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Violence against healthcare workers in Kenya:

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Abstract

Background Global concern exists for workplace violence against healthcare workers (HCWs), especially in low and middle-income nations. This violence includes physical, verbal, or sexual abuse and has a signi cant impact despite initiatives like Occupational Safety and Health Administration (OSHA) guidelines. We conducted a study in Kenya to address this issue.

Methods We did a cross-sectional survey that collected responses during June 6th to August 9th, 2022, focused on healthcare professionals in Kenya within the global ViSHWaS study. Violence against healthcare professionals in multiple Kenyan counties was analysed, The study reached participants through social media, emails, and other channels using a snowball sampling technique.

Results The survey included 1,458 HCWs, primarily females (66.5%), aged 36–45 (42.4%), and of African race, representing 40 counties, with the majority from Nairobi (28.9%) and working in government academic (35.5%) and private academic institutions (20.6%). Most had over 11 years of healthcare experience (64.4%), and registered nurses were the most common cadre (27.8%). Approximately half of enrolled participants (49.9%) reported experiencing violence, with verbal violence (80.6%) and emotional abuse (78.6%) being common. Online harassment was reported by only 3.5%, mainly on Facebook (63.2%), involving hate speech (92.1%). Patients or their relatives were the most common aggressors (44.7%), while supervisors accounted for 12.5%. The frequency of violence varied, and 80.2% noted an increase after the COVID-19 pandemic. Only 41.2% of incidents were reported. Most were familiar with safety guidelines (93.6%). Self-violence was associated with familiarity with guidelines, concern about violence, preparedness, and night shifts, while colleague violence was associated with age, gender, race, work experience, training, preparedness, and night shifts.

Conclusion Our Kenya-based cross-sectional sub-analysis highlights that a signi cant number of HCWs experienced violence, especially during the COVID-19 pandemic, which negatively a ected job satisfaction. Although most HCWs were familiar with OSHA guidelines, there were di culties in their practical implementation.

Keywords Violence against healthcare workers, Violence, Healthcare workers, Kenya, Physician abuse, Nurses abuse

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Background

over 105 countries, this subgroup analysis delves speci -
cally into data sourced from Kenya within the overarch-
ing global dataset [16]. e IRB approval was received

Table 1 Demographic characteristics of all 1186 participants

Demographics		N(%)
Gender (*n* = 1183)	Male	389 (32.9)
	Female	787 (66.5)
	Other/ Prefer not to disclose	7 (0.6)
Age(Years) (*n* = 1184)	18–25	45 (3.8)
	26–35	326 (27.5)
	36–45	502 (42.4)
	46–55	238 (20.1)
	56–65	68 (5.7)
	65+	5 (0.4)
Race (*n* = 1182)	African	1134 (95.9)
	Asian	35 (3.0)
	Other	13 (1.1)
Type of Institution (*n* = 1182)	Community Hospital	77 (6.5)
	Government Academic	417 (35.3)
	Government-Non-Academic	183 (15.5)
	Private Academic	243 (20.6)
	Private Non-Academic	149 (12.6)
	Military Hospital	15 (1.3)
	Mission/Non-Pro t Hospital	93 (7.9)
	Other	5 (0.4)
Years of Experience (*n* = 1183)	< 1	12 (1.0)
	1 to 2	54 (4.6)
	2 to 5	167 (14.1)
	6 to 10	188 (15.9)
	11 to 20	491 (41.5)
	21 to 30	205 (17.3)
	< 30	66 (5.6)
Work Position (*n* = 1103)	Administration	95 (8.0)
	Nurse Practitioner (ARNP)	11 (0.9)
	Attending Physician	218 (18.4)
	Auxiliary/Support Sta	46 (3.9)
	Dentist/Dental Surgeon	36 (3.0)
	EMT	20 (1.7)
	Fellow in Training	20 (1.7)
	Medical Student	97 (8.2)
	Occupational Therapist	37 (3.1)
	Pharmacist (PharmD)	52 (4.4)
	Physical Therapist	30 (2.5)
	Physician Assistant (PA)	45 (3.8)
	Registered Nurse (RN)	330 (27.8)
	Researcher	20 (1.7)
	Resident in Training/Junior Resident	31 (2.6)
	Respiratory Therapist	15 (1.3)
Primary Area of Work (*n* = 741)	Anaesthesiology	34 (4.0)
	Cardiology	46 (5.4)
	Critical Care Medicine	41 (4.8)
	Dermatology	6 (0.7)
	Emergency Medicine	113 (13.2)
	Emergency Medical Transport (Air or Ground)	6 (0.7)
	Endocrinology	32 (3.8)
	Family Medicine	24 (2.8)
	Gastroenterology	15 (1.8)
	Hematology/ Oncology	20 (2.3)

Table 2

professionals. The demographic profile of the participants revealed that the majority were in the young adult age group. In terms of experience, more than half of the participants had over 11 years of experience in the healthcare field. Registered nurses were the most common cadre, and emergency medicine was the most common primary area of work. Regarding violence characteristics, nearly half of the participants reported experiencing violence themselves at their workplaces, while a significant percentage reported violence against their colleagues. Verbal violence and emotional abuse were the most common forms of violence. Interestingly, a small percentage reported online, virtual, or cyber harassment, with Facebook being the most common platform.

The most common type of aggressor was the patient or a relative or family member. Verbal violence was most common, followed by emotional violence. More than half of the HCWs who encountered violence reported feeling less motivated or dissatisfied with their job as a result of these incidents.

Our studies revealed a high incidence of workplace violence among young adults (80%) in the healthcare field, with females experiencing a greater frequency of such incidents compared to their male counterparts. This

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Have YOU ever experienced violence of any form at your workplace	**No**	**594 (50.1)**
	Yes	592 (49.9)
Have any of your COLLEAGUES ever experienced violence of any form at their workplace ($n = 593$)	No	100 (16.9)
	Yes	493 (83.1)
Form of Violence ($n = 1085$)	Cultural Violence	153 (14.1)
	Emotional Abuse	853 (78.6)
	Physical Violence	293 (27.0)
	Sexual Violence	

against HCWs, revealing a rate of 22%. Among these cases, 36% comprised non-physical acts of violence, while 10% resulted in physical harm to the HCW [15]. Similar findings have been documented in prior studies, where non-physical violence, particularly in the form of verbal abuse, was consistently identified as the most common type of violence directed towards HCWs [17–21]. Our results indicate that almost 50% of the participants identified patients or their relative's caretakers as the individuals responsible for acts of aggression. Conversely, approximately 12.5% of the respondents experienced aggression from their supervisors, while about 7% reported mistreatment from their colleagues. Interestingly, other research studies have similarly identified patients and their family members as the primary sources of aggression, reinforcing our own findings [22–24].

According to data from the International Committee of the Red Cross, during the initial six months of

the COVID-19 pandemic, there were over 600 recorded incidents of violence directed towards HCWs [25]. In a comprehensive review of research concerning violence against HCWs, Chirico et al., identi ed a signi cant prevalence of such incidents amid the COVID-19 pandemic. ey concluded that HCWs faced an exceptionally elevated risk of experiencing such episodes during this unprecedented health crisis [26]. e pandemic-induced overcrowding and less hospitable hospital setting can lead to heightened stress levels for HCWs, patients, and their families. is, in turn, escalates the potential for increased incidents of violence against HCWs [25

which manifest as reduced productivity and focus, compromised work quality, increased reliance on defensive medical practices, and psychological effects such as excessive stress, depression, or Post-Traumatic Stress Disorder. These factors collectively impact the quality of patient care [28].

The connection between age and the risk of WPV against HCWs has shown varying results in different studies. Our study identified a trend where an increase in age (26–45) is linked to a heightened likelihood of experiencing physical and psychological violence among HCWs, after which the trend seemed to decline. A US-based study found that increased age is associated with higher odds of violence against HCWs [29]. On the contrary, the European Nurses' Early Exit (NEXT) study has reported that as age increases, the odds of encountering workplace attacks decrease [30]. In a separate study by Wu et al., they found no significant association between age and the risk of WPV among physicians [31].

In our research, we identified a notably heightened risk of violence among HCWs with more extensive work experience. This contradicts the findings of some other studies that suggest the opposite trend [32]. After assessing the association between healthcare facility type and workplace violence, our studies concluded that workplace violence related to healthcare was more common in government academic and non-academic institutions compared to private academic and non-academic institutions; this is similar to a study done by Shaikh et al., from Pakistan that reported a reduced likelihood of WPV in private healthcare settings [33].

The data also revealed that a significant proportion (93.6%) of participants were familiar with occupational safety and health (OSH) guidelines, and most reported the availability of violence reporting procedures. However, a considerable number (58.8) of violent incidents were not reported to the administration, hospital, or police, even though nonreporting has been seen in other studies (citations. This may be due to several reasons, including negative repercussions such as retaliation from violence perpetrators or reporting incidents that would be of no use, as noted by Al Anazi et al. [34], where 92% expressed this. Al-Turki et al., in their investigation conducted in family medicine centers within Riyadh city, identified that HCWs tended to underreport instances of violence due to their perception that reporting would yield no meaningful outcomes, and some were apprehensive about jeopardizing their employment [35]. Similarly, in two Saudi studies, participants regarded reporting as ineffectual or of little significance [36, 37]. In an Iranian study, HCWs who had experienced victimization believed that reporting held limited value, as they perceived no meaningful action would be taken [38]. Therefore, even though HCWs possess a good understanding of OSH guidelines and the necessary procedures, it is recommended that efforts be made to streamline and simplify these processes while ensuring that reporting does not expose HCWs to harm or adverse consequences.

A recent systematic review by Njaka et al. [39] focusing on the African continent highlighted that nurses are significantly affected by workplace violence, with verbal abuse being the predominant form, often perpetrated by patients and their relatives. The consequences of such violence encompass decreased productivity, diminished job satisfaction, physical injuries, and psychological distress. Consequently, urgent policy interventions are recommended to mitigate workplace violence, safeguard the well-being of healthcare professionals, and enhance job satisfaction across Africa. This paper is in line with our current findings, further emphasizing the critical need for addressing workplace violence in healthcare settings.

Yosep et al. [40] suggests that hospital management should implement policies related to workplace violence and bullying, provide counseling services for health workers, and form special teams to provide therapy and training to reduce the impact of workplace violence. Collaboration between nurses, psychologists, and other health workers is crucial in addressing workplace violence effectively. While various measures can potentially be implemented within healthcare systems, several initiatives could be introduced externally. For instance, the introduction of liaison figures between patients and healthcare workers could prove invaluable as pointed out by Volonnino et al. [41]. These figures would offer psychological and logistical support to individuals seeking care and their caregivers. Additionally, they could function as early indicators of situations where emotions such as anger and fear might escalate into violent episodes.