Policy Brief

# Workplace Violence Against Nurses in the European Union

In 2021, 23% of the health sector workforce in the European Union (EU) experienced at least one form of negative social behaviour during the last 12 months of work[1].

Workplace violence broadly refers to the "violent acts, including physical assault and threats of assault, directed towards persons at work or on duty"[2]. The European Agency for Safety and Health at Work wrote that "work-related violence refers to both physical and psychological violence directed at employees from either outside or inside the workplace […] including behaviours that humiliate, degrades or intentionally deteriorates a person's well-being and dignity"[3]. A systemic review of the incidence of workplace violence showed that the health care sector is among the sectors with the highest violence levels, and that health professionals are 16 times more at risk of violence than other professionals[4,5,6,7].

The World Medical Association recently denounced the problem of workplace violence towards nurses as an international emergency that "undermines the very foundations of health systems and impacts critically on patient's health"[8]. The problem of verbal and physical violence against nurses is an underestimated component of today's worldwide public health problem. This issue is receiving inadequate attention from policymakers. At the moment, legislative efforts to resolve the problem remain insufficient.

## Data and testimonies from EU nurses associations

*'Nurses as a group, and women in particular, appear to be especially vulnerable, with double the risk of being the victims of violence.'*

The European Federation of Nurses Associations (EFN) has gathered exclusive data on the current reality of workplace violence against nurses in the European Union (EU). The April 2021 General Assembly meeting focused on "profession-based violence and discrimination". National Nurses Associations of EU Member States shared country-specific data, testimony, and best practices on the topic, aiming to bring it higher on the EU political agenda through the mediating advocacy of EFN. Twenty-eight national nurses' associations across Europe confirmed almost unanimously that violence against nurses is a significant concern, and that current policy efforts are insufficient. The latest data from a study by the National Institute of Occupational Health in Finland found that between 2015 and 2019, client violence against hospital and healthcare staff increased clearly in four years. Representative associations from Denmark, Portugal, and the UK pointed out that up to 30% of nurses are potentially subject to sexual harassment in the workplace[9].

Three themes emerged from the April 2021 EFN General Assembly, validating much of the Findings from the existing literature reviews on the subject[10,11,12,13,14,15,16]

**Keywords: workplace violence, violence and aggression, PMVA, horizontal violence, Type 2 violence, Type 3 violence, violence against nurses, sexual harassment**

*'The actual rate of assaults against nurses is often much higher than documented.' '*

First is the under-reporting of violent incidents due to fear of victimisation.

Overall, the actual rate of assaults against nurses is often much higher than documented by the published literature; hospitals may even discourage workers from reporting it, as mentioned by a spokesperson from the International Council of Nurses[17].

Surprisingly, the most recurrent reason for underreporting is that nurses do not believe reporting will make any difference[18,19,20,21]: if nurses feel unsupported by institutions, it fosters a spiral of unrecorded incidences, which leads to legislators developing a distorted perception about the gravity of the problem creating a policy vacuum.

Second, the realisation that perpetrators of violent acts extend beyond the classical category of patients and families and include also health professionals of different ranks. Colleagues from higher ranks, such as doctors and physicians, are often the perpetrators of violence[22,23,24,25].

*'Communication with nurses is often stereotypic, degrading, lacking respect and consideration for their knowledge and work.'*

What is known as 'horizontal' or 'Type 3' violence[27] is part of discrediting the nursing profession. Slovenian testimonies shared that gender-based violence against nurses at their workplace is predominantly connected with their weak position in the hierarchical structure of health organisations, subordination, and lack of social and political power. As a consequence, communication with nurses is often stereotypic, degrading, lacking respect and consideration for their knowledge and work. In Germany, up to 41% of nurses reported abuse from other health professionals. This was mentioned also in Ireland, the United Kingdom (UK), and Cyprus[9].

Third, violent incidences have a significant negative effect on nurses' health and retention. Representative associations from Switzerland reported that nurses reduce their working hours or opt for a part-time job as a consequence of violence, increasing up to 70% the likelihood of their leaving the profession[9].

## Why it matters

In the past 15 years, researchers have gathered consistent evidence on the urgency of the problem and the consequence that workplace violence against nurses produces on several interconnected dimensions of society, from the individual health to the collective sustainability of health care systems, to the comprehensive resilience of societies in tackling unexpected challenges such as that of the COVID-19 pandemic[5,28,29,30].

Resolving workplace violence against nurses matters for two predominant reasons:

1. From an individual standpoint, workplace violence against nurses needs to be resolved to protect the individual health of nurses, both to uphold the fundamental principles of human rights, guaranteeing women the right to working conditions free from harassment and discrimination, and both to maintain those same principles of fundamental rights strong in all circumstances, preserving the individual dignity of health professionals in their everyday work. Nursing is considered a female-driven and female dominant profession. The World Health Organization (WHO) estimated that 89% of nurses worldwide are women[31].

*'Workplace violence against nurses needs to be resolved to protect the individual health of nurses.'*

At the same time, harassment and female discrimination are a phenomenon that is still predominant in many sectors, including healthcare[32,30]. Workplace violence against nurses greatly overlaps with elements of violence against women, since many violent incidences reported in health care have

taken the form of sexual harassment and gender-based discrimination[33,34,35]. For this reason, many of the policy efforts aimed at reducing the significant incidence of violence against nurses contribute to combating violence against women.

2. From an organisational standpoint, workplace violence against nurses needs to be resolved to ensure the sustainable functioning of healthcare systems. The delivery of quality health care strongly depends on the availability and working conditions of healthcare personnel who are involved in psychologically and emotionally demanding tasks which often exposes them to a high risk of burnout. The shortage of qualified nurses remains an unresolved challenge for the profession[36,37,38]. The persistence of workplace violence in healthcare can influence the perceived attractiveness of the job itself, deterring many young adults from choosing to become nurses, with the risk of aggravating even further the occupational bottleneck[39]. The European Observatory on Health Systems and Policies has recognised healthcare working conditions as a key determinant for improving healthcare quality in Europe[40].

The pandemic has exacerbated healthcare professionals' workload, responsibilities, and working conditions. In the past two years, the number of violent cases across many European countries has significantly increased[41,22,42]. The strains on organisational support, the demands, and contact hours with patients have also increased, making it more likely for nurses to be subject to violence, abuse, and harassment.

Workplace violence against nurses is a problem at the cross-section of several other policy challenges that the EU institutions are currently seeking solutions to. These objectives are combating violence against women, and enhancing the quality of healthcare in Europe while accelerating the recovery from the COVID-19 pandemic. Enacting legislative efforts to reduce workplace violence can make a strong contribution to achieving these policy objectives.

## Current policy developments

### Violence against women is violence against nurses: current legislative initiatives

European institutions have set up several policy initiatives that are relevant to combat workplace violence against nurses. Yet, these initiatives are not binding for EU Member States nor sufficient to address the problem at its root. The very first European framework aimed at setting regulatory standards to address workplace bullying and harassment was the EC Framework Directive 89/391/EEC: having employers become legally responsible for the health and safety at work of their workers[43]. Sexual harassment has been addressed in the context of equal treatment directives, such as the Council Directive 2000/78/EC, establishing a general framework for equal treatment in employment and occupation[44]. More recently, the European Commission mentioned the intent to "adopt a new comprehensive legal framework with both preventive and reactive measures against harassment in the workplace" within the new gender equality strategy 2020–2025[45].

The European Foundation for the Improvement of Living and Working Conditions (Eurofound) highlighted that more women than men report harassment at work[46]. In a recently published survey on violent crime, the European Union Agency for Fundamental Rights (FRA) confirmed that work-related harassment predominantly affects women[47].

EU gender equality laws recognize harassment within the areas of competency of the labour market and the supply of goods and services (Directive 2006/54/EC, Council Directive 2004/113/EC). At the same time, the Victims' Right Directive recognises sexual harassment as a type of gender-based violence, namely a form of discrimination and violation of the fundamental freedoms of the victim[47]. Nevertheless, the EU has not yet developed a solid unified strategy to counter violence against women through legally binding instruments to specifically protect women from violence.[48]

From an international perspective, there have been several significant legislative steps forward against workplace violence. Since 2019, the Violence and Harassment Convention (N.190) from the International Labour Organization have offered a gender-responsive approach to prevent and eliminate violence and harassment in the workplace. However, among the EU Member States, the convention has been ratified only by Greece and Italy. Europe's only legally binding instrument in the field has been the Convention on preventing and combating violence against women and domestic violence (Istanbul Convention), signed and ratified by most EU Member States as of November 2021[48].

*'EU legislation can have a trickle-down effect on EU Member States in activating further engagement towards policy priorities.'*

According to a recent study by the European Parliament, EU Member States that have not ratified the Istanbul Convention are also less likely to fully recognize certain forms of violence, including workplace violence. In doing so, the absence of legal protection and criminal persecution renders the violence itself invisible, contributing in part to under-reporting the estimated real amount of violence against women[49]. At the same time, it was shown that 14 EU countries have adopted national action plans on violence against women since ratifying the Convention; this evidence shows that EU legislation can have a trickle-down effect on EU Member States in activating further engagement towards policy priorities.

As an attempt to bypass the limitations of the Istanbul Convention, the Commission's work programme for 2021 included a legislative proposal to prevent and combat specific forms of gender-based violence, setting standards to criminalise certain forms of violence against women, to the extent of EU competence, inserting these forms of violence as a new area of crime listed in Article 83(1) of the Treaty on the Functioning of the European Union (TFEU)[48].

Yet, EU Member States have adopted different approaches to the problem, leaving the effort uncoordinated and fragmented. The lack of comprehensive EU political framework of legally binding instruments to eliminate violence against women affects the ability to reduce workplace violence in female-dominated sectors such as healthcare.

*'The lack of a comprehensive EU political framework… to eliminate violence against women affects also the ability to reduce workplace violence in... healthcare.'*

At the April 2021 EFN General Assembly, the National Nurses Associations mentioned several national policy advancements that are moving towards the recognition of this problem. For instance, Italy approved in 2020 a new law addressing violence against health and socio-health professionals, along with establishing a National Observatory on the Safety of the Health and Socio-Health Professions under the Ministry of Health. In 2020, Portugal approved the establishment of a Security Office for the Prevention and Combating of Violence against Health Professionals, along with approving two draft resolutions concerning the prevention of violence against health professionals in their workplaces. The National Health Service in the UK published, in 2021, a new national violence prevention and reduction standard, to complement existing health and safety legislation[9]. However, many other EU countries have not yet implemented significant changes in their national legislation to support the policy changes needed.

*'EU Member States have adopted separate forms of national action plans targeted at reducing forms of gender-based violence in the workplace.'*

The two policy challenges of violence against women and workplace violence against nurses ought to be treated together, given that the two are intrinsically connected: policy advancements

in one area can yield results in the other. As the European Commission has been exploring legislative options and opportunities to advance an intersectional approach to combating violence against women, the focus on prevention and protection of violence in the healthcare sector can be an ideal starting point, given the exceptionally high concentration of female workers in health.

So far, EU Member States have adopted separate national action plans targeted at reducing forms of gender-based violence in the workplace. While this is an initial step, there are wide socio-cultural differences among the EU Member States that affect the interpretation of legislation even in the most fundamental subjects such as violence against women, and therefore hinder their ratification[50,49].

*'It is expected that the countries experiencing the highest number of incidences are also those carrying out the most research on the topic.'*

## A stronger commitment towards research and data collection

A recent systematic review observed worldwide differences with regards to the prevalence of violence and found that European countries had the lowest prevalence of violence compared to other high-income regions, namely Asian countries, North America (United States, Canada) and Australasia (Australia, New Zealand)[17,33]. Yet, at the same time, according to a worldwide bibliometric analysis of published literature on violence against healthcare workers, most European countries lag behind the United States, Australia, and the UK in terms of published documents and data about this topic[51]. It is expected that the countries experiencing the highest number of incidences are also those carrying out the most research on the topic. We should not exclude the possibility that it is precisely the increased dedication to researching the topic of violence against nurses that might enable these same countries to record the cases of abuse that would otherwise remain under-reported.

Although European countries are performing relatively well compared to other regions around the world in the incidence of violent cases, studies suggest that not reporting is also due to national and professional cultural norms' differences, a characteristic that may be particularly pronounced between EU countries[21]. A 2014 Medscape Ethics study found that European doctors were twice as likely not to report suspected domestic violence than their United States counterparts, suggesting that the recognition of abuses and violence may be subject to the sensibility of cultural settings[52]. The lack of adequate data is a major obstacle to a full picture of workplace violence against nurses in EU countries, which ultimately affects the ability to enforce proper measures[33]. This discrepancy between data and reality is also why the EU Parliament has repeatedly called for a coherent system in the collection of relevant statistics on gender-based violence in the Member States[53].

*'There are specific structural and working conditions that facilitate the occurrence and frequency of violence in most countries.'*

The newly established European Observatory on Violence against Women and Girls in 2017 has represented a positive step towards filling existing measurement gaps. Eurostat launched a new survey in 2020 with the aim of collecting data on various forms of violence against women, indicating a further positive commitment to resolving the lack of consistent data: the results are due to be public in 2023. Yet, the survey implementation at the national level is purely on a voluntary, which recasts the risk of having an uncoordinated commitment among the EU Member States in collecting data relevant to combat violence against women, including workplace violence[53].

Cross-cultural comparative analysis indicates that there are specific structural and working conditions that facilitate the occurrence and frequency of violence in most countries[54]; this is where legislation can have an effective role. A first step in preventing workplace violence is to ensure that violent incidences can be reported and that the problem is well understood, both in its causes and consequences. This calls for a more assertive

and cohesive response from the EU institutions in areas that are cross-sectoral and comprehensive, such as healthcare.

*'Quality of healthcare depends on the quality of the work environment.'*

### Current legislative initiatives

Based on the work of the OECD's Health Care Quality Indicators (HCQI) project[55], the European Commission and WHO concluded that quality healthcare can be defined around three main dimensions: effectiveness, safety, and patient-centeredness[56,57,58].

Studies and testimonies have proven that positive working conditions are a prerequisite for the provision of quality health care and for improving both patient and organisational performance outcomes. The organisational and societal costs of leaving workplace violence in healthcare unchecked are underestimated, as much as its consequences on the sustainability of entire national health care systems. The stable delivery of quality health care depends upon the ability of healthcare employees to do their job in adequate working conditions.

One of the founding priority areas for achieving Health 2020 (see below) is "ensuring positive work environments"[31]. Violence in the workplace hinders this objective. Health 2020 is the EU's most recent policy framework aimed at a renewed commitment to uphold health and well- being as a priority among the EU Member States.

Over 80% of the 191 countries responding to the WHO/ICN Nursing 2020 report said that having regulation on working conditions remains a major driver of "attractiveness of employment, performance and productivity, and retention of the health workforce"[31].

*'Regulation of working conditions remains a major driver of "attractiveness of employment, performance and productivity, and retention of the health workforce.'*

The Global Strategy on Human Resources in Healthcare identifies workplace violence as a threat to eradicate for the achievement of improved healthcare. One of its pillar is the notion that institutions must "uphold the personal, employment and professional rights of all hearth workers, including safe and decent working environments and freedom from all kinds of discrimination, coercion, and violence"[60].

## Consequences of workplace violence against nurses

There is abundant evidence on the negative physical, mental, social, and professional effects of violence on nurses[9]. The consequences of workplace violence have also ramifications that span across several other dimensions including emotional, work functioning, relationship with patient and quality of care, social and financial burden for the healthcare organisations[61].

*'Studies in the healthcare sector have shown workplace violence to be associated with higher rates of anxiety.'*

Violent incidents affect the personal health of nurses. Beyond the physical injuries, there are psychological consequences that have both mental and emotional implications which may result in long-term effects[62,63].

Numerous studies show a strong relationship between being subject to workplace violence and the risk of developing mental health problems[64,65]. Studies in the healthcare sector have shown workplace violence to be associated with higher rates of anxiety[66], a higher likelihood of developing depressive symptoms[67,68,69,] with evidence being consistent across countries very different from each other, such as Turkey[70], Kuwait[71] and South Korea[72]. Incidence of workplace violence induces several other psychophysical responses on victims, such as increased sleeping disorders[73] increased frequency of medication intake[24], and even symptoms of post-traumatic stress disorder with long-lasting effects from six months up to four years after exposure[74,75,69]. The negative effects

of workplace violence include reported signs of psychological depletion[76,77], a decrease in overall perceived quality of life[78] along with effects on a person's perception of themselves, such as lower self-esteem[79].

The incidences of violence impact not only nurses' work performance but also the organisation in general[80], decreasing perceived job satisfaction[81], and actual productivity[82], increasing the likelihood of burnout[83,84,33] and impacting on job turnover, absenteeism, and job commitment[85,86].

The occurrence of workplace violence often derives from the workplace environment itself and the organisational structure surrounding the work of nurses. Negative social behaviours that affect the daily interactions of nurses with patients and colleagues can endanger the development and retention of motivated health professionals[89,90], can impose added organisational cost to institutions in mitigating the consequences of violence[91] and can ultimately lower the quality of patient care, impacting on the opportunity of patients to receive adequate and affordable care[92,93,94].

*'Negative social behaviours that affect the daily interactions of nurses with patients and colleagues can endanger the development and retention of motivated health professionals.'*

Eurofound conducted a study on violence and harassment among the European workplace and clustered the main organisational risk factors and working conditions driving incidences into three groups. First, factors that increase job demands, such as high workload, staff shortages, unsocial hours, and demanding tasks. Second, factors associated with uncertainties, such as organisational changes. Third, social resources at the workplace, such as leadership, and relationships among employees[95].

*'Poor interpersonal relationships combined with time pressures were associated with higher incidences of harassment by employers, colleagues, and patients.'*

Several of these factors came into play with the emergency of the recent pandemic: inadequate staffing, heavy workload, and scarce resources[96,24]. Other organisational factors involve management aspects such as shortage of training programs dealing with violence, lack of violence management protocols, and delays in response time[10]. A study conducted in eight European countries found that poor interpersonal relationships combined with time pressures were associated with higher incidences of harassment by employers, colleagues, and patients[24,54]. Worsening of workplace conditions and incidence of workplace violence feed into each other, through both individual job stress and work environment characteristics, such as hospital policies and overall organisational culture[97,98,99,100,101].

## Recommendations

Workplace violence is an occupational problem that can be resolved through a set of interventions at different levels of resolution. Given the wide amount of literature suggesting different frameworks to classify the scope of interventions, EFN chose a binary perspective with which to view the set of potentially effective interventions. Policy options need to consider the complementary role of creating an enabling external environment (i.e., law enforcement, legislative changes, and organizational support/ resources) and aiming at promoting internal capacity within the profession (i.e., training, empowerment, voicing channels for nurses).

### External environment

An effective way to conceive evidence-based interventions against workplace violence is through the lenses of three major dimensions: policy updates, procedural enhancements, and education[102].

Policy updates are often the most effective, but also the slowest to implement. Legislative changes constitute the broader more encompassing dimension. Yet, legislative changes also depend on the maturity of each EU Member State's legal framework, as legislations proceed at different paces and with different scope. Furthermore, there is the added challenge of different sociocultural attitudes on what constitutes workplace violence and harassment, which is a major hindrance in the definition itself of what constitutes violence in the first place[50].

*'EU national policy interventions could be classified according to different approaches to tackling workplace violence.'*

Eurofound conducted a comprehensive study in 2015, mapping the level of development of different types of public preventive policies across the EU Member States[95], and found that EU national policy interventions could be classified according to different approaches to tackling workplace violence: recommendation to follow general prevention measures against psychosocial risk, promotion of non-binding measures to encourage employers' actions, and the imposition of actual legal obligations on the employer to intervene beyond the scope of risk preventions[95].

On top of this distinction, the study also identified five different national-level patterns of governance for prevention policies, ranging from decentralised activities to coordinated governmental initiatives with social partners. Given the fragmented landscape, there is clear evidence that national legislative changes can be better accelerated through stronger pressure from EU institutions in forcing the Member States to comply with an increasingly set of specific measures concerning workplace violence.

EU National Nurses Associations gathered at the April 2021 EFN General Assembly shared a set of best practices that can be best implemented at the sectoral level, with the participation of social partners and supported partially by governmental initiatives

*'Increase security fits with the broader scope of improving the organizational context of healthcare facilities.'*

Some of the practices are preventive, aimed at creating an environment that reduces the chances for violence to occur, such as strengthening the link between hospitals and police in healthcare settings and improving security through better monitoring systems of emergency departments. For instance, in Spain, a mobile app called "Alert Cop" was introduced, which establishes a primary communication mechanism for healthcare professionals to alert security and police.

Increased security fits with the broader scope of improving the organisational context of healthcare facilities. Other similar changes include improvements in workplace and managerial procedures, such as restricting the number of relatives entering wards, improving the doctor patient ratio, or introducing a method to 'flag' patients in electronic medical records to alert staff of potential risks[102,103].

There is evidence suggesting that multi component interventions can produce greater effects, such as introducing workplace violence reporting systems along with structured education programs[104,105].

Availability of funding and management of existing organisational resources both play a role in securing the workplace: the infrastructural design of emergency departments can influence the incidence of violence[106]. The management of human resources is a powerful domain of intervention, at the cross-section between the external environment and internal capacity. Human resources practices can design and implement ways to encourage job autonomy for nurses and empower their role by including them in decision-making around their work environment[107,108].

### Internal capacity

One of the most transformative tools for promoting internal capacity within the profession is enhancing educational opportunities for nurses and doctors, to both empower and instill

awareness on best practice among healthcare professionals.

Structured education implies setting up training programmes that inform nurses on how to respond to workplace violence by patients and how to develop effective interpersonal skills in clinical settings, along with equipping supervisors with the leadership skills to be aware of workplace dynamics and provide the support that disrupts negative social behaviours[103,105,109,110,111].

Training has been proven one of the most effective tools to reduce violence incidence, suggesting that much of the workplace abuses are not only due to the physical vulnerability of female nurses but also to the way in which many nurses perceive their role and profession[112].

Apart from training, the public has a central role in the state of workplace violence as well: influencing public attitudes can significantly reduce incidences of violence[113,114]. In general, the public expresses sympathy towards nurses subject to violence[115].

*'Training has been proven one of the most effective tools to reduce violence incidence. Influencing public attitudes can significantly reduce incidences of violence.'*

Raising public awareness of the problem of workplace violence can help place the topic higher in the national agenda and advance strategies aimed at improving overall public perception of the nursing profession.

## Conclusion

In the hospital environment, nurses are the first point of contact with the public and are also the primary caregivers of patients. The nature of nurses' work responsibilities places them at risk of physical violence and verbal abuse, to the extent that evidence has confirmed how nursing professionals have accepted violent attacks as an integral part of their job[116,117].

It is commonly known that violent incidences are more common in mental health and emergency departments, as nurses have to confront a particular segment of patients that have severe conditions and often express unpredictable behaviours of aggression[118]. In these settings, violence may be seen as justified and nurses are expected to understand their abusive behaviour, forgive and not complain. However, violence against nurses is not limited to specific hospital departments.

Based on the numerous literature reviews of the past decades, many violent cases against nurses can be summarised as being: the consequence of organisational deficiencies which increases work pressure and predispose nurses to abuses by others in general[119,120,121,25]; a manifestation of power abuses perpetrated by colleagues from higher ranks[122,123]; or the expression of a general discrediting of the nursing profession combined with persistent discrimination against women in the workplace[124,47,40].

*'Workplace violence in healthcare is not a predictable reality of the job.'*

The evidence suggests that in healthcare, workplace violence should not be a predictable reality of the job. Rather, it is an expression of a broader problem that is deeper, rooted in organisational inefficiency and the absence of appropriate legislation aimed at maintaining minimum standards of safe work environments.

What emerged from the testimonies of the Nurses Associations in the April 2021 EFN General Assembly is a lack of law enforcement, combined with incoherent EU-wide legislation targeting workplace violence in the healthcare profession. Healthcare professionals need: more institutional support through either dedicated funding aimed at targeted interventions; more legislative commitment to ratify policies against discrimination; and an opportunity to convey these messages to the appropriate policymakers.

Violence and harassment against nurses are not new and is totally unacceptable, as it has an enormous negative impact on nurses' psychological and physical well-being and on their job motivation, leads to nurses leaving the profession, and puts the quality of care and patients' safety at risk. Therefore, it is time to act.

Nurses also need to be protected from any kinds of gender-related violence and discrimination.

It is crucial that both nurses and women, including nurse researchers, have a strong voice in the design of health and social policies. They are ideally positioned to both lead and support such developments. Policymakers and politicians have here a golden opportunity to ensure that the reform process addresses the challenges of the long-standing inequality between women and men, both as providers and as recipients of care.

It is time that the EU institutions, EU Member States, international organisations, civil society actors and activists, look at the achievements so far and discuss the steps forwards in strategic co-operation between EU institutions, Member States, international organisations, NGOs, and academics in combatting violence against women. It is imperative that nurses are protected and supported through the development of policies, initiatives, and legislation at national and European level.

Given the severity of the situation, inaction could lead to irreplicable damage to the nursing workforce, compounding pressures resulting from the COVID-19 pandemic. Ultimately, this situation can drive existing nurses out of the profession.

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This Policy Brief was developed based on the data collected from the EFN members at the EFN April 2021 General Assembly, who provided very important data that shows that violence against nurses has reached epidemic proportions, with anecdotal evidence during the COVID-19 pandemic pointing to a sharp increase across countries in Europe. Nurses take the brunt of the public's aggression, since they are frequently the first point of contact. Violence against nurses takes many forms, including death threats, punches, sexual harassment and verbal insults. Evidence on the frequency and impact of violence on nurses is accumulating, pointing to negative physical, mental, social and professional effects. We are extremely grateful for the EFN members data contribution to this Policy Brief.

# Recommendations

## What should policy makers do?

1. **Recognise the rising problem of violence,** harassment, and discrimination against nurses at EU level.
2. **Make sure to implement policies and legislation that promote safety** and the well-being of nurses.
3. **Strengthen the framework and the working condition** in the healthcare sector.
4. **Engage with nurses and their representatives,** through a tripartite social dialogue, at national and European level to plan the provision of adequate support for nurses against violence and harassment.
5. **Promote the importance of safe and inclusive workplaces for all health care professionals** by implementing preventive measures against violence and harassment at national, organisational and personal level.
6. **Fund initiatives and projects aimed at National Nursing Associations and nursing researchers** committed to tackling the violence problem in their countries focusing on political and legal solutions.

## What should nurse leaders do?

1. **Make the reduction of violence and harassment against nurses a number one priority** of the national, regional, local and EU political agendas.
2. **Strengthen nursing curriculums to support and empower nurses** to deal with diverse forms of violence and harassment.
3. **Promote the training of nurses and other healthcare professionals** on the risks of violence and harassment and how to prevent, identify and cope with it.
4. **Existing legislation should be monitored** for its implementation and successful enforcement.
5. **Clear messaging should be available** that encourages nurses to report violent incidents without fear of retaliation, humiliation or victimisation.
6. **Make sure that all health professionals unite behind the common goal** of reducing and preventing violence by supporting each other.

## What should researchers do?

1. **Raise awareness on the need to stop violence,** harassment, and discrimination against nurses/women among Member States and EU citizens, based on concrete data.
2. Make sure that **initiatives to support women and nurses are more closely aligned.**
3. **Conduct scoping and systematic reviews on the impact of violence on nurses** and the solutions put in place.
4. **Develop a European framework to protect nurses against violence,** to be implemented during the seven-year EU budget 2021-2027.
5. Make sure that **violence against nurses is part of the national research agenda.**

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