Study on Workplace Violence within the Health Sector in Rwanda: Final Report

July 2008

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Foreword

In 2002, a joint program of ILO, WHO, CII and SPI published a report about workplace violence[1] in Brazil, Bulgaria, Lebanon, Portugal, South Africa and Thailand, which documented the serious problem of physical and psychological violence in the workplace within the health sector. The prevalence rates ranged from 47% of providers who had been victims of violence in Brazil to 62% in South Africa. This shocking data suggests that workplace violence has become a global priority for every job category in developed countries, as well as in developing countries.

Workplace violence has an impact on health providers' health, productivity and dignity throughout the world. It has an impact on individual, organizational and social levels. It is associated with inequity, discrimination, stigmatization and conflict in the workplace. It also harms the efficiency and quality of health care services provided by health facilities, as well as the access to these services[2]. Recent studies have shown that the health sector is facing specific challenges. While workplace violence affects both men and women, some providers are more likely to suffer from violence than others.

A study on workplace violence within the health sector in Rwanda was conducted in 2007 in collaboration with the Capacity Project, led by IntraHealth International; in order to determine the type, impact, context, consequences and prevention strategies of workplace violence in Rwanda; to assist the Ministries of Health, Public service and Labor (MIFOTRA) as well as other stakeholders in developing a political, legal and programmatic response to improve providers' safety, satisfaction and retention. This study also explored the characteristics of gender-based violence, including gender-based discrimination and its relation to workplace violence. The most compelling results of the study in Rwanda were the following: Among all the types of violence we considered, verbal abuse (27%), psychological harassment (16%) and sexual harassment (7%) are the most frequent. It was estimated that the total prevalence rate in Rwanda was 39%. Even though it is not the highest documented rate so far, it remains shocking and unacceptable. Regarding gender-based discrimination, the study has shown a link between gender equity and violence (in other words, equity helps decreasing violence). The study has identified specific issues that women face in the workplace within the health sector: Sexual harassment on the way to work and in the workplace; possible maternity or family responsibilities based discrimination which is likely to result in unequal job opportunities. Therefore, we must enforce a zero-tolerance policy regarding gender-based discrimination.

As we are involved in the development of the health sector, we cannot ignore the causes and consequences of workplace violence, if we are to increase and retain the human resources necessary to meet the current critical needs in health services. We must be prepared to solve this crisis. Rwandan policy-makers and health managers can play a key role in the prevention and intervention process using the results from the "Study on workplace violence within the health sector in Rwanda". In order to improve workplace safety and the quality of health services, the Ministry of Health (MOH) will: conduct

[1] Di Martino, Vittorio. Workplace violence in the health sector. Joint Program on Workplace Violence in the Health Sector. Geneva, 2002.

[2] Joint Program on Workplace Violence. Framework Guidelines for Addressing Workplace Violence in the Health Sector. Geneva, 2002.

a thorough study on maternity-based discrimination; set up an MOH policy to respond to workplace violence within the health sector, which will address gender-based discrimination; and organize a specific program to respond to violence in health facilities. We hope that managers and policy makers in other sectors will use these methods and multi-sector partnerships, as explained in this report, in order to work together and find efficient and long-term solutions to prevent workplace violence.

July 2008

Dr. Jean Damascene Ntawukuriryayo
Rwandan Minister of Health

Mr. Pape A. Gaye
President and CEO, IntraHealth International

Acknowledgements

The following study has been made possible by the efforts of several people, to whom we would like to show our gratitude.

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We sincerely thank the members of the study's technical steering committee, who have been available in all key stages from the conception and revision of tools and methods to the validation of results used in this study.

We would like to congratulate the study's technical team at IntraHealth International for their crucial assistance in producing a high quality document. This team includes: Constance Newman, senior technical advisor; Jeanne d'Arc Kanakuze, gender coordinator; Alyssa Fine, research assistant; Dr. Gerard Ngendahimana, former assistant director of the Capacity Project/Rwanda; and Dr. Daniel de Vries, in charge of monitoring and evaluation.

We are also grateful to all the people who helped us collect and capture data for their significant contribution to this study, as well as the Kigali-based CIEDEP team, which managed the study and the National Statistics Institute, which adopted the methodology.

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Finally, we wish to thank everyone who contributed to this report. We hope its results will help better prevent and respond to workplace violence and discrimination in every sector.

Dr. Ousmane Faye, Capacity Project/Rwanda Director
July 2008

Acronyms and abbreviations

ILO	International Labor Organization
CIEDEP	Ingamba Center for Socio-demographic Studies and Population Development
GDD	Group Discussions
HF	Health Facility
HIDA	Human Capacity Development Agency
IEC	Information, Education, Communication
INS	National Statistics Institute
IRC	International Rescue Committee
MIFOTRA	Ministry of Public Service and Labor
MIGEPROF	Ministry of Gender and Family promotion
MINIJUST	Ministry of Justice
MINISANTE	Ministry of Health
SPS	Health Providers' Trade Union
WHO	World Health Organization
USAID	United States Agency for International Development

Summary

The Rwandan Ministry of Health (MINISANTE) is always looking for new ways to improve the health of patients and enhance the efficiency of health care services delivery. Through its partnership with USAID's Capacity Project, led by IntraHealth International, it is contributing to the improvement of providers' skills, human resources for health planning, family planning (FP) and PMTCT services delivery. In order to successfully perform the activities mentioned above, numerous obstacles have to be overcome. The most threatening one among them is workplace violence.

The MINISANTE initiated a study on workplace violence within the health sector in Rwanda, with a particular focus on gender issues, in order to improve efficiency, morale and protection among health care providers. Although men and women are both at risk, the documented study conducted by WHO/ILO/CII in 2004 throughout the world revealed that women experience workplace violence more often than men. ILO recently determined that discrimination and violence are linked and that discrimination is one of the causes of workplace violence. Therefore, this study on workplace violence focused on the relation between violence and discrimination.

The study conducted in Rwanda was aimed at identifying the different types of workplace violence within the health sector, the perpetrators, the victims, the consequences, the gender dimensions involved and the strategies to prevent violence.

Considering the harmful effects of workplace violence for the victims, the institutions and society as a whole, the MINISANTEtried to determine the nature, the extent, the context and the consequences of workplace violence within the health sector in Rwanda. It aimed at exploring the gender dimensions related to violence, in order to help relevant institutions develop policies, programs and/or a legal and social environment, which could possibly improve safety, satisfaction and protection among health workers.

This study relies on the analysis of collected data and examines several types of violence identified by ILO/WHO/ICN/PSI joint program and formative research conducted in Rwanda regarding workplace violence within the health sector. Researchers worked in partnership with the Rwandan MINISANTE and a steering committee, whose members belonged to focal institutions such as MIFOTRA, MIGEPROF, HIDA, SPS, Pro-Femmes, with the support of the National Institute of Statistics in Rwanda, as well as other stakeholders, in order to institutionalize approaches for the identification and management of violence in the workplace and in society as a whole. This steering committee kept a keen eye on the project's guidelines and monitored its activities from beginning to end.

The types of violence included in the following study are: physical violence, verbal abuse, psychological harassment, sexual harassment (including two worldwide-recognized categories aka "hostile environment" and "quid pro quo") and sexual assault.

The types of gender-based discrimination we studied were related to pregnancy, marital status, family responsibilities, job and employment segregation and sexual harassment.

A total of seven tools have been used to collect data during the study on workplace violence within the health sector. 297 health care providers were interviewed in 45 health facilities. In order to be more

representative, sites were randomly chosen in the different provinces and the city of Kigali. Within each district, three health facilities were chosen randomly. Seven sample categories were determined as follows: districts, health facilities, providers, directors/managers of health facilities, key informants coming from MINISANTE, MIFOTRA, MIGEPROF, MINIJUST, HIDA, Pro-Femmes Twese Hamwe, members of the providers' trade union along with MIFOTRA's labor inspectors and a sample of patients.

The on-field data collection process started immediately after the interviewers completed their training and passed a pre-test. It started on 06/11/2007 and finished on 07/09/2007 and lasted 26 business days. Three teams of seven people, including a team leader, were set up, in order to conduct the study.

The results show that workplace violence within the health sector is real. Almost four out of ten providers (39.4%) suffered from it (physical violence, verbal abuse, psychological harassment, sexual harassment and sexual assault) over the past twelve months prior to the study. The incidents mostly occurred in the workplace.

Verbal abuse is the most common form of workplace violence. It has been experienced by over one fourth of providers (27%), followed by psychological harassment (16%), sexual harassment (7%), physical violence (4%) and sexual assault (3%). The prevalence of each form of violence, when taken separately, does not vary much depending on the sector of the facility. However, the prevalence of certain types of violence, like physical violence and sexual harassment, slightly varies depending on the location of the facility.

See **Figure 1** for the characteristics of victims and perpetrators, contributing factors and consequences of workplace violence.

The study shows that women encounter more problems at work than men. This can be explained by the combination of all the elements contributing to discrimination that are related to women's position in society and family responsibilities.

Female providers do not have equitable access to positions of responsibility; the quantitative study showed that men are overrepresented in these positions. Women must also face negative stereotypes, obstacles in their career management, such as blackmail for employment, promotion or even a raise, and possibly job segregation. According to the different groups we interviewed, women seem more exposed to violence than men. While the quantitative study showed that men and women were both exposed to workplace violence, we noticed that sexual harassment was twice as prevalent for women.

Regarding the consequences of workplace violence, we learned that victims of psychological harassment missed work for a longer period of time than victims of other categories (4 days on average). They are followed by victims of verbal abuse (3.4 days), physical violence (3 days) and sexual harassment (2.8 days). Generally, 55% of health care providers, who experienced workplace violence, quit or thought of quitting their job after the incidents.

Moreover, violence affects providers' performance at work; almost 29% of those who experienced violence said it had a negative impact on their work.

Workplace violence has the greatest impact on psychological health. Two out of three providers said they had psychological problems after the incidents.

The health institutions' response to violence has, so far, been insufficient; only 30% of victims said their directors took action after they experienced violence.

Policies for the prevention of violence seem to be lacking in health facilities. Among the providers we interviewed, less than 12% said their directors implemented specific policies preventing workplace violence. These measures are more often available in private clinics than in public or religious health facilities. In addition, these policies are not always adequate. Only private health structures have implemented appropriate policies, in order to respond to workplace violence.

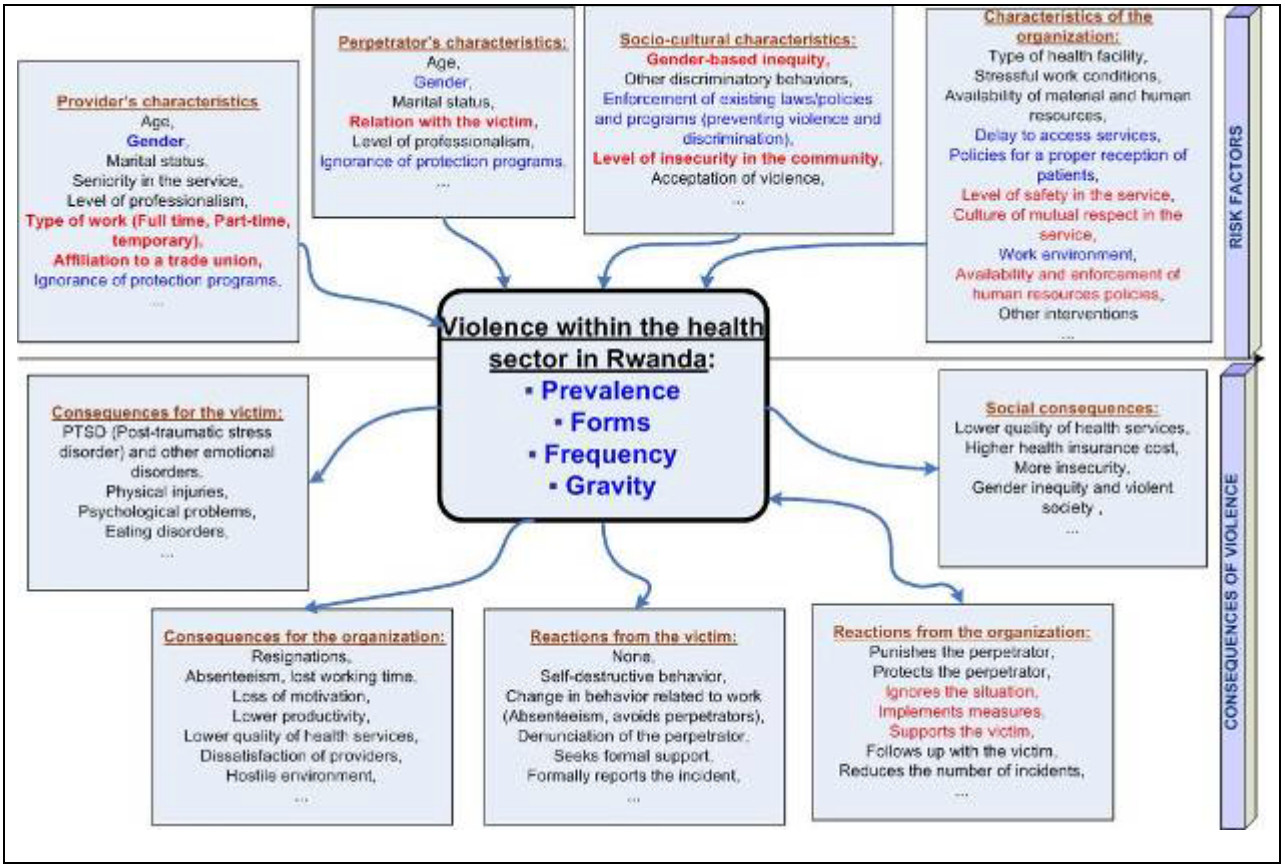
The results from the qualitative analysis reveal that there is no actual policy or program preventing workplace violence; however, there is a general policy that has been implemented by the government. Many measures are kept in writing but are never enforced. Therefore, the development of appropriate laws would help prevent workplace violence. "If the government doesn't do anything about it, nothing will ever change," some participants said during the study.

This report presents three types of recommendations:

- General measures and legal and judicial framework
- Organizational measures (including environmental and administrative measures)
- Measures aimed at changing the providers' behaviors.

Figure 1: Conceptual framework to understand the risk factors and the possible impacts of workplace violence within the health sector adapted from Ellsberg and Heise, (Capacity Project, 2005).

Arrows pointing outside = Consequences
Arrows pointing inside = Contributing factors
Arrows pointing both ways = Presumed interaction
Red = Significant risk factors (quantitative study)
Blue = Significant factors (qualitative study)



I. General introduction and main issues

I.1. Context and justification

The Ministry of Health, in collaboration with USAID's Capacity Project, led by IntraHealth, is always looking for new ways to improve the health of patients and increase the efficiency of health services, by strengthening providers' skills, planning human resources for health, improving family planning (FP) and PMTCT services. In order to meet these objectives, we must overcome numerous challenges, including workplace violence.

The MINISANTE initiated a study on workplace violence within the health sector in Rwanda, focusing on gender issues, in order to improve efficiency, morale and protection among health care workers. Although men and women are both at risk, documented studies conducted in 2004 by WHO/ILO/CII[3] have shown that throughout the world women are more likely to suffer from violence than men. ILO recently determined that there is a link between discrimination and violence and that discrimination is a cause of workplace violence. A study on workplace violence should; therefore, explore the correlation between violence and discrimination.

In existing studies[4], on average, half of interviewed nurses have experienced workplace violence. Psychological violence is more prevalent than physical violence and, in this context, verbal abuse is the most common type of psychological violence (rate ranging from 39.5% to 73%). Psychological harassment is a main source of psychological stress (rate ranging from 10% to 30.9%), while the prevalence of racial harassment is relatively low (ranging from 0.7% to 0.8%), with only one exception, in South Africa where the rate is 22.5%. Finally, the prevalence of sexual harassment (0.8% to 4.6%) is relatively low in comparison with verbal abuse, racial harassment and psychological harassment. However, there are specific problems related to the availability of measures and differences in perceptions regarding the definition of sexual harassment.

[3] WHO,ILO,CII. Joint Program Report on Violence in the Health Sector, 2003

[4] Di Martino, Vittorio. Workplace violence in the health sector. Joint Program on Workplace Violence in the Health Sector. Geneva, 2002.

Thailand	Brazil	South Africa
54% **of providers were victims of violence in the past year**	**47%** **of providers were victims of violence in the past year**	**62%** **of providers were victims of violence in the past year**
USA	**Rwanda**	**Mozambique**
71% **of nurses were victims of verbal or emotional abuse**	**39%** **of providers were victims of violence between 2006 and 2007**	**73%** **of providers were victims of violence in the past year**

Even though existing studies show that a great number of interviewed health workers have experienced workplace violence, the reporting rate does not exceed 20%. For instance, in South Africa, approximately 2.3%of participants who experienced any type of workplace violence claimed they told someone about the incident (Steinman, 2003), while 49.5% of these providers declared they experienced verbal violence last year. 20.4% experienced psychological harassment. 3.3% have been victims of physical violence and 5% have suffered from sexual harassment. In brief, results regarding reports of workplace violence tend to show that most incidents are kept a secret. A low reporting rate can be explained by the following reasons: problems with the complaint procedure; lack of confidence in that procedure; lack of awareness regarding workplace violence in the health sector; modesty and shame; fear of retaliation or bullying; solution found between the parties.

The following study was aimed at identifying the different types of workplace violence in the health sector, the perpetrators, the victims, the consequences, gender dimensions involved and the strategies we can implement to prevent it. Even though a study on violence against women in Rwanda (IRC/MIGEPROF, 2004) has recently been conducted, it did not take the health sector into account. Also, it did not consider the different types of violence. The study conducted by IRC/MIGEPROF described a type of violence which is experienced by 33% of interviewed Rwandan women, known as "community violence" and somewhat similar to sexual harassment. It is described as a form of sexual violence perpetrated by individuals, other than partners, and is characterized by an "obscene language."

Considering harmful effects of workplace violence on victims, on the institution and on society as a whole, the MINISANTE aimed at establishing the type, the impact, the context and the consequences of workplace violence within the health sector in Rwanda, exploring gender dimensions related to violence and helping relevant institutions implement policies and programs, as well as defining a social and legal environment which could improve safety, satisfaction and protection among health care workers.

This initiative also meets the needs of the MINISANTE for gender and family promotion. The MIGEPROF recently noted that sexual harassment was a serious issue for girls at school and that, "as no research has been conducted in that area, it could result in more discrimination and oppression for women in the workplace" (MIGEPROF, National Policy for Gender, January 2004).

The following study is based on the analysis of collected data and examines different types of violence, as they were identified by the ILO/WHO/ICN/PSI Joint Program and formative research on workplace violence within the health sector in Rwanda. Researchers worked in partnerships, not only with the MINISANTE, but also with a steering committee, whose members came from focal institutions, such as MIFOTRA, MIGEPROF, HIDA, SPS, Pro-Femmes and other stakeholders, in order to institutionalize approaches for the identification and management of risks of violence in the workplace and society in general.

I.2. General objective for the study

Establish the type, the impact, the context, the consequences, the gender dimensions and the prevention strategies of workplace violence within the health sector in Rwanda.

I.3. Specific objectives for the study

- Evaluate the prevalence of different types of violence and sexual harassment in the workplace, the characteristics of victims, perpetrators and institutions which are affected by violence;
- Explore factors leading to violence and sexual harassment in the workplace (physical, institutional, cultural or gender-based factors) within the health sector and in society in general;
- Analyze victims' reactions to violence and the consequences of workplace violence;
- Identify the mechanisms for management and prevention of workplace violence within the health sector, on the institutional level and in national legislation and determine if the implementation, the improvement or the extension of these mechanisms is feasible;
- Identify obstacles to the implementation of strategies aimed at reducing workplace violence;
- Propose strategies aimed at responding to workplace violence within the health sector.

II. Methodology

II.1. Research processes and techniques

11.1.1. Organization of the study

A structure responsible for the development and the implementation of the survey has been set up. It includes a steering committee and a research team.

The steering committee included the MINISANTE, MIFOTRA/HIDA, MIGEPROF, Pro-Femmes, the providers' trade union (SPS) and MINIJUST, with the support of the National Statistics Institute of Rwanda. This steering committee established the guidelines for the plan and monitored the various activities related to the project throughout the process.

The research team included IntraHealth's staff working on the Capacity Project in Kigali and at the headquarters, the CIEDEP and an international consultant. The team was in charge of developing methods and conducting the study.

The Capacity Project also contributed to the study materially and financially.

11.1.2. Research methodology

Definitions and concepts

In order to better evaluate the prevalence and impact of different types of workplace violence within the health sector, the collected data has been analyzed under two aspects, the quantitative aspect and the qualitative aspect. The tools used for data collection were developed according to these two aspects. They enabled us to describe five types of psychological and physical violence occurring at different frequencies and to better study the gender dimensions.

Types of violence

Workplace violence is defined as, negative behavior or action between two people (or more), which is characterized by unexpected and sometimes repeated aggressiveness. It includes incidents, in which employees are abused, threatened, attacked or in which they are subject to other kinds of offensive behaviors or actions in circumstances related to their work (including on the way to and from the workplace).

Physical violence: Based on existing definitions, we defined physical violence as a way to use force to make someone suffer either physically or psychologically. It includes: hitting, biting, throwing objects at someone, strangling, pushing someone around, shoving, punching, kicking, dragging someone on the floor, pushing someone against the wall, beating someone with a stick, threaten an individual with a gun, a knife or any kind of weapon.

Verbal abuse: Based on existing definitions, we defined verbal abuse as follows: verbal behavior aimed at degrading or humiliating someone, as well as showing a lack of respect to someone's worth and dignity.

This type of violence consists in humiliating someone in front of the patients or his/her coworkers. This humiliation is usually based on insults and sarcasms, which are intentionally addressed to someone for various reasons (different opinion, jealousy, etc.)

Psychological harassment: Based on existing definitions, we defined psychological harassment as follows: psychological violence used in order to ridicule someone, to scare someone, to isolate him/her and to make him/her miserable in his job. Psychological harassment also includes verbal abuse, malicious allegations, blackmail aimed at making someone lose his/her job or face disciplinary actions, isolation and denigration of his/her work. It may include giving someone an offending nickname, chores, canceling benefits such as days off, wrongfully punishing someone, and slandering someone's reputation directly or indirectly.

- Psychological harassment differs from verbal abuse and physical violence as it is a *repetitive* behavior, which does not end and which is followed by other malicious acts.
- Psychological harassment may be perpetrated by an individual or a group of people. In which case it is defined as "mobbing".

Sexual harassment: Based on existing definitions, we defined sexual harassment as follows: type of violence consisting in comments addressed to an individual, as well as gestures and/or actions related to sex without the person's consent. These actions may be detrimental to the person's human dignity.

Sexual harassment may include non-verbal physical acts. This type of violence could be seen as an attempt to establish or force sexual relations, to threaten someone into having sex (sexual blackmail), and to offer money, gifts or privileges in exchange of sexual favors. Sexist innuendos denigrating a person's work, skills or a person's dignity are also considered sexual harassment.

Examples:

- ⇨ Pornography in the workplace
- ⇨ Force someone into having a conversation about sex
- ⇨ Force a person into following conversations related to sex
- ⇨ Look at a someone in a lascivious way
- ⇨ Invite someone to meetings in order to have sex without his/her consent

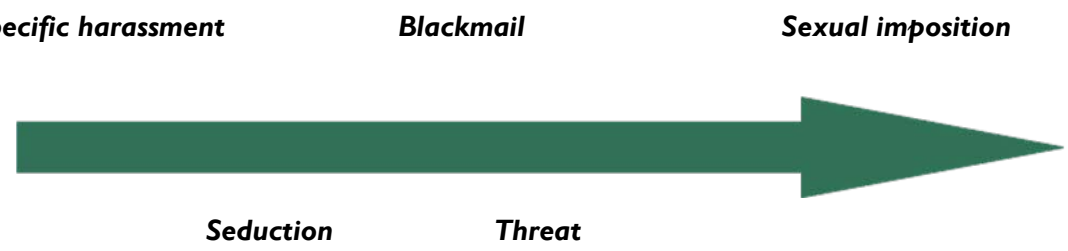
Two types of sexual harassment are usually recognized worldwide include "hostile environment" and "quid pro quo":

- Hostile environment harassment: Behaviors leading to an intimidating, hostile and humiliating work environment for the victim.
- Quid pro quo harassment: Decisions based on an individual's rejection of or submission to sexual favors, which may adversely affect the conditions of work for the victim.

It is widely recognized that sexual harassment is an unacceptable work condition as well as an obstacle to equal opportunities and equal treatment between men and women. Sexual harassment in the workplace is:

- Both a type of violence and a type of gender-based discrimination
- A violation of human rights and workers' rights
- A professional risk on safety and health levels

Sexual assault: We also studied sexual assault, which is an extreme type of physical violence related to sexual harassment and which is aimed at having sex. The perception of sexual harassment and assault can be studied on the sexual imposition scale. It ranges from harassment, to seduction, blackmail, threats and forced imposition[5].



Sexual assault is defined as any way used to have sexual relations without mutual consent between the two parties. It may consist of intimidating someone in order to have sexual relations, as well as caressing or kissing someone without his/her consent and forcing sexual relations (rape).

Gender-based discrimination

Gender dimensions were addressed in the study with the concept of "gender-based discrimination" defined by the CEDAW (Article 1) as, "… any form of distinction, exclusion or restriction made on a gender basis and resulting in or aiming at preventing women from fully enjoying their human rights and essential liberties in political, economic, social, cultural, civil or other areas, independently from their marital status."

Gender-based discrimination refers to distinctions in biological characteristics and functions, which differentiate men and women. These distinctions are learned, they change with time and they vary within and between cultures. Gender-based discrimination includes all forms of discrimination whether:

- It appears in the law, at the political level, in regulations or in practice
- It is direct or indirect[6].

[5] Orange County Rape Crisis Center Trainers Manual, Chapel Hill, North Carolina, 2000.

[6] According to ILO, indirect discrimination occurs with an apparently neutral law or practice, but has a disproportionate impact on a particular group and does not have an objective justification related to work. Forms and consequences of this discrimination are often hard to define.

More precisely, it is related to pregnancy, marital status, family responsibilities and professional segregation (for employment or assigned responsibilities) and sexual harassment. It results in inequities in pay, benefits, and job or promotion opportunities.

Professional segregation prevents women from accessing jobs other than the ones they are traditionally given and which do not pay as much. Typically, women are confined to a series of insignificant, lower paid ("horizontal") jobs and often hold caring and nurturing occupations, such as nurses, social workers, teachers; and remain at a lower rank ("vertical") in non-managerial positions. On the contrary, men typically get technical and managerial jobs or occupations for which they use physical skills: scientists, physicians, managers, police officer, fire fighters, coal miners.

Professional segregation still exists because of stereotypes and prejudices regarding the roles of men and women. The prejudices are deep-rooted in policies, laws, curricula and culture. Causes for professional segregation may vary. They usually reflect unequal opportunities and they may involve direct or indirect discrimination.[7]

Data collecting tools

A total of seven data collecting tools have been used for the study on workplace violence within the health sector.

11.1.3. Questionnaire about health care providers (Tool #1)

The goal of this questionnaire is to:

- Assess the prevalence, the frequency, the context, the location and the identification of workplace violence perpetrators within the health sector in Rwanda
- Determine to what extent health care providers, perpetrators of violence, as well as organizational aspects contribute to violence in this setting
- Identify the main consequences of workplace violence on the health and organizational levels
- Identify gender dimensions in a work setting
- Check if health care providers know and enforce policies and programs to respond to violence, which have been implemented and if they benefit from them
- Gather suggestions to improve the situation.

11.1.4. Structured interview guide with health care providers (Tool #2)

The questions included in this tool have only been asked to the participants, who, during the first interview (Tool#1) said they witnessed or experienced violence.

The goal of the structured interview is to:

[7] These definitions are based on the ILO international standards for gender-equitable work opportunities, including paragraphs C.100 Pay, C. 111 Discrimination, C. 156 Family responsibilities, and C. 183 Maternity protection.

- Determine the circumstances, the causes and the consequences of workplace violence within the health sector, including gender dynamics on this situation.
- Have a better understanding of the providers' experiences with workplace violence. Understanding their experience will help us better interpret the quantitative data gathered with other tools.

11.1.5. Discussion group with patients (Tool #3)

Discussion groups with a sample of patients were organized in four health centers, one of each type.

The tool was aimed at defining clients' perception on safety within the health facility. We also had the opportunity to find out if there was a culture of mutual respect between patients and health providers and among health workers.

11.1.6. Interview with health facilities managers (Tool #4)

This interview helped us understand the experience and the perception of health facilities managers regarding workplace violence in the health sector. It also helped us identify potential factors for a cause-effect relation, as well as the organizational consequences associated with workplace violence within the health sector. Finally, it aims at better defining relevant policies and programs, as well as obstacles to their implementation.

11.1.7. Inventory of risk factors at the health facility level (Tool #5)

The purpose of this tool was to gather basic data on health centers, focusing on the noticeable aspects, the environment and the work habits, which may help prevent workplace violence in Rwanda.

11.1.8. Interview with representatives from the providers' trade union and the labor inspectors (Tool #6)

This tool helped us:

- Understand the type of violence, as it is perceived by the people involved in the supervision or advocacy of the best work conditions.
- Describe the existing policies and programs, the efforts made in advocacy policies, as well as the organizational interventions at the community and national levels and the obstacles to their implementation.

11.1.9. Interview with key informants (Tool #7)

This tool gave us a better understanding of the Rwandan official approach, its experience and its perception of workplace violence within the health sector. It describes the principles of Rwanda's policy and strategy to respond to workplace violence, as well as their implementation.

The key informants we interviewed belong to the MIFOTRA, MINISANTE, MINIJUST, MIGEPROF, HIDA and Pro-Femmes Twese Hamwe.

Table 1: Tools given to participants by category, gender and location

Category	Gender			Location		
	Men	Women	Total	Urban areas	Rural areas	Total
Questionnaires for providers	92	205	297	158	139	297
Interview with health facilities' managers	14	9	23	6	17	23
Interviews with key informants	14	15	29	29	-	29
Interviews with representatives from the providers' trade union and inspectors from the MIFOTRA	8	1	9	7	2	9
Group discussions with the patients	52	59	111	56	55	11
Total	**180**	**289**	**469**	**256**	**213**	**469**
Inventory of risk factors at the health facility level	-	-	44	31	13	44

II.2. Sites chosen for the study

To be more representative, the sites were chosen randomly in all provinces and in the city of Kigali. Fifteen districts were selected this way on the basis of three per province, including the city of Kigali. Within each district, three health facilities were selected randomly. The names of the districts and of the selected health facility are shown in Annex A.

II.3. Sampling strategies and selection of participants

A representative sample of administrative districts and a sample of health facilities were selected before the study.

The participants, e.g. relevant individuals, were selected randomly among health care providers, patients that were met during our visits in health facilities, key informants from ministries and institutions which

were directly concerned by violence, members of the providers' trade unions and the representatives from the MIFOTRA's labor inspectors.

Therefore, we created seven sample categories in the following order:

II.3.1. Districts sample

15 out of the 30 administrative districts on the national level were selected from an official list of districts, which was elaborated as part of the country's geographic distribution process. This sample, which was obtained through a poll, provides a good representation of the national, provincial and districts levels.

II.3.2. Health facilities sample

This sample was selected randomly to provide a representation of health facilities at the national, provincial and administrative districts levels.

These facilities include a referral hospital, district hospitals, health centers, clinics, public health units or health posts, which are managed either by the government (public) or by non-governmental organizations authorized by the government (accredited facilities) or even by the private sector.

All selected facilities were visited. Only one facility, whose staff was unavailable, was substituted by another one, which was chosen randomly and had the same characteristics as the one we selected at first.

II.3.3. Providers sample

The health care provider sample was created by selecting providers among the ones who were in the facility on the day we conducted the study and who worked in the services targeted by the study. We targeted ten providers for each selected facility but few facilities met this criterion. Moreover, the number of interviewed participants that we selected in each service was proportional to the actual size of the service. Therefore, our study targeted four nurses, two representatives from social services, one physician, one health auxiliary, one midwife and one laboratory technician. Finally, in order to take the gender aspect into consideration, the investigators selected, wherever it was possible, six women for four men.

II.3.4. Health facilities' directors sample

Among the 45 health facilities' directors, 20 were chosen randomly to be interviewed. When the director was not available, we interviewed his/her assistant.

II.3.5. Key informants sample

In order to gather information about policies, laws and programs related to violence, key informants, in other words the people involved in the decision-making process in centralized and decentralized institutions, were interviewed. We originally planned five interviews in each of the targeted institutions. However, in some ministries, this criterion could not be met as certain targeted cadres were on a mission at the time of our visit. The targeted institutions were: MINISANTE, MIFOTRA, MIGEPROF, MINIJUST, HIDA, and Pro-Femmes Twese Hamwe.

II.3.6. Members of the providers' trade union and the MIFOTRA's labor inspectors sample

Five members of the providers' trade union (SPS) and five representatives from the MIFOTRA's labor inspectors were selected in the sampled districts, in order to be interviewed.

II.3.7. Patients sample

Group discussions were organized for the patients in each type of selected health facilities.

They were organized in four health facilities, which were especially prepared for this kind of study. Three group discussions took place as follows: One for men, one for women and a mixed one in each of the four types of facilities, which makes a total of 12 group discussions. Moreover, each group discussion gathered at least eight people and ten at the most. For this activity, random sampling was not necessary.

II.4. Pre-test for data collecting instruments

At the end of the investigators' training seminar, a two-day pre-test took place in the districts' health facilities of Gasabo, Kamonyi and Nyarugenge. Each investigator had the opportunity to examine the different tools, which were made available. They also had the opportunity to find possible mistakes in the tools that were provided. During the plenary session, which ended this activity, the participants gave their opinions on the tools and their content, the duration of the interviews and the group discussions, the logistical organization and the ethical aspect of the interview.

II.5. Ethics and safety consideration

The psychological well-being and the safety of interviewees and interviewers

The investigation and the structured interviews took place according to the existing relevant recommendations regarding ethics and safety, in order to preserve the psychological well-being and the safety of the interviewees and the interviewers. Even though, as of today, there are no common agreed-upon standards in that respect regarding studies about workplace violence, we adapted the recommendations for domestic violence, whenever possible[8], with a particular focus on the ones published by the World Health Organization: "Women first: Ethics and Safety recommendations regarding the research on violence against women." It is important to mention here the main conclusions drawn from this publication by WHO, which are related to workplace violence:

More than 50 community studies that dealt with domestic violence have been conducted in Asia, Africa, the Middle-East, Latin America, Europe and Northern America and they showed that the study we conducted could adhere to ethics and safety considerations.

If such studies remain unprejudiced and ensure a reasonable level of confidentiality, several women will accept to share their experience on violence.

[8] WHO. Women First: Ethics and safety recommendations regarding research on domestic violence,2001, pp. 8-11. "These recommendations have not been developed for other types of violence… even though it is likely that certain aspects of the guidelines are applicable… There could also be significant differences" (p.8). Furthermore, the joint program from WHO, ILO and CII regarding the research protocol on workplace violence in the health sector did not include ethics and safety standards.

Evidence suggests that women benefit from their participation in the research process[9] about violence.

These WHO recommendations apply to interviews conducted either with men or women or for every type of violence documented in this study: physical violence, verbal abuse, psychological harassment, sexual harassment and sexual assault. These recommendations were taken into account for the selection and training process of the interviewers and the data analysts, as well as in the supervision and implementation of the research.

Instructions given to interviewers

During the research and the structured interviews, interviewees were asked to talk about their experience with violence. Instructions given to interviewers highlighted the fact that "some questions require information on sensitive subjects, such as sexual harassment or rape. Remembering such experiences can be stressful, irritating, painful, embarrassing or even impossible for certain interviewees. This means interviewees may not answer some questions or have difficulties detailing these specific incidents. This can also mean that, during the interview, contradictions may appear in the given answers, depending on how comfortable the interviewee feels with his/her interviewer.

Every answer must be taken into account and recorded without any kind of prejudice, while allowing enough time for the participant to concentrate before answering and understanding his/her unwillingness to answer certain questions or his/her desire to end the interview at any time… At the end of the interview, it is necessary to thank the participant and to remind him/her of the objectives. The interviewee should be provided with relevant information about the services intended to help and assist anyone facing violence in the workplace or on the way to work."

All the interviewers received several copies of lists of places, in each province[10], where counseling and legal services are available.

Assistance provided to the participants

As revealing cases of workplace violence can result in a feeling of helplessness for the participants, the gender coordinator within the Capacity Project and the supervisors of data collection at CIEDEP were asked to write a report about interviewers, who identified, throughout the investigation and the structured interviews, experiences of workplace violence, in order to support them appropriately.

II.6. Data collection

The on-field data collection lasted 26 business days. It started immediately after the training and the pre-test, on 06/11/2007 and ended on 07/09/2007. Three teams, consisting of seven people and including a

[9] The fact that victims can appreciate interviews on gender-based violence was confirmed in the program or in research experiments conducted by several organizations, including the 2006 study by the Capacity Project about retention factors in forced labor in Uganda, the 2002-2004 study conducted by IntraHealth in Armenia regarding violence against women, the IPPF's baseline in three countries regarding GBV in 2002 and a screening of domestic violence, which was conducted by the Department of Community Medicine at the University of North Carolina-Chapel Hill.

[10] This list of referral places was made in consultation with Pro-Femmes, based on table 1 and 2 of the following final report: GBV programming in Rwanda: Actors, Activities, Collaboration and Coordination, May 2006, Chemonics.

team leader, were set up, in order to implement the investigation. In addition to collecting tools, each investigator was provided with necessary supplies and documents for on-field work, such as the investigator's guidebook, ID, a blotting-pad to take notes, a bag to carry the tools, a list of referral structures for providers, who experienced violence and who feel the need to be counseled, etc. The Capacity Project provided Jeeps to facilitate travel. Each of the three vehicles transported eight people, including the driver. It also provided the supervisors with a 4x4. Quality control was ensured throughout the monitoring and the supervision of teams during their on-field work. Team leaders were responsible for the quality of their team's work; they held meetings on a regular basis with their team members, in order to improve their training and correct mistakes that occurred during the data collection process. All the selected health facilities and institutions were covered by this activity.

II.7. Verification and codification

The questionnaires were filled out on the field and, then, they were sent to the CIEDEP headquarters in Kigali, where they were checked and recorded. Incomplete or improperly filled-out questionnaires were sent back on the field for correction and non pre-coded questions were coded before being entered. This activity was managed by teams of three people. It started on 06/20/2007 and ended on 07/18/2007.

II.8. Entering data

Data were entered by teams consisting of six specifically trained agents. A computer engineer/programmer supervised all activities related to data processing. For the quantitative survey, data were entered using the CsPro software and was transferred to SPSS, in order to be analyzed.

For the qualitative survey, data were entered using Microsoft Word before being translated into Kinyarwanda and being transferred onto Microsoft Excel to be analyzed in French.

III. Results

Results will be presented according to the research steps previously mentioned with the specific objectives of the study.

The gender aspect will be taken into account in this study, as well as gender-based discrimination.

Data analysis was primarily based on quantitative data, the results of which were supported and detailed by the ones found in the qualitative analysis.

III.1. Prevalence and incidence of the different types of workplace violence within the health sector

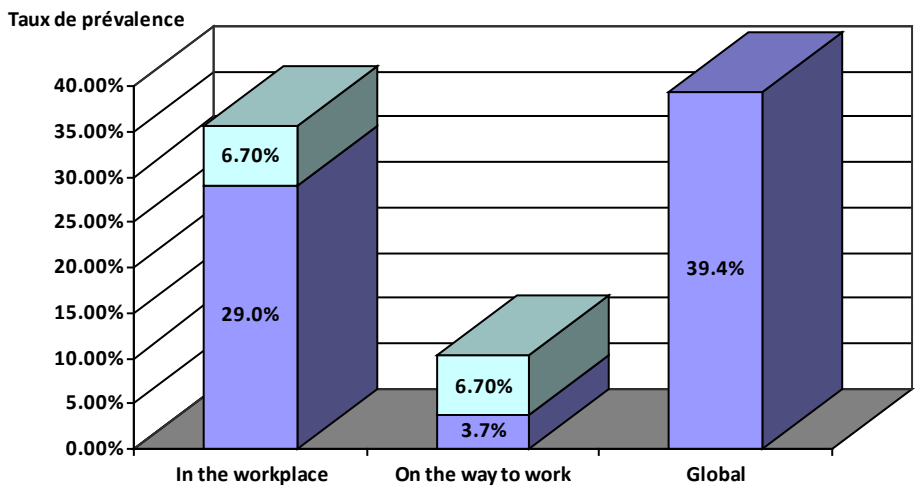
The main purpose of our research on workplace violence within the health sector in Rwanda was to assess the prevalence and the seriousness of the different types of violence in the workplace and on the way to and from work.

III.1.1. Global prevalence of workplace violence within the health sector

In this section, we will assess the number of health care providers, who have been victims of workplace violence over the duration of the study. The quantitative study (Tool # 1) helped us assess the percentage of participants who suffered from or witnessed violence in the past year.

Results show that almost four out of ten providers (39.4%) were victims of at least one incident of workplace violence (physical violence, verbal abuse, psychological harassment, sexual harassment, sexual assault) during the 12 months prior to the study. These incidents mostly occurred in the workplace. Indeed, 29% of participants declared they have only suffered from violence in the workplace, compared with 3.7%, who have only been victims of violence on the way to and back from work over the past 12 months. In addition, 6.7% told us they suffered from at least one type of violence, both during their travel time to work and in the workplace. Therefore, we found that the prevalence rate of violence was 35.7% (29.0%+6.7%) in the workplace and 10.4% (3.7%+6.7%) during travel time. These results can be found in the graph below.

Graph 1: Prevalence of violence in the workplace and on the way to and back from work

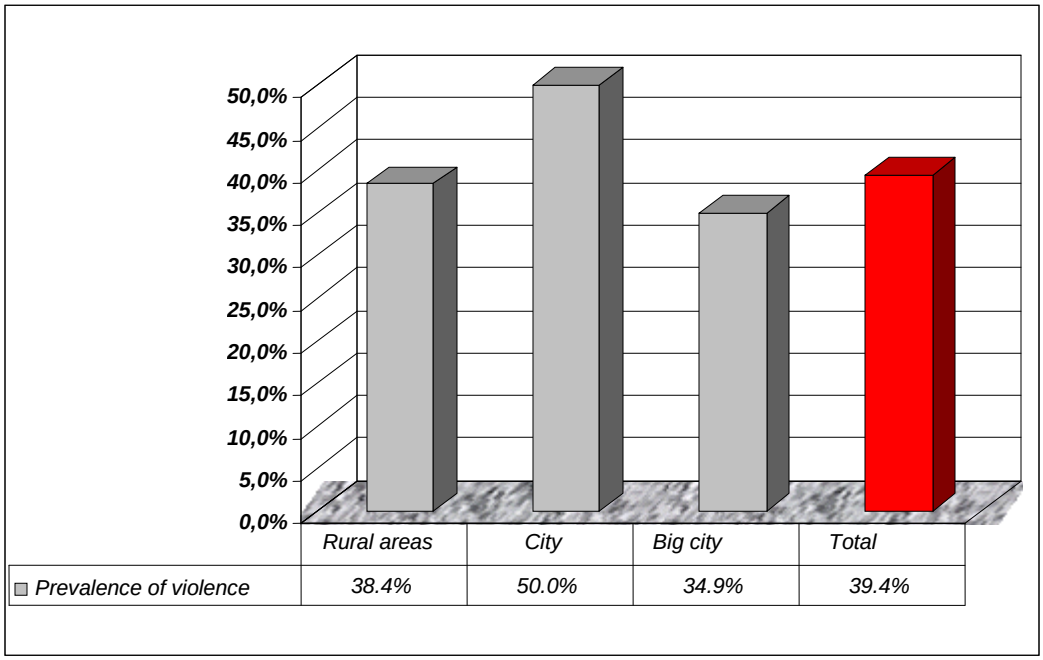


Light blue: Victims in the workplace and on the way to work
Source: Table 1 – Annex B (Tool #1)

In addition to these results, we can notice a positive and significant relation between the prevalence of workplace violence and the prevalence of violence during travel time, $r(397) = 0.21$, $p<0.01$; the more prevalent violence is in the workplace, the more prevalent it is during travel time. This correlation is also shown by the high percentage of victims, who suffer from violence both in the workplace and on their way to and from work.

Generally, the global prevalence of violence is not significantly different in other health facility locations. Nevertheless, it is higher in health services located in the inland cities (50%) and lower in rural areas (38%) and in health services located in the city of Kigali (35%), as it is shown in the graph below:

Graph 2: Prevalence of workplace violence depending on the location of health facilities



Source: Table 2 –Annex B (Tool #1)

Also, there are few variations in the prevalence of violence among health facilities. However, we can notice that the prevalence of violence is higher in districts hospitals (44%), health centers (41%) and general hospitals *(polycliniques)* (41%) than in health posts (28.6%) and free clinics *(dispensaires)* (17%).

Table 2: Prevalence of violence experienced and witnessed in the workplace depending on the type of health facility

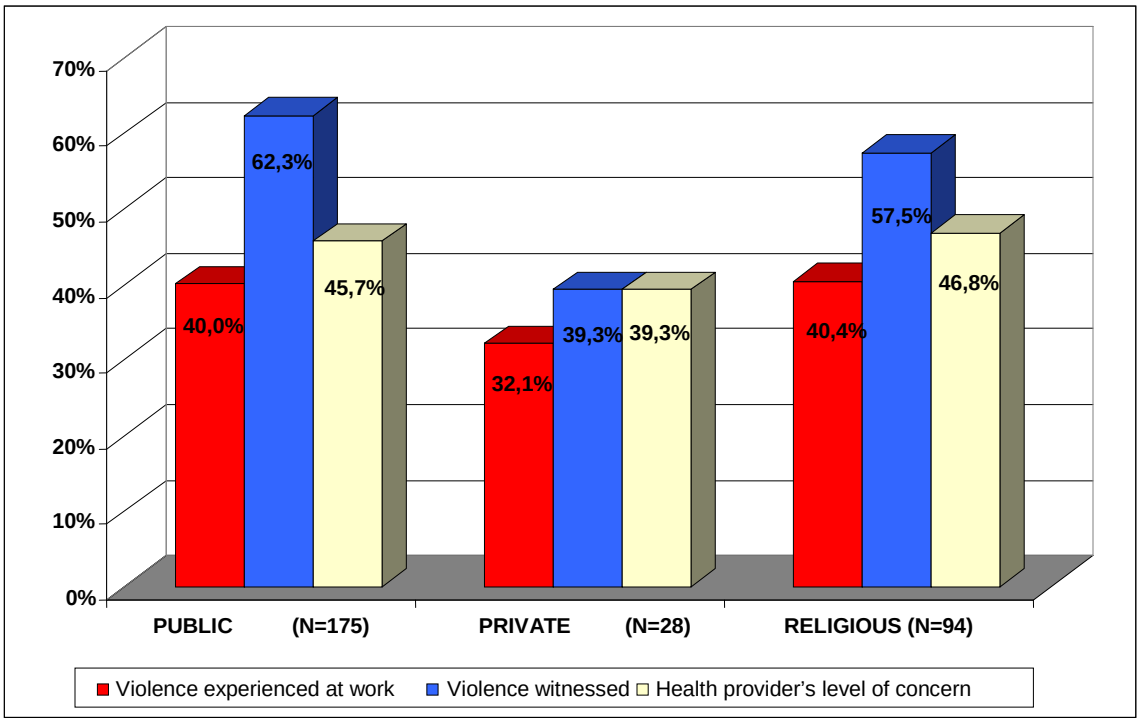
Type of health facility	Prevalence of violence experienced in the workplace		Prevalence of violence on the way to work		Prevalence of global violence		Prevalence of witnessed violence	
	Yes	*No*	*Yes*	*No*	*Yes*	*No*	*Yes*	*No*
Health center	76	133	24	185	85	124	124	85
	36.4%	*63.6%*	*11.5%*	*88.5%*	*40.7%*	*59.3%*	*59.3%*	*40.7%*
Free Clinic	2	10	0	12	2	10	2	10
	16.7%	*83.3%*	*0.0%*	*100.0%*	*16.7%*	*83.3%*	*16.7%*	*83.3%*
District hospital	14	22	6	30	16	20	22	14
	38.9%	*61.1%*	*16.7%*	*83.3%*	*44.4%*	*55.6%*	*61.1%*	*38.9%*

Type of health facility	Prevalence of violence experienced in the workplace		Prevalence of violence on the way to work		Prevalence of global violence		Prevalence of witnessed violence	
	Yes	*No*	*Yes*	*No*	*Yes*	*No*	*Yes*	*No*
Referral hospital	3	6	0	9	3	6	6	3
	33.3%	*66.7%*	*0.0%*	*100.0%*	*33.3%*	*66.7%*	*66.7%*	*33.3%*
Health post	4	10	1	13	4	10	11	3
	28.6%	*71.4%*	*7.1%*	*92.9%*	*28.6%*	*71.4%*	*78.6%*	*21.4%*
General hospital	7	10	0	17	7	10	9	8
	41.2%	*58.8%*	*0.0%*	*100.0%*	*41.2%*	*58.8%*	*52.9%*	*47.1%*
Total	106	191	31	266	117	180	174	123
	35.7%	*64.3%*	*10.4%*	*89.6%*	*39.4%*	*60.6%*	*58.6%*	*41.4%*

The global level of witnessed violence is much higher than the level of experienced violence. 58.6% of participants said they witnessed at least one type of violence, while 39.4% of interviewees actually experienced it over the past 12 month. These results are confirmed in all the sectors and types of facilities we considered, except for free clinics. However, this exception should be considered with caution, as results there are not as reliable.

There is a positive relation between the prevalence of experienced violence and the level of witnessed violence, which is shown in a significant correlation $r(297) = 0.68$, $p<0.01$. The higher the prevalence of violence is, the higher the proportion of witnesses becomes (see graph 3 below). However, the significance of this correlation varies depending on the sector of the selected facility. It is very high in private facilities, $r(28) = 0.86$, $p<0.01$ and slightly lower in religious ($r(94) = 0.71$, $p<0.01$) and public ($r(175) = 0.64$, $p<0.01$) health facilities.

Graph 3: Prevalence of violence experienced and witnessed and level of concern regarding safety in the workplace by sector



Source: Table 3 – Annex B (Tool #1)

This level of prevalence of workplace violence reflects safety issues felt by a number of health providers. 45.5% of interviewed providers think their workplace is unsafe. This level of insecurity is also felt by the patients we interviewed.

The qualitative analysis shows that few men and women said they felt safe in the health facility, in which they seek treatment. Indeed, four out of 29 women, four out of 18 men and nine out of 23 mixed groups said they felt completely safe. The others, that is to say the 25 women, the 14 men and the 14 groups describe the incidents they experienced or witnessed as elements of insecurity: lack of fences and walls, absence of night watchmen, excessive postponement of appointments, and problems in managing emergencies.

This feeling of insecurity slightly varies depending on the sector of the facility. 45.7% of providers working in public facilities and 46.8% of those working in religious facilities said the level of safety was low, compared with 39.3% in the private sector (Graph 3). The high prevalence of violence in the public and religious facilities, compared with private facilities, clearly highlights this statement.

As far as incidence of violence is concerned, we noticed considerable discrepancies between sectors. When comparing the proportion of providers, who experienced more than one type of workplace violence, we noticed that the public sector ranked first with 13.7% (10.3%+3.4%) of its providers, followed by religious facilities with 11.8% (7.5+4.3%) and the private sector with 10.7%.

Table 3: Number and types of violent incidents that occurred in the workplace per person

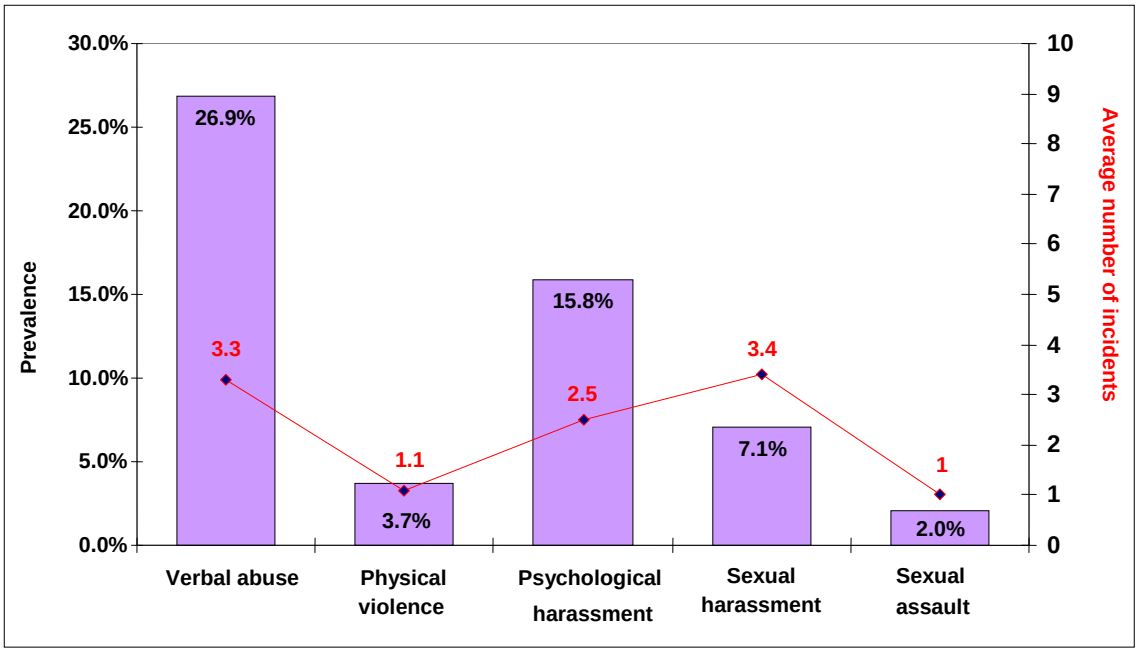
Number and types of violence experienced per person	PUBLIC		PRIVATE		RELIGIOUS		TOTAL	
	N	*%*	*N*	*%*	*N*	*%*	*N*	*%*
One type of violence	46	*26.3%*	6	*21.4%*	27	*28.7%*	79	*26.6%*
Two types of violence	18	*10.3%*	3	*10.7%*	7	*7.5%*	28	*9.4%*
More than two types of violence	6	*3.4%*	0	*0.0%*	4	*4.3%*	10	*3.4%*
At least one type of violence	70	*40.0%*	9	*32.1%*	38	*40.4%*	117	*39.4%*
Average number of incidents per person	4.3		3.4		3.9		4.1	

In addition, the average frequency of violent incidents over the past 12 months prior to the study is slightly lower for providers working in the private sector (3.4 times), compared with their counterparts in the religious (3.9 times) and public sectors (4.3 times).

III.1.2. Prevalence and frequency of violence by types

Verbal abuse is the most common form of workplace violence. One out of every four providers suffers from it in health facilities (27%), followed by psychological harassment (16%), sexual harassment (7%), physical violence (4%) and sexual assault (2%), as shown in Graph 4 below.

Graph 4: Prevalence and frequency of different types of violence

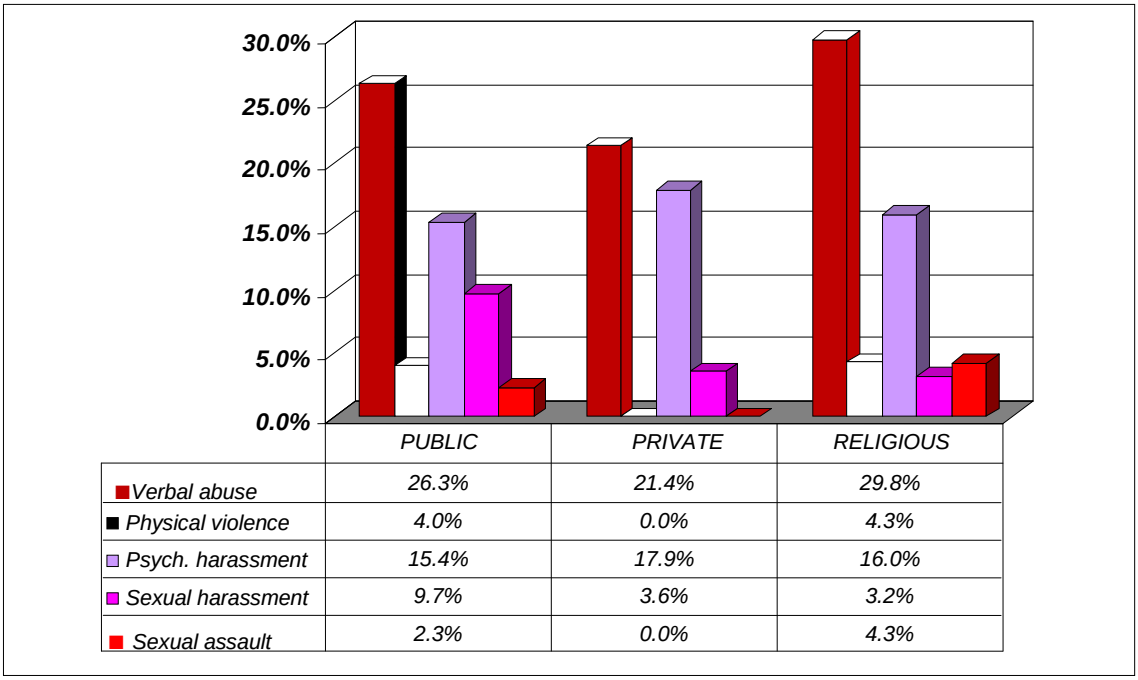


Source: Table 4 – Annex B (Tool #1)

Even though sexual harassment is not as widespread as verbal abuse in the health sector, the frequency of this type of violence is; however, much higher than other types of violence. The study shows that the average number of incidents is higher for sexual harassment (3.4 times) and verbal abuse (3.3 times) than for the other types (see graph above). The types of violence, which occur the least are physical violence (1.8 times per victim) and sexual assault (one time per victim).

Taken separately, the prevalence of each type of violence does not vary much, depending on the sector of the facility. Verbal abuse exceeds 20% in any sector but it is more prevalent in religious (30%) and public facilities (26%). Psychological harassment is higher in the private sector (18%) than in the public sector (15%). Sexual harassment is almost three times higher in public facilities (9.7%) than in private (3.7%) or religious ones (3.2%). No case of sexual assault has been recorded in the private sector.

Graph 5: Prevalence of different types of workplace violence by sector



	PUBLIC	PRIVATE	RELIGIOUS
Verbal abuse	26.3%	21.4%	29.8%
Physical violence	4.0%	0.0%	4.3%
Psych. harassment	15.4%	17.9%	16.0%
Sexual harassment	9.7%	3.6%	3.2%
Sexual assault	2.3%	0.0%	4.3%

Source: Table 5 – AnnexB (Tool #1)

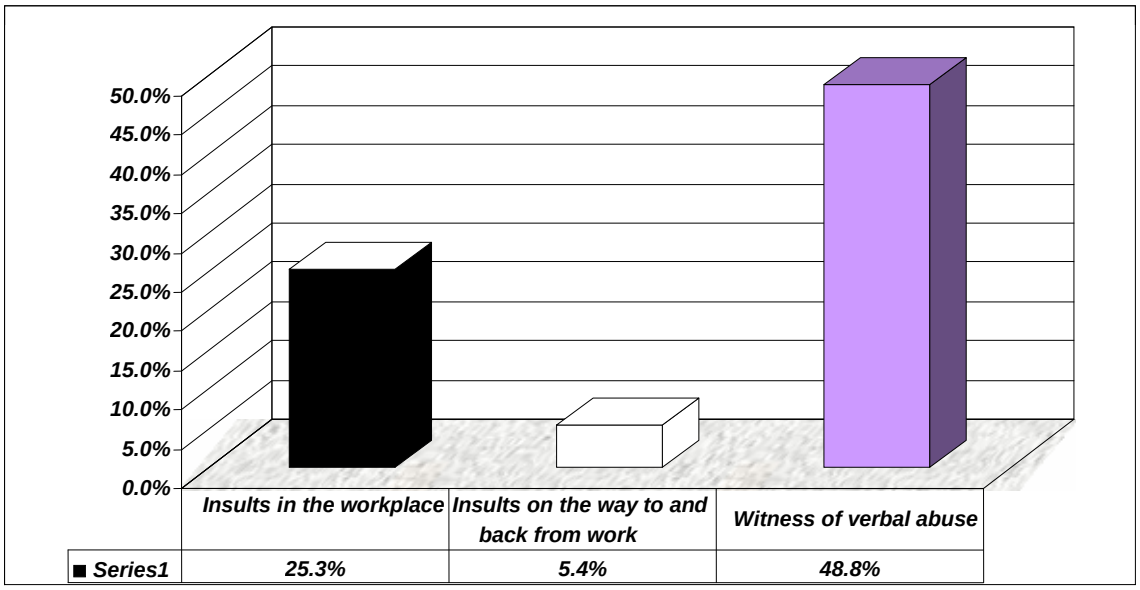
Since the sample is so small, we will not reconsider the analysis of violence and its different types at the "health facility" and the "province" levels, as the quantity and the reliability of results cannot be ensured on such a small scale.

a) Verbal abuse

27% of providers suffer from verbal abuse (see Graph 4). This type of violence can mostly be observed in the workplace, as 25.3% of participants experienced it in that setting, compared with 5.4% on their

way to and from work. A very high proportion of health providers (48.8%) said they witnessed a coworker being insulted, either at work or during travel time.

Graph 6: Prevalence of verbal abuse depending on the location



Source: Table 6 – Annex B (Tool #1)

The prevalence of verbal abuse does not vary significantly from one geographical location to another. Verbal abuse has been reported by 29.5% of providers working in health facilities located in rural areas, compared with 22.7% in urban areas and 22.2% in the city of Kigali. Similarly, its incidence remains about the same in any of the facilities' geographical locations.

Table 4: Prevalence and incidence of verbal abuse depending on location

Location of health services	Rural areas	Urban areas	City of Kigali	Total
Verbal abuse	56	10	14	80
	29.5%	*22.7%*	*22.2%*	*26.9%*
Witnesses of verbal abuse	98	21	26	145
	51.6%	*47.7%*	*41.3%*	*48.8%*
Average number of incidents	**3.3**	**3.9**	**3.1**	**3.3**

About 48% of providers in urban and inland facilities have witnessed their coworkers suffer from verbal abuse. So have 52% of providers in rural areas.

b) Physical violence

Globally, the study recorded few victims of physical violence (3.7%). Like verbal abuse, this type of violence mostly occurs in the workplace. Over the past 12 months prior to the study, 3.4 providers in health facilities said they have been victims of physical violence in the workplace, while 0.7% suffered from it on their way to and from work. Almost one out of ten providers (11.4%) said they witnessed a coworker suffer from physical violence (see graph 7 below).

Graph 7: Prevalence of physical violence depending on location

Source: Table 7 – Annex B (Tool #1)

There is a slight relation between cases of physical violence reported and the location of the service, $\chi^2(2, N=297) = 1.02$, $p<.01$. Physical violence is more widespread in facilities, which are located in inland urban areas (4.6%) and in rural areas (4.2%), than in the ones located in the city of Kigali (1.6%). The same differentiation can be noticed in the witnessing of physical violence. In this case, rural areas have the highest number of providers witnessing such acts (13.2%), followed by urban areas (11.4%) and the city of Kigali (6.4%).

Table 5: Prevalence and incidence of physical violence depending on where the service is located

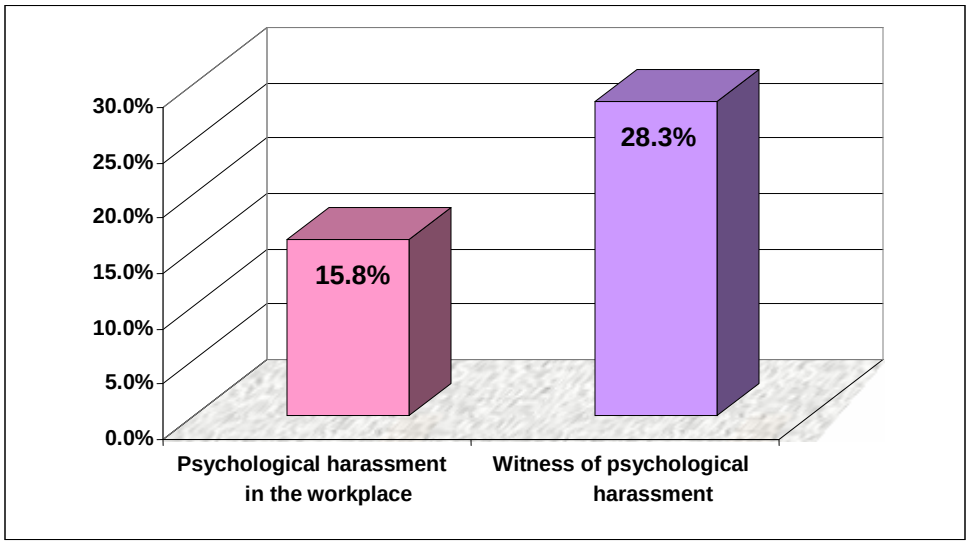
Location of health services	Rural areas	Urban areas	City of Kigali	Total
Physical violence	8	2	1	11
	4.2%	*4.6%*	*1.6%*	*3.7%*
Witness of physical violence	25	5	4	34
	13.2%	*11.4%*	*6.4%*	*11.5%*

The size of the sample for physical violence is too small for us to analyze the incidence rate.

c) Psychological harassment

One out of six providers (16%) has suffered from psychological harassment in the workplace, while one out of four (28%) has witnessed a coworker suffer from the same type of violence.

Graph 8: Prevalence of psychological harassment



Source: Table 8 –Annex B (Tool #1)

Note: The prevalence of psychological harassment during travel time has not been measured during the study.

Depending on where the health facility is located, the prevalence of psychological harassment slightly varies. But this difference is not significant (Table 6).

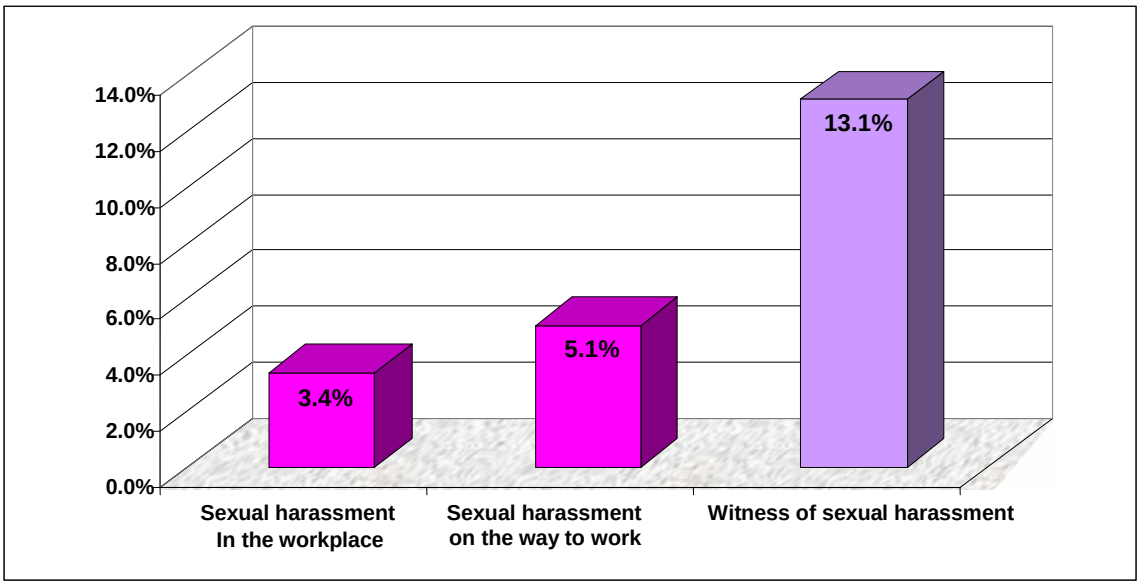
Table 6: Prevalence of psychological harassment depending on the location of the service

Location of health services	Rural areas	Urban areas	City of Kigali	Total
Psychological harassment	31	7	9	47
	16.3%	*15.9%*	*14.3%*	*15.8%*
Witnesses of psychological harassment	58	10	16	84
	30.5%	*22.7%*	*25.4%*	*28.3%*

d) Sexual harassment

Not only is sexual harassment more frequent (see high level of incidence on Graph 4), another particular element of this type of violence is that it is more likely to occur on the way to and from work (5.1%), than in the workplace (3.4%); unlike other forms of violence. Indeed, 13.5% of the participants have witnessed sexual harassment.

Graph 9: Prevalence of sexual harassment depending on location



Source: Table 9 – Annex B (Tool #1)

According to the explanations given by ten providers (3.4%) who have suffered from sexual harassment in the workplace (see table 9 –Annex B), we can notice that this type of violence does not occur the same way for every victim. Indeed, five of them were forced into a friendship aimed at resulting in a sexual relation. One said s/he had been threatened into having sex. Another one told us s/he had been mocked for sexual reasons. The three remaining victims did not specify the circumstances (see Table 10 – Annex B).

The prevalence of witnessed sexual harassment does not vary depending on the location of the health facility but the percentage is lower in rural areas (see Table 7 below).

Table 7: Prevalence of sexual harassment depending on the location of services

Location of health services	Rural areas	Urban areas	City of Kigali	Total
Sexual harassment	10	8	3	21
	5.3%	*18.2%*	*4.8%*	*7.1%*
Witnesses of sexual harassment	21	9	9	39
	11.1%	*20.5%*	*14.3%*	*13.1%*

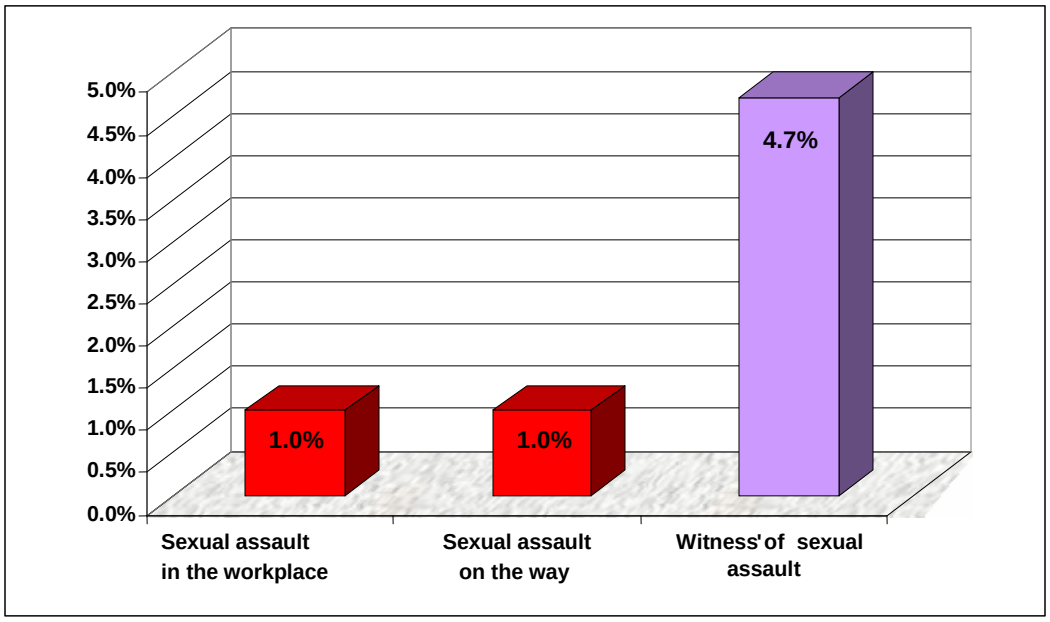
Location of health services	Rural areas	Urban areas	City of Kigali	Total
Average number of incidents	3.5 [1 – 13]	3.1 [1 – 5]	3.5 [2 – 5]	3.4 [1 – 13]

The number of sexual harassment incidents in the workplace varies between one and 13 in rural areas, with an average frequency of 3.5 times per victim, while it fluctuates between one and five with an average of 3.1 in urban areas, compared with two to five and an average of 3.5 in Kigali.

e) Sexual assault

It is the least recorded type of violence in this study (2.0%). In other words, it represents six out of 297 interviewed providers[11]. Sexual assault occurs as often in the workplace as it does on the way to and from work. One percent of sexual assault cases happen in the workplace and the percentage is the same for cases occurring during travel time.

Graph 10: Prevalence of sexual assault depending on location



Source: Table 11 – Annex B (Tool #1)

This phenomenon mostly occurs in urban areas (4.5% of urban providers suffer from it) and in rural areas (2.1%). No case of sexual assault and no witnessing of that type of violence has been recorded during our study in Kigali (see next table). However, considering the small size of the sample, we cannot jump to any conclusions.

[11] Even though the number of sexual assault cases (6) was too low to be used in an analysis, we included this category in all tables and graphs. A special study on sexual assault with a larger sample will be necessary in order to assess its prevalence.

Table 8: Prevalence of sexual assault depending on the location of services

Location of health services	Rural areas	Urban areas	City of Kigali	Total
Sexual assault	4	2	0	6
	2.1%	*4.5%*	*0.0%*	*2.0%*
Witnesses of sexual assault	11	3	0	16
	5.8%	*6.8%*	*0.0%*	*4.7%*

Conclusions about the prevalence:

The analyses throughout this section show that workplace violence within the health sector in Rwanda is real.

58.6% of health care providers said they have witnessed at least one form of violence, while 39.4% have actually experienced it over the past 12 months. 45.5% of providers do not feel safe in the workplace; this insecurity is also felt among the patients we interviewed. This feeling slightly differs from one sector to the other; from 45.7% to 46.8% of providers in the public and religious sectors felt it, compared with 39.3% in the private sector.

Like verbal abuse, physical violence mostly occurs in the workplace.

Verbal abuse and sexual harassment are the most frequent types of violence. On average, victims suffer from more of these incidents (three per victim), than victims of other types of violence.

Sexual harassment is particular in the way that, unlike other types of violence, it mostly occurs on the way to and from work.

III.2. Characteristics of victims, perpetrators and institutions which are affected by violence

Several factors contribute to the emergence of workplace violence within the health sector. These factors may be directly related to individuals or social order. They may also be linked to work environment or organizational issues. Based on a bivariate analysis and data from our qualitative survey, we will aim at identifying the factors contributing to workplace violence. Finally, we will provide a factorial analysis, in order to have a global perspective of workplace violence, as well as an econometrical analysis, to measure the impact of these factors.

III.2.1. What are the characteristics of the victims?

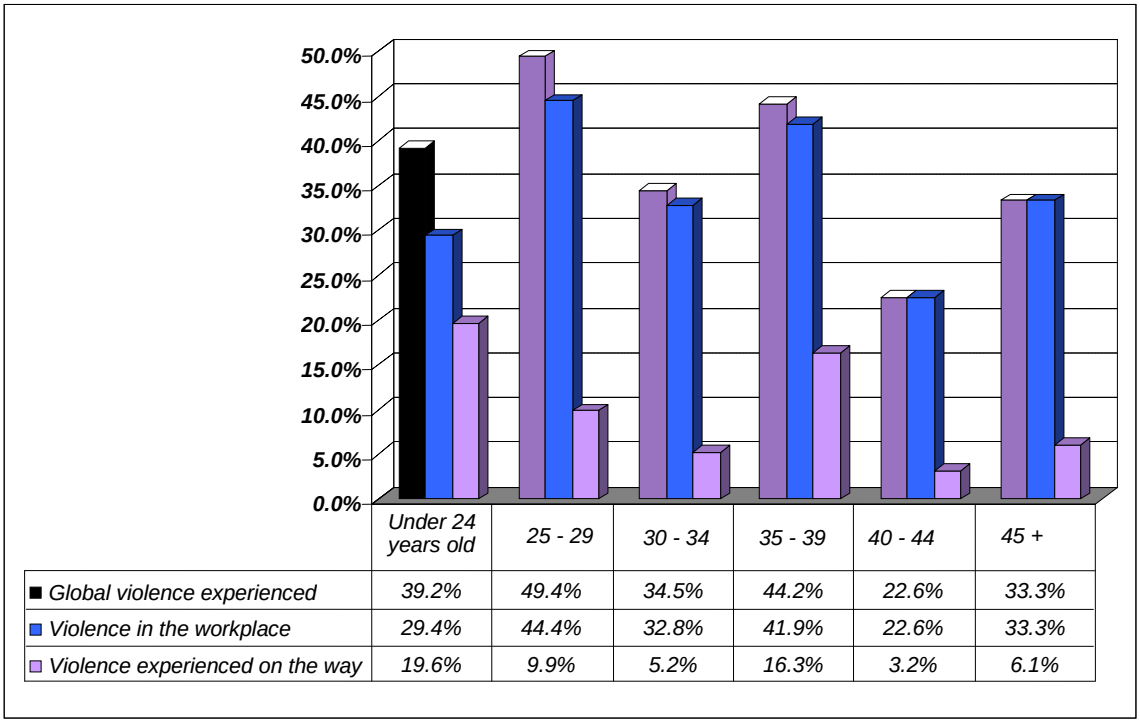
a) Victims by age

Age does not seem to have a significant impact on the prevalence of violence. There is; however, a negative correlation between age and the prevalence of violence, $r(297) = 0.10$, $p=0.08$, even though it

becomes significant with a tolerance threshold of 10%, which may imply that the probability of experiencing violence decreases with age.

When we analyzed the prevalence of global violence by age group, we highlighted a trend. We noticed a switchback decline. Peaks can be observed for age groups ranging from 25 to 29 years old (49%), 35 to 39 (44%) and 45 and older (39%), compared with the other groups "under 25 years old," "30-34" and "40-44" (see graph 11below).

Graph 11: Prevalence of violence by age group



	Under 24 years old	25 - 29	30 - 34	35 - 39	40 - 44	45 +
Global violence experienced	39.2%	49.4%	34.5%	44.2%	22.6%	33.3%
Violence in the workplace	29.4%	44.4%	32.8%	41.9%	22.6%	33.3%
Violence experienced on the way	19.6%	9.9%	5.2%	16.3%	3.2%	6.1%

Source: Table 12 – Annex B (Tool #1)

With the graph above, we can also notice that young providers (under 25) experience violence on the way to work more often than older providers. Regarding violence in the workplace, providers in age groups "25-29" and "35-39" are the most exposed.

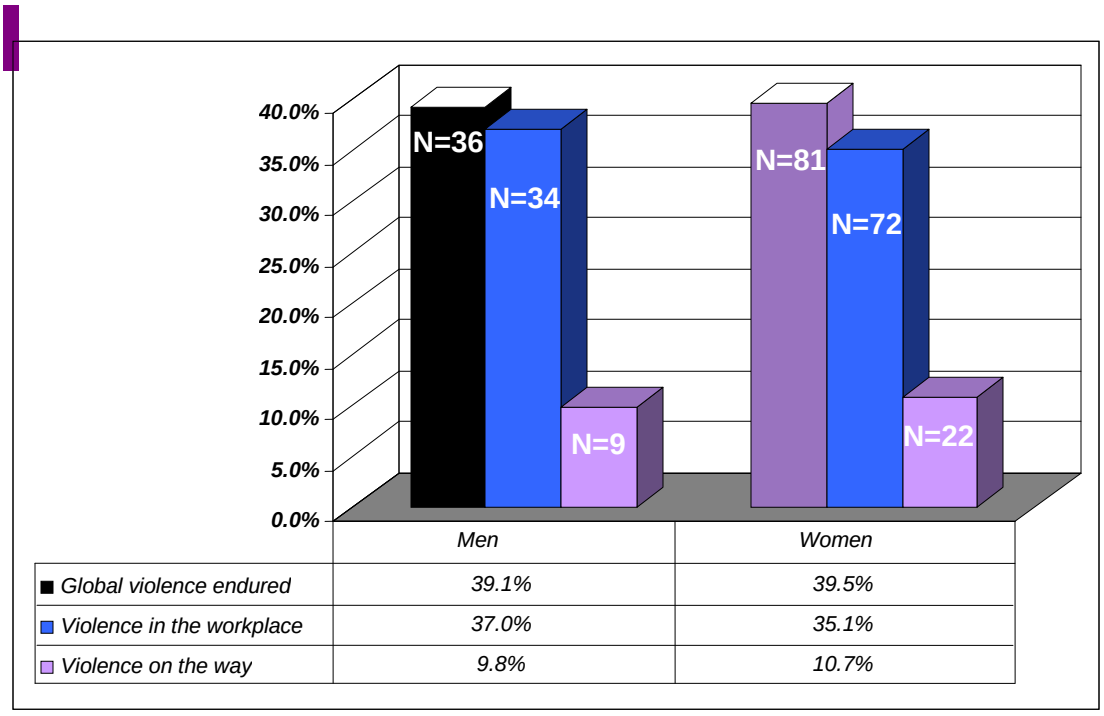
Unfortunately, these results are not significant enough for us to conclude that age, when considered separately, might explain the differences we observed in the prevalence of violence.

b) Gender effect on workplace violence

There is no significant difference between the percentages of male and female providers who experienced workplace violence, $\chi^2(5, N=297) = 0.50$, $p>.05$; they have the same level of exposure to workplace violence (39%).

Women are slightly more exposed to violence on the way to and from work than men, 11% compared with 10%.

Graph 12: Prevalence of violence depending on providers' gender



Source: Table 13 – Annex B (Tool #1)

Results from the qualitative study show that both genders suffer from violence but female providers are more likely to be victims, particularly when it comes to sexual harassment (Tool #4, 11b).

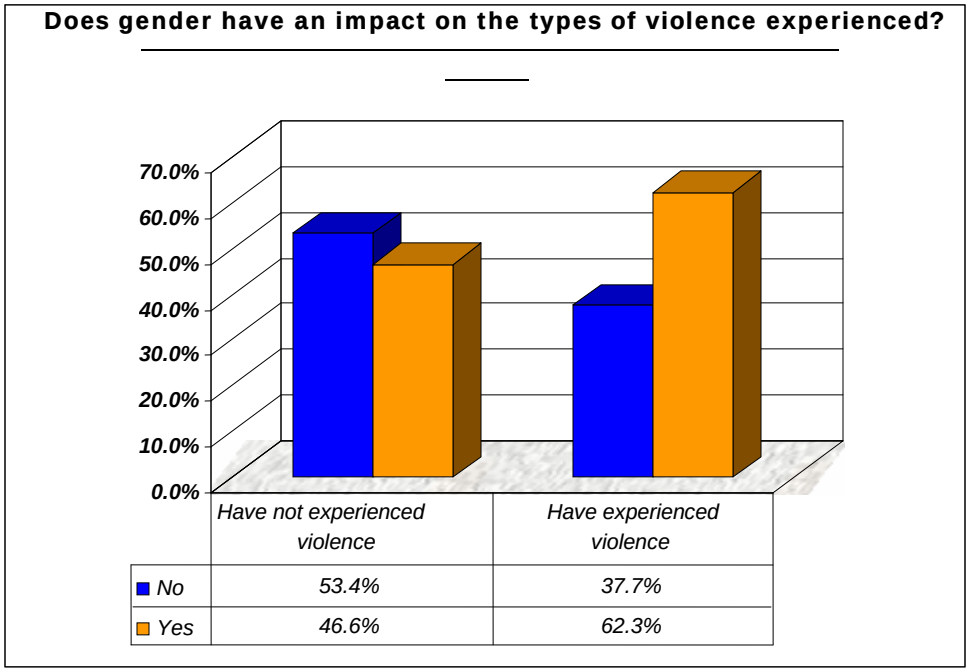
Unlike the results shown above, a little more than one out of four providers in health facilities (40.7%) said that gender has an impact on the way workplace violence is experienced (Table 9 below). 52.8% think that the types of experienced violence may vary, depending on gender.

Table 9: Opinion of interviewed participants regarding the effect of gender on the different types of violence

Opinion regarding the effect of gender	*Yes*	*No*	*Total*
The way violence is experienced depends on gender	120	175	295
	40.7%	*59.3%*	*100.0%*
Types of experienced violence depend on gender	152	136	288
	52.8%	*47.2%*	*100.0%*

By analyzing the opinions of providers who experienced violence, compared with the ones who did not, we noticed that the former believe types of violence vary according to gender more than the latter, 57% compared with 45%.

Graph 13: Providers' opinions regarding the different ways violence is experienced, depending on gender

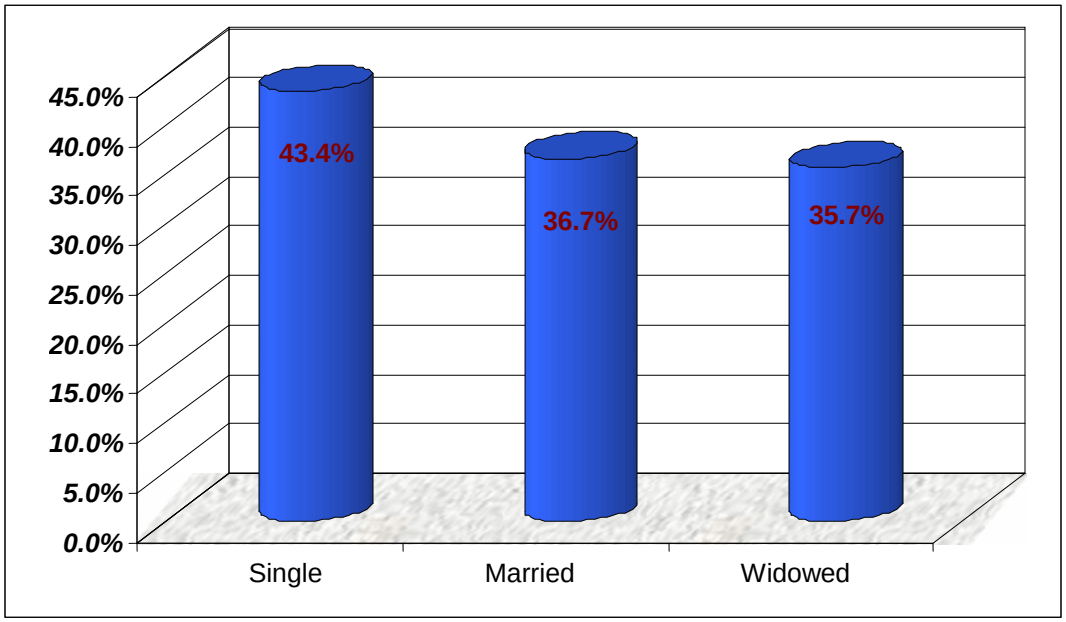


Source: Table 14 – Annex B (Tool #1);
Note: Pearson chi2(1) = 6.8370, Pr = 0.009 < 0.01

c) The impact of marital status

The prevalence of workplace violence does not vary much depending on the providers' marital status. However, the proportion of single providers who experienced violence is slightly more important (43.3%), than the proportion of currently married providers (36.7%) and the proportion of widowed or divorced providers (35.7%).

Graph 14: Prevalence of violence depending on marital status



Source: Table 15 – Annex B (Tool #1)

The different types of violence do not vary much depending on marital status, except for sexual harassment. Widowed providers (14%) and singles (11%) suffered from this type of violence more than married providers.

Table 10: Types of violence in the workplace depending on marital status

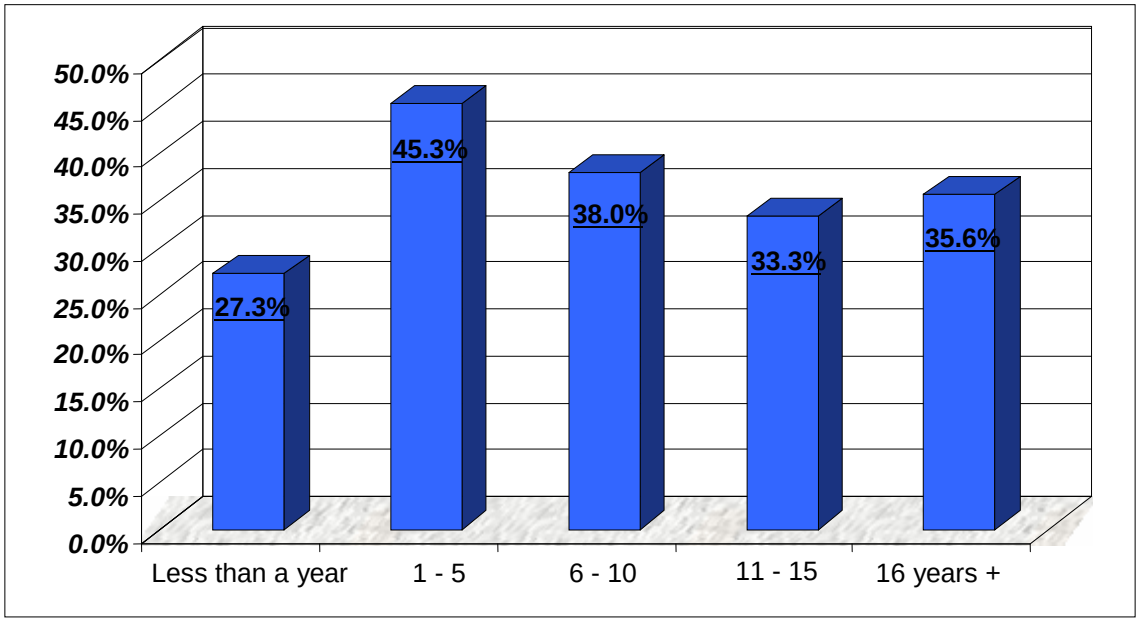
Types of violence	**Marital status**			**Total**
	Single	*Couple*	*Widowed*	
Verbal abuse	37	40	3	80
	30.3%	*24.8%*	*21.4%*	26.9%
Physical violence	5	5	1	11
	4.1%	*3.1%*	*7.1%*	3.7%
Psychological harassment	23	24	0	47
	18.9%	*14.9%*	*0.0%*	15.8%
Sexual harassment	13	6	2	21
	10.7%	*3.7%*	*14.3%*	7.1%

Types of violence	Marital status			Total
	Single	*Couple*	*Widowed*	
Sexual assault	5	3	0	8
	4.1%	*1.9%*	*0.0%*	2.7%

d) Effect of seniority on violence

The seniority of providers does not have a particular effect on workplace violence. However, we notice that providers who just completed one to five years of service are more vulnerable than others; 45% of providers who belong to this category have suffered from violence over the past twelve month.

Graph 15: Prevalence of violence depending on seniority in the health sector

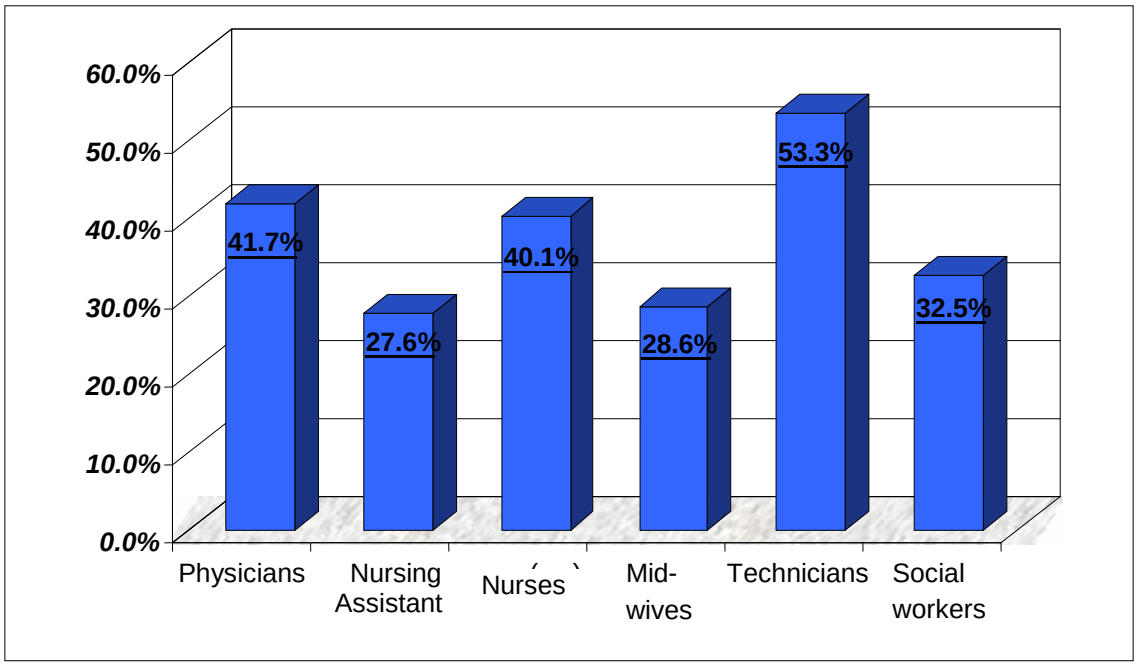


Source: Table 16 – Annex B (Tool #1)

e) Effect of job category on violence

The prevalence of violence is higher for technicians (53%), physicians (42%) and nurses (40%) and lower for midwives (29%) and nursing auxiliaries (28%). However, this variation is not significant enough to let us conclude that job categories have an effect on workplace violence.

Graph 16: Prevalence of violence depending on job category

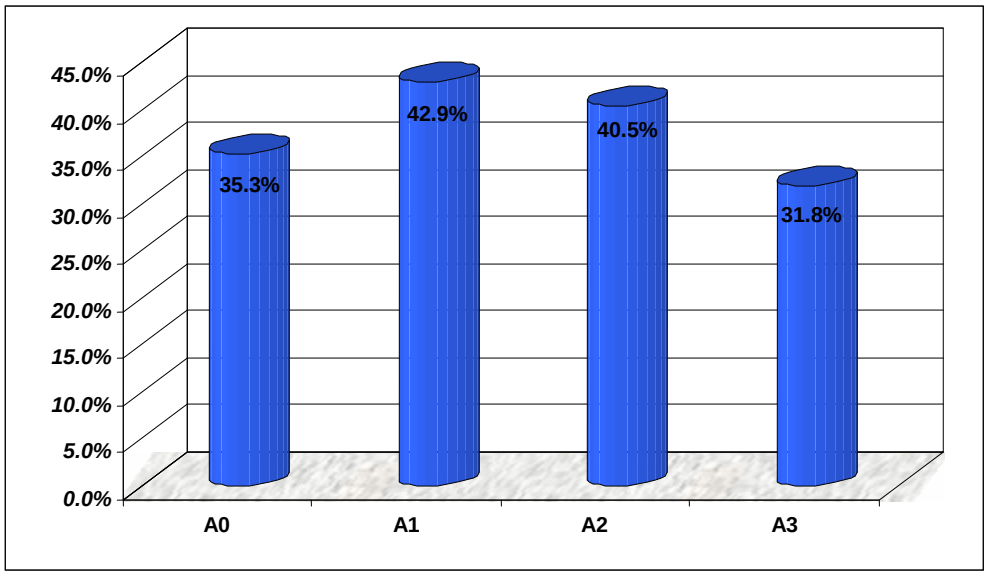


Source: Table 17 – Annex B (Tool #1)
Note: Nursing assistants = Nursing auxiliaries

f) Prevalence of violence and education

Also education, when taken separately, does not have a statistical impact on violence. Nevertheless, we noticed that the proportion of victims of workplace violence tends to decrease, as the level of education increases.

Graph 17: Prevalence of violence depending on the level of education

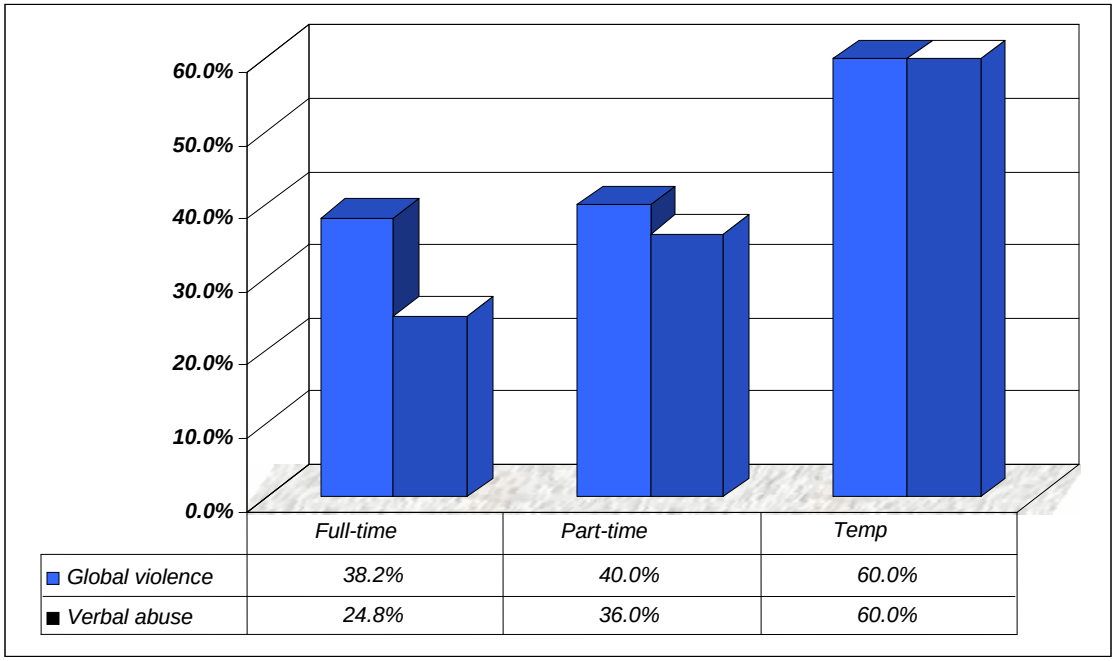


Source: Table 18 – Annex B (Tool #1)

g) Type of work and workplace violence

The type of work has an important impact on the prevalence of violence, particularly on verbal abuse, $\chi^2(2, N=297) = 7.20$, $p<.05$. While ¼ (24.8%) of permanent providers suffer from verbal abuse, three out of five temporary workers (60%) are exposed to this type of violence. Globally, temporary workers are the most vulnerable when it comes to workplace violence, followed by part-time workers (40%).

Graph 18: Prevalence of violence depending on the type of work



	Full-time	Part-time	Temp
Global violence	38.2%	40.0%	60.0%
Verbal abuse	24.8%	36.0%	60.0%

Source: Table 19 – Annex B (Tool #1)

h) Trade union affiliation and workplace violence

We noticed a significant difference in the prevalence of violence between providers who joined a trade union and those who did not, $\chi^2(1, N=297) = 6.48$, $p<.05$. Members of trade unions are more often victims of violence than non-members. We assessed the prevalence of global violence for members at 50%, compared with 35% for non-members. Data confirmed the vulnerability of trade union members no matter where violence is perpetrated, either in the workplace or during their travel time (see Table 11 below).

Table 11: Prevalence of violence depending on the affiliation to a trade union

Prevalence of violence	Member of a trade union		Total
	Yes	*No*	
In the workplace	42	64	106
	44.7%	*31.5 %*	*35.7%*
On the way to and back from work	16	15	31
	17.0%	*7.4%*	*10.4%*
Prevalence of global violence	47	70	117
	50.0%	*34.5%*	*39.4%*

III.2.2. What are the institutional factors contributing to the emergence of workplace violence?

Most cases of violence take place in the workplace (42% of victims compared with 10% during travel time). Therefore, it becomes crucial to understand what factors related to health facilities contribute to workplace violence.

Health institutions may differ in type (type and sector of the facility), in supplies (availability of material and human resources), in socio-cultural characteristics (culture of mutual respect among employees, supervisors and patients, level of safety) and in organizational aspects (presence or absence of gender-based discrimination, policies responding to workplace violence.) These differences may have an impact on the risk of workplace violence. In order to measure this impact, we will test the effect of each institutional factor on the prevalence of violence.

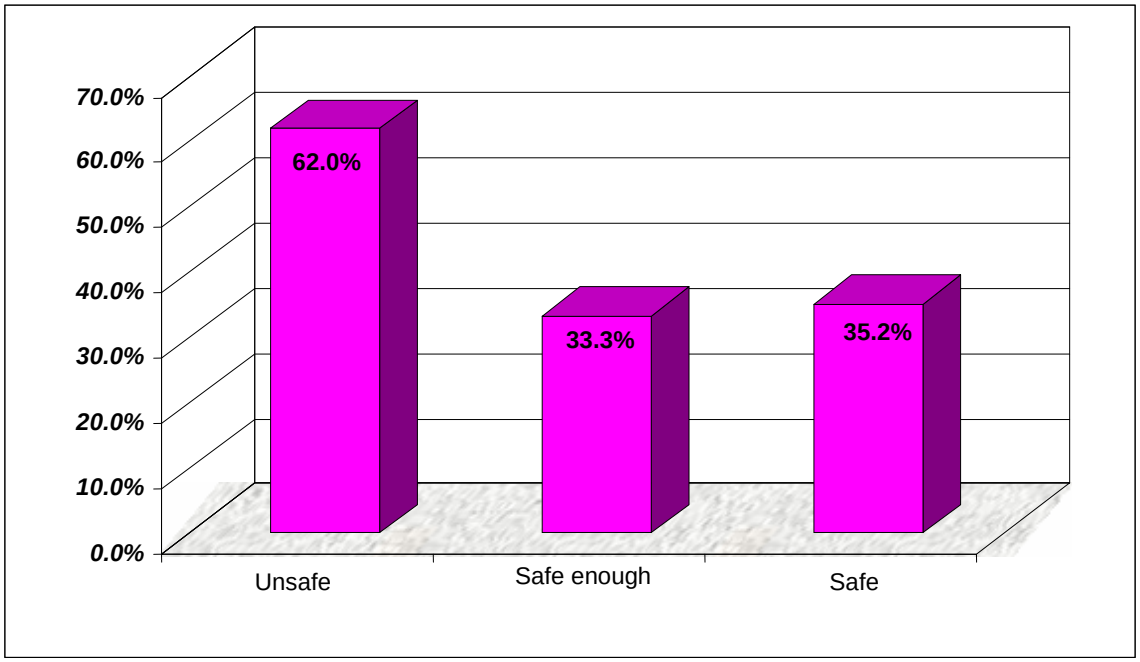
a) Type of facilities

During the first part of our analysis, we have shown that the sector of health facilities (public, private and religious) does not contribute significantly to the emergence of violence. The same rule applies to the different types of facilities (health centers, free clinics, districts hospitals, etc.)

b) Safety in health facilities

Generally, 67.0% of providers claim they feel safe in the workplace. The level of safety in the facility has a significant impact on the prevalence of violence, $\chi^2(2, N=297) = 8.90$, $p<.05$. Facilities with the highest level of insecurity have the highest prevalence of violence; 62%, in other words, twice what we recorded in facilities with an average level of safety (33%), compared with 35% in safe facilities.

Graph 19: Prevalence of violence depending on the level of safety felt by the worker in the facility



Source: Table 20 – Annex B (Tool #1)

The safer people feel at work, the less they are exposed to violence in the workplace: r(297)=- 0.18, p<.05. This assessment is confirmed for verbal abuse and sexual harassment (r(297)=- 0.13, p<.05). The other types of violence do not have significant effects (source: Tool #1 – HCWs).

Several aspects should be considered in the level of insecurity. The qualitative study shows that the feeling of insecurity is related to the incidents that have been experienced or witnessed, the time it takes to be admitted in the facility, multiple postponements of appointments, poor management of emergencies and negligence of women going into labor (see group discussions).

c) Availability of resources within the health facility

The level of equipment available in health facility does not really influence the risk of violence in the workplace. However, in well-equipped structures, we recorded a lower average prevalence (32%).

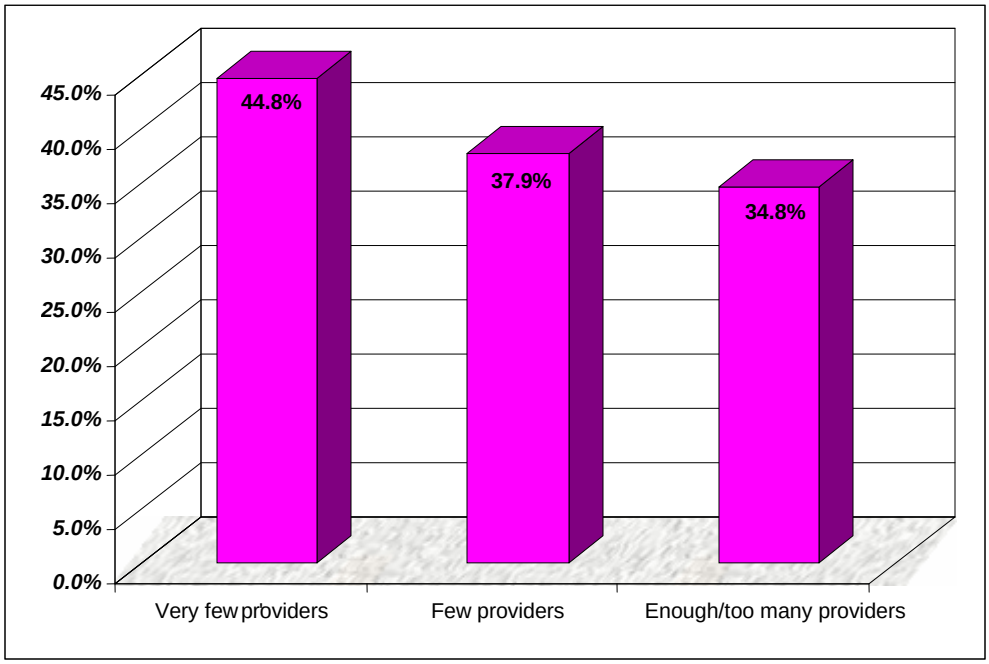
Table 12: Prevalence of violence depending on the level of equipment in the health facilities

Prevalence of violence	**Level of equipment**			*Total*
	Not well-equipped	*Averagely equipped*	*Well-equipped*	
Global violence	37	60	20	117
	35.9%	*45.5%*	*32.3%*	*39.4%*

Also, the availability of human resources does not have a significant impact on the prevalence of violence. However, there is something we can learn from that. In facilities, where the number of providers barely matches or does not match the workload, the prevalence of violence is high (45% and 39%). Only health structures with the appropriate number of providers are relatively less exposed to violence (35%).

Graph 20: Prevalence of violence and availability of human resources Also, the availability of human resources does not have a significant impact on the prevalence of violence. However, there is something we can learn from that. In facilities, where the number of providers barely matches or does not match the workload, the prevalence of violence is high (45% and 39%). Only health structures with the appropriate number of providers are relatively less exposed to violence (35%).

Graph 20: Prevalence of violence and availability of human resources



Source: Table 21 – Annex B (Tool #1)

Thus, access to public health services is at risk when providers face adverse work conditions, characterized by shortages in the health workforce. The accumulation of stress and tension due to these constraints, which are imposed by health professionals, contribute to the emergence of violence.

a) Impact of the culture of respect on violence in health facilities

The culture of interpersonal respect is crucial to the reduction of violence within the health sector in Rwanda. The table below shows how this culture has a significant and negative impact on the emergence of violence (according to Pearson's tests). Thus, the importance of mutual respect among employees contributes to the considerable reduction of workplace violence, $\chi^2(3, N=297) = 16.27, p<.05$. In facilities where there is very little respect among employees, up to 61% of people are victims of

violence, while in structures with a high level of respect, only 28% of them suffer from violence. We notice the same trend, when we consider the level of respect between employees and their supervisor, $\chi^2(3, N=297) = 11,74, p<.05$.

Table 13: Impact of interpersonal respect on violence in the workplace

Prevalence of violence	Level of respect					Impact on violence
	Very little respect	*Little respect*	*Enough respect*	*Much respect*	*Correlation*	
Mutual respect between employees (1)	20	22	35	40	*-0.23***	*Significant and negative*
	60.6%	***50.0%***	***44.3%***	***28.4%***		
Respect between employees and their supervisor (2)	21	24	24	48	*-0.19***	*Significant and negative*
	60.0%	***50.0%***	***36.4%***	***32.4%***		
Respect between patients and providers (3)	28	18	28	43	-0.17**	*Significant and negative*
	65.1%	***37.5%***	***32.9%***	***35.5%***		
Respect between providers and patients (4)	13	15	39	50	-0,12*	*Significant and negative*
	61.9%	***41.7%***	***40.2%***	***35.0%***		

Note :

** = significant with a tolerance threshold of 1%
* = significant with a tolerance threshold of 5%
(1) Pearson chi2 (3) = 16.2686 Pr = 0.001 < 0.01;
(2) Pearson chi2 (3) = 11.7442 Pr = 0.008 < 0.01;
(3) Pearson chi2 (3) = 14.2247 Pr = 0.001 < 0.01;
(4) Pearson chi2 (3) = 5.7367 Pr = 0.001 < 0.05.

The level of respect between providers and patients is also crucial to reduce the risk of violence and vice versa. The more mutual respect there is among health providers and patients, the fewer the victims of violence are. In order of importance, mutual respect among employees is the most likely to reduce violence, followed by respect between providers and supervisors, respect between patients and providers and finally respect shown by providers towards patients (see these correlations in Table 13).

The qualitative analysis helps us better understand the notion of respect according to health facilities' clients.

Based on the qualitative study, signs of respect for a patient range from the way s/he is admitted in the facility, the level attention s/he is given to the level of help s/he is provided with when looking for an ambulance or regular transportation. Respecting a patient also includes considering him/her a priority in case of an emergency, taking time to examine patients and prescribe medication on time, especially

when the patient has just been admitted in the unit. Respect also includes finding solutions to potential problems, like creating consultation rooms, when there are too many patients.

Some kinds of behaviors are considered disrespectful by patients:

→ Negligence and delay when admitting patients, especially pregnant women going into labor. Some providers do not respect patients or refuse to treat them because they do not have any money or because they are late. "I got here at 4 am and waited until 10 before someone took care of me." Generally patients wait a long time and go home, before they even see a health care provider.

→Unavailability of physicians, insults or offending remarks like, "I don't have any time to lose with you", "You are not the only one who's sick" or even "Shut up! Can't you stop yelling? You should be yelling at the one who made you pregnant." These are examples of disrespect and, to a certain extent, violence towards patients.

→ Favoritism, especially when priority is given to friends and acquaintances instead of patients who came in first, "It is a sign of disrespect towards other patients to treat someone just because he's rich or because you know him."

→ Refusing to prescribe medication to some patients, under the pretence that they are poor and that they have no insurance, "I have seen a health provider being violent because a patient was poor. He barely looked at him and refused to treat him."

→ The lack of patience of providers towards patients, "My child was seriously ill. I asked for some medicine and he said 'What are you doing with these papers? Can't you see I'm on my break?' It was five minutes before closing time. It really hurt my feelings."

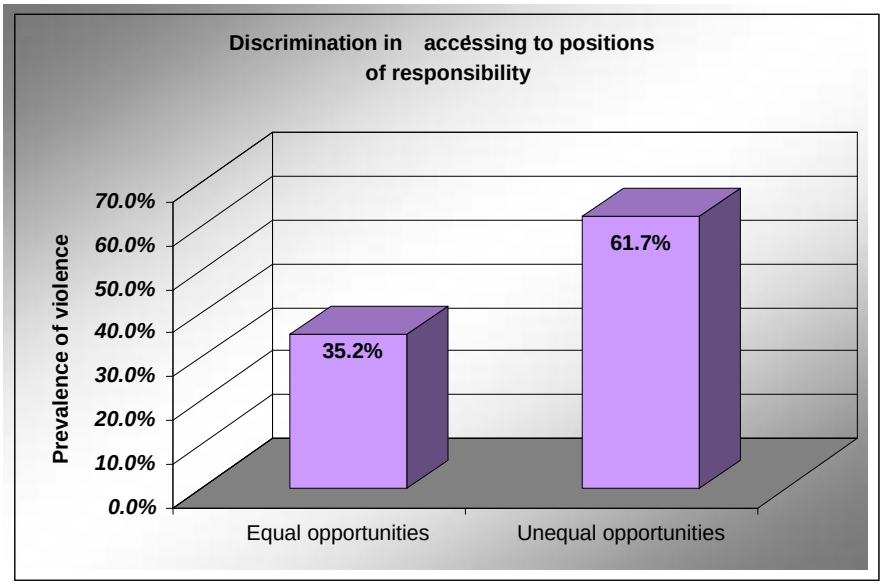
Group discussions showed that patients also lacked respect towards providers. This type of disrespect mostly consisted of insults towards providers, who are considered mean or incompetent because it takes them too long to provide expensive services. It may also consist of defamation, aiming at having the employee fired on the pretence he is bad at his job. Some patients also harass providers, in order to be allowed in the facility after closing time.

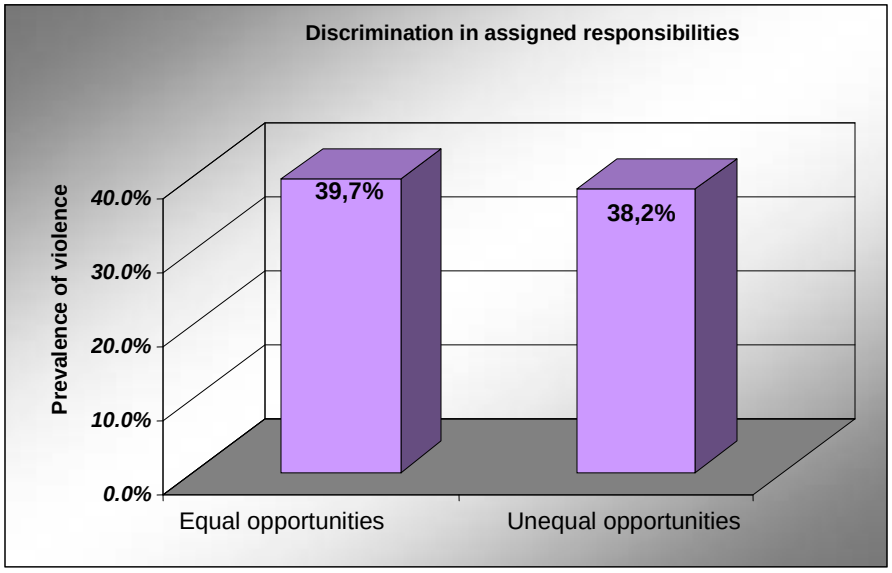
Therefore, lack of respect in the facility, along with a tense work environment and incompatibility among providers and patients may contribute to violence.

b) Gender-based discrimination and workplace violence

Gender-based discrimination in the workplace is associated with the prevalence of violence. In health facilities where providers think that men and women do not have the same opportunities to access positions of responsibility, the prevalence of violence is almost twice as high (62%) as the one in facilities where equity between men and women is ensured (35%). However, discrimination in assigned responsibilities (type of work and workload) does not seem to influence the level of violence.

Graph 21: Prevalence of violence and gender-based discrimination





Source: Table 22 – Annex B (Tool #1)

III.2.3. Factorial analysis of workplace violence within the health sector

Previous analyses helped us identify a certain number of factors, which have an impact on workplace violence. In reality, these factors do not have an immediate individual impact on the level of violence. Rather, they jointly interact. Taking these factors into account in a multidimensional analysis will help us define workplace violence within the health sector.

Several methods for factorial analysis are available:

- The Principal Components Analysis (PCA): It helps describe data sets with lines for individuals and columns for variables. The weakness of this method is that it is more adapted to quantitative data matrixes (for example: age, size, number of employee, etc.), while our study mostly consists of qualitative elements (gender, rank, marital status, type of health facility, etc.)
- The Correspondence Factor Analysis (CFA): This method helps analyze two qualitative variables in terms of correlations. The weakness of this method is that it does not enable the joint analysis of several variables.
- The Multiple Correspondence Analysis (MCA): This is a generalization of the CFA. It enables a joint analysis of several qualitative variables. It also enables the integration of quantitative variables in the analysis. We will use this method, as it is the most adapted to the data we collected.

a) Identification of variables

In order to identify the variables which we will use in the factorial analysis, we will focus on previous analyses regarding workplace violence. After reviewing them, here is the list of variables we decided to take into account:

- Variables directly linked to the individual, such as gender, age, job category, level of education, marital status, seniority, trade union affiliation and type of work
- Institutional and organizational variables, such as type and sector of the facility, level of insecurity in the service, availability of material and human resources, culture of respect within the facilities, level of gender-based discrimination and existence of specific policies on violence
- Geographical and social characteristics, such as location, province, level of insecurity felt by participants.

The distribution and the details of these variables will be shown in Annex C.

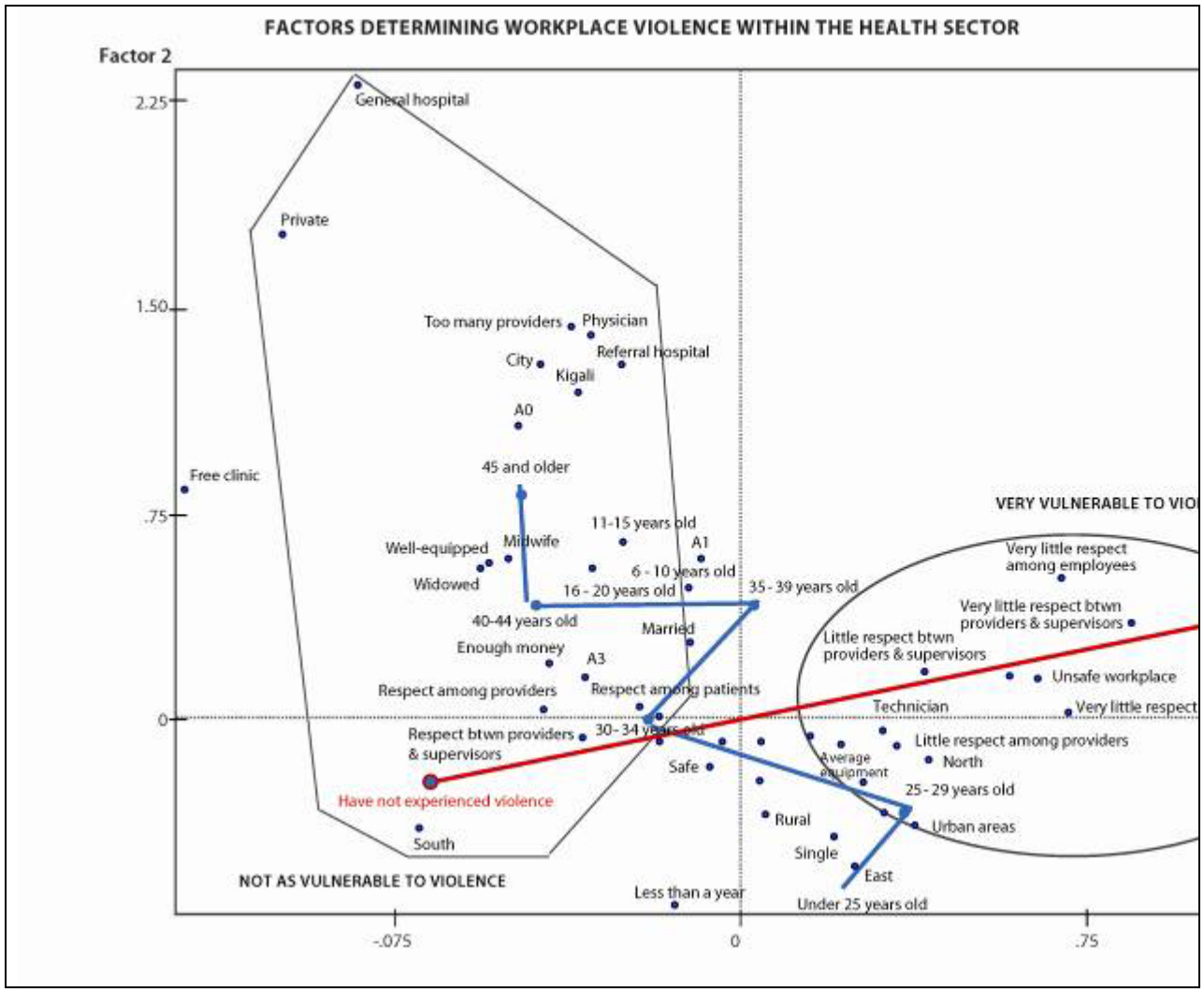
Procedure for the multiple correspondence analysis (MCA):

The principle of this method is to approach the data with an open mind and to describe it by analyzing the hierarchization of information contained in the data.
MCA is organized in two stages:
→ With the help of the SpadN software, an MCA is conducted on all selected variables. This phase helps explore the variables and find possible associations and dissociations between modes and main dimensions.
→Then, it is necessary to look at the MCA factors, in order to find that the one that best corresponds to the dimension we are interested in, in other words, workplace violence.
→The graphic representation and the interpretation of results are based on this factorial axis.

b) b) Results of the factorial analysis

A first analysis on selected variables helped us reject the ones, which did not really contribute to the emergence of violence (see Annex C). After reorganizing the data, we conducted a second MCA on selected variables, the results of which are shown in the graph below:

Graph 22: Determination of factors contributing to the emergence of workplace violence based on the MCA



Interpretation of MCA graph:

This figure has to be interpreted based on a particular rule:

→ On the graph, we selected the variables, which best represented the first factorial plan (i.e. the first two factorial axes). Indeed, the software helps us directly obtain the relative inertia of each mode in relation to each factorial axis. Relative inertia helps us select the modes, which contributed the most to the development of the two axes. We selected the modes, whose relative inertia in relation to axis 1 or axis 2 exceeded 1.7.

→ Here, these coordinates measure the distance of modes in relation to the origin (the origin being the center of gravity for modes of the different variables). Associations between the variables can be read according to the proximity of the modes. In order to understand the graph, it is necessary to interpret not only oppositions between modes, but also the proximities between them. Considering the distance between elements on the graph, modes, which are close to each other, focus on the same kind of individuals.

c) Interpretation of results

The graph above shows a strong association between the first factorial axis[12] and the violence axis (red line). Therefore, the first axis clearly shows the ongoing differentiation in workplace violence within the health sector. Also, on the graph, two blocks can be clearly identified:

- On the left hand side, we find the providers that are the least exposed to workplace violence:

This block mostly focuses on older (at least 30 years old), married or widowed providers, with at least six years of seniority, and working in general or referral hospitals, free clinics and health facilities located in the city of Kigali, or more generally, in the private sector. These providers are mostly midwives and physicians. Health structures have a very high level of equipment, in comparison with other facilities in the country and the work environment is characterized by a very high level of respect (respect among employees, between patients and employees, between supervisors and employees, and from employees toward patients), as well as ensured safety.

- On the right hand side, the graph shows the victims of violence:

They are mostly young and single and they work in health facilities, which are located in rural or urban areas. These facilities have an average or low level of equipment and the work environment there is hostile (very little respect among health care providers and towards patients, high level of insecurity).

Graph 22 also highlights the "zigzag effect" of age on violence.

[12] While we noticed that factorial axis 1 showed the best representation of workplace violence, we also saw that by analyzing factor 2, the graph rendered an opposition between the public and the private sectors, as well as an opposition between rural and urban areas in the city of Kigali. Also, considering age groups on the graph, we observed that factor 2 opposes young providers to older ones.

Another thing we can learn from this analysis is the small impact of individual characteristics on the level of violence in comparison with the institutional factors. Indeed, the factorial analysis revealed that in addition to age, seniority in the service, marital status, job category and level of education, which have an average contribution, other characteristics like gender and rank, slightly effect the level of violence. The most determining factors are institutional (sector and type of the health facilities, interpersonal relations within the facilities, level of safety) and geographical characteristics (location and setting).

III.2.4. Econometrical analysis of workplace violence

In this section, we will aim at modeling the prevalence of workplace violence. This phenomenon is measured with a dichotomous variable. Its value is "1" if the interviewed provider has experienced a type of violence over the past twelve months. "0" if s/he has not. Considering the dichotomous aspect of the variable, the utilization of classical linear regressions is not appropriated anymore[13]. Therefore, we will use the logistic regression, as it takes the discrete nature of the explained variable into account and helps simultaneously assess the effect of different factors on violence.

a) Model formalization

In order to interpret the results, we will use an association measure of factors contributing to violence, a.k.a. "Odds Ratio" (OR).

Definition of the Odds Ratio:

Let us consider variable Y, with "1" indicating that the individual "i" has experienced violence or "0" if s/he has not. In this case, the odds associated with the experience of violence is: $p = P(Y_i=1)$, the opposite odds being $1- p = P(Y_i=0)$. Let us adopt the following coding: "0" for women and "1" for men, so that the odds of experiencing violence will be p_0 for a woman and p_1 for a man.

The odds will be defined as follows:

It shows the relation between the odds someone will experience violence and the odds someone else will not.

The Odds Ratio (OR) is associated to the gender variable as follows:

$$\mathrm{OR} = \frac{\frac{p_1}{1-p_1}}{\frac{p_0}{1-p_0}}$$

[13] Simple linear modes are conceived based on a certain number of statistical previsions; heteroscedasticity, non-collinearity and normality of errors and variables, which are normally distributed. These previsions are not applicable on qualitative endogenous variables. More adapted assessment methods can also be used (logit and probit analysis).

When we start the logistic regression on 'Stata', we directly obtain the logarithm for the odds ratio.

Therefore, an Odds Ratio of 1 (log(OR) = 0) means that the odds of experiencing violence is the same for men and women. If the OR higher than 1 (log(OR) > 0), it would mean men would be more likely to experience violence than women. It would be the opposite if OR was below 1 (log(OR) < 1). The Odds Ratio can; therefore, be assimilated with a relative risk measure.

We used three logistic models to assess (1) workplace violence, (2) violence on the way to and from work and (3) global violence (on the way to and from work, as well as in the workplace). In order to take into account the effects, which are related to some general characteristics of the interviewed population, we introduced several control variables such as, gender, age, rank, level of education, sector of the facility and geographical localization (even though these last two are not necessarily significant as previous studies have shown).

b) Presentation of results

The results for the logistic assessment of workplace violence will be presented in Table 13 below.

Before interpreting the results, it is important to note the model is globally significant (chi2(33)= 99.95, Prob>chi2=0.00) and can considerably explain the variability of workplace violence (Pseudo R-sq= 0.2510). Among the variables used in the regression, eight of them have had a significant effect on workplace violence: Trade union affiliation, providers' marital status, level of insecurity in the health facilities, culture of respect (mutual respect among employees and respect from patients towards providers), gender-based discrimination (discrimination in assigned responsibilities, discrimination in treatment of employees) and finally the location of the facilities (province).

Regarding individual characteristics, we notice that the providers, who are not affiliated with a trade union, are less likely to suffer from violence than those who joined one (OR=0,39 < 1). Married providers are also less exposed to violence than the ones who are single (OR=0,51 < 1).

The level of insecurity felt by providers in health facilities increases the risk of violence (OR=1,32 > 1). On the contrary, mutual respect among employees (OR=0,25 < 1) and respect from patients towards providers (OR=0,27 < 1) significantly reduces violence in the workplace.

Other factors related to gender-based discrimination can be added: gender-based discrimination which has been noted in access to positions of responsibility (OR=3,53 > 1) and in the way employees are treated (OR=2,59 > 1), can significantly increase the risk of violence.

Finally, in relation to the location of health structures, it has been noted that the risk of violence is lower in southern facilities (OR=0,13 < 1) and the ones located in the city of Kigali (OR=0,21 < 1) than the ones in the northern regions of the country.

Table 15: Results of the logistic regression of violence in the workplace

VARIABLES	Log Odds Ratio	Odds Ratio (OR)	P-value
Constant	3.328	**27.88**	0.017
INDIVIDUAL CHARACTERISTICS			
Affiliation to a trade union			
"Non-members" compared with "members"	-0.938	**0.39**	0.006
Marital status			
"Married couples" compared with "singles"	-0.671	**0.51**	0.051
LEVEL OF SAFETY IN THE FACILITY			
Level of safety in the service			
"Unsafe" compared with "safe"	1.317	**3.73**	0.002
CULTURE OF RESPECT IN THE FACILITY			
Mutual respect between the employees			
"Enough respect" compared with "very little"	-1.156	**0.31**	0.036
"Much respect" compared with "very little"	-1.403	**0.25**	0.008
Respect between patients and providers			
"Little respect" compared with "very little"	-1.271	**0.28**	0.023
"Enough respect" compared with "very little"	-1.301	**0.27**	0.007
GENDER-BASED DISCRIMINATION			
Access to positions of responsibility			
"Unequal opportunities" compared with "equal opportunities"	1.262	**353**	0.005
Treatment of men and women			
"Different" compared with "same"	0.952	**2.59**	0.035
GEOGRAPHICAL LOCALIZATION			
Province			

VARIABLES	Log Odds Ratio	Odds Ratio (OR)	P-value
"South" compared with "North"	-2.031	**0.13**	0.001
"City of Kigali" compared with "North"	-1.576	**0.21**	0.028

Notes : Number of observations = 297

LR chi2(33) = 99.95 ; Prob > chi2 = 0.0000

Pseudo R2 = 0.2510

Maximal value of log-likelihood = -149,15

Variables, which are not significant at the tolerance threshold of 10%, are not presented in this table (gender, level of education, sector of the facility, location.)

We will take the analysis of the assessment results further by calculating the odds of experiencing violence according to the different factors. We will start from the reference category to measure the distribution of odds of experiencing violence, each time by letting one or several of its characteristics fluctuate. The reference category is defined with the assessment below (Table 15). It includes singles affiliated with a trade union and working in health facilities in Northern Rwanda, where safety is ensured and gender-based discrimination is not predominant (regarding the access to positions of responsibility and the treatment of employees) but where there is very little respect among employees and between patients and providers. For this group of providers, the OR equals 27.9; this corresponds to a 0.96 probability of experiencing violence (see table 16).

Table 16: Distribution of the probability of experiencing violence in relation to the reference category (or group)

Variation of characteristics for the reference category	Log Odds-Ratio	Probability	Variation (%)
Reference group	3.328	0.965	
Providers non-affiliated to a trade union	2.390	0.916	-5.4%
Married providers	2.657	0.934	-3.3%
Unsafe	4.645	0.990	2.5%
Providers show much mutual respect to each other (1)	1.925	0.873	-10.6%
Patients show enough respect to providers (2)	2.027	0.884	-9.3%

Variation of characteristics for the reference category	Log Odds-Ratio	Probability	Variation (%)
Providers and patients respect each other [(1) and (2)]	0.624	0.651	-48.2%
Men and women do not have equal access to positions of responsibility (3)	4.590	0.990	2.5%
Men and women are treated differently in the workplace (4)	4.280	0.986	2.1%
Ongoing discrimination [(3) and (4)]	5.542	0.996	3.1%
Ongoing respect but no equity between men and women within the service[(1), (2), (3) and (4)]	2.839	0.945	-2.2%

Therefore, nonaffiliation with a trade union decreases the risk of violence by 5.4%. The probability of suffering from violence among married providers is 3.3% lower than among singles. Regarding the culture of respect in the facilities, we noticed that the risk of violence is considerably lower, when mutual respect among providers is very high (10.6% lower) or when patients respect providers (9.3% lower). When these two conditions are met (good environment and mutual respect between patients and providers), the risk of emergence of violent incidents decreases by half (48.2%). However, when men and women do not have the same access to positions of responsibility and when they are treated differently, the risk of violence increases by 3.1%. It is also important to note that in a health facility, where patients and providers respect each other a lot, the risk of violence, instead of decreasing by 48%, will only decrease by 2%, if gender equity in the treatment of employees and career management (access to positions of responsibility) is not ensured.

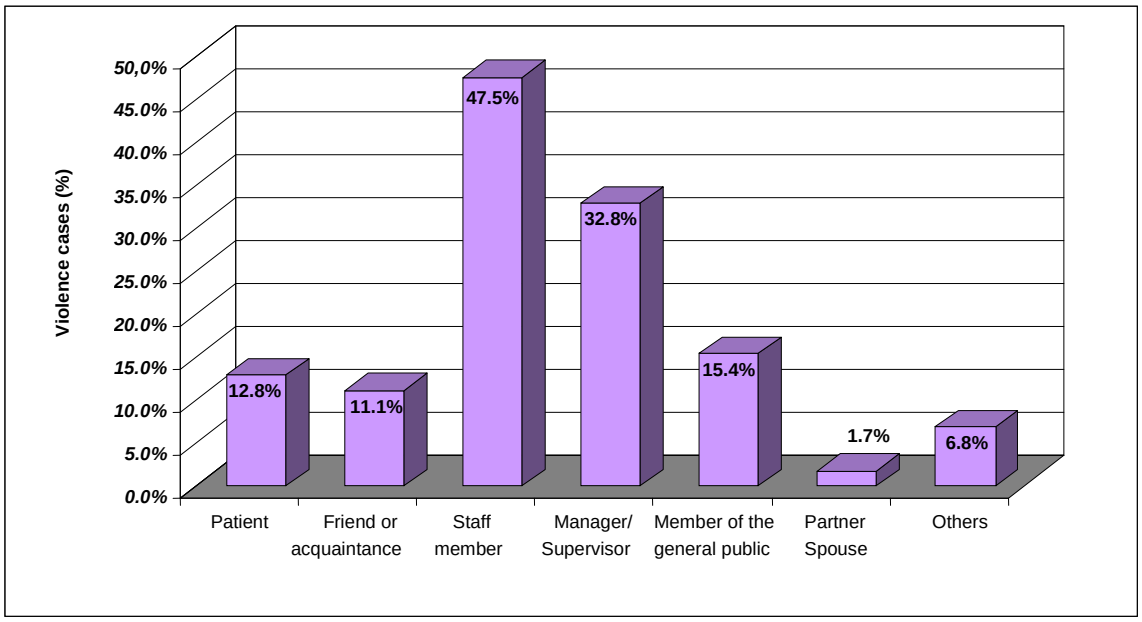
These results show that safety, mutual respect and gender equity are very important levers to fight violence within the health sector. The following section (Focus on gender: Perception of gender-based discrimination) will actually elaborate on the "gender issue."

III.2.5. Who are the perpetrators of violence?

The perpetrator may be a co-worker, a patient, a relative, a friend, or even a person outside the organization.

If we consider all types of violence as a whole, providers are involved in 47.5% of violent acts in the workplace, followed by supervisors (33%) and the general public (15%). A little bit more than 1 out of 10 times (13%), the patient is the perpetrator. 11% of cases are perpetrated by acquaintances and friends, while only 2% of cases are perpetrated by a partner or a spouse. The results are illustrated in the following graph:

Graph 23: Perpetrators of violence in the workplace



Source: Table 17 below (Tool #1)

According to the description given by the victims, the type of perpetrator depends on the type of violence:

- Regarding verbal abuse, physical violence and psychological harassment, providers in the facilities are the most involved in the perpetration of workplace violence. One out of two times (49.4%), the perpetrator of verbal abuse is a provider and one out of five times (20.8%), the perpetrator is the director or the supervisor. The providers are involved in the perpetration of 58% of physical violence cases, compared with 27% for supervisors. Psychological harassment is mostly perpetrated by supervisors (62%).

Patients are involved in 15% of verbal abuse cases and 17% of physical violence cases (see Table 17 below).

- Regarding harassment and sexual assault, the general public (people outside the service) is most involved with respectively 47% and 57% of all cases. Providers in the facility are responsible for 16% of all sexual harassment cases and 29% of sexual assaults cases. Supervisors are involved in 21% of sexual harassment cases. Partners and spouses are responsible in 18% of all cases.

Table 17: Perpetrators of violence depending on the type of violence

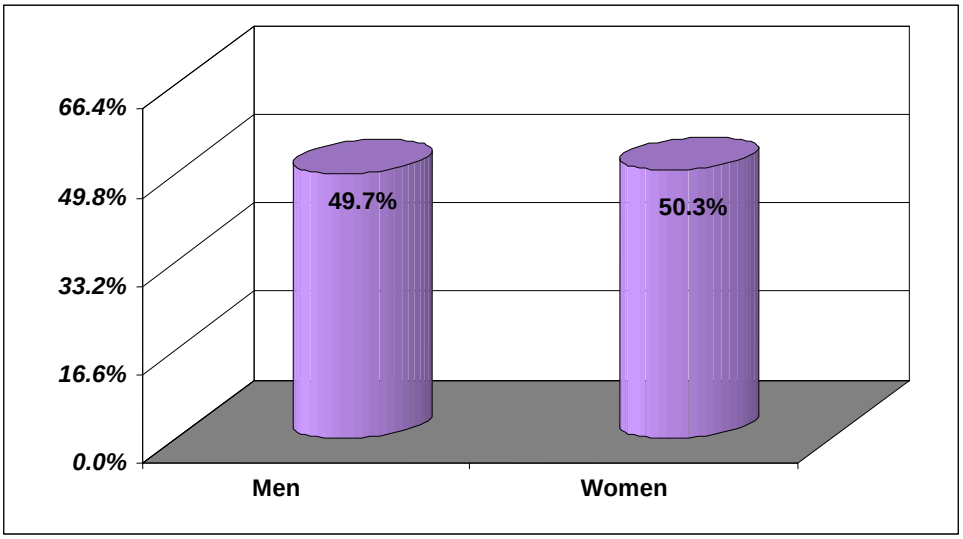
Perpetrators	Verbal abuse	Physical violence	Psych. harassment	Sexual harassment	Sexual assault	Global violence
Patient	14.5%	16.7%	4.2%	10.5%	0.0%	12.8%
Friends or acquaintances	11.8%	8.3%	6.3%	0.0%	0.0%	11.1%
Staff member	49.4%	58.3%	35.4%	15.8%	28.6%	47.5%
Manager/ supervisor	20.8%	27.3%	61.7%	21.1%	0.0%	32.8%
Member of the general public	7.8%	9.1%	0.0%	47.1%	57.1%	15.4%
Partner/Spouse	0.0%	0.0%	5.6%	18.2%	0.0%	1.7%
Others	6.5%	9.1%	2.1%	10.5%	14.3%	6.8%

a) Perpetrators' characteristics

Perpetrators' gender:

Generally, violence is perpetrated by men and women alike. There is no significant difference. Men are responsible in 49.7% of the cases. Women are considered perpetrators slightly more often, in 50.3% of violent incidents.

Graph 24: Perpetrators' gender



Source: *Table 23 – Annex B (Tool #1)*

Paradoxically, based on the results from the qualitative analysis, interviewed participants believe men commit more violent acts than women. There are numerous reasons why:

> Men have power in the workplace. Violence is committed by male supervisors because they are the people who most often manage health facilities. This power is granted to them by society and they also receive it because of their physical strength.

We will find an explanation for this inconsistency in the analysis of the link between the perpetrators' gender and the type of violence they commit. Indeed, while the results of the qualitative study show us that men are more often perpetrators than women, it is probably due to the fact that certain types of violence are specifically related to one gender. For instance, sexual harassment and sexual assault are usually attributed to men (Tool #4 11b).

As a matter of fact, the study with victims of violence (Tool #2) revealed that men commit serious violent acts more often than women. Indeed, among male perpetrators, 85% of them have committed serious acts of violence, compared with 72% for female perpetrators.

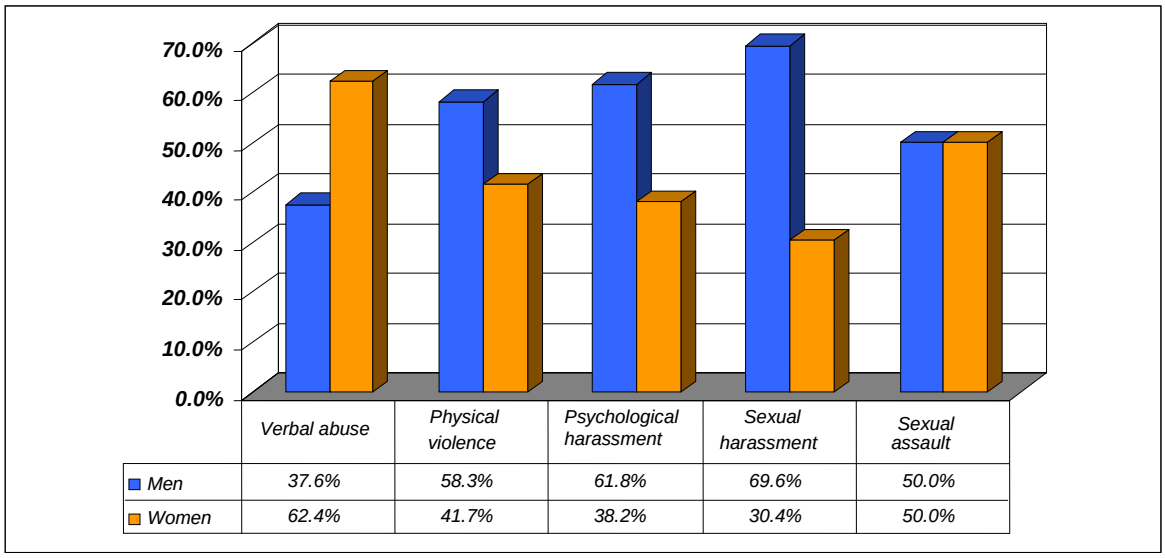
Table 18: Seriousness of violence and perpetrators' gender

Extent of the violence	Serious	Not serious	Total
Men	70	12	82
	85.4%	***14.6%***	***100.0%***
Women	64	25	89
	71.9%	***28.1%***	***100.0%***
Total	134	37	171
	78.4%	**21.6%**	**100.0%**

Note: *Pearson chi2(1) = 4.557 Pr = 0.033 < 0.05*

In addition, we notice that the perpetrators' gender changes according to the type of violence.

Graph 25: Perpetrators' gender by type of violence



	Verbal abuse	Physical violence	Psychological harassment	Sexual harassment	Sexual assault
Men	37.6%	58.3%	61.8%	69.6%	50.0%
Women	62.4%	41.7%	38.2%	30.4%	50.0%

Source: Table 23 – Annex B (Tool #1)

Only acts of verbal abuse are committed more often by women than by men (62% for women compared with 38% for men).On the other hand, men are responsible for more acts of sexual harassment (70%), psychological harassment (62%) and physical violence (58%). Therefore, the analysis of perpetrators' gender by type of violence seems to reflect the opinion of the groups we interviewed for the qualitative study, who said men committed more violent acts than women. If this gender analysis does not seem to match their opinion, it might be because women perpetrate verbal abuse more often, while it is the most common form of violence, creating a compensation effect.

Surprisingly, women commit sexual assaults as often as men do. However, based on the number of sexual assault cases recorded during the study (6), this result cannot really be applied on a national level.

We believe that this result is not only due to the small size of the sample but also to a data problem:

i. The analysis shows that men commit more acts of sexual harassment than women (see above). This trend should also be observed for sexual assaults. This paradox between those two types of violence does not seem to make any sense.

ii. Most publications on violence stress the fact that women are the main victims of sexual harassment and sexual assaults, and that perpetrators of such acts are undeniably men.

iii. This result differs noticeably from the perception of groups we interviewed during the qualitative study, regarding perpetrators of sexual assaults, "acts of sexual harassment are generally attributed to men" (#4 11b.)

Therefore it is necessary to take into account results from the quantitative analysis regarding sexual harassment and the results from the qualitative analysis regarding sexual assault.

Even though women globally commit as many act of violence as men, the analysis of the different types of violence (except for verbal abuse) show that men are the main perpetrators.

Proximity between perpetrators and victims:

Regarding the proximity between the perpetrator and the victim, the qualitative study reveals that, most of the time, these two elements are not related:

135 declarations confirm that there were no link between the two. In a few of them perpetrators are co-workers (21 out of 184 times), patients (six times), friends (four times) or supervisors (four times).

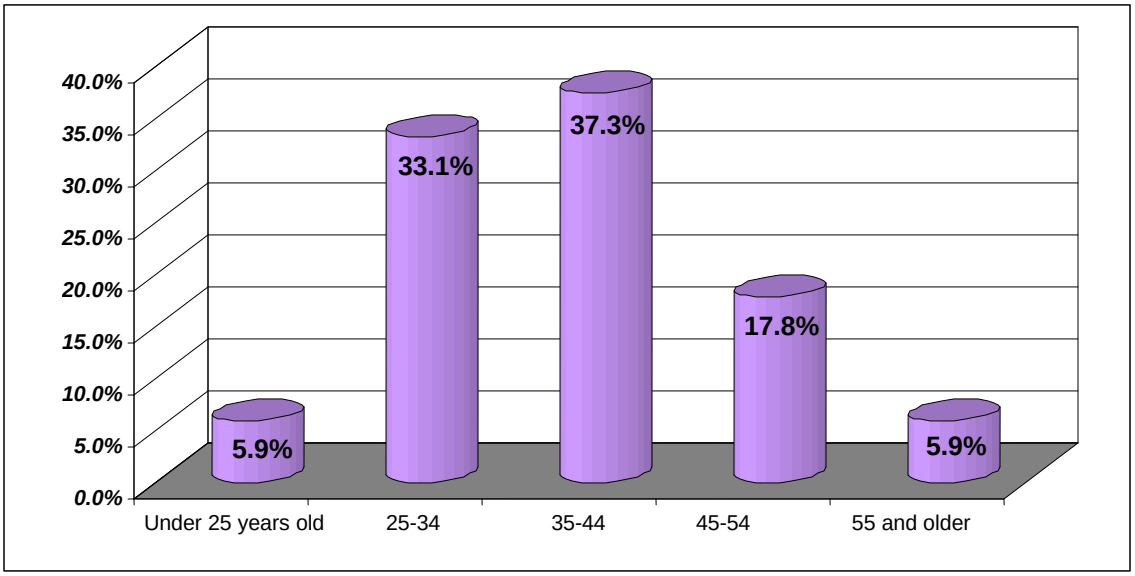
Table 19: Relation between the perpetrator and his condition

Answers	Number of participants
No relation/healthy	68
No relation	67
Patient	6
Co-worker	21
Friend	4
Too many people, cannot identify them	8
Supervisors and workers	4
Drunk	1
Both	1
Adult	1
Bi-polar individual	1
Do not know	1
Brother-in-law	1
Total	**184**

Age of the perpetrators:

The majority of offenders are 35 to 44 years old (37%) and 25 to 34 years old (33%). One out of four perpetrators is older than 44 (17.8% + 5.9%) and one out of twenty offenders is under 25.

Graph 26: Age of the perpetrators in the workplace

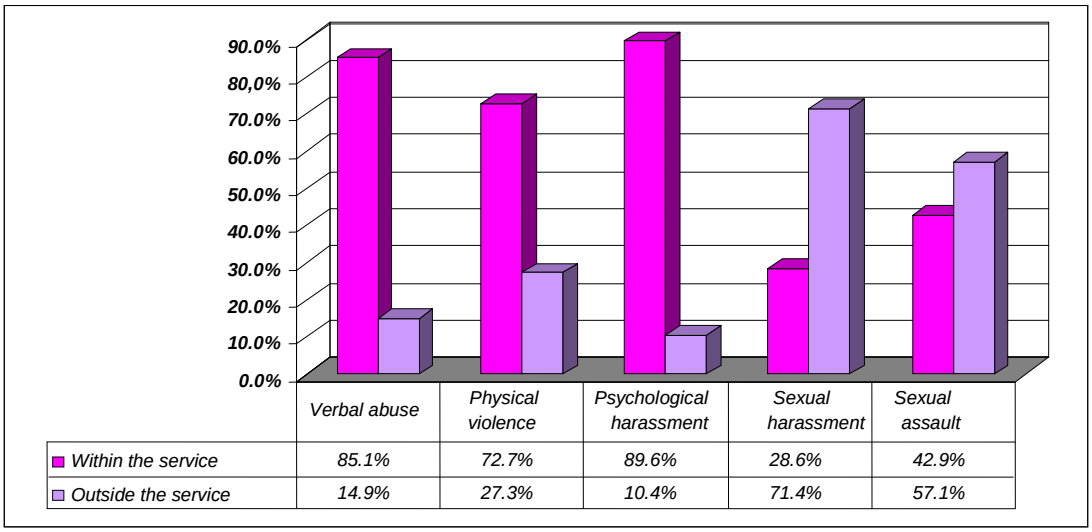


Source: table 24 – Annex B (Tool #1)

Location of violent acts

Most acts of violence are committed within health institutions, especially verbal abuse (85.1%), psychological harassment (89.6%) and physical violence (72.7%). Paradoxically, acts of sexual violence (harassment and assault) are more often perpetrated outside the services (either outside the health facility, at the victim's or during travel time). 71.4% of sexual harassment cases and 57.1% of sexual assaults occur outside the facility.

Graph 27: Places where the different types of violence have been perpetrated



	Verbal abuse	Physical violence	Psychological harassment	Sexual harassment	Sexual assault
Within the service	85.1%	72.7%	89.6%	28.6%	42.9%
Outside the service	14.9%	27.3%	10.4%	71.4%	57.1%

Source: Table 25 – Annex B (Tool #1)

Conclusion:

After the analysis of the victims' and perpetrators' characteristics, we learned that:

Age does not have a significant statistical effect on the emergence of violence. However, results seem to indicate the probability of experiencing violence decreases with age.

There is no significant difference between the percentages of male and female providers who experienced workplace violence. Although opinions collected during the study seemed to show that women experience violence more than men, the key informants declared that there was no difference, when men and women both have the same education level and the same experience.

The prevalence of workplace violence does not vary much depending on the provider's marital status. However, the proportion of single providers, who experienced violence, is relatively more important. Moreover, the study shows that widowed providers (14%) and single providers (11%) suffer from sexual harassment more often than married providers (4%).

We notice that providers, who have between 1 and 5 years of seniority in the service, are more vulnerable than their senior co-workers.

The prevalence of violence is also higher for technicians (53%), physicians (42%) and nurses (40%). It is lower for midwives (29%) and nursing auxiliaries (28%).

We also notice that globally, temporary workers are the most vulnerable to workplace violence.

There are more victims of violence among the providers who are affiliated with a trade union, than among non-affiliated providers. We assessed that the prevalence of global violence among trade union members was 50% compared with 35% among non-members.

We noted that facilities with the highest level of insecurity have the highest violence prevalence rates.

Regarding the availability of material and human resources, we noticed that the level of equipment in health facilities does not really influence the risk of workplace violence, unlike staffing. In facilities where the number of providers does not match the workload, the prevalence of violence is high.

Respect among employees helps reduce workplace violence drastically. In facilities, where there is not much respect between employees, up to 61% of providers suffer from violence, while in structures where the level of respect is high, only 28% of them are victims of violence.

Certain kinds of behaviors are seen as a sign of disrespect by patients:

→ Negligence and delays while they are admitted in the facility; especially women who are in labor.
→Prolonged appointments with physicians and insults, as well as offending remarks.
→ Favoritism among patients.
→ Refusal to give medications to some patients under the pretence that they are poor or uninsured.
→ Lack of patience of providers towards patients.

The participants we interviewed also agree that patients lack respect towards providers.

In facilities, where providers think that men and women do not have the same access to positions of responsibility, the prevalence of violence is almost twice as high (62%) as the one in facilities where gender equity is ensured (35%).

According to the factorial analysis above, victims of violence are young single providers working in health facilities, located in rural or urban areas. These facilities have an average or very low level of equipment and the work environment there is hostile (very little respect among providers and towards patients, as well as a very high level of insecurity in the workplace).

The econometrical model helped us identify mutual respect among providers and from providers towards patients, as factors reducing the risk of emergence of violence. However, the absence of gender equity in the treatment of employees and in the access to positions of responsibilities, are incentives to violence.

Therefore, safety, mutual respect and gender equity are considered very important levers in the fight against violence within the health sector.

As far as perpetrators are concerned, the providers are globally involved in 47.5% of acts of workplace violence. Perpetrators may vary depending on the type of violence:

→ Regarding verbal abuse, physical violence and psychological harassment, health care providers are the most involved in these types of workplace violence. For sexual harassment, the general public and co-workers are mostly responsible.

Generally violence is perpetrated by men and women alike. There is no significant difference. According to the results from the qualitative study, interviewed participants think men commit more acts of violence than women. This contrast is due to the fact that certain types of violence are more specific to one gender. Indeed, the analysis by type of violence showed that men are the main perpetrators of most violence types (except verbal abuse).

Usually, there is no link between the perpetrator and the victim. In addition, the majority of offenders are between 35 and 44 years old (37%) and between 25 and 34 years old.

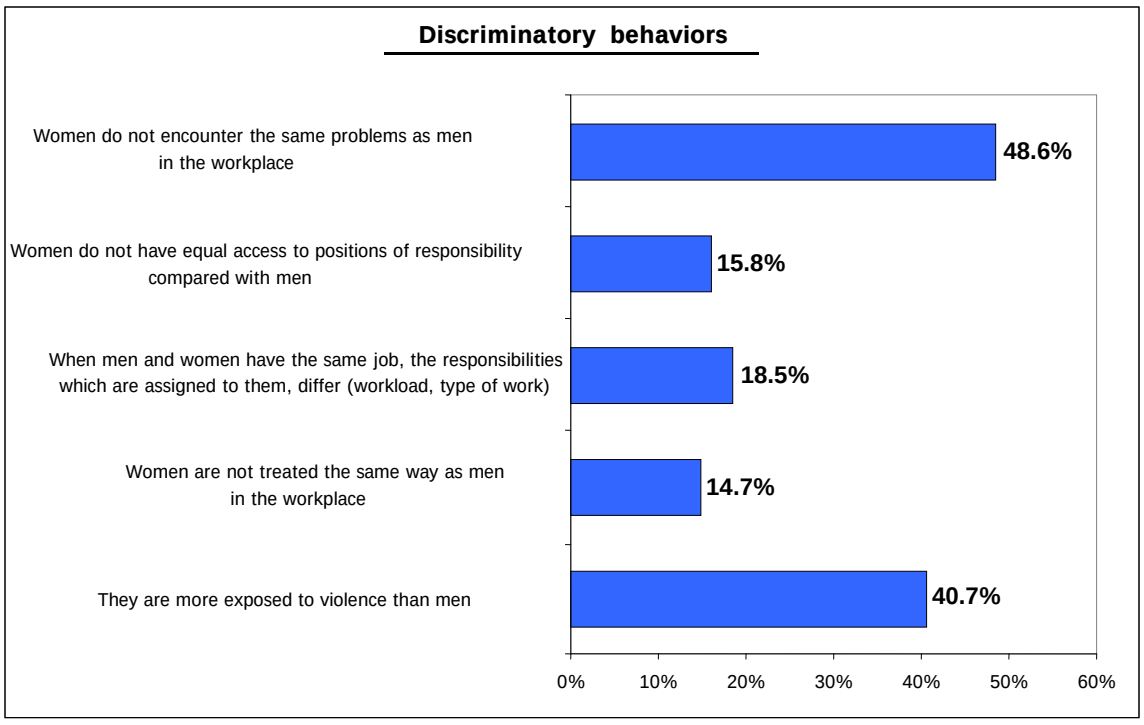
Regarding the places, where violence is perpetrated, most acts of violence occur within the facility, especially for verbal abuse (85.1%), psychological harassment (89.6%) and physical violence (72.7%). Only acts of sexual violence (harassment and assault) are more often perpetrated outside the service (in the health facility, at the victims' or during travel time).

Since we got mixed results with the "gender" issue, we will elaborate on this topic in the following section.

III.3. Focus on gender: Perception of gender-based violence

According to health care providers, there are several types of workplace discrimination against women in Rwanda. We looked at the results about the different types of discriminatory behaviors, which are the most often perceived by providers, as they could be of interest in our framework (see graph 28 below.)

Graph 28: Discriminatory behaviors women are confronted to in health facilities



Source: *Tables 26, 27, 28, 29 and 30 – Annex B (Tool #1)*

III.3.1. Perceptions of problems men and women are confronted with in the workplace

According to the graph above, almost half of the participants we interviewed (48.6% = 141 providers) agree that women do not encounter the same problems as men in the workplace. During the qualitative study, the main conclusion we drew from the different interventions we had with the interviewed providers was that women encounter more difficulties at work than men. These problems can be explained by gender specificities and cultural habits.

Indeed, as part of their gender specificities, women may become pregnant, have a child, breastfeed and according to participants, all these responsibilities prevent them from fully completing the workload they have been assigned because of prolonged absences (child sickness, faintness during pregnancy, maternity leave, etc.)

During the interviews, 62 out of 91 participants (see Table 31 – Annex B) told us about that problem. Three participants believe that because of their family responsibilities (taking care of their family and children, pregnancy, breastfeeding), women are constantly weakened and it has consequences on the work they can accomplish. According to one participant, it bothers other workers so much that they accuse women of avoiding work under the pretence that they are sick. Four participants also claimed that patients do not trust female providers.

Because of their situation in society, female providers are targets for numerous negative stereotypes, as well as unfair and exaggerated criticism. They are also victims of traditional prejudices. Traditional gender roles established by society are the roots of domination by males and passivity of women, no matter how unfairly they may be treated. These results are emphasized by the qualitative analysis:

The participants claimed that "women like to keep silent," that "they can be easily bullied," that "they are not as strong as men" or that "they cannot make certain decisions." In other words, silence, weakness and indecision are the main characteristics of female providers in Rwanda according to participants.

III.3.2. Discrimination in career management: Professional segregation

Based on Graph 28, most providers think that women and men have the same access to positions of responsibility, while 16% of providers do not think women have the same opportunities in that area. Nevertheless, this perception is confirmed when we analyze the level of responsibilities depending on gender. Indeed, the total sample we used during our study included 297 individuals, divided in the following way: 205 women (69%) and 92 men (31%). Thus, if there was equity in the access to positions of responsibility, the proportion of men and women in each level of responsibility should noticeably reflect the distribution of the original sample. In other words, there should be 69% of female directors, assistant directors, providers and independent workers. But the data we gathered does not reflect this trend, as it is emphasized by Table 20 below:

Table 20: Expected and actual distribution of providers by rank and by gender

(Vertical) segregation of the director position

Level of responsibility	*Expected equitable distribution*		*Actual distribution observed during the study*	
	Men	*Women*	*Men*	*Women*
Directors	*3*	*7*	*6*	*4*
	31.0%	*69.0%*	*60.0%*	*40.0%*
Assistant directors	*16*	*37*	*16*	*37*
	31.0%	*69.0%*	*30.2%*	*69.8%*
Providers	*69*	*155*	*68*	*156*
	31.0%	*69.0%*	*30.4%*	*69.6%*
Total	*92*	*205*	*92*	*205*
	31.0%	*69.0%*	*31.0%*	*69.0%*

Source: Table 32 – Annex B(Tool #1)

Table 20 shows that despite the general perception of the participants, men and women do not have the same access to positions of responsibility. While men only represent 31% of the sample, they account for 60% of directors (that is to say they are overrepresented in this category). For intermediate levels (assistant directors and providers), gender distribution reflects the sample's content.

Altogether, the results show that gender segregation in executive positions within the health sector is neither perceived nor known.

The interviewed participants claimed that due to prejudices, women are considered weak, in every sense of the word (on a physical and professional level, because of pregnancy, breastfeeding, child delivery, days off) and that in some cases violence results from this situation. As a matter of fact, some providers told us they witnessed cases in which raises, promotions and opportunities were denied to providers because they were women. "Before I even gave birth, I was working as an assistant director. After I had my child, I was demoded for no reason so I thought it was because of me being pregnant." "I passed the test but I was told I would not be hired because I would go on maternity leave at some point." "She received bad evaluations, as she could not come to work because of the feeling of general discomfort she had during her pregnancy." "A woman was refused a job because she was pregnant" (Tool #1 22A.)

Female providers are sometimes blackmailed for a job, a promotion or even a raise. 3% of interviewed female providers (Tool #1) said they got a promotion because their supervisors thought they would have sexual relations with them in return (Table 21).

Table 21: Promotions in exchange of sexual favors

Give someone a job, a promotion or a raise in exchange of sexual favors	*Number*	%
Yes	6	2.9%
No	198	97.1%
Total	204	100.0%

Source: Tool #1

Among the six providers who declared they had been refused a promotion (for positions of responsibilities) or a raise, five were women (see Table 33 – Annex B). Even though such cases are rare, (six out of 204 women) they must be mentioned because of their seriousness and their implications in career management[14].

III.3.3. Discrimination in assignments

Nearly one out of four providers (19%) says that even though men and women have the same positions, the responsibilities that are assigned to them differ in terms of workload and type of work (see Graph 28).

Thus, women are often relegated to positions of secondary importance, even if this kind of mentality is strongly discouraged by politics in the country. According to the qualitative analysis:

> Such situations can be seen in the workplace and make people underestimate women to such an extent that some people believe, "they cannot even pull teeth." According to some key informants, people are prejudiced against women. People tend to call them "weak" in every sense of the word (no physical strength, low level of efficiency at work) and in some cases, violence against them is a consequence of this situation. In addition, some people think that, "certain activities should only be done by men" (Tool #7 and #8.)

These results suggest that there is a gender-based segregation regarding work assignments within the health sector.

III.3.4. Vulnerability to workplace violence

Here are the reasons why women are vulnerable to workplace violence: women face particular problems in the workplace, they suffer from negative stereotypes and they are discriminated

[14] In order to document this type of discrimination, we will need to use methods based on the analysis of responsibilities and tasks and not only on perceptions.

against in their work evaluations and in their career management plans. To a certain extent, the responsibilities they are assigned are consequences of these problems and stereotypes. Most health services are run by men; therefore, women are relegated to positions of secondary importance. Finally, they suffer from discriminatory social and cultural considerations. Indeed, two out of five interviewed providers (41%) have told us that women are more exposed to violence than men (see Graph 28.)

In the case of acts of violence, the groups we interviewed as part of the qualitative study have acknowledged that men are the main perpetrators of violence in the workplace. Moreover, many participants (49 out 127) said men seem to handle violence better than women. Also, an important number of individuals (34 out of 127) confirmed this fact when they told us that women are more sensitive than men and that they tend to interiorize their feelings more; especially regarding sexual harassment, a type of violence which mostly targets women (Table 22).

Table 22: Tool 1 29a (qualitative)

#	**Do men and women react to violence differently in the workplace?**	**Occurrences**
1	Men can handle violence more than women	49
2	Women are sensitive. They suffer more than men.	34
3	Women suffer inwardly	19
4	It depends on everyone's sensitivity and personality	11
5	Everyone suffers the same way	4
6	Men and women react differently	4
7	It depends on the type of violence. When women suffer from sexual violence, they keep silent	3
8	Women become pregnant and they catch aids	2
9	Men suffer financially more than women	1
	Total	**127**

The data we collected during the study did not help us figure out what perceptions result from these stereotypes.

Conclusion:

Overall, we can notice that women encounter more problems in the workplace than men. The discrimination they suffer from results from different elements, which are related to their position in society and their family responsibilities.

Female providers do not have equal access to positions of responsibility; the quantitative study showed that men are overrepresented in these positions. Women also suffer from negative stereotypes and must overcome obstacles in their career management, such as blackmail, when they look for a job and ask for a promotion or even a raise. They are also victims of job segregation. According to the groups we interviewed, women are more exposed to violence than men. While the quantitative analysis showed that men and women were both exposed to workplace violence, twice as many women suffer from sexual harassment.

Analysis of the victims' reactions and impact of workplace violence

III.3.5. Reactions and responses to workplace violence

a) Reporting acts of violence

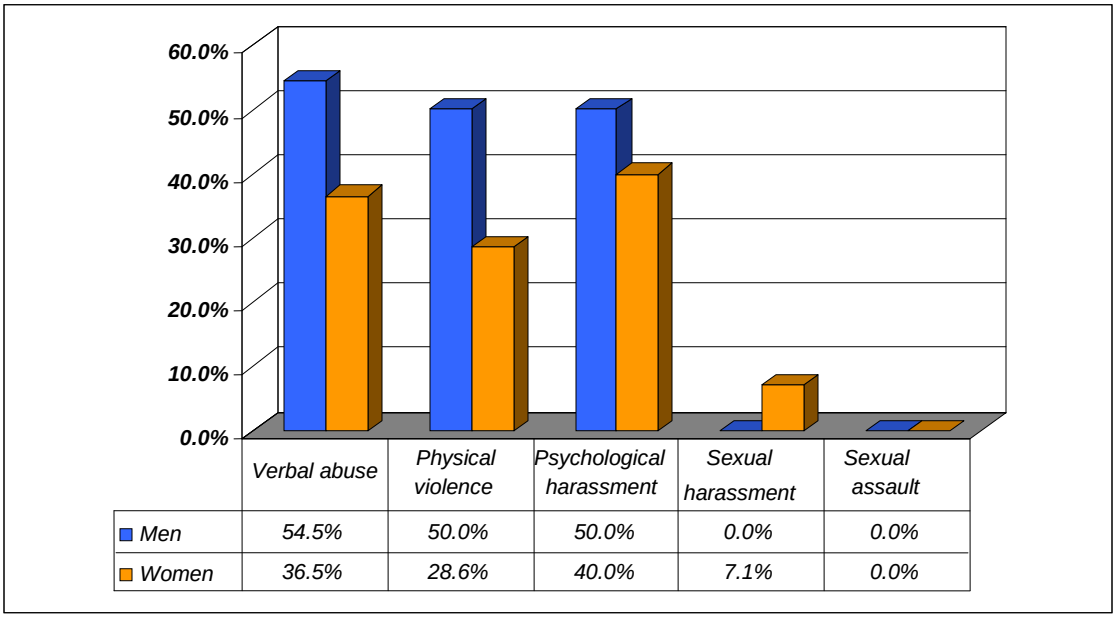
Most of the participants in the study, who experienced verbal abuse (49%), physical violence (36%) and psychological harassment (42%), said they reported the incidents to their coworkers, while two out of five victims did not report anything related to the incidents. Psychological harassment in the workplace is the type of violence most reported to supervisors and relatives.

Table 23: Complaints regarding acts of violence by type of violence

Person talked to	Verbal abuse	Physical violence	Psychological harassment	Sexual harassment	Sexual assault
None	20.0%	25.0%	18.8%	40.0%	50.0%
Coworker	48.7%	36.4%	42.6%	15.0%	0.0%
Supervisor	19.5%	18.2%	34.0%	10.5%	0.0%
Friend	6.7%	27.3%	17.0%	20.0%	16.7%
Relative	10.5%	0.0%	21.3%	10.5%	0.0%
Counselor	2.7%	0.0%	0.0%	0.0%	0.0%
Perpetrator	10.7%	9.1%	6.4%	15.6%	0.0%
Other	0.0%	27.3%	10.6%	16.7%	0.0%

As indicated in Graph 30, women do not tend to formally report incidents like men do but the difference is not statistically significant.

Graph 30: Percentage of victims of violence in the workplace who formally complained about it



	Verbal abuse	Physical violence	Psychological harassment	Sexual harassment	Sexual assault
Men	54.5%	50.0%	50.0%	0.0%	0.0%
Women	36.5%	28.6%	40.0%	7.1%	0.0%

Source: Table 34 – Annex B (Tool #1)

More than half of men who experienced verbal abuse (54.5%), physical violence (50%) and psychological harassment (50%) formally reported the incidents. Women tend to talk about psychological harassment (40%) more than other types of violence. Only 7% of women who experienced sexual harassment reported it.

The analysis of qualitative data show that providers and key informants agree on the fact that women keep the incident a secret and decide to talk about it when it is too late (Tool #6.)

Men (46%) and women (47%) mostly report verbal abuse to their directors and supervisors (Table 24 below.) Also, men and women report acts of physical violence to the police (respectively 94% and 92%). So do they when it comes to sexual harassment (respectively 100% and 96%.) It is important to note that providers almost never report these incidents to professional associations.

Table 24: Declaration of acts of violence by victims' gender

People receiving the report	Male				Female			
	Verbal abuse	Physical violence	Sexual harassment	Sexual assault	Verbal abuse	Physical violence	Sexual harassment	Sexual assault
Director/ supervisor	11	0	0	0	18	2	1	0
	45.8%	*0.0%*	*0.0%*	*0.0%*	*47.4%*	*8.3%*	*4.5%*	*0.0%*
Police	7	15	14	0	15	22	21	0
	29.2%	*93.8%*	*100.0%*	*0.0%*	*39.5%*	*91.7%*	*95.5%*	*0.0%*
Professional association	1	0	0	0	0	0	0	0
	4.2%	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*

People receiving the report	Male				Female			
	Verbal abuse	Physical violence	Sexual harassment	Sexual assault	Verbal abuse	Physical violence	Sexual harassment	Sexual assault
Other	5	1	0	0	5	0	0	0
	20.8%	*6.3%*	*0.0%*	*0.0%*	*13.2%*	*0.0%*	*0.0%*	*0.0%*

Based on the results of the qualitative analysis, numerous participants admitted they had not reported incidents (60 out of 104 participants, Tool 21j) and had not done anything about them afterwards (58 out of 107 participants, Tool 21k). Most of the ones who reported the incidents, directly talked to the perpetrator, while others told their friends, their supervisors or even the police.

Table 25: Victims' reactions after suffering from violence

#	What the victim said after suffering from violence	Occurrences
1	Nothing	60
2	I begged him not to do it again	14
3	I told a friend/a person I trust	5
4	I said I did not want to (have sexual intercourse)	4
5	I got mad/I insulted him/I asked for mercy	4
6	I accepted	3
7	I told my supervisors	3
8	That they lied about me	2
9	We held a meeting	2
10	That they earn less than these people do	1
11	What are they going to do with the money	1
12	That the man wanted me to lose my job	1
13	That I will not represent others anymore	1
14	That we will keep on welcoming people	1
15	I explained the reason why I did it	1
16	I explained myself and I asked if there would be any problems being a Muslim in a Christian health center	1
	Total	**104**

Source: Tool 21j (qualitative study)

b) Other victims' reactions

Regarding the immediate reaction after the act of violence has occurred, we notice, through the qualitative analysis, that each individual tells his/her own story and that is the reason why no clear tendency can be defined. However, many participants told us the following: "I lost my self-esteem/Life had no meaning/I felt insecure after it happened/I don't want to talk about it anymore/I want to work independently from my coworkers and my supervisors/I avoided my boss after the incident/I was angry/I wanted to quit/ I am still scared." These statements reflect fear, frustration and rebellion from the victims. There are discrepancies in some of the victims' feelings. One provider said that since the day it happened, she has raised awareness among other people so it would not happen to them, while another provider admitted she resigned herself to accept violence (Tool #24.)

With the qualitative data, we tried to find out what the victim thought after they had suffered from violence. Most victims were very affected by what had happened to them. However, the majority of the victims do not always think about reporting the incidents after they occur, as they are surprised and shocked about what happened to them. Indeed, 32 interventions show that victims did not say anything. 17 interventions reveal that the victims thought about quitting their job because they had been shocked, angry and upset of what happened. Few people thought about they would do to the perpetrator and only six interventions showed that the victim was thinking about turning the perpetrator in. Some victims did not report the incident because they did not have anybody to turn to or because they were worried about their children's reaction.

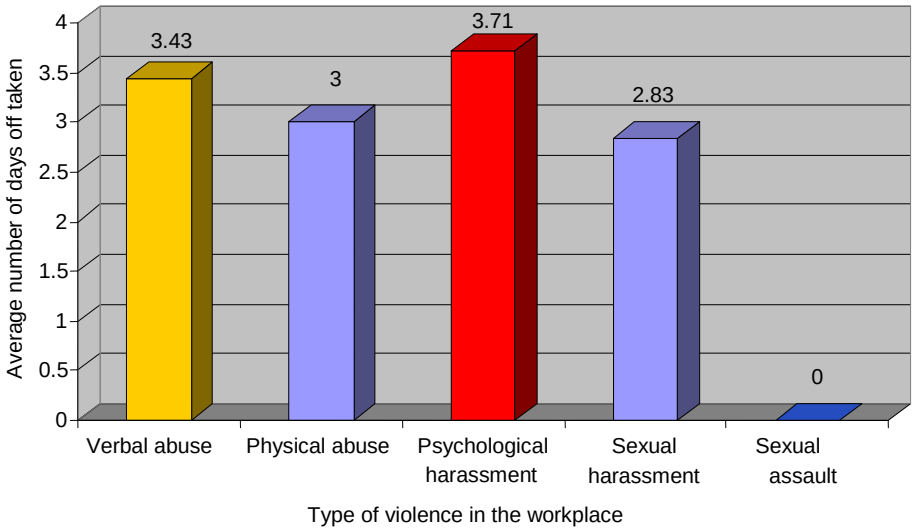
III.3.6. Consequences of violence

a) Consequences in the workplace

⇨ Absenteeism

As indicated in Graph 30, on average, victims of psychological harassment missed work for a longer period of time than victims in other categories (almost four days.) They are followed by victims of verbal abuse (3.4 days) physical violence (three days) and sexual harassment (2.8 days.)

Graph 31: Average number of days off taken because of a violent incident

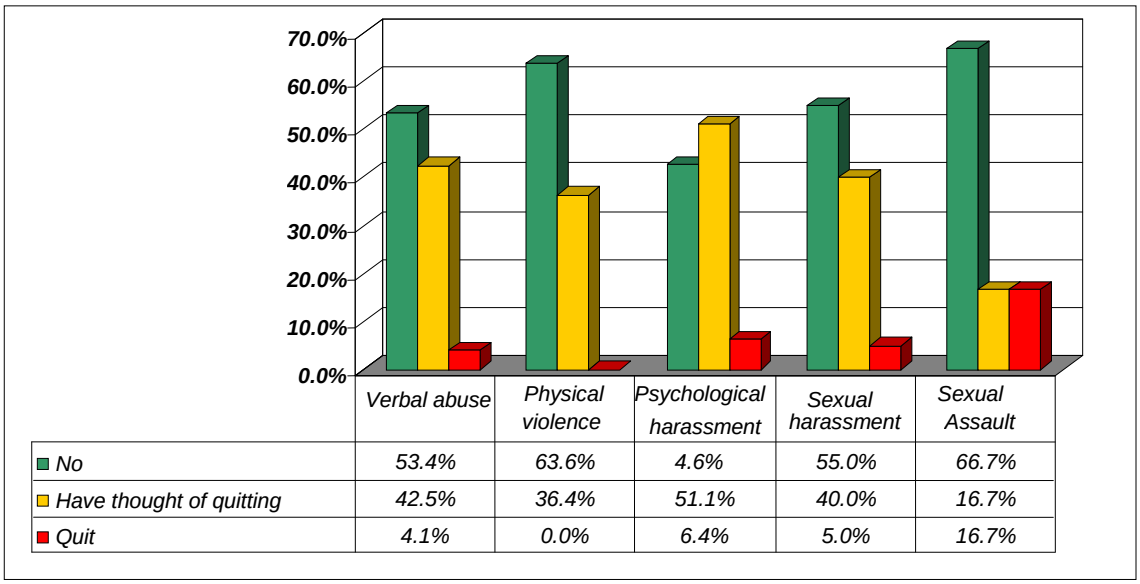


Source: *Table 35 – Annex B (Tool #1)*

⇨ Resignation

As indicated in Graph 32, most providers considered resigning instead of suddenly quitting. 5% of providers quit because of sexual harassment and 6.4% because of psychological harassment. Many of those, who experienced psychological harassment (51%) and verbal abuse (43%) thought about quitting.

Graph 32: Reactions of victims depending on the type of violence they suffered from



	Verbal abuse	*Physical violence*	*Psychological harassment*	*Sexual harassment*	*Sexual Assault*
No	*53.4%*	*63.6%*	*4.6%*	*55.0%*	*66.7%*
Have thought of quitting	*42.5%*	*36.4%*	*51.1%*	*40.0%*	*16.7%*
Quit	*4.1%*	*0.0%*	*6.4%*	*5.0%*	*16.7%*

Source: *Table 36 – Annex B (Tool #1)*

Approximately 55% of health care providers who experienced workplace violence quit or have thought about quitting their job after the incidents.

For men, physical violence (60%) and psychological harassment (50%) are the main reasons why they would quit, compared with psychological harassment (52%), sexual harassment (47%) and sexual assault (46%) for women.

Table 26: Reactions of victims by gender and type of violence

Reactions	Male					Female				
	Verbal abuse	Physical violence	Psych. harass-ment	Sexual harass-ment	Sexual assault	Verbal abuse	Physical violence	Psych. Harass-ment	Sexual harassment	Sexual assault
No	*60.9%*	*40.0%*	*50.0%*	*80.0%*	*100.0%*	*50.0%*	*83.3%*	*38.7%*	*46.7%*	*50.0%*
Have thought of quitting	*34.8%*	*60.0%*	*50.0%*	*20.0%*	*.0%*	*46.0%*	*16.7%*	*51.6%*	*46.7%*	*25.0%*
Quit	*4,3%*	*.0%*	*.0%*	*.0%*	*.0%*	*4.0%*	*.0%*	*9.7%*	*6.7%*	*25.0%*

According to the qualitative analysis, women adopt a different behavior and sometimes end up quitting, while men seem to keep on working as though nothing happened. However, when it comes to claiming unpaid salaries, men and women react the same way (Tool # 6.)

These results show us that violence has an impact on how providers work. Some stop liking their job (eight out of 39), while others are not motivated anymore (five out 39 interventions).

Very few health facilities managers answered this question, but six interventions show that violence creates misunderstanding and a bad work environment.

b) Consequences for the family

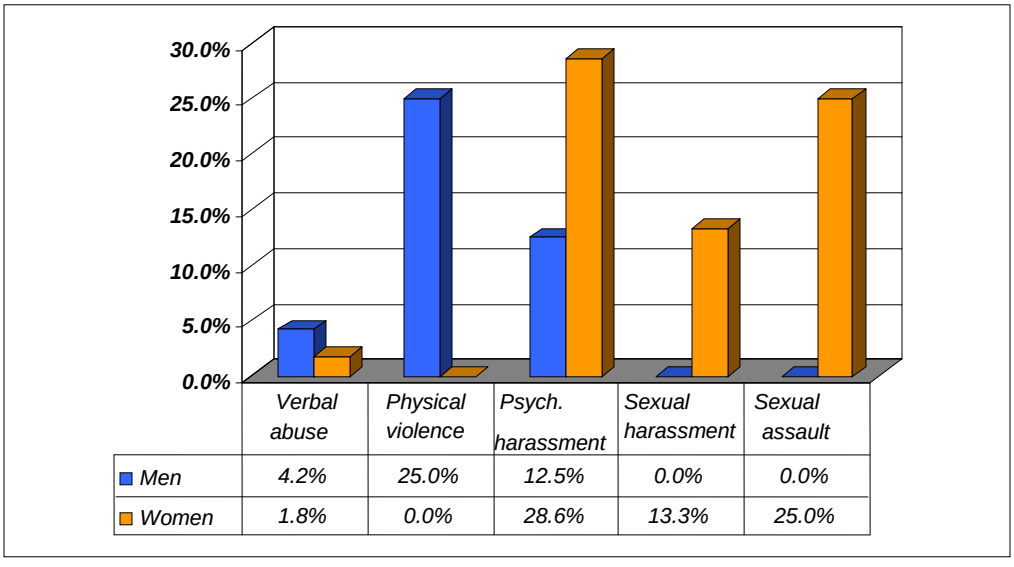
In general, 22.2% of workplace violence victims say that their experience has had an impact on their family. It has been said by women (23.6%) more often than by men (19.4%.) However, the gender differentiation is not very significant (Table 27).

Table 27: Impact of violence on family depending on gender

		Gender of the participant		Total (n=108)
		Male (n=36)	Female (n=72)	
Impact of workplace violence on family	No	80.6%	76.4%	77.8%
	Yes	19.4%	23.6%	22.2%
Total		100.0%	100.0%	100.0%

The graph below shows that experiencing psychological harassment, sexual harassment and sexual assault has a bigger impact on the family when the victim is a woman. For verbal abuse, only one man (4.2%) and one woman (1.8%) said that their experience of workplace violence had an impact on their family.

Graph 33: Impact of violence on family depending on the victim's gender



Source: Table 37 – Annex B (Tool #1)

The results from the qualitative analysis show that some participants said that the family is affected, when the victim of workplace violence is a woman. Indeed, if she decides to quit, her family will suffer financially. In addition, as certain participants mentioned, her spouse will be morally affected and sometimes he will blame his wife. Finally, many participants said that violence results in a kind of trauma, the characteristics of which are anxiety, tension and lack of energy and dignity (Tool 25a.) There is no doubt that these feelings will have consequences on the victim's family.

c) Physical consequences

29% of providers said that their experience of violence had an impact on their physical health.

Table 28: Impact of violence on physical health

Impact of violence on physical health	Number	%
Large	26	15.1%
Average	22	12.8%
None	124	72.1%
Total	172	100.0%

Regarding the way violence has affected the victim's physical health, qualitative data showed that among the people, who said that they had been physically affected by violence, ten out of 38 participants have had a sort of trauma which was characterized by anxiety, tension, nausea and the feeling that coworkers and directors had no more trust in him/her. Eight out of 38 participants said they lost weight. Those who quit have experienced consequences in their life. Restlessness, fatigue, lack of energy, stomachaches are the kind of sufferings the participants experienced. One individual even noticed one of his cheeks had swollen (Tool 25a.)

d) Psychological consequences

Two out of three providers (65.7%) said they experienced psychological problems after they suffered from workplace violence. For more than one-third of the victims (37.2%), experiencing violence has resulted in serious psychological problems (Table 29.)

Table 29: Impact of violence on psychological health

Impact of violence on psychological health	Number	%
Large	64	37.2%

Average	49	28.5%
None	59	34.3%
Total	172	100.0%

Through the qualitative analysis, we tried to find out how violence psychologically affects the victims.

> Many people are haunted by violence after it has occurred and they keep thinking about it (27 out of 85 participants = 32%). Others (22 out of 85 participants = 26%) feel hatred towards the perpetrator or lose their self-esteem to the point where they want to run away from the one who harmed them: "I cannot be around the one who harmed me anymore" or "I hate the one who put me through this".
>
> At the same time, some feel rejected by others and by the community. Finally, in a few cases, victims change their behavior or their way of life by isolating themselves, not eating… (Tool 26a)

e) Consequences on the providers' performance and on how they carry out their responsibilities

Violence has a considerable impact on the providers' performances. Almost 29% of health care providers, who experienced violence, said it affected their work (table 30).

Table 30: Impact of violence on health care providers' good practice

Impact of violence on providers' performance	Number	%
Large	25	14.5%
Average	21	12.2%
None	123	71.5%
Total	169	98.3%

f) Harshness of violence and consequences for the victims

The harsher the violence is, the worse the consequences are on psychological and physical health. The table below shows us that the impact of violence on psychological and physical health increases with the level of harshness. Also, there is a relation between the harshness of violence and the resentment of employees towards their job, even though this relation is not statistically significant.

Table 31: Relation between harshness of violence and consequences for health

Impact of violence		Harshness of violence		Correlation	Pearson Chi2	Significant
		Harsh	*Not harsh*			
Consequences on physical health	Large	24	2	**0.12**	**7.87**	**Pr = 0.020**
		17.8%	***5.4%***			
	Average	13	9			
		9.6%	***24.3%***			
	None	98	26			
		72.6%	***70.3%***			
Consequences on mental health	Large	60	4	**0.27**	**14.27**	**Pr = 0.001**
		44.4%	***10.8%***			
	Average	35	14			
		25.9%	***37.8%***			
	None	40	19			
		29.6%	***51.4%***			
Consequences on performance at work	Large	24	3	**0.11**	**2.28**	**Pr = 0.320**
		18.5%	***8.1%***			
	Average	16	5			
		12.3%	***13.5%***			
	None	90	29			
		69.2%	***78.4%***			

Thus, violence has a negative impact on the providers' health, especially psychological health, and results in lost working time for the company. Absenteeism is a perfect example for that.

111.3.7. How does the institution respond to violence?

When asked if the supervisor or the director of the facility took measures to help the victim or to respond to violence, three out of ten participants said yes (30%.) The proportion of health

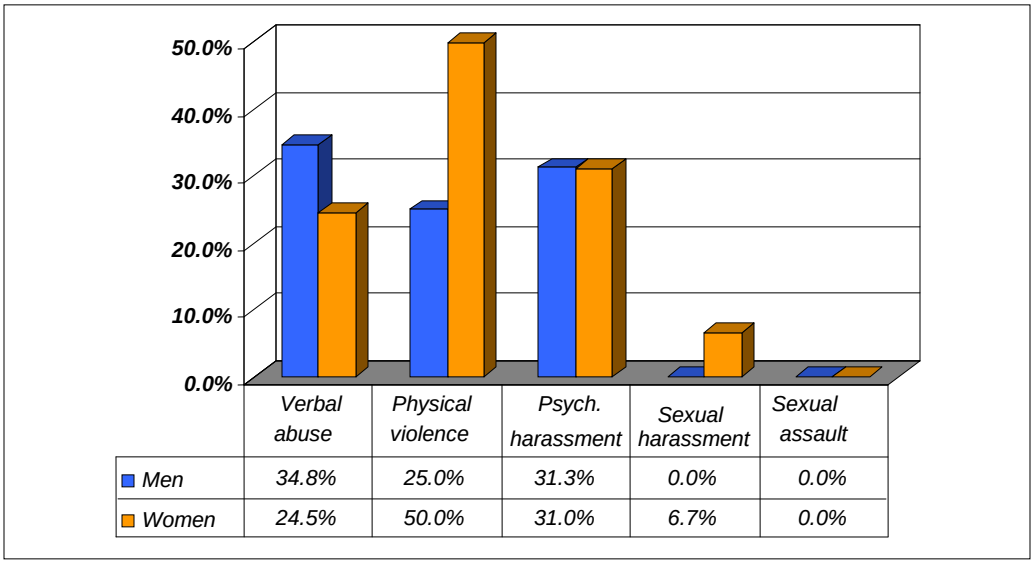
care providers, who agreed that the directors had tried to solve the problem, is higher among men (33%) than among women (29%.) The gender difference is; however, not significant.

Table 32: Opinion of the victims regarding measures taken by directors of the facilities against violence

Opinion of the victims	Men	Women	Total
No measure taken	66.7%	71.4%	69.8%
Measure taken	33.3%	28.6%	30.2%
Total	**100.0%**	**100.0%**	**100.0%**

Almost a third of men (29%) and approximately one out of four women (19.4%) said that the supervisor or the director took measures to prevent verbal abuse. One-fourth of women who suffered from physical violence, said that their employers and supervisors took some measures to prevent violence and/or to help the victims. 31% of women who suffered from psychological harassment have received support from their supervisor, while only 6.7% of women who have been victims of sexual harassment, have noticed their supervisors taking action to prevent this type of violence.

Graph 34: Opinion of the victims regarding measures taken by directors of facilities by gender and type of violence



Source: Table 38 – Annex B (Tool #1)

Conclusion:

The majority of victims from verbal abuse, physical violence and psychological harassment said they reported the incidents to their coworkers. More than half of men formally reported acts of violence they experienced. Women tend to talk about psychological harassment more than other types of violence.

Both men and women report incidents to the police when it comes to physical violence (respectively 94% and 92%) and sexual harassment (respectively 100% and 96%.) It is very rare for providers to report these incidents to professional associations.

Regarding the consequences of violence on the providers' performances, victims of psychological harassment missed work for a longer period of time after the incident than victims of other types of violence (four days on average.) They are followed by victims of verbal abuse (3.4 days), physical violence (three days) and sexual harassment (2.8 days.) Generally, 55% of providers who experienced workplace violence have quit or have thought of quitting their job after the incidents.

Violence also affects the performance of providers; about 29% of providers who experienced violence said it had an impact on their work.

Generally, 22.2% of victims say that experiencing violence has had an impact on their family. 29% said that it affected their physical health. Ten out of 38 participants have experienced a kind of trauma, which was characterized by restlessness, tension, nausea and the feeling that coworkers and supervisors did not trust them anymore. Eight out of 38 participants said they lost weight.

Workplace violence has the greatest impact on psychological health. Two out of three providers said they experienced psychological problems after the incidents. Some of them are still haunted by the act of violence as they keep thinking about it. Other victims feel rejected in the workplace and in the community.

The harsher the violence, the greater the impact on physical and psychological health.

The response from institutions to this issue has so far been insufficient; only 30% of the victims said that measures had been taken by their directors to prevent violence.

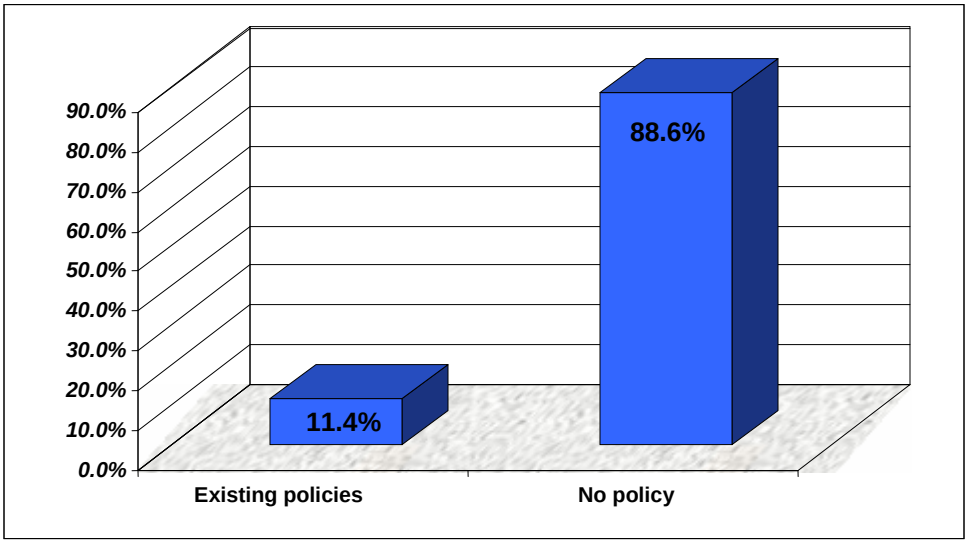
III.4. Policies and strategic programs to prevent violence

Considering the previous analyses of violent incidents, victims' and perpetrators' characteristics, institutional factors contributing to the emergence of violence and its consequences, it is crucial to define the specific processes and programs responding to workplace violence within the health sector in Rwanda. In order to understand the programmatic and political environment, we interviewed health care providers and key informants at the national level belonging to MINISANTE, MIFOTRA, MINIJUST, MIGEPROF, HIDA and Pro-Femmes.

III.4.1. Implemented policies and programs preventing workplace violence

We notice that the Rwandan health sector still has a lot to do in the implementation of measures responding to workplace violence. Among the participants we interviewed, less than 12% of them said that their directors had set up particular policies in order to prevent workplace violence.

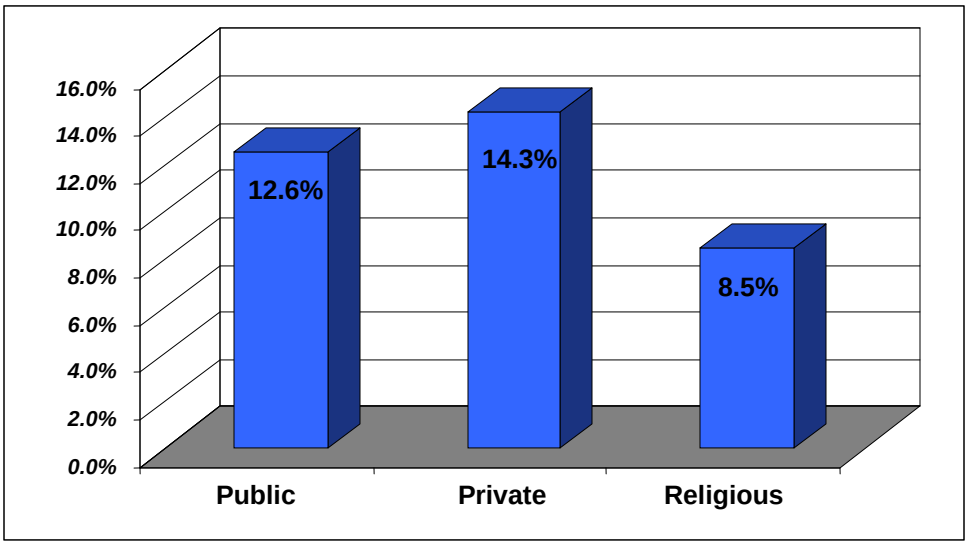
Graph 35: Availability of specific policies responding to violence



Source: *Table 39 – Annex B (Tool #1)*

The development of these policies does not differ significantly from one sector to the other, $\chi^2(2, N=297) = 1.24$, $p > .05$, but more private clinics have developed such policies than public or religious facilities have.

Graph 36: Availability of specific policies to respond to violence in different sectors



Source: Table 40 – Annex B (Tool# 1)

Moreover, policies are not always appropriate. Even if, according to providers, the public sector has implemented adequate policies, it is not the case for the public and religious sectors, where only 59% and 38% of providers feel that way.

Table 33: Classification of policies responding to violence in different sectors

Sectors	Classification of existing policies					
	Very inadequate		*A little adequate*		*Very adequate*	
Public	4	18.2%	5	22.7%	13	59.1%
Private	0	0.0%	0	0.0%	4	100.0%
Religious	4	50.0%	1	12.5%	3	37.5%

The participants' gender does not have an effect on the difference in classification of existing policies. However, three-fourths of men (75%) say that policies are very adequate, compared with half of the women (50%.)

Table 34: Classification of policies responding to violence by participants' gender

Gender	Classification of existing policies					
	Very inadequate		*A little adequate*		*Very adequate*	
Male	1	8.3%	2	16.7%	9	75.2%
Female	7	31.8%	4	18.2%	11	50.0%

Reporting procedure:

There is a significant difference in existing procedures depending on the sector of the facility, $F(5, 283) = 4.42$, $p<.01$. Up to 91.4% of health care providers in district hospitals agree that there is a reporting procedure available. This proportion is lower in free clinics (36%) and in health posts (33%), as the table below shows.

Table 35: Existing procedures for complaints

Existing procedures for complaint in your facility		No		Yes		Total	
		N	**%**	**N**	**%**	**N**	**%**
Sector of the	Government	57	*34.5*	108	*65.5*	165	*100.0*

Existing procedures for complaint in your facility		No		Yes		Total	
		N	%	N	%	N	%
facility	Private	14	*51.9*	13	*48.1*	27	*100.0*
	Religious	34	*37.0*	58	*63.0*	92	*100.0*
Total		105	*37.0*	179	*63.0*	284	*100.0*
Type of facility		76	*38.0*	124	*62.0*	200	*100.0*
	Clinic	7	*63.6*	4	*36.4*	11	*100.0*
	District hospital	3	*8.6*	32	*91.4*	35	*100.0*
	Referral hospital	3	*33.3*	6	*66.7*	9	*100.0*
	Health post	8	*66.7*	4	*33.3*	12	*100.0*
	General hospital	8	*47.1*	9	*52.9*	17	*100.0*
Total		105	*37.0*	179	*63.0*	284	*100.0*

There is no significant difference between the sector and the type of facility, when it comes to the way the reporting procedures are set up by employers. We can notice from the table below, that the percentage of people who claim that reporting procedures are adequate is high for every type of facility. However, providers in general hospitals, referral hospitals and private structures are more satisfied. One-fourth of the participants we interviewed in health posts said the reporting procedures are very inadequate. One out of ten providers in religious facilities considers that reporting procedures are inadequate.

Table 36: Adequacy of procedures according to the type and sector of the facility

Classification of complaint procedures for workplace violence		Very inadequate (n=14)	Somewhat inadequate (n=11)	Average (n=12)	A little adequate (n=22)	Very adequate (n=120)	Total
Sector	Government	*6.5*	*7.4*	*5.6*	*13.9*	*66.7*	*100.0*
	Private	*7.7*	*.0*	*.0*	*15.4*	*76.9*	*100.0*
	Religious	*10.3*	*5.2*	*10.3*	*8.6*	*65.5*	*100.0*
Total		*7.8*	*6.1*	*6.7*	*12.3*	*67.0*	*100.0*
Type	Health Center	*6.5*	*6.5*	*8.9*	*12.1*	*66.1*	*100.0*
	Clinique	*.0*	*.0*	*.0*	*50.0*	*50.0*	*100.0*

Classification of complaint procedures for workplace violence		Very inadequate (n=14)	Somewhat inadequate (n=11)	Average (n=12)	A little adequate (n=22)	Very adequate (n=120)	Total
	District hospital	*12.5*	*9.4*	*3.1*	*12.5*	*62.5*	*100.0*
	Referral hospital	*.0*	*.0*	*.0*	*16.7*	*83.3*	*100.0*
	Health post	*25.0*	*.0*	*.0*	*.0*	*75.0*	*100.0*
	General hospital	*11.1*	*.0*	*.0*	*.0*	*88.9*	*100.0*
Total		*7.8*	*6.1*	*6.7*	*12.3*	*67.0*	*100.0*

Results from the qualitative analysis show that according to the data we gathered during interventions, there is no policy or program aimed at preventing workplace violence. However, we were told that the State implemented a "general policy," which includes a section about workplace violence and other types of violence.

The participants also stressed the fact that the constitution emphasizes equality before the law and prohibits all forms of discrimination. They also highlighted the fact that a 30% quota for women has been included in the decentralization policy. In addition, there is another policy tackling violence in general, as well as violence against women and children, which has been developed by MIGEPROF. They also told us about the code of ethics regarding workplace behavior and the punishment incurred for workers who do not comply with the article 51/2001 of the law approved in 2001[15].

The number of participants who said that the existing documents are clear and helpful, equals the number of those who said they did not know anything about these policies and programs.

For the most part, they think these policies and programs would be useful only if they were disseminated and known, not only by the workers but also by the directors, some of whom intentionally or unintentionally do not respect these rights.

Almost all the participants said that international laws were also used. They gave a few examples: law regarding human rights, children rights, the Beijing convention and the African Charter on Human and Peoples' Rights. They said these international laws were used in order to develop national laws or used as such once they have been approved by the State. In this

[15] When we reviewed the Labor Code mentioned above, we did not find any content related to workplace violence but it included: general protection against discrimination, health/safety, workplace inspection, protection of maternity, employer's responsibility in educating workers about health and safety.

case, after they have been approved, a report is written in order to assess how they will be implemented.

Almost all the interventions tally and show that services for the protection of workers are necessary, as they prevent people from doing whatever they want and help workers by supporting them legally (providing lawyers), by keeping a keen eye on those who encounter problems and by ensuring their rights. However, they admitted that these services were scarce and that as a result, their action is insignificant. One participant actually said that their actions in the workplace remain almost "invisible."

In the same analysis, it has been noted that very few health facilities directors introduced strategies or measures taken at the facility level, in order to prevent violence.

Training and discussions with educative purposes, through several communication channels, could improve the behavior of directors, providers and patients, in order to reduce violence in health facilities.

III.4.2. Obstacles to the implementation of strategies preventing violence

a) General understanding and prioritization of violence types

Definition of workplace violence

Based on the qualitative analysis, the key informants and the facilities managers admitted that there is no definition for workplace violence, although the labor code has already been elaborated. However, we noticed that key informants have their own personal definition of workplace violence. The general trend is to describe it as follows:

- Refuse people rights they are conferred by law.
- Refuse someone his/her right to fully carry out his/her duty.
- Use power to disadvantage a worker who does not share the same views. For instance, refusing to pay a provider is a form of violence.
- Have someone lose his/her benefits by not respecting the terms of the contract.
- Treat a worker unfairly.
- Make offending remarks in writing or in speaking during a meeting.
- Generate disorder in order to divide the workers and prevent any kind of dialogue from taking place in the facility.

Many participants stressed the fact that violence can be visible (physical violence) and also invisible (psychological violence). However, this non-standardized vision of workplace violence is a major obstacle in the prevention of this phenomenon.

b) Enforcement of existing policies and programs

Regarding the awareness that has been raised among the population about existing laws, policies and programs, the participants told us that it has been done through TV and radio broadcast, meetings, training sessions, newspapers and trade union pamphlets. Regarding the training sessions, they told us about RIAM, which trains the providers within the State facilities and institutions. However, a great number of key informants believe that raising awareness has not been enough, that it has not reached enough people and that more effort should be put into it.

The majority of key informants think that existing codes, laws and programs are well done, clear and useful because they provide people with guidelines on how to respond to discrimination and with information about gender equity. According to some informants, some of these policies should be completed, updated and, above all, published to ensure that they are in effect.

Despite all the methods that have been used in order to raise awareness, the participants do not know the legal authorities which are responsible for the publication of these policies and programs. At the most, they were able to give the names of two civil organizations; Pro-Femmes, a coalition of women associations and HAGURUKA, an association preventing violence against young girls and women. They also mentioned the seminars that are organized by MIFOTRA, as well as the trade unions, which according to some of the participants, are the only groups with a good understanding of labor laws and codes.

Most interventions revealed that some services aimed at preventing violence are well-known and they are taking action. Participants told us about HAGURUKA's mobile posts and about trade union members traveling to facilities and private and public institutions, in order to check if employers abide by the rules protecting workers. These people that we interviewed know that these services cannot reach everyone, as they are insufficient and poorly distributed across the country. Indeed, they emphasized the fact that they were more often located in urban areas than in rural areas. In addition, they mentioned that these services do not have the power to solve the problems the workers face neither the capacity to manage all the cases they come across.

c) Perception and management of violence

Health facilities managers, who could take part in the study, said they were concerned by the violence which could occur in their facility, as they would be the first authority having to manage the potential cases. They said they knew the damaging effects of sexual assault, verbal abuse and other types of violence.

What we found the most surprising is that while some of these managers say violence does not occur in their facility, their providers have reported slanderous remarks, physical violence and have even given concrete examples of violent incidents.

The managers confirmed that the workers are well-informed, even if some providers do not feel concerned by violence. They also confirmed their intention of getting rid of violence, even though they admitted that measures that have been taken so far are still insufficient.

The directors that we interviewed told us that they did not know of any State policies, laws or programs responding to violence and discrimination or helping victims of violence.

d) Obstacles to the enforcement of strategies preventing violence

According to health facilities directors and key informants, the obstacles preventing the measures from being enforced are as follows:

- Ignorance of human rights by patients, providers and managers
- Nonobservance of these rights
- No concept of the meaning of violence
- Lack of awareness, "We rarely talk about workplace violence."
- Ignorance of the directors, who do not know the obstacles preventing the measures from being enforced
- The fact that all types of violence are now quite commonplace in the facilities because of the directors, "They keep saying we don't have a problem with violence."
- The lack of funds to improve the prevention of violence and help MINISANTE work in other places
- The lack of fund to support victims of violence
- The lack of collaboration between the policy-makers who design the programs and the absence of follow-up services
- Culture and individual behaviors are also obstacles for the implementation of these measures, as victims do not always report the incidents.

Conclusion:

Overall, policies preventing violence in health facilities are lacking. Among the providers we interviewed, less than 12% said that their directors have implemented specific policies regarding workplace violence. These policies are more widespread in private clinics than in public and religious facilities.

Moreover, policies are not always appropriate. Only private health structures have implemented adequate policies in response to violence.

In addition, the results from the qualitative analysis reveal that there is no actual policy or program preventing workplace violence. There is; however, a general policy that has been developed by the State. The writings still need to be put in practice.

Therefore, the development of adequate laws and the enforcement of existing policies would help curb violence in the workplace. "If the Government does not put any effort into it, it won't work," some participants said.

IV. Discussions and recommendations

IV.1. Discussion: What have we learned about workplace violence within the health sector?

Workplace violence is a real phenomenon experienced within the health sector in Rwanda. 39% of providers have experienced it and 59% have witnessed it over the past 12 months. This violence is characterized by several forms including verbal abuse (27%), followed by psychological harassment (16%), sexual harassment (7%), physical violence (4%) and sexual assault (2%.) This last element is not entirely reliable, as not enough data can back it up.

The factors contributing to the emergence of violence are more related to institutional, organizational and social characteristics than individual characteristics. This is an advantage in the development of policies responding to violence. Indeed, it would be easier for legal authorities and managers to rely on levers that are related to the institution and the community, in order to develop strategies for the prevention of violence, than on the providers' individual characteristics, which cannot be managed as easily because of their diversity and complexity. For example, it will not be relevant to encourage marriage to respond to violence, under the pretence that singles experience it more often than married couples.

Another important factor in the emergence of violence that should be taken into account is related to gender-based discrimination. Gender equity is the key to reduce workplace violence within the health system. Discrimination against women makes them a prime target for violence (negative stereotypes, discrimination in career management and work responsibilities, rejection related to pregnancy and family responsibilities, being considered "weak" by society.)

Gender-based discrimination may exist in a national political environment, which supports gender equity. Equity could exist but it remains unknown or unperceived.

Workplace violence does not only occur between supervisors and their employees; it can occur with every type of work relations. Therefore, the study shows that the perpetrator can be a coworker (48%), a supervisor (33%), and people outside the workplace (15%). Patients only account for 13% of all cases. This result differs from the ones in other studies that showed patients were more involved.

By combining the quantitative and qualitative analyses, we notice that men are responsible for more serious offenses than women. This result reflects the general opinion. Indeed, all studies that have been conducted about violence, confirm that perpetrators are more often men than women, no matter what type of violence is considered.

During the study, we noticed that acts of violence were not reported as often as they should have been by the victims. Based on the results of the quantitative and qualitative analyses, a great number of participants admitted they had not done anything after the incidents occurred. Men are more likely to report incidents than women.

Consequences of violence can be diverse:

- Absenteeism: Victims miss an average of three days of work after they experienced violence
- Resignation or intention to resign: One out of six providers who has experienced violence, has quit his/her job. More than 40% of the victims have thought about quitting.
- Consequences for the family: Experiencing violence causes traumas that have an impact on the victim's family
- Serious psychological consequences for the victims: Even if this kind of suffering does not result in some kind of disease, it has an impact on performance at work and affects the victims' health (trauma, tension, nausea, lack of energy, lack of self-esteem). Violence can also cause fear, anxiety, shame and guilt and tends to isolate the victim.

Therefore, environments contributing to violence hide abuses, dehumanize potential victims and isolate them.

Despite serious prejudices regarding the worker's health, lost working time and decaying working conditions in the company, very few measures have been implemented by health structure to prevent this phenomenon.

IV.2. Recommendations: A few solutions to respond to workplace violence within the health sector

Considering the obstacles preventing the enforcement of measures in response to violence, as they have been described by our target groups, and taking into account factors contributing to violence in health facilities, we tried to make an inventory of solutions regarding this issue. These recommendations include intervention at the society and organization levels, while emphasizing preventive (focusing on the causes) and reactive measures (focusing on the consequences.)

IV.2.1. General measures and legal environment

Make an inventory of existing legal and regulatory documents; make a list of all legal documents related to the protection of people.

Verify that these texts have been published and, if necessary, make sure that it is done in a reasonable timeframe.

Disseminate the texts and codes in a decentralized way, through meetings and training interventions.

Follow up the dissemination of legal and regulatory documents, in order to clarify them, explain them and facilitate their implementation.

Even if there already are laws, policies and programs addressing violence, such as the constitution or the national policy to prevent violence against women and children, it is necessary to set up an actual national policy against violence (or for health and safety) in the workplace. With such a policy, the MINISANTE will be able to elaborate a specific program to prevent violence in health facilities.

Ratify the standards for gender equity from the International Labor Organization on the protection of maternity (C.183) and on the workers with family responsibilities (C.156.) Disseminate them so they can become part of labor codes or labor laws.

Conduct a special study about maternity-based discrimination, including other types of violence related to discrimination, followed by a national discussion about the implementation of maternity insurance in health facilities.

Implement policies punishing workplace violence and create mechanisms for them to be enforced.

Disseminate and enforce the law regarding violence against women, which is related to sexual harassment and sexual assault.

Encourage a non-discriminatory enforcement of the laws. Use all the available texts and develop a global strategy for the protection of people and their rights independently from their status, age, handicap or gender.

Integrate workplace violence and gender-based discrimination in the next version of the Ministry of Health's strategy in Human Resources.

Intensively involve the government in the response to violence.

The Government must have a zero-tolerance policy and encourage relevant organizations to take into account, use and exploit the existing results.

IV.2.2. Organizational implications

The way health facilities are organized must be changed, in order to prevent violence or discrimination. Repressive legal action can certainly have an impact but it will not be sufficient to get rid of discrimination.

Work environment measures:

Improve the reception of patients transferred to hospitals, as they often are seriously ill and do not know how the facility is organized. Signs do not always help, as some patients cannot always read.

Enhance comfort and security for both patients and providers.

Make sure the pharmacies in the health facility are appropriately supplied with medicine, in order to avoid conflicts between the patients (especially the ones who have insurance) and the medicine suppliers.

Increase the number of providers in the facility to decrease the number of hours worked by the rest of the workers. This will reduce stress and tension.

Prohibit favoritism, as it is a source of conflict between the patients and the providers.

Administrative measures:

Ensure that policies implemented in the facilities include **measures aimed at managing the effects of violence and aggressions.**

Remind institutions that they have a legal obligation to enforce policies and laws related to all forms of abuse.

Ensure that that people's rights are respected and that workers comply with standards and norms (safety, work condition.)

Clarify the conditions under which the facilities must inform legal and administrative authorities that abuse or violent incidents occurred in the workplace.

Systematically set up clear protocols defining what providers are expected to do when they are confronted to such situations.

As the participants requested, **create a network** between the different organizations fighting workplace violence or strengthen it if it already exists.

Fast action by the managers in case of an incident is crucial. A lack of feedback regarding the measures that have been taken to manage or reduce the number of incident can discourage people from reporting them.

Ensure that the policies within the structures **encourage people to report violent incidents**.

Implement measures providing psychological support to the victims. The lack of psychological support may keep providers from reporting cases of violence that they experienced.

Measures aimed at **changing health care providers' behavior:**

In order to prevent ignorance, indifference and dismissal regarding violence, **workers should be provided with detailed information on violence**, its definition, its extent and its consequences for the perpetrator and the victim.

Create tools aimed at disseminating and popularizing legal documents in that matter and adapt them to different context.

Train all relevant providers, so that they can better manage violence.

Periodically **raise awareness among health facilities managers** for them to improve their relations with providers and to follow up on what is happening in their health facility.

Periodically **raise awareness among providers and patients** in order to improve mutual respect.

Raise awareness among labor inspectors, trade unions and workers regarding their rights, their obligations and their responsibilities at work.

Emphasize the necessity of **formal and institutional discussion forums**.

Rehabilitate the virtues of social dialogue and providers' representation; as the response to violence can only be efficient if it is effectively supported by staff representatives, professional associations and trade unions and employee's common efforts.

Ideally, a "roadmap" intended for health structures should be developed regarding workplace violence, as **it would ease prevention and control**.

V. Limitations of the study

Certain factors might have limited the scope of the study:

The sample of providers was smaller than we had planned. Had it been larger, the results would have been more solid and reliable (297 or 6% instead of 450 or 9% of the providers' population). It is especially true for sexual assault, a relatively rare type of violence, which required a larger sample.

The fact that we measured the impact of discrimination mostly through the perceptions of gender-based discrimination, except in the case of the vertical segregation of the director position, for which we linked the perceptions of equal opportunities to data that revealed the under-representation of women in positions of responsibility, despite the general perception of gender equity. People can answer questions regarding discrimination when they can identify or perceive one of its types or when they are informed on that matter. Indirect discrimination is particularly hard to identify, as it is not defined by a law or a policy, which directly excludes certain categories of people. Multiple methods will be necessary to identify all of its forms. Therefore, we recommend linking the perception of inequities to the SIS disaggregated data (for example, in order to quantitatively demonstrate the gaps in salaries between providers holding the same positions.) We also recommend controlling the distribution of responsibilities and possible job segregation and, of course, the number of men and women in higher positions.

In spite of these limitations, we hope that this study showed how other types of workplace discrimination could be identified and managed.

Annex A: List of health facilities by province and by district

***Selected health facilities**:*

I. EAST PROVINCE

1. District Nyagatare	**2. District Kayonza**	**3. District Ngoma**
1.1. Matimba	2.1. H.C Mukarange	3.1. H.C Remera
1.2. H.C Rukomo	2.2. H.C Kabarondo	3.2. H.C Zaza
1.3. Nyagatare(H)	2.3. Buhabwa/Health Post	3.3. Gasetsa/Health post

II. WEST PROVINCE

4. District Rubavu	**5. District Ngororero**	**6. District Nyamasheke**
4.1. H.C Gisenyi(H)	5.1. H.C Muramba	6.1. H.C Yove
4.2. H.C Karambo	5.2. H.C Ntaganzwa	6.2. H.C Nyamasheke
4.3. Free clinic Gisenyi	5.3. H.C Kabaya	6.3. Kibogora (H)

III. NORTH PROVINCE

7. District Musanze	**8. District Gicumbi**	**9. District Rulindo**
7.1. Nyakinama	8.1. H.C Muko	9.1. H.C Rukozo
7.2. Kinigi	8.2. H.C Rwesero	9.2. H.C Rulindo
7.3. Free clinic/Ruhengeri (Muhoza)	8.3. Muhondo/Health post	9.3. H.C Rutonde

IV. SOUTH PROVINCE

10. District Kamonyi	**11. District Huye**	**12. District Nyaruguru**
10.1. H.C Gihara	11.1. Kabutare(H)	12.1. H.C. Nyamyumba
10.2. H.C Kigese	11.2. H.C Karama	12.2. H.C Muganza
10.3. Free clinic UBUZIMA BWIZA	11.3. Free clinic/ KIZA	12.3. FC/Umushumba

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V. CITY OF KIGALI

13. District Nyarugenge	**14. District Gasabo**	**15. District Kicukiro**
13.1. Biryogo	14.1. H.C KIMIRONKO	15.1. H.C Kicukiro
13.2. Polyclinique la Médicale	14.2. H.C Gikomero	15.2. Polyclinique Carrefour
13.3. Kigali University Hospital (HR)	14.3. Health post/JARI	15.3. Free clinic Sainte Ange

Annex B: Descriptive analysis of workplace violence within the health sector

Characteristics of violence and its different types

Table 1: Prevalence of violence in the workplace and on the way to and from work

Prevalence of violence	Yes		No		Total	
	Number	%	Number	%	Number	%
Violence in the workplace	106	35.7%	191	64.3%	297	100.0%
Violence on the way to and and back from work	31	10.4%	266	89.6%	297	100.0%
Violence both in the workplace and on the way to work	20	6.7%	277	93.3%	297	100.0%
Global prevalence of violence	117	39.4%	180	60.6%	297	100.0%

Table 2: Prevalence of violence in the workplace according to the geographical location of health facilities

Victim of violence in the workplace	Geographic location of the facility			Total
	Rural area	*City*	*Big city*	
Yes	73	22	22	117
	38.4%	**50.0%**	**34.9%**	**39.4%**
No	117	22	41	180
	61.6%	**50.0%**	**65.1%**	**60.6%**
Total	190	44	63	297
	100.0%	**100.0%**	**100.0%**	**100.0%**
Pearson chi2(2, N=297) =	*7.3951*	*Pr = 0.025*		

Table 3: Prevalence of violence experienced and witnessed and level of concern regarding safety in the workplace by sector

Prevalence of violence	PUBLIC (N=175)	PRIVATE (N=28)	RELIGIOUS (N=94)	Total (N=271)
Violence in the workplace	40.0%	32.1%	40.4%	39.4%
Violence testified	62.3%	39.3%	57.5%	58.6%
Health providers' level of concern	45.7%	39.3%	46.8%	45.5%

Table 4: Prevalence and incidence of different forms of violence in the workplace

Forms of violence	Victims		Total	Incidence
	Yes	*No*		
Verbal abuse	80 *26.9%*	217 *73.1%*	297 *100.0%*	**3.3**
Physical violence	11 *3.7%*	286 *96.3%*	297 *100.0%*	**1.1**
Psych. harassment	47 *15.8%*	250 *84.2%*	297 *100.0%*	**2.5**
Sexual harassment	21 *7.1%*	276 *92.9%*	297 *100.0%*	**3.4**
Sexual assault	6 *2.0%*	291 *98.0%*	297 *100.0%*	**1**

Table 5: Prevalence of different forms of violence in the workplace by sector

Forms of violence	PUBLIC	PRIVATE	RELIGIOUS	TOTAL
Verbal abuse	46 *26.3%*	6 *21.4%*	28 *29.8%*	80 *26.9%*
Physical violence	7 *4.0%*	0 *0.0%*	4 *4.3%*	11 *3.7%*
Psych. harassment	27 *15.4%*	5 *17.9%*	15 *16.0%*	47 *15.8%*
Sexual harassment	17 *9.7%*	1 *3.6%*	3 *3.2%*	21 *7.1%*
Sexual assault	4 *2.3%*	0 *0.0%*	4 *4.3%*	8 *2.7%*

Table 6: Prevalence of verbal abuse by location

Verbal abuse	Insult in the workplace		Insult on the way to and back from work		Witness of verbal abuse	
	N	*%*	*N*	*%*	*N*	*%*
Yes	75	25.3%	16	5.4%	145	48.8%
No	222	74.7%	281	94.6%	152	51.2%
Total	**297**	**100.0%**	**297**	**100.0%**	**297**	**100.0%**

Table 7: Prevalence of physical violence by location

Physical violence	Physical violence in the workplace		Physical violence on the way		Witness of physical violence	
	N	*%*	*N*	*%*	*N*	*%*
Yes	10	3.4%	2	0.7%	34	11.4%
No	287	96.6%	295	99.3%	263	88.6%
Total	**297**	**100.0%**	**297**	**100.0%**	**297**	**100.0%**

Table 8: Prevalence of psychological harassment

Psychological harassment	Psychological harassment in the workplace		Witness of psychological harassment	
	N	*%*	*N*	*%*
Yes	47	15.8%	84	28.3%
No	250	84.2%	213	71.7%
Total	**297**	**100.0%**	**297**	**100.0%**

Table 9: Prevalence of sexual harassment by location

Sexual harassment	Sexual harassment in the workplace		Sexual harassment on the way		Witness of sexual harassment	
	N	*%*	*N*	*%*	*N*	*%*
Yes	10	3.4%	15	5.1%	39	13.1%
No	287	96.6%	282	94.9%	258	86.9%
Total	**297**	**100.0%**	**297**	**100.0%**	**297**	**100.0%**

Table 10: Description of sexual harassment in the workplace

Description of sexual harassment	Number	%
Accept friendship in exchange of sexual favors	5	50.0%
Force someone into a sexual relationship	1	10.0%
Receive money, gifts and privileges in exchange of sexual favors	0	0.0%
Sexual innuendos or remarks aimed at embarrassing someone	0	0.0%
Make fun of someone because of sexual behavior	1	10.0%
Other	1	10.0%
Not willing to answer	2	20.0%
Total	10	100.0%

Table 11: Prevalence of sexual assault by location

Sexual assault	Sexual assault in the workplace		Sexual assault on the way		Witness of sexual assault	
	N	*%*	*N*	*%*	*N*	*%*
Yes	3	1.0%	3	1.0%	14	4.7%
No	294	99.0%	294	99.0%	283	95.3%
Total	**297**	**100.0%**	**297**	**100.0%**	**297**	**100.0%**

Causes of workplace violence

Table 12: Prevalence of violence by age group

Prevalence of violence	Age group						
	Under 24	*25 - 29*	*30 - 34*	*35 - 39*	*40 - 44*	*45 +*	*Total*
Violence in the workplace	15 *29.4%*	36 *44.4%*	19 *32.8%*	18 *41.9%*	7 *22.6%*	11 *33.3%*	106 *35.7%*
Violence on the way	10 *19.6%*	8 *9.9%*	3 *5.2%*	7 *16.3%*	1 *3.2%*	2 *6.1%*	31 *10.4%*
Global violence	20 *39.2%*	40 *49.4%*	20 *34.5%*	19 *44.2%*	7 *22.6%*	11 *33.3%*	117 *39.4%*

Table 13: Prevalence of violence by gender

Prevalence of violence	Gender		Total
	Men	*Women*	
Violence in the workplace	34 *37.0%*	72 *35.1%*	106 *35.7%*
Violence on the way	9 *9.8%*	22 *10.7%*	31 *10.4%*
Global violence	36 *39.1%*	81 *39.5%*	117 *39.4%*

Table 14: Providers' opinion regarding differences in the way violence is experienced depending on gender

Experiencing forms of violence depends on gender	*Yes*	*No*	*Total*
Among those who experienced violence	71 *62.3%*	43 *37.7%*	114 *100.0%*
Among those who did not experience violence	81 *46.6%*	93 *53.4%*	174 *100.0%*
Total	152 *52.8%*	136 *47.2%*	288 *100.0%*

Table 15: Prevalence of violence depending on marital status

Prevalence of violence	Marital status			Total
	Single	*Couple*	*Widowed*	
Global violence	53	59	5	117
	43.4%	*36.7%*	*35.7%*	39.39%

Table 16: Prevalence of violence depending on seniority in the health sector

Prevalence of violence	Seniority in the service					Total
	Less than a year	*1 - 5 years*	*6 - 10 years*	*11 - 15 years*	*16 years +*	
Global violence	9	63	19	10	16	117
	27.3%	*45.3%*	*38.0%*	*33.3%*	*35.6%*	*39.4%*

Table 17: Prevalence of violence by job category

Prevalence of violence	Job category						Total
	Physicians	*Nursing assistant*	*Nurses*	*Midwives*	*Technicians*	*Social workers*	
Global violence	5	8	63	4	24	13	117
	41.7%	*27.6%*	*40.1%*	*28.6%*	*53.3%*	*32.5%*	*39.4%*

Table 18: Prevalence of violence by level of education

Prevalence of violence	Education level				Total
	A0	*A1*	*A2*	*A3*	
Global violence	12	9	89	7	117
	35.3%	*42.9%*	*40.5%*	*31.8%*	*39.4%*

Table 19: Prevalence of violence by type of employment

Prevalence of violence	Type of employment			Total
	Full time	*Part-time*	*Temp*	
Global violence	100	11	6	117
	38.2%	*40.0%*	*60.0%*	*39.4%*
Verbal abuse	65	9	6	80
	24.8%	*36.0%*	*60.0%*	*26.9%*

Pearson chi2(2) = 7.20 Pr = 0.027

Table 20: Prevalence of violence depending on the safety of the facility

Prevalence of violence	Safety			Total
	Unsafe	*Safe enough*	*Safe*	
Global violence	31	16	70	117
	62.0%	*33.3%*	*35.2%*	*39.4%*

Table 21: Prevalence of violence and availability of human resources

Prevalence of violence	Human resources			Total
	Very few providers	*Few providers*	*Enough/Too many*	
Global violence	47	39	31	117
	44.8%	*37.9%*	*34.8%*	*39.4%*

Table 22: Prevalence of violence and gender-based discrimination

Prevalence of violence	Discrimination regarding responsibilities		Total
	Equity	*Inequity*	
Global violence	88	29	117
	35.2%	*61.7%*	*39.4%*

Prevalence of violence	Discrimination regarding assignments		Total
	Equity	*Inequity*	
Global violence	96	21	117
	39.7%	*38.2%*	*39.4%*

Violence perpetrators

Table 23: Gender of violence perpetrators

Perpetrators	Verbal abuse	Physical violence	Psychological harassment	Sexual harassment	Sexual assault	Global violence
Men	32	7	34	16	4	82
	37.6%	***58.3%***	***61.8%***	***69.6%***	***50.0%***	***49.7%***
Women	53	5	21	7	4	83
	62.4%	***41.7%***	***38.2%***	***30.4%***	***50.0%***	***50.3%***
Total	85	12	55	23	8	165
	26.9%	***9.1%***	***14.6%***	***15.0%***	***14.3%***	***29.1%***

Table 24: Age of workplace violence perpetrators

Age	Under 25	25-34	35-44	45-54	55+	Total
Number	10	56	63	30	10	169
Percentage	5.9%	33.1%	37.3%	17.8%	5.9%	100.0%

Table 25: Places where the different types of violence were perpetrated

Perpetrators	Verbal abuse	Physical violence	Psychological harassment	Sexual harassment	Sexual assault
In the service	57	8	43	6	3
	85.1%	***72.7%***	***89.6%***	***28.6%***	***42.9%***
Out of the service	10	3	5	15	4
	14.9%	***27.3%***	***10.4%***	***71.4%***	***57.1%***
Total	67	11	48	21	7
	100.0%	***100.0%***	***100.0%***	***100.0%***	***100.0%***

Gender-based discrimination in the workplace within the health sector in Rwanda

Table 26: Problems encountered by men and women in the workplace

Problems encountered by men and women in the workplace are…	Gender		Total
	Male	Female	
Different	42	99	141
	47.7%	49.0%	48.6%
The same	46	103	149
	52.3%	51.0%	51.4%
Total	88	202	290
	100.0%	100.0%	100.0%

Table 27: Equal access to positions of responsibility

Opportunities for men and women to have the same position of responsibility are…	Gender		Total
	Male	Female	
Different	10	37	47
	10.9%	18.1%	15.8%
The same	82	168	250
	89.1%	82.0%	84.2%
Total	92	205	297
	100.0%	100.0%	100.0%

Table 28: Responsibilities (workload and type of work)

Do men and women with similar jobs have the same responsibilities?	Gender		Total
	Male	Female	
Yes	71	171	242
	77.2%	83.4%	81.5%
No	21	34	55
	22.8%	16.6%	18.5%
Total	92	205	297
	100.0%	100.0%	100.0%

Table 29: Management of men and women

Are men and women managed the same way in the workplace ?	Gender		Total
	Male	Female	
Yes	80	169	249
	87.0%	84.5%	85.3%
No	12	31	43
	13.0%	15.5%	14.7%
Total	92	200	292
	100.0%	100.0%	100.0%

Table 30: Exposure to violence

Are women more exposed to violence than men ?	Gender		Total
	Male	Female	
Yes	36	84	120
	39.1%	41.4%	40.7%
No	56	119	175
	60.9%	58.6%	59.3%
Total	92	203	295
	100.0%	100.0%	100.0%

Table 31: Differences between what men and women experienced while working in health facilities (Qualitative survey – Tool 19a)

#	Providers' opinions	Occurrences
1	Women encounter more problems than men (in the workplace, at home, during pregnancy, because of breast-feeding)	62
3	Women are more underestimated by patients	4
6	Women tend to trust women more often	4
5	Women are weak	3
16	Women are more likely to be victims of sexual assaults	3
13	Women lack respect towards their bosses and co-workers	2
2	Women argue while men agree	1
4	Men and women have the same responsibilities	1
7	Women cannot pull teeth	1
8	Women like to remain silent and they can be easily bullied	1
9	Men tend to simplify things while women make them worse	1
10	When women go on maternity leave, they cannot claim their salaries	1
11	Women tend to show their discontent and it has an impact on their work and their patients	1
12	Women cannot make wise decisions	1
14	Women are not as resistant as men. They cannot manage stress as well	1
15	Patients would rather see female providers in FP services	1
17	Women are always given an advantage over men	1

#	Providers' opinions	Occurrences
18	Men are more likely to be hired	1
19	Male patients prefer female providers and female patients prefer male providers	1
Total		**91**

Table 32: Distribution of providers by rank and by gender

Level of responsibility	*Theoritical equitable distribution*		*Actual distribution during the survey*	
	Men	*Women*	*Men*	*Women*
Directors	3	7	6	4
	31.0%	*69.0%*	*60.0%*	*40.0%*
Assistant directors	16	37	16	37
	31.0%	*69.0%*	*30.2%*	*69.8%*
Providers	69	155	68	156
	31.0%	*69.0%*	*30.4%*	*69.6%*
Independent workers	3	7	2	8
	31.0%	*69.0%*	*20.0%*	*80.0%*
Total	**92**	**205**	**92**	**205**
	31.0%	***69.0%***	***31.0%***	***69.0%***

Table 33: Promotion denied because of family responsibilities

Promotion denied because of family responsibilities	*Gender*		*Total*
	Male	*Female*	
Yes	1	5	6
	1.1%	*2.4%*	*2.0%*
No	89	200	289
	98.9%	*97.6%*	*98.0%*
Total	90	205	295
	100.0%	*100.0%*	*100.0%*

Reactions of victims and impact of violence in the workplace

Table 34: Formal reports of violence in the workplace

Formal reports	Men		Women	
	Yes	*No*	*Yes*	*No*
Verbal abuse	12	10	19	33
	54.6%	45.5%	36.5%	63.5%
Physical violence	2	2	2	5
	50.0%	*50.0%*	*28.6%*	*71.4%*
Psychological harassment	8	8	12	16
	50.0%	*50.0%*	*42.9%*	*57.1%*
Sexual harassment	0	4	1	17
	0.0%	*100.0%*	*5.6%*	*94.4%*
Sexual assault	0	3	0	3
	0.0%	*100.0%*	*0.0%*	*100.0%*

Table 35: Average number of days-off due to a violent incident

Incidents	Number	Average	Minimum	Maximum
Verbal abuse	14	***3.43***	2	15
Physical violence	2	***3.00***	3	3
Psych. harassment	17	***3.71***	0	15
Sexual harassment	6	***2.83***	2	3
Sexual assault	0	***0.00***		

Table 36: Reactions of victims depending on the type of violence they experienced

Reactions of victims	Verbal abuse	Physical violence	Psychological harassment	Sexual harassment	Sexual assault
None	39	7	20	11	4
	53.4%	*63.6%*	*42.6%*	*55.0%*	*66.7%*
Have thought about leaving work	31	4	24	8	1
	42.5%	*36.4%*	*51.1%*	*40.0%*	*16.7%*
Left work	3	0	3	1	1
	4.1%	*0.0%*	*6.4%*	*5.0%*	*16.7%*

Table 37: Impact of violence on family depending on the victim's gender

Impact of violence on families	Verbal abuse	Physical violence	Psychological harassment	Sexual harassment	Sexual assault
Men	1	1	2	0	0
	4.2%	*25.0%*	*12.5%*	*0.0%*	*0.0%*
Women	1	0	8	2	1
	1.8%	*0.0%*	*28.6%*	*13.3%*	*25.0%*

Table 38: Measures taken by facility managers depending on genders and types of violence

Opinions of the victims regarding the measures	Verbal abuse	Physical violence	Psychological harassment	Sexual harassment	Sexual assault
Men	8	1	5	0	0
	34.8%	*25.0%*	*31.3%*	*0.0%*	*0.0%*
Women	12	3	9	1	0
	24.5%	*50.0%*	*31.0%*	*6.7%*	*0.0%*

Table 39: Available policies targeting violence

Availability of policies	Number	%
Existing policies	34	11.4%
No policies	263	88.6%
Total	297	100.0%

Table 40: Availability of policies targeting violence by sector

Availability of policies	Public	Private	Religious
Existing policies	22	4	8
	12.6%	14.3%	8.5%
No policies	153	24	86
	87.4%	85.7%	91.5%

Annex C: Elements of the factor analysis

Principle and approach for the analysis of multiple correspondences:

Distribution of variables used for ACM:

Selection of different variables

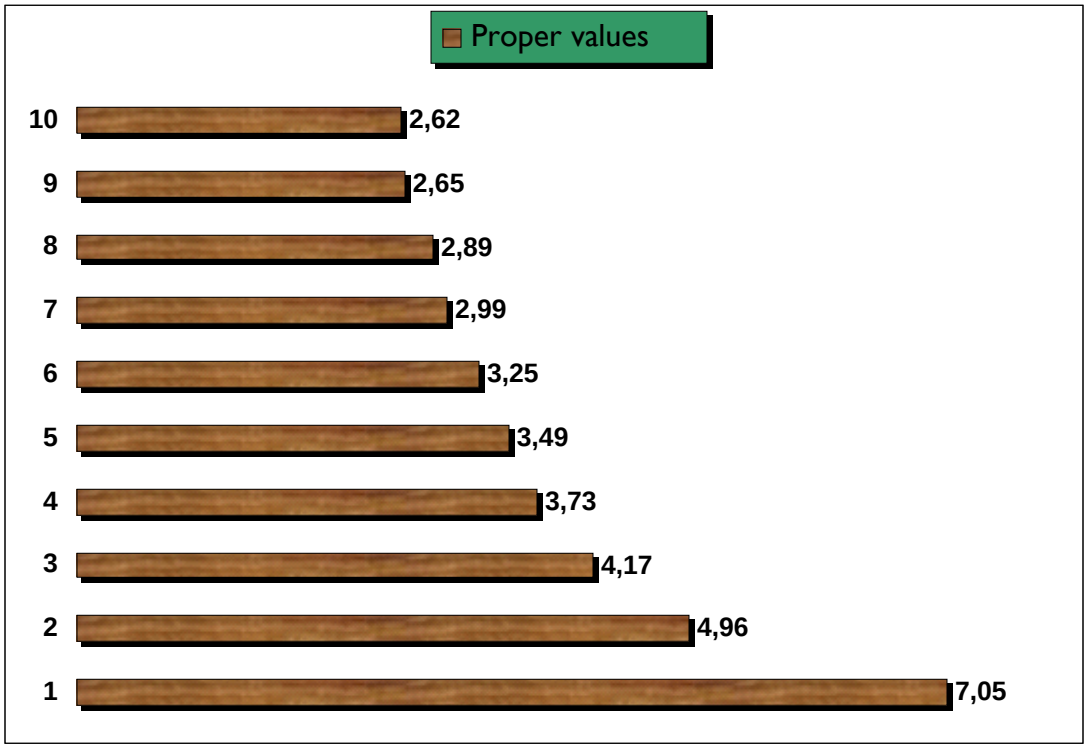
VARIABLES	Description	Distribution after auditing	
		NUMBER	PERCENTAGE
Gender	*men*	92	31.0%
	women	205	69.0%
Age group	*Under 25years old*	51	17.2%
	[25-29]	81	27.3%
	[30-34]	58	19.5%
	[35-39]	43	14.5%
	[40-44]	31	10.4%
	45 years old and older	33	11.1%
Job category	*Physician*	12	4.0%
	Nursing-assistant	29	9.8%
	Nurse	157	52.9%
	Midwife	14	4.7%
	Technician	45	15.2%
	Social worker	40	13.5%
Education level	*A0*	34	11.4%
	A1	21	7.1%
	A2	220	74.1%
	A3	22	7.4%
Rank	*Director*	10	3.4%
	Assistant director	53	17.8%

VARIABLES	Description	Distribution after auditing	
		NUMBER	PERCENTAGE
	Staff	224	75.4%
	Independent worker	10	3.4%
Nature du travail	*Full-time*	262	88.2%
	Part-time	25	8.4%
	Temp	10	3.4%
Trade union affiliation	*Member of a trade union*	94	31.6%
	Not a member	203	68.4%
Marital status	*Single*	122	41.1%
	Married	161	54.2%
	Widowed	14	4.7%
Seniority in the service	*Less than a year*	33	11.1%
	[1-5 years]	139	46.8%
	[6-10 years]	50	16.8%
	[11-15 years]	30	10.1%
	Over 15 years	45	15.2%
Type of facilities	*Health centers*	209	70.4%
	Free clinic	12	4.0%
	District hospital	36	12.1%
	Referral hospital	9	3.0%
	Health post	14	4.7%
	General hospital	17	5.7%
Sector	*public*	175	58.9%
	private	28	9.4%
	religious	94	31.6%

VARIABLES	Description	Distribution after auditing	
		NUMBER	PERCENTAGE
Level of safety in the facility	*Unsafe*	50	16.8%
	Safe enough	48	16.2%
	Safe	199	67.0%
Mutual respect between the employees	*Very little respect*	33	11.1%
	Not much respect	44	14.8%
	Enough respect	79	26.6%
	Much respect	141	47.5%
Respect between employees and supervisors	*Very little respect*	35	11.8%
	Not much respect	48	16.2%
	Enough respect	66	22.2%
	Much respect	148	49.8%
Respect between patients and employees	*Very little respect*	43	14.5%
	Not much respect	48	16.2%
	Enough respect	85	28.6%
	Much respect	121	40.7%
Respect between employees and patients	*Very little respect*	21	7.1%
	Not much respect	36	12.1%
	Enough respect	97	32.7%
	Much respect	143	48.1%
Availability of equipment	*Not well equipped*	103	34.7%
	Equipped	132	44.4%
	Well equipped	62	20.9%
Availability of human resources	*Very few providers*	105	35.4%
	Few providers	103	34,7%

VARIABLES	Description	Distribution after auditing	
		NUMBER	PERCENTAGE
	Enough providers	69	23.2%
	Too many providers	20	6.7%
Equal access to positions of responsibility	*Yes*	250	84.2%
	No	47	15.8%
Equal responsibilities	*Yes*	242	81.5%
	No	55	18.5%
Development of policies	*Policies available*	34	11.4%
	No policies available	263	88.6%
Existing whistle-blowing procedures	*Yes*	179	60.3%
	No	118	39.7%
Localization/Areas	*Rural areas*	190	64.0%
	Urban areas	44	14.8%
	City	63	21.2%
Province	*North*	57	19.2%
	South	49	16.5%
	East	60	20.2%
	West	63	21.2%
	Kigali	68	22.9%

Graph of the first 10 factorial axis with the greater "proper values"



Contribution of the variable modes in the development of the first five factorial axes

Categories	Relative importance	Distance	Axis 1	Axis 2	Axis 3	Axis 4	Axis 5
Gender							
Men	0,89	2,23	0,00	0,12	0,50	1,57	0,48
Women	1,97	0,45	0,00	0,05	0,22	0,70	0,21
			0,00	0,18	0,72	2,27	0,69
Age group							
Under 25 years old	0,49	4,82	0,16	1,81	3,24	1,91	0,09
[25-29]	0,78	2,67	0,71	0,79	1,53	0,03	0,01
[30-34]	0,56	4,12	0,18	0,00	0,00	0,47	0,80
[35-39]	0,41	5,91	0,00	0,73	0,98	0,38	1,97
[40-44]	0,30	8,58	0,42	0,49	1,89	0,20	0,91

45 and older	0,32	8,00	0,49	2,23	2,66	0,07	0,66
			1,97	6,05	10,30	3,05	4,45

Job category

Physician	0,12	23,75	0,08	2,17	0,14	0,87	0,52
Nursing assistant	0,28	9,24	0,41	0,49	5,59	0,17	4,47
Nurse	1,51	0,89	0,12	0,72	1,25	0,16	0,63
Midwife	0,13	20,21	0,22	0,43	0,47	0,02	0,03
Technician	0,43	5,60	0,28	0,01	0,09	0,04	0,05
Social worker	0,38	6,43	0,08	0,00	0,11	0,11	0,00
			1,19	3,83	7,65	1,37	5,71

Education level

A0	0,33	7,74	0,50	3,55	1,09	0,01	0,05
A1	0,20	13,14	0,01	0,67	0,58	1,38	7,32
A2	2,12	0,35	0,19	1,13	1,63	0,19	0,00
A3	0,21	12,50	0,16	0,05	3,96	0,01	5,16
			0,87	5,39	7,25	1,60	12,53

Rank

Director	0,10	28,70	0,36	0,37	2,81	1,38	0,06
Assistant director	0,51	4,60	0,58	0,17	0,02	0,96	0,45
Staff	2,15	0,33	0,03	0,00	0,08	0,37	0,06
Independent	0,10	28,70	0,16	0,01	0,00	0,29	0,34
			1,13	0,56	2,91	3,00	0,91

Type of work

Full-time	2,52	0,13	0,03	0,03	0,14	0,08	0,03
Part-time	0,24	10,88	0,07	0,03	0,29	0,02	0,37

Temp	0,10	28,70	0,16	1,53	1,17	2,73	0,00
			0,26	1,60	1,60	2,82	0,40

Trade union affiliation

Member	0,90	2,16	0,30	0,47	2,98	1,73	0,93
Non-member	1,95	0,46	0,14	0,22	1,38	0,80	0,43
			0,44	0,69	4,36	2,53	1,36

Marital status

Single	1,17	1,43	0,33	2,19	5,65	0,05	0,65
Married	1,55	0,84	0,12	1,22	2,78	0,06	0,20
Widowed	0,13	20,21	0,29	0,39	1,85	0,04	0,76
			0,74	3,80	10,27	0,15	1,61

Seniority in the service

Less than a year	0,32	8,00	0,04	1,54	1,21	0,75	0,05
[1-5 years]	1,34	1,14	0,46	1,27	2,47	0,30	0,27
[6-10 years]	0,48	4,94	0,04	1,03	0,00	0,03	0,27
[11-15 years]	0,29	8,90	0,13	1,12	2,96	0,41	1,90
15 years old and older	0,43	5,60	0,29	1,23	5,33	0,34	0,29
			0,95	6,19	11,97	1,83	2,79

Type of facilities

Health center	2,01	0,42	0,17	1,31	0,12	0,18	2,69
Free clinic	0,12	23,75	1,14	0,76	4,96	0,32	0,00
District hospital	0,35	7,25	0,06	0,02	2,63	4,12	7,51
Referral hospital	0,09	32,00	0,04	1,39	0,61	0,40	1,80
Health post	0,13	20,21	0,01	0,09	0,44	1,79	0,18
General hospital	0,16	16,47	0,76	8,36	2,87	0,08	1,41

			2,18	11,92	11,63	6,89	13,60

Sector

Public	1,68	0,70	0,36	0,88	1,17	0,04	1,06
Private	0,27	9,61	1,79	8,12	7,21	0,04	0,80
Religious	0,90	2,16	0,01	0,07	0,00	0,03	3,59
			2,17	9,08	8,38	0,10	5,45

Level of safety in the facility

Unsafe	0,48	4,94	1,36	0,09	0,26	3,05	0,11
Safe enough	0,46	5,19	0,00	0,14	0,03	7,21	0,88
Safe	1,91	0,49	0,37	0,11	0,12	4,81	0,40
			1,74	0,34	0,42	15,06	1,39

Mutual respect between employees

Very little respect	0,32	8,00	1,05	0,81	0,11	0,03	1,54
Little respect	0,42	5,75	0,33	0,05	1,47	0,54	0,14
Enough respect	0,76	2,76	0,36	0,36	0,00	1,21	1,82
Much respect	1,36	1,11	1,62	0,02	0,76	1,75	0,04
			3,37	1,23	2,34	3,53	3,54

Respect between employees and supervisors

Very little respect	0,34	7,49	1,65	0,39	0,03	0,82	0,05
Little respect	0,46	5,19	0,50	0,12	0,31	1,55	0,05
Enough respect	0,63	3,50	0,00	0,14	0,88	0,46	2,93
Much respect	1,42	1,01	1,11	0,06	0,74	2,57	0,83
			3,26	0,71	1,96	5,41	3,85

Respect between patients and employees

Very little respect	0,41	5,91	1,41	0,00	0,14	0,51	0,13
Little respect	0,46	5,19	0,00	0,15	1,70	0,19	0,05
Enough respect	0,82	2,49	0,02	0,26	0,04	2,04	1,06
Much respect	1,16	1,45	0,37	0,02	0,59	3,58	0,62
			1,81	0,44	2,48	6,31	1,87

Respect between employees and patients

Very little respect	0,20	13,14	0,85	0,12	0,02	0,04	0,88
Little respect	0,35	7,25	0,08	0,13	0,68	0,01	0,54
Enough respect	0,93	2,06	0,16	0,32	0,26	3,23	0,44
Much respect	1,38	1,08	0,69	0,02	0,63	1,82	0,31
			1,79	0,59	1,59	5,11	2,17

Availability of equipments

Not well equipped	0,99	1,88	0,01	0,48	0,35	0,32	0,55
Equipped	1,27	1,25	0,41	0,11	0,08	0,04	0,12
Well-equipped	0,60	3,79	1,17	1,87	0,12	1,05	0,20
			1,60	2,45	0,55	1,41	0,88

Availability of human resources

Very few providers	1,01	1,83	0,61	1,04	0,00	0,30	0,33
Few providers	0,99	1,88	0,01	0,06	1,64	0,11	0,00
Enough providers	0,66	3,30	0,78	0,28	1,31	0,28	0,27
Too many providers	0,19	13,85	0,18	3,76	0,63	1,07	0,26
			1,58	5,15	3,59	1,77	0,87

Equal access to positions of responsibility

Yes	2,41	0,19	0,11	0,35	0,04	0,01	0,18
No	0,45	5,32	0,58	1,87	0,23	0,08	0,96
			0,69	2,22	0,28	0,09	1,14

Equal responsibilities

Yes	2,33	0,23	0,00	0,06	0,55	0,03	0,09
No	0,53	4,40	0,00	0,26	2,41	0,12	0,38
			0,00	0,32	2,96	0,15	0,47

Development of policies

Existing policies	0,33	7,74	0,48	0,15	0,03	2,32	1,21
No policies	2,53	0,13	0,06	0,02	0,00	0,30	0,16
			0,54	0,17	0,03	2,62	1,36

Existing whistle-blowing procedures

Yes	1,72	0,66	0,00	0,28	0,45	1,23	0,76
No	1,14	1,52	0,00	0,43	0,69	1,87	1,15
			0,00	0,71	1,14	3,10	1,91

Localization

Rural areas	1,83	0,56	0,04	2,10	0,10	0,01	4,80
Urban areas	0,42	5,75	0,40	0,59	1,18	1,70	6,87
City	0,61	3,71	0,76	9,98	0,12	1,48	2,61
			1,20	12,67	1,40	3,19	14,28

Province

North	0,55	4,21	0,63	0,13	0,04	0,01	5,83
South	0,47	5,06	1,54	0,72	0,24	0,16	0,63
East	0,58	3,95	0,24	1,65	0,15	0,04	1,38

West	0,61	3,71	0,41	0,61	1,75	2,43	0,73
Kigali	0,65	3,37	0,55	9,03	0,45	2,45	0,92
			3,37	12,14	2,62	5,09	9,48

Global violence

Has experienced	1,13	1,54	8,13	1,36	0,11	0,82	0,14
Has not experienced	1,73	0,65	5,28	0,88	0,07	0,53	0,09
			13,41	2,24	0,19	1,35	0,23

Violence in the workplace

Has experienced	1,02	1,80	7,32	2,13	0,13	0,60	0,43
Has not experienced	1,84	0,55	4,06	1,18	0,07	0,33	0,24
			11,38	3,31	0,20	0,93	0,68

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The Capacity Project is an innovative global initiative funded by the United States Agency for International Development (USAID). The Capacity Project applies proven and promising approaches to improve the quality and use of priority health care services in developing countries by:

- Improving workforce planning and leadership
- Developing better education and training programs for the workforce
- Strengthening systems to support workforce performance.

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