable patients like HIV/AIDS patients were associated with WPV Chi^2 (1, n=195), P=<0.001). The psychological concerns are the most consequences of WPV among nurses at a selected UTH. Finally, the hospital management needs to be aware of the WPV, develop and implement appropriate policies and strategies, and avoid WPV; nurses will concentrate psychologically to their job and improve nursing productivity.

6.2 Recommendations

Drawing based on the results of this study, the recommendations are elaborated in relation to nursing management, nursing practice, nursing education and nursing research.

6.2.1 Nursing management

In nursing management, the hospital leaders and managers in nursing should be aware and understand WPV in the healthcare settings. Develop and implement appropriate

policies and strategies in order to combat against WPV and conduct risk assessment regularly in order to discover the potential hazard of WPV.

The employers should protect the safety and health of their workers, by availing the security presence and panic alarm system. Provide summoning assistance in the case of a security threat and have liaison with police. All weapons shall be removed from patients, staff and visitors, when entering the hospital premises and kept in a safe and secured place and signed for as prescribed except where otherwise authorized.

All incidents related to WPV, or potential risk of WPV should be reported through incident reporting system. Therefore, conduct the investigation of all incidents, draw correctives measures, implement and monitor them in order to reduce WPV.

6.2.2 Nursing education

In nursing education, the hospital should provide adequate in service training and continuous professional education to employees allowing them to deal with WPV and be aware of their rights and obligations.

6.2.3 Nursing practice

In nursing practice, it could be better to not allow a nurse to work alone if possible and in the instance where working alone is quite possible, the lone nurse is encouraged to frequently assess the situation s/he is in and the menaces to which s/he is exposed to.

Communicate with the patients/clients by using therapeutic communication and use different techniques of communication to establish a good relationship with them.

6.2.4 Nursing research

In research, the future cross-country study using both quantitative and qualitative approaches that explore all information regarding WPV including all categories of healthcare workers at different hospital settings is needed to get a map on WPV in Rwanda.

REFERENCES

Akaranga, S. I. and Makau, B. K. (2016) 'Ethical considerations and their applications to research: a case of the University of Nairobi', *Journal of Educational Policy and Entreprenuerial Research*, 3(12), pp. 1–9. doi: 2016.

Al-Turki, N., Afify, A. A. M. and Alateeq, M. (2016) 'Violence against health workers in family medicine centers', *Journal of Multidisciplinary Healthcare*, 9 (May), pp. 257–266. doi: 10.2147/JMDH.S105407.

Alameddine, M., Mourad, Y. and Dimassi, H. (2015) 'A national study on nurses' exposure to occupational violence in Lebanon: Prevalence, consequences and associated factors', *PLoS ONE*, 10(9), pp. 3–15. doi: 10.1371/journal.pone.0137105.

Banda, Mayers, P. and Duma, S. (2016) 'Violence against nurses in the southern region of Malawi', *Health SA Gesondheid*. Elsevier Ltd, 21(January), pp. 415–421. doi: 10.1016/j.hsag.2016.01.002.

Boafo, I. M. and Hancock, P. (2017) 'Workplace Violence Against Nurses', *SAGE Open*, 7(1), pp. 1–52. doi: 10.1177/2158244017701187.

Boafo, I. M., Hancock, P. and Gringart, E. (2015) 'Sources, incidence and effects of non-physical workplace violence against nurses in Ghana', *Nursing Open*, 3(2), pp. 99–109. doi: 10.1002/nop2.43.

Chapman, J. (2012) '30-Level timber building concept based on crosslaminated timber construction', *Structural Engineer*, 90(8), pp. 180–191. doi: 10.1002/nur.

Chappell, S. (2015) 'The American Organization of Nurse Executives and Emergency Nurses Association Guiding Principles on Mitigating Violence in the Workplace.', *The Journal of nursing administration*, 45(7–8), pp. 358–360. doi: 10.1097/NNA.0000000000000214.

Cohsasa (2015) *Hospital standards 6.7 version*.

Cooper, C. and Swanson, N. (2002) *Workplace Violence in the Health Sector: State of the Art*, *Geneva: ILO/ICN/WHO/PSI Joint Programme on Workplace Violence in the Health Sector* .

Darawad, M. W. *et al.* (2015) 'Violence Against Nurses in Emergency Departments in Jordan', *Workplace Health & Safety*, 63(1), pp. 9–17. doi: 10.1177/2165079914565348.

Ferri, P. *et al.* (2016) 'Workplace violence in different settings and among various health professionals in an Italian general hospital: A cross-sectional study', *Psychology*

Research and Behavior Management, 9(September), pp. 263–275. doi: 10.2147/PRBM.S114870.

Fute, M. *et al.* (2015) 'High prevalence of workplace violence among nurses working at public health facilities in Southern Ethiopia', *BMC Nursing*, 14(1), p. 9. doi: 10.1186/s12912-015-0062-1.

Hamdan, M. and Abu Hamra, A. (2015) 'Workplace violence towards workers in the emergency departments of Palestinian hospitals: a cross-sectional study', *Bio Med Central.*, 13(1), p. 28. doi: 10.1186/s12960-015-0018-2.

Heale, R. and Twycross, A. (2015) 'Validity and reliability in quantitative studies', *Evidence-Based Nursing*, 18(3), pp. 66–67. doi: 10.1136/eb-2015-102129.

Huston, C. J. (2014) *Professional issue in nursing: challenges and opportunities*. Lippincott. Edited by C. C. Burns. Philadelphia: Library of Congress Cataloging-in-Publication Data.

Igwenagu, C. (2017) *Fundamentals of research methodology and data collection*. doi: 10.1006/pmed.2000.0793.

ILO *et al.* (2002) *International Labour Office ILO International Council of Nurses ICN World Health Organization WHOPublic Services International PSI Joint Programme on Workplace Violence in the Health Sector*, *World Health*. Available at: http://who.int/violence_injury_prevention/violence/interpersonal/en/WVguidelinesEN.pdf?ua=1&ua=1[Accessed on 27th, May, 2018] .

International Labour Office (2003) *International Council of Nurses (ICN), World Health Organization (WHO), and Public Services International (PSI) : Workplace Violence in the Health Sector:International Labour Office (2003) International Council of Nurses (ICN), World Health Organization .*

James P. Phillips (2016) 'Workplace Violence against Health Care Workers in the United States', *The New England Journal of Medicine*, 374(April), pp. 1661–1669. doi: 10.1056/NEJMra1501998.

Liu, H. *et al.* (2015) 'Extent, nature, and risk factors of workplace violence in public tertiary hospitals in China: A cross-sectional survey', *International Journal of Environmental Research and Public Health*, 12(6), pp. 6801–6817. doi: 10.3390/ijerph120606801.

Di Martino, V. (2003a) *Relationship of Work Stress and Workplace Violence in the*

Health Sector, *Geneva: ILO/ICN/WHO/PSI Joint Programme on Workplace Violence in the Health Sector* .

Di Martino, V. (2003b) *Workplace violence in the health sector. Relationship between work stress and workplace violence in the health sector*. Available at: http://www.ilo.org/public/english/dialogue/sector/papers/health/stress-violence.pdf [Accessed on 27th, May, 2018] .

MoH Rwanda (2014) *Rwanda Hospital Accreditation Standards*, retrieved on www.moh.gov.rw*/ 2* [Accessed on 28th, May, 2018] .

Newman, C. J. *et al.* (2011) 'Workplace violence and gender discrimination in Rwanda's health workforce: Increasing safety and gender equality', *Human Resources for Health*, 9(1), p. 19. doi: 10.1186/1478-4491-9-19.

Occupational Safety and Health Administration (2016) *Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers*. Available at: https://www.osha.gov/Publications/osha3148.pdf [Accessed on 28th, May, 2017] .

Pallant, J. (2016) *SPSS Survival Manual website , go to www.allenandunwin.com/spss This is what readers from around the world say about the SPSS Survival Manual :* doi: S0003497598001581.

Pandey, D. P. P. D. M. M. (2015) *Research Methodology:Tools and techniques*.

Puszczak, K., Fronczyk, A. and Urbański, M. (2013) 'Analysis of Sample Size in Consumer Surveys', *Uma ética para quantos?*, 3(2), pp. 1–34. doi: 10.4039/Ent85108-3.

Rodríguez, V. A. and Paravic, T. M. (2013) '[A model to investigate workplace violence in the health sector]. ', *Revista gaúcha de enfermagem / EENFUFRGS*, 34(1), pp. 196–200. doi: 10.1590/S1983-14472013000100025.

Shi, L. *et al.* (2017) 'A cross–sectional study on the prevalence and associated risk factors for workplace violence against Chinese nurses', *BMJ Open*, 7(6), p. e013105. doi: 10.1136/bmjopen-2016-013105.

Sisawo, E. J., Ouédraogo, S. Y. Y. A. and Huang, S.-L. (2017) 'Workplace violence against nurses in the Gambia: mixed methods design', *BMC Health Services Research*. BMC Health Services Research, 17(1), p. 311. doi: 10.1186/s12913-017-2258-4.

Spector, P. E., Zhou, Z. E. and Che, X. X. (2014) 'Nurse exposure to physical and nonphysical violence, bullying, and sexual harassment: A quantitative review', *International Journal of Nursing Studies*. Elsevier Ltd, 51(1), pp. 72–84. doi:

10.1016/j.ijnurstu.2013.01.010.

Speroni, K. G. *et al.* (2014) 'Incidence and cost of nurse workplace violence perpetrated by hospital patients or patient visitors', *Journal of Emergency Nursing*. Emergency Nurses Association, 40(3), pp. 218–228. doi: 10.1016/j.jen.2013.05.014.

Stark, C. and Patterson, B. (1994) *Violence at work*, *Bmj*. doi: 10.1136/bmj.308.6920.62b.

Teymourzadeh, E. *et al.* (2014) 'Nurses exposure to workplace violence in a large teaching hospital in Iran', *International Journal of Health Policy and Management*, 3(6), pp. 301–305. doi: 10.15171/ijhpm.2014.98.

Tiruneh, B. T. *et al.* (2016) 'Prevalence of workplace violence in Northwest Ethiopia: a multivariate analysis', *BMC Nursing*. BMC Nursing, 15(1), p. 42. doi: 10.1186/s12912-016-0162-6.

UN High Commissioner for Human Rights and World Health Organization (WHO) (2008) 'The Right to Health Factsheet 31', *report*, 31(June), pp. 1–52. doi: 1014-5567, retrieved onhttp://www.ohchr.org [Accessed on 30th, May, 2018].

Uzembo, B. A. M. *et al.* (2015) 'Workplace violence towards Congolese health care workers : A survey of 436 healthcare facilities in Katanga province , Democratic Republic of Congo', *J Occ Health*, 57(October), pp. 69–80.

Vidal-martí, C. and Pérez, C. (2017) 'Aggression and Violent Behavior Is Chappell and Di Martino ' s interactive model of workplace violence valid ? An article analysing workplace violence towards healthcare professionals in Spain', *Aggression and Violent Behavior*. Elsevier, 35(May), pp. 83–90. doi: 10.1016/j.avb.2017.05.006.

World Health Organisation (2003) *Joint Programme on Workplace Violence in the Health Sector - questionnaire*, *Human Rights*. Available at: http://www.who.int/violence_injury_prevention/violence/interpersonal/en/WVquestionnaire.pdf?ua=1, [Accessed on 28th, May, 2018].

www.theguardian.com/global-development/2019/apr/30/killings-of-police-and-polio-workers-halt-vaccine-drive-in-pakistan [Accessed on 22nd, June, 2019].

https://www.theguardian.com/uk-news/2019/may/17/london-bridge-attackers-tried-to-decapitate-woman-inquest-hears [Accessed on 22nd, June, 2019].

www.economist.com/middle-east-and-africa/2019/03/23/why-are-ebola-clinics-in-congo-being-attacked [Accessed on 22nd, June, 2019].

www. reliefweb.int/report/democratic-republic-congo/attack-irc-supported-hospital-drc-leads-loss-life-irc-ebola[Accessed on 26th, June, 2019].

Xing, K. *et al.* (2015) 'Physical violence against general practitioners and nurses in Chinese township hospitals: A cross-sectional survey', *PLoS ONE*, 10(11), pp. 1–14. doi: 10.1371/journal.pone.0142954.

Xing, K. *et al.* (2016) 'Concern about workplace violence and its risk factors in chinese township hospitals: A cross-sectional study', *International Journal of Environmental Research and Public Health*, 13(8), pp. 1–200. doi: 10.3390/ijerph13080811.

APPENDIX I: PERMISSION OF USING STUDY TOOL USED IN PREVIOUS STUDY

Re: Request to use workplace violence questionnaire

Expéditeur : ILO Library (ask@ilo.libanswers.com)

À : mvalens2000@yahoo.fr

Date : mercredi 3 janvier 2018 à 14:30 UTC+2

ILO Library (Indira)

Jan 03 2018, 01:30pm

Dear Valence,

Thank you for contacting the ILO Library.

We'd like you to consult this search on workplace violence and the health sector. Most ILO documents are freely availbale online, please check the link "Online access" in the records.

These titles could be particularly useful in your research: Preventing and responding to violence at work and Framework guidelines for addressing workplace violence in the health sector : the training manual

We hope this information is helpful to you. Please do not hesitate to contact us again if you require further assistance.

Best regards,

Indira
ILO Library
library@ilo.org

Original Question

Jan 01, 2018

Request to use workplace violence questionnaire

Hello,
I am student at university of Rwanda in nursing master's program and working at University Teaching Hospital of Kigali, Rwanda.
I am very interested to conduct a Study on "WORKPLACE VIOLENCE IN THE HEALTH SECTOR COUNTRY CASE STUDIES RESEARCH INSTRUMENTS".
Could you give me a permission to use your questionnaire in order to conduct the study Called **"Workplace violence against physicians and nurses at University Teaching Hospital of Kigali" as** requested by my institution for liability and validity of a study.

Thank you very much

Regards

APPENDIX II: INSTRUMENT

International Labor Office **ILO** International Council of Nurses **ICN**

World Health Organization **WHO** Public Services International **PSI**

Joint Programme on WPV in the Health Sector

WPV IN THE HEALTH SECTOR

COUNTRY CASE STUDIES RESEARCH INSTRUMENTS

SURVEY QUESTIONNAIRE

ENGLISH

GENEVA 2003

INSTRUCTIONS:

-To fill this questionnaire you must have at least one year of experience at a selected University Teaching Hospital in Rwanda

-Please do not mention your name or any other address on this questionnaire

-Please complete the questionnaire by either ticking boxes ☐ writing in the spaces provided.

A. PERSONAL AND WORKPLACE DATA

PD 1 What is your age:

☐ 20-24 ☐ 25-29 ☐ 30-34 ☐ 35-39

☐ 40-44 ☐ 45-49 ☐ 50-54 ☐ 55-59 ☐ 60+

PD 2 Are you: ☐ female ☐ male

PD 3 What is your marital status: ☐ single ☐ married ☐ living with partner

☐ separated /divorced ☐ widow/widower

PD 4 How many years of work experience in the health sector do you presently have:

☐Under 1 year ☐ 1-5 ☐ 6-10 ☐ 11-15 ☐ 16-20 ☐ Over 20

PD 5 The patients/clients you most frequently work with are:

☐ Newborns ☐Children ☐Adults

PD 6 The sex of the patients you most frequently work with are:

☐ Female ☐Male ☐ Male and female

PD 7 Please indicates if you spend more than 50% of your time working with any of the following type of specialties:

☐ Physically disabled ☐ Mother/child care ☐ Terminally ill

☐ HIV/AIDS ☐Emergency care ☐ Chronic disease ☐other, please specify-------------------

PD 8 In which department or service do you spend **most** of your time (more than 50%) in your main job? ---

PD 9 The number of staff presents in the same work setting with you during **most** (more than 50%) of your work time is:

☐ None ☐ 1-5 ☐ 6-10 ☐ 11-15 ☐ over 15

B. PHYSICAL WORK PLACE VIOLENCE

Please note: Physical violence refers to the use of physical force experience another person or group that results in physical harm sexual or psychological harm. It can include beating, kicking, slapping, stabbing, shooting, pushing, biting, and/or pinching, among others.

PV 1 In the last 12 months, have you been physically attacked in your workplace?

☐ Yes, *please answer questions* ☐ No, if NO, Please go to question **C**

1.1. If yes, please think of the last time that you were physically attacked in your place of work. How would you describe this incident?

☐ Physical violence without a weapon ☐ Physical violence with a weapon

1.2. Were you injured as a result of the violent incident?

☐ Yes ☐ No;

C. PSYCHOLOGICAL WORK PLACE VIOLENCE (Emotional Abuse)

Please note: Psychological violence is defined as: Intentional use of power, including threat of physical force, experience another person or group, that can result in harm to physical, mental, spiritual, moral or social development. Psychological violence includes verbal abuse, bullying/mobbing, harassment, and threats.

C. I. VERBAL ABUSE

VA 1 In the last 12 months, have you been verbally abused in your workplace?

☐ Yes ☐ No

C. II. BULLYING / MOBBING

BULLYING / MOBBING repeated and over time offensive behavior through cruel or malicious attempts to humiliate or demoralize an individual or groups of employees.

BM 1 In the last 12 months, have you been bullied / mobbed in your workplace?

☐ Yes ☐ No

C. III. SEXUAL HARASSMENT

SEXUAL HARASSMENT: Any unwanted, unreciprocated and unwelcome behavior of a sexual nature that is offensive to the person involved, and causes that person to be threatened, humiliated or embarrassed.

SH 1 In the last 12 months, have you been sexually harassed in your workplace?

☐ Yes ☐ No

D. CONSEQUENCES OF VIOLENCE ***if you have experienced any type of violence answer this section***

D.1 What are the problems and complaints that you have in response to stressful life experiences like the event that you suffered *since you were attacked? Please tick all relevant boxes*

Repeated, disturbing memories, thoughts, or images of the attack? Yes☐ No ☐

Avoiding thinking about or talking about the attack or avoiding having feelings related to it?

Yes☐ No ☐

Being "super-alert" or watchful and on guard? Yes ☐ No ☐

Feeling like everything you did was an effort? Yes☐ No ☐

Reduction of work performance Yes ☐No ☐

Thinking leaving the job Yes ☐No ☐

Felt ashamed or guilty Yes ☐ No ☐

THANK YOU VERY MUCH

ILO, ICN, WHO and PSI would like to thank you for your contribution to our survey and campaign

APPENDIX III: TIMEFRAME

Timetable

TASKS TO BE PERFORMED	**Year 2018- 2019**													
	Feb	**Ma**	**Ap**	**May**	**Oct**	**No**	**Dec**	**Ja**	**Fe**	**Ma**	**Ap**	**May**	**Jun**	**Jul**
1. Research Proposal preparation and submission	xx xx	xxx x	xx xx	xx xx	xx xx									
2. Proposal presentation						x								
3. Ethical clearance and permission to do the work						xx								
4. Pre-testing and finalizing research instruments (questionnaires)										x				
5. Data Collection (Fieldwork)											xx			
6. Data coding, and entry into computer												x		
7. Data analysis												x		
8. Report Writing (First Draft)												xx		
9. Report Submission (To supervisors)												x		
10. Report Writing													x	

(Final draft)														
11. Submission of Final Project													x	
12. Oral presentation of the project													x	
13. Feedback to the Community/stakeholders														x

x: a week (3days dedicated to the research project)

APPENDIX IV: IRB ETHICAL CLEARANCE

COLLEGE OF MEDICINE AND HEALTH SCIENCES

CMHS INSTITUTIONAL REVIEW BOARD (IRB)

Kigali, 14/01/2019
Ref: CMHS/IRB/**011**/2019

MUSENGAMANA Valens
School of Nursing and Midwifery, CMHS, UR

Dear MUSENGAMANA Valens

RE: <u>ETHICAL CLEARANCE</u>

Reference is made to your application for ethical clearance for the study entitled ***"Exploration of Workplace Violence Experience among Nurses at Selected University Teaching Hospital in Rwanda"***

Having reviewed your protocol and found it satisfying the ethical requirements, your study is hereby granted ethical clearance. The ethical clearance is valid for one year starting from the date it is issued and shall be renewed on request. You will be required to submit the progress report and any major changes made in the proposal during the implementation stage. In addition, at the end, the IRB shall need to be given the final report of your study.

We wish you success in this important study.

Professor Jean Bosco GAHUTU
Chairperson Institutional Review Board,
College of Medicine and Health Sciences, UR

Cc:
- Principal College of Medicine and Health Sciences, UR
- University Director of Research and Postgraduate studies, UR

EMAIL: *researchcenter@ur.ac.rw* P.O. Box: 3286, Kigali, Rwanda WEBSITE: http://cmhs.ur.ac.rw/ www.ur.ac.rw

APPENDIX V: A SELECTED UNIVERSITY TEACHING HOSPITAL IN RWANDA REVIEW APPROVAL NOTICE

CENTRE HOSPITALIER UNIVERSITAIRE
UNIVERSITY TEACHING HOSPITAL

Ethics Committee / Comité d'éthique

February 08th , 2019 **Ref.: EC/CHUK/015/2019**

Review Approval Notice

Dear **Musengamana Valens,**

Your research project: ***"Exploration of workplace violence experience among nurses at CHUK"***

During the meeting of the Ethics Committee of University Teaching Hospital of Kigali (CHUK) that was held on 08th February, 2019 to evaluate your request for ethical approval of the above mentioned research project, we are pleased to inform you that the Ethics Committee/CHUK has approved your research project.

You are required to present the results of your study to CHUK Ethics Committee before publication.

PS: Please note that the present approval is valid for 12 months.

Yours sincerely,

Dr. Emmanuel Rusingiza
The Chairperson, Ethics Committee,
University Teaching Hospital of Kigali

<<University teaching hospital of Kigali Ethics committee operates according to standard operating procedures (Sops) which are updated on an annual basis and in compliance with GCP and Ethics guidelines and regulations>>

B.P. :655 Kigali- RWANDA www.chk.rw Tél. Fax : 00 (250) 576638 E-mail :chuk.hospital@chukigali.rw

APPENDIX VI: CONSENT INFORMED CONSENT FORM

Consent form to participate in project about "Exploration of WPV experience among nurses at a selected University Teaching Hospital in Rwanda".

Greetings! My name is **Valens MUSENGAMANA**. I am student nurse working on a dissertation with the objective of exploration WPV experience among nurses.

Purpose of the study

One hundred ninety five (195) nurses are enrolled to participate in this study to explore WPV experience among nurses.

What participation involves?

If you agree to join the study, you will be asked to answer questions. The questionnaire consists of section A Personal and workplace data**,** section B Physical WPV, C Psychological WPV (emotional abuse) and D Consequences of violence. Participation in the study involves completing a questionnaire, which will take approximately 5 minutes.

Confidentiality

The study will not include details that directly identifying you, such as your name. Only a participant identification number will be used in the survey. If, the results of the current study will be published or presented in scientific meeting, names or other information that might identify you will not be used**.**

Risks and Discomforts

There are no risks or discomforts expected from your participation in the study. However, you should experience any distress, please inform the researcher on the addresses provided.

Voluntary participation and right to withdraw

Participation in this study is voluntary; if you choose not to participate, your right to do this will be respected. You are free to withdraw consent in this study at any time without prejudice

Benefits

There are no direct benefits from your participation in the study. However, it is hoped that the findings will inform the hospital leaders about WPV experience among nurses-so that future strategies can be carried out to address the problem

Opportunity to ask questions

You have the right to ask any questions regarding the questionnaire or the study. If you have any question or would like further information about the study, please email me at mvalens2000@yahoo.fr or phone me at **+250788 486 880** or contact my supervisor Gilbert BANAMWANA at banagilberto@yahoo.fr or phone number **+250788 400 735** You may also contact the University in Rwanda, Chairperson of the IRB/CMHS at +25**0788 490 522** or the Deputy Chairperson at +25**0783 340 040**

DECLARATION OF CONSENT

Study title: **Exploration of WPV experience among nurses at a selected University Teaching Hospital in Rwanda.**

I ____ have read the Information Letter. I understand the requirement of me and I have had all my questions answered. I do not feel that I am forced to take part in this study and I am doing so on my own free will. I know that I can withdraw at any time if I so wish and that it will have no bad consequences for me.

______________________________ ____________________

Participant signature Date

__________________________________ _______________________

Researcher signature Date