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Workplace Violence against Female Workers

Dr. Mohamed El-Helaly[1,2]
[1]Associate Prof. of Occupational Medicine & Environmental Health, Community Medicine Department, Faculty of Medicine, Mansoura University, Egypt
[2]Director EHOHS, King Abdulaziz Medical City, Riyadh, Saudi Arabia

***Corresponding Author:**
Dr. Mohamed El-Helaly
Email: mhelaly72@googlemail.com

Abstract: Women are concentrated in many of the high risk occupations, particularly as farmers, teachers, social workers, nurses and other health-care workers, as well as bank and shop workers. As women gain more opportunities for employment in occupations and positions, their exposure to violence is heightened. Internationally, workplace violence against female workers is recognized as a global serious concern. This article considers the analysis of the prevalence, sources, forms and female occupational groups at risk of Work Place Violence (WPV). Also, to study the impacts of workplace violence on the victim, the victim's family and the work. Moreover, this article discusses preventive and control measures and strategies to stop WPV against female workers.
Keywords: Workplace; violence; Female worker; Prevention, Control.

INTRODUCTION

Violence is a major obstacle to development. It is estimated that one in every five women faces some form of violence during her lifetime, in some cases leading to serious injury or death. Until recently, most governments have considered violence against women (VAW) to be a relatively minor social problem. Today, due in large part to the efforts of women's organizations and the evidence provided by research, including that of WHO, VAW is recognized as a global concern [1].

Women are concentrated in many of the high risk occupations, particularly as teachers, social workers, nurses and other health-care workers, as well as bank and shop workers [2]. As women gain more opportunities for employment in occupations and positions where they are traditionally underrepresented, their exposure to sexual harassment and abuse is heightened [3].

The objectives of this review are: a) to define violence against women violence and its types including workplace violence. b) to analyze the prevalence of violence against female workers both world-wide and at the national level. c) to describe the sources, perpetrators, forms and risk assessment of violence against female workers. d) to determine female occupational groups at risk of violence. e) to study the impacts of VAW on the victim, the victim's family and the work. f) to discuss preventive and control measures and strategies to stop violence against female workers.

DEFINITIONS AND TERMS

Violence against women (VAW) is defined in accordance with the United Nations Declaration on the Elimination of VAW of 1993 (A/RES/48/104); as any act of gender-based violence that results in, or is likely to result in, physical, sexual, or psychological harm or suffering to women, including threats of such acts, coercion, or arbitrary deprivation of liberty, whether occurring in public or private life [4].

Gender-based violence is an overall term for any harm that is perpetrated against a person's will and that results from power inequities that are based on gender roles. Globally, gender-based violence always has a greater negative impact on women and girls; thus, the term is often used interchangeably with VAW [5].

Intimate partner may or may not be cohabitating, and the relationship need not involve sexual activities. It includes current or former spouses (legal and common-law), and non-marital partners (boyfriend, girlfriend, same-sex partner, dating partner) [6].

Sexual violence is any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting. It includes rape, defined as the physically forced or

otherwise coerced penetration of the vulva or anus with a penis, other body part or object [7].

Harassment occurs when one or more workers or managers are repeatedly and deliberately abused, threatened and/or humiliated in circumstances relating to work [8].

Workplace Violence (WPV): According to the National Institute for Occupational Safety and Health (NIOSH) WPV is any physical assault, threatening behavior or verbal abuse occurring in the work setting. It includes, but is not limited to beatings, stabbing, suicides, shootings, rapes, near suicides, psychological traumas such as threats, obscene phone calls, an intimidating presence, and harassment of any nature such as being followed, sworn at or shouted at [9].

Moreover, ILO & WHO defined workplace violence as "Incidents where staff are abused, threatened or assaulted in circumstances related to their work, including commuting to and from work, involving an explicit or implicit challenge to their safety, well-being or health" [10].

SCOPE AND MAGNITUDE OF THE PROBLEM

Because of the sensitivity of the subject, violence is almost universally under-reported. Nevertheless, the prevalence of such violence suggests that globally, millions of women are experiencing violence or living with its consequences [11]. The WHO Multi-country study on women's health and domestic VAW [12] found that, among women aged 15 to 49 years: between 15% of women in Japan and 70% of women in Ethiopia and Peru reported physical and/or sexual violence by an intimate partner; between 0.3–11.5% of women reported experiencing sexual violence by a non-partner; the first sexual experience for many women was reported as forced – 24% in rural Peru, 28% in Tanzania, 30% in rural Bangladesh, and 40% in South Africa [12].

In Arab and Islamic countries, VAW is not yet considered a major concern despite its increasing frequency and serious consequences. Surveys in Egypt, Palestine and Tunisia show that at least one out of three women is beaten by her husband. The indifference to this type of violence stems from attitudes that domestic violence is a private matter and, usually, a justifiable response to misbehavior on the part of the wife. However, a fair reading of the Quran shows that wife abuse, like genital mutilation and "honour killings" are a result of culture rather than religion [13].

In Egypt, the international and Egyptian researchers have confirmed that violence against women is both varied and widespread in Egypt. According to the 2005 Egypt Demographic and Health Survey (EDHS), 47 % of ever-married women reported ever having experienced physical violence since the age of 15. Although the majority of those women identified an intimate partner (their current or previous husbands) as the perpetrator of at least one episode of violence, 45 % had been subjected to physical violence by a male perpetrator other than their husband, and 36 % identified a female perpetrator [14].

The prevalence of workplace violence against female workers appears infrequently in the literature [1], however, National Institute for Occupational Safety and Health (NIOSH) conducted a research which revealed that workplace violence is the leading cause of traumatic-injury death on the job for women [15]. Homicide is the leading cause of fatal occupational injuries for women and accounts for 39% of all fatal injuries for women at work [16]. The number of violent victimizations in the workplace has been estimated to be as high as 2 million per year among workers [17]. More than two-thirds of women in the workplace experienced at least one type of violence against women. These women hold positions at various workforce levels, indicating that victims of VAW are not limited to the lower employment rungs. [18].

SOURCES AND PERPETRATORS OF VIOLENCE AGAINST FEMALE WORKERS:

Because WPV is perpetrated by a person OSHA categorizes incidents based on the relationship between the assailant and the worker or workplace [1]:

a. Violence by Strangers: An individual that has no legitimate relationship with an employee or the employer, e.g., a robber of a convenient store.
b. Violence by Customers/Clients: In these incidents, the violence is committed by someone who receives a service provided by a business, such as a current or former customer, client or patient, a passenger, a criminal suspect or a prisoner.
c. Violence by Co-Workers: In co-worker incidents, the perpetrator has an employment relationship with the workplace. The perpetrator can be a current or former employee, a prospective employee, a current or former supervisor or a manager. Co-worker violence that occurs outside the workplace, but which resulted or arose from the employment relationship would be included in this category. This type of violence can again be divided into two types. Violence between supervisors and subordinates, and violence between workers at the same levels.
d. Violence by Personal Relations: In personal relations incidents, the violence is committed by someone who has a personal relationship with the worker, such as a current or former spouse or partner, a relative or a friend. Included in this category is the perpetrator who has a personal dispute with the worker and enters the workplace to harass, threaten, injure or kill.

FORMS OF VIOLENCE AGAINST FEMALE WORKERS

VAW takes many forms, from the overt to the subtle. WHO has adopted the following definitions of physical and sexual violence [19] to aid in research and programming, concentrating on identifiable acts:

a. Physical violence: means a woman has been: slapped, or had something thrown at her; pushed, shoved, or had her hair pulled; hit with a fist or something else that could hurt; choked or burnt; threatened with or had a weapon used against her.
b. Sexual violence: means a woman has been: physically forced to have sexual intercourse; had sexual intercourse because she was afraid of what her partner might do; or forced to do something sexual she found degrading or humiliating.
c. Emotional violence: does not yet have a widely accepted definition, but includes, for example, being humiliated or belittled; being scared or intimidated purposefully.
d. Intimate-partner violence (or domestic violence): means a woman has encountered any of the above types of violence, at the hands of an intimate partner or expartner; this is one of the most common and universal forms of violence experienced by women [19].

OCCUPATIONAL GOUPS AT RISK OF VIOLENCE AGAINST FEMALE WORKERS:

Violence against female workers in retail industry

A study analyzed female workplace homicides in Chicago revealed that most of the occupational homicides occurred in retail trade, predominately in eating and drinking establishments; robbery was a frequent occurrence, and the women often worked alone. Only three medical examiner reports cited a known assailant. The leading cause of occupational death in small retail establishments is WPV [20]. Retail employees are at risk for violence and two thirds of workplace homicides are robbery-related [21, 22]

Violence against female workers in health care facilities and social services:

Healthcare workers experience violence at work frequently, and considerably more often than in other sectors. Almost half of all non-fatal injuries from violent acts against US workers occur in the healthcare sector [23, 24]. The increasing rates of workplace violence have induced a public discussion about an ‘epidemic’ of violence against healthcare workers [25]. Healthcare presents many security challenges, particularly when it comes to workplace violence prevention. With a staff population that is approximately 80% female, 24-hour operations, numerous points of ingress and egress, and the high tension environment that exists in today's hospitals and urgent care centers, the stage is set for the "perfect storm" of workplace violence [24]. Although WPV occurs in all areas of the hospital [26], two settings have been identified as particularly prone to these events, namely emergency departments (ED) [10, 27] and mental health units [10, 28].

There is a consensus in the international literature that WPV directed at nurses is increasing and that nursing is one of the professions most ‘at risk’ [29]. Nurses, in a range of work environments, face the terrifying possibility of being victims of aggressive, harassment and violent incidents while caring for patients[30, 31]. In Egypt, a recent study that was carried out on 1600 nurse randomly selected from Ismailia city, revealed that 27.7% of participant nurses reported abuse including 69.5% verbal abuse; and 9.3% physical abuse [32]. A recent survey of Jordanian nurses revealed that 22.5% of the participants were exposed to physical WPV [33]. In another survey of Iraqi nurses, 49% of the participants reported that they have been physically attacked at work [34]. In surveyed Australian medical-surgical units about a third of nurses on perceive emotional abuse in recent shifts and a fifth report actual violence; perception of violence in the workplace is associated with unstable or negative working conditions and adverse patient outcomes [35].

The Perpetrator risk factors for patients and visitors associated with WPV against nurses include mental health disorders, drug or alcohol use, inability to deal with situational crises, possession of weapons, and being a victim of violence. Worker risk factors are gender, age, years of experience, hours worked, marital status, and previous WPV training [36]. Unmet needs of patients, overcrowding, and reaction to injury or illness were the leading contributing factors for violence [37]. Moreover, occupational violence and aggression have been reported against female more than male general practitioners (GPs) [38]. The non-reporting of violent acts is well documented in the literature [10, 30]. Concerning healthcare workers, other studies where nurses were shown not to report because they consider that being a recipient of a violent act is normal and accepted as part of the nature of their job [29, 35, 39].

Violence against female serving in military:

Violence towards military women has identifiable risk factors. Work and living environments where unwanted sexual behaviors occurred were associated with increased odds of rape. Officer leadership played an important role in the military environment and safety of women. Assailant alcohol and/or drug abuse at time of rape was notable[40, 41]. A survey of a representative sample of 3,001 policemen and 1,295 policewomen in the Dutch police force showed that policewomen were more often bothered by sexual harassment than men, but gender did not moderate the relation between sexual harassment and mental and physical health [42]. Also, Sexual

harassment significantly contributed to female veterans' post traumatic stress disorder (PTSD) symptoms [43, 44].

Violence against Female workers in educational facilities:

The available information on the prevalence and resulting health effects among female faculty and staff in academic settings is relatively limited [3]. According to a survey of United States (US) medical school faculty, female faculty are over 2.5 times more likely than male faculty to perceive discrimination on the basis of gender [45]. A recent survey of 387 female faculty and staff from colleges in Awassa, Ethiopia; revealed that workplace abuse and sexual harassment are highly prevalent among the participants [3].

Violence against female sex workers (FSWs):

FSWs are frequently marginalized from society due to sex work lacking social or moral approval. In addition to experiencing physical and sexual violence from their intimate partners, they can also experience violence from others in their personal and working lives, including clients, madams and the police [46].

A survey of FSW in Leeds, England, and Glasgow and Edinburgh, Scotland, revealed that 30% had been slapped, punched or kicked by a client while working, 13% had been beaten, 11% had been raped and 22% had experienced an attempted rape [47]. Another recent survey of mobile FSWs in India reported that 30.5% reported experiencing violence at least once in the past year; 11% reported experiencing physical violence, and 19.5% reported experiencing sexual violence [48]. Multiple studies demonstrate that up to 40% of women in prostitution started this work prior to age 18. In studies across India, Nepal, Thailand and Canada, young age at entry to sex work has been found to heighten vulnerability to physical and sexual violence victimization in the context of prostitution, and relates to a two to fourfold increase in HIV infection [49]. These figures show the extent to which women in sex work are vulnerable to violence as a result of the conditions of their work and their marginalized status.

Trafficking, forced prostitution and exploitation of labor:

During the past decade, a rapidly growing worldwide industry has developed in trafficking women and girls for forced labor and sexual exploitation. War, displacement, and economic and social inequities between and within countries, and the demand for low-wage labor and sex work drive this illicit trade in women. There are no reliable statistics on the number of women and children who are trafficked. Rough estimates suggest that 700 000 to 2 million women and girls are trafficked across international borders every year.[50] Women are often deceived into believing they have secured jobs as nannies, waitresses, or dancers, only to discover that they have been trafficked into bonded or forced prostitution and other forms of slavery-like situations, such as domestic servitude, sweatshop labor, and begging [11].

IMPACTS OF VIOLANCE AGAINST FEMAL WORKERS:

A) Impact on the victim:

Thus far, epidemiological studies on the health consequences of WPV are scarce and mainly focused on mental health outcomes [51]. Psychological reactions such as anger, sadness, frustration, irritability, fear, self-blame and depression are frequently experienced by assaulted workers [52]. Regarding physical symptoms, fatigue, sleep problems and headache are most often reported. Very few studies have examined whether musculoskeletal symptoms are also more prevalent among assaulted workers and which anatomical areas are most affected [25]. In a systematic review of the predominant non-somatic effects of patient assault on nurses, the predominant responses were anger, fear or anxiety, post-traumatic stress disorder symptoms, guilt, self-blame, and shame. These main effects occurred across most countries and nursing domains [52].

Women suffer violent deaths either directly – through homicide – or indirectly, through suicide, maternal causes and AIDS. Violence is also an important cause of morbidity from multiple mental, physical, sexual and reproductive health outcomes, and it is also linked with known risk factors for poor health, such as alcohol and drug use, smoking and unsafe sex. [53, 54] Increased health problems such as injury, chronic pain, gastrointestinal, and gynaecological signs including sexually-transmitted diseases, depression, and post-traumatic stress disorder are well documented by controlled research in abused women in various settings.[55] Violence during pregnancy has also been associated with an increased risk of miscarriage, premature delivery and low birth weight. [1, 56]

In Mexico City, for example, rape and intimate partner violence against women was estimated to be the third most important cause of morbidity and mortality, accounting for 5.6% of all disability-adjusted life years lost.[57] In Victoria, Australia, partner violence accounted for 7.9% of the overall disease burden among women of reproductive age and was a larger risk to health than factors such as raised blood pressure, tobacco use and increased body weight.[58]

B) Impact on the victim's family:

Violence against women has been shown to affect the welfare and education of children in the family.[59]

C) Impact on work:

NIOSH estimates the economic cost of WPV nationwide at around $121 billion a year. Nonfatal workplace assaults alone result in more than 876,000 lost workdays and $16 millions in lost wages. Researches also show that violence has huge economic costs, including the direct costs to health, legal, police and other services. In 2002, Health Canada estimated that the direct medical costs of all forms of violence against women were 1.1 billion Canadian dollars. In low-resource settings, relatively few women may seek help from formal services, but because of the high prevalence of violence, the overall costs are substantial. In Uganda, for example, the cost of domestic violence was estimated at 2.5 million United States dollars in 2007.[54] The broader social costs of violence against women are profound but difficult to quantify. VAW is likely to constrain poverty reduction efforts by reducing women's participation in productive employment. Violence also undermines efforts to improve women's access to education, with violence and the fear of violence contributing to lower school enrolment for girls. Domestic violence has also been shown to affect the welfare and education of children in the family.[59]

Depending on the nature and severity of the incident, subsequent costs might be incurred due to lost productivity and/or materials (e.g., plant closings), debriefing/counseling, contract/sales losses, cleaning and refurbishing of impacted areas, increase in insurance costs, lawsuits and settlements, increased retention and recruiting issues, and organizational change initiatives. In addition, there is a profound impact on the business operations from decreased productivity, delayed shipments, lost sales, management distraction, increased absenteeism, worker compensation and medical claims [2].

PREVENTION AND CONTROL:

According to Occupational Health and Safety Administration (OSHA) [15], the elements of an effective violence prevention program should include the following: a) management commitment b) employee involvement c) worksite analysis d) hazard prevention and control e) safety and health training f) recordkeeping and program evaluation.

A. Management commitment: This Includes the endorsement and visible involvement of top management, provides the motivation and resources to deal effectively with workplace violence.

B. Employee involvement: Employee involvement and feedback enable workers to develop and express their own commitment to safety and health and provide useful information to design, implement and evaluate the program.

C. Worksite analysis: A worksite analysis involves a step-by-step, commonsense look at the workplace to find existing or potential hazards for workplace violence. This entails reviewing specific procedures or operations that contribute to hazards and specific areas where hazards may develop.

D. Hazard prevention and control:
After hazards are identified through the systematic worksite analysis, the next step is to design measures through engineering or administrative and work practices to prevent or control these hazards. If violence does occur, post-incident response can be an important tool in preventing future incidents.

E. Safety and health training:
Training and education ensure that all staff are aware of potential security hazards and how to protect themselves and their coworkers through established policies and procedures.

CONCLUSION AND RECOMMENDATIONS:

Workplace violence against female workers is increasingly recognized as a serious problem with implications for both managers and staff. We recommend enhancing capacity for collecting data on violence against women at the workplace; promoting primary prevention responses; strengthen responses for victims of violence and integrating violence prevention into social and educational policies. Moreover, we recommend to define priorities for, and support research on the causes, consequences, costs and prevention of violence against female workers.

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