ORIGINAL ARTICLE

Violence against health care workers in rural areas of Sindh, Pakistan

Saleema Arif[1], Lubna Ansari Baig[2], Shiraz Shaikh[3], Ibrahim Hashmi[4], Zaini Sarwar[5], Zarrukh Ali Baig[6]

Abstract

Objective: To determine the magnitude of violence against healthcare workers in a rural setting, and the consequences of this violence on their personal and professional lives.

Method: The descriptive, quantitative, cross-sectional study was conducted in 4 rural districts of the Sindh province of Pakistan from February to December 2019, and comprised healthcare workers, including doctors, nurses, support staff and field workers. Data was collected using a structured questionnaire. Data was analysed using SPSS 22

Results: Of the 1622 subjects, 929(57.3%) were males and 693(42.7%) were females. The overall mean age was 35.55+/-10.05 years. The largest cluster was that of doctors 396(24.4%), followed by technicians 202(12.5%). Overall, 522(32.2%) subjects had a professional experience of 1-5 years. Violence at workplace in any form was experienced by 693(42.7%) subjects. Verbal violence had been experienced by 396(24.4%) subjects, while 228(14.1%) had witnessed it. The corresponding numbers for physical violence were 122(7.5%) and 22(1.4%). Verbal violence was more prevalent compared to physical violence ($p<0.01$). The major effect was that the healthcare workers remained alert 537(33.1%), felt frustrated 524(32.3%) and disturbed 503(31%). Also, 272(16.8%) subjects were planning to migrate or quit the profession.

Conclusion: Violence was found to be a significant issue in rural Sindh.

Keywords: Violence, Healthcare, Danger, Rural, Pakistan, Sindh. (JPMA 72: 2150; 2022)

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Introduction

The fear of violence affects the performance of healthcare providers and decreases their responsiveness towards the patients. The World Health Organisation (WHO) defines violence as "the intentional use of physcial force or power, threatened or actual, against oneself, another person, or against a group or community that either resutls in or has a high likelihood of resulting in injury, death, psychological harm, mal-development, or deprivation".[1] Almost one-fourth of workplace violence takes place in the healthcare sector.[1] Violence against healthcare workers (HCWs) is a global phenomenon. Many countries have reported a high incidence of physical and verbal violence in all departments.[2,3] In recent years, there has been a rise in violence against HCWs in the subcontinent.[4]

Almost every primary care doctor in Pakistan has suffered from some kind of violence in the preceding 12 years of work.[5] A large-scale multi-centre research in Karachi, the capital city of Sindh, is being conducted since 2015 to determine the kinds of violence faced by all HCW cadres and to identify strategies that could prevent and de-escalate violence.[6,7] The current study was planned to understand the magnitude of violence against HCWs in the rural areas of the province, and the psychological consequences of this violence on their personal and professional lives.

[1-4]APPNA Institute of Public Health, Jinnah Sindh Medical University, Karachi, Pakistan; [5]Cumming School of Medicine, University of Calgary, Calgary, Canada; [6]Department of Surgery, University of Saskatchewan, Saskatoon, Canada.

Correspondence: Lubna Ansari Baig. e-mail: lubna.baig@jsmu.edu.pk

Subjects and Methods

The descriptive, quantitative, cross-sectional study was conducted in Hyderabad, Nawabshah, Thatta and Larkana districts of the Sindh province of Pakistan from February to December 2019. The sample size was calculated from the 4 districts with the aim of covering at least 10% of the HCWs from the total number of HCWs in each setting based on different cadres of HCWs mentioned in the national data available on human resources for health in Pakistan (Table 1).[8]

Table-1: Distribution of sample size between different cadres of healthcare workers (HCWs).

Cadre	Numbers expected in each district	Number to be included from each district
Doctors	1000	100
Nurses	500	50
Technicians / assistants	500	50
Support staff (Guards, administration staff, housekeeping staff)	250	25
Ambulance staff	250	25
Vaccinators	500	50
LHWs	500	50
LHVs / midwives	500	50
		400 / Rural District
Number added for lost data		3% for each cadre = 4
		1624 total

LHW: Lady health worker, LHV: Lady health visitor.

The sample was raised using two-stage cluster sampling technique. In first stage, the rural districts were selected randomly. In each district cluster, quota sampling was used to select respondents from each cadre as per the proportion present in the healthcare facility. Informed consent was taken from all the HCWs and the ones who refused were excluded.

Data was collected using a structured questionnaire that has already been validated.[8] The questionnaire was contextualised to include rural dimensions through qualitative research using in-depth interviews (IDI) and focus group discussions (FGDs). These were conducted in two rural districts that were not included in the final study.

The study encompassed basic health units (BHUs), Taluka headquarter hospitals (THQs), district headquarter hospitals (DHQs), private clinics, and hospitals in tehsils and districts. The survey covered all cadres of HCWs, including doctors, nurses, technicians, ward-boys, cleaners, administrative assistants, support staff, ambulance workers, vaccinators, lady health visitors (LHVs)/midwives, community health workers, lady health workers (LHWs) and community midwives (CMs).

Data was analysed using SPSS 22 to measure the magnitude of violence, determinants, types of violence, and its impact on individuals. Data was collected after approval from scientific committee and IRB of Jinnah Sindh medical University on 18 September 2018.

Results

Of the 1622 subjects, 929(57.3%) were males and 693(42.7%) were females. The overall mean age was 35.55±10.05 years (Table 2). The largest cluster was that of doctors 396(24.4%), followed by technicians 202(12.5%). Overall, 522(32.2%) subjects had a professional experience of 1-5 years (Table 3).

Table-2: Demographics of research participants (n=1622).

Demographics	n (%)
Mean Age (years)	35.55±10.051
Gender	
Male	929 (57.3)
Female	693 (42.7)
Religion	
Islam	1540 (94.9)
Christianity	13 (0.8)
Hinduism	68 (4.2)
Any other	1 (0.1)
Primary language spoken at home	
Urdu	249 (15.4)
Sindhi	1251 (77.1)
Punjabi	92 (5.7)
Pashto	13 (0.8)
Balochi	15 (0.9)
Gujarati	2 (0.1)

Table-3: Job characteristics of research participants (n=1622).

Variable	n (%)
Nature of Job	
Doctor	396 (24.4)
Nurse	198 (12.2)
Technician	202 (12.5)
Support Staff	122 (7.5)
Ambulance Staff	104 (6.4)
Vaccinator	200 (12.3)
LHW	200 (12.3)
LHV/Midwife/SBA	200 (12.3)
Work experience	
one year	95 (5.9)
> 1-5 years	522 (32.2)
> 5-10 years	384 (23.7)
> 10-15 years	186 (11.5)
> 15-20 years	152 (9.4)
> 20 years	283 (17.4)
Place of work	
BHU	180 (11.1)
DHQ Government	165 (10.2)
District private	246 (15.2)
THQ Government	192 (11.8)
Tehsil private	205 (12.6)
LHW	110 (6.8)
LHV/Midwife	250 (15.4)
Vaccinator	188 (11.6)
Ambulance Service	86 (5.3)

LHW: Lady health worker, LHV: Lady health visitor, SBA: Skilled birth attendant, BHU: Basic health unit, DHQ: District headquarter hospitals, THQ: Taluka headquarter hospitals.

Table-4: Types of violence experienced or witnessed (n=1622).

	Experienced n (%)	Witnessed n (%)
Verbal violence	396 (24.4)	228 (14.1)
Physical violence	122 (7.5)	22 (1.4)
Facility damage	5 (0.3)	6 (0.4)
Weapon attacks	5 (0.3)	5 (0.3)
Harassment	47 (2.9)	26 (1.6)
Bullying	27 (1.7)	14 (0.9)
Robbing	4 (0.2)	3 (0.2)
Extortion	3 (0.2)	7 (0.4)
Kidnapping	2 (0.1)	3 (0.2)
False accusation	61 (3.8)	27 (1.7)
Others	21 (1.3)	2 (0.1)

Violence at workplace in any form was experienced by 693(42.7%) subjects. Verbal violence had been experienced by 396(24.4%) subjects, while 228(14.1%) had witnessed it. The corresponding numbers for physical violence were 122(7.5%) and 22(1.4%) (Table 4). Verbal violence was more prevalent compared to physical violence (p<0.01).

The major effect was that the healthcare workers remained alert 537(33.1%), felt frustrated 524(32.3%) and disturbed

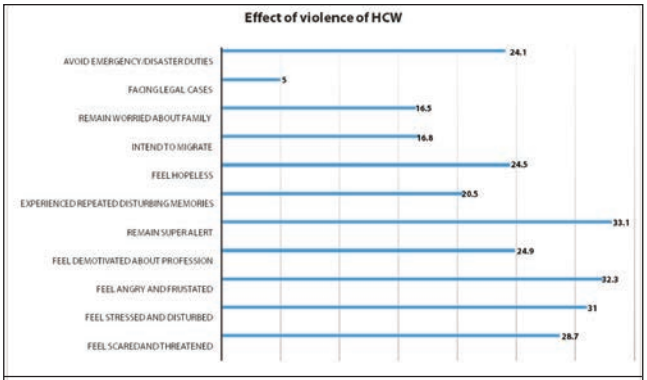

Figure: Effects of violence on healthcare workers (HCWs).

503(31%). Also, 272(16.8%) subjects were planning to migrate or quit the profession (Figure).

Discussion

The current study, to the best of our knowledge, is the first to include not only physicians and nurses but also technicians, support staff, ambulance workers, vaccinators, and midwives in determining the extent of violence against HCWs. Previous literature has established the incidence and negative consequences of violence in urban centres in Pakistan.[5,6,9]

The findings of the current study are similar to those reported earlier.[2,3,6,7] The exposure to physical and verbal violence determined in rural areas in the current study was similar to the findings reported in Bulgaria, Rio de Janeiro, Beirut, Thailand and Johannesburg.[10]

This overall incidence of violence noted in rural Sindh was less than previously reported data.[2,7,11] The lower incidence in rural Sindh could be because urban centres are more violence-prone in Pakistan. However, this is not congruent with global literature.[12] However, one of the major confounders in this comparison of centres in Pakistan is that the urban centres include Karachi, a city with an extremely high level of violence at baseline. With its recent history of political, ethnic and sectarian violence, Karachi likely experiences one of the highest incidences of violence against HCWs. In the last decade, violence against HCWs in Karachi has included targeted killings of physicians and bombing outside a public hospital's main entrance in 2010.[13] The incidence of violence against HCWs in Karachi has been reported to be 65-75%.[14-16]

Further studies are required to evaluate the cause of violence against HCWs in urban versus rural centres in Pakistan, which could be a result of overcrowding in the emergency department, varying numbers of politically motivated attacks, and varying frequencies of intoxicated patients in urban centres.[17]

One of the significant findings of the current study was the negative consequences of this violence on the personal and professional lives of the HCWs. The experience of violence severely affected the ability of HCWs to provide care which is in line with literature.[6]

The mental health aspect of violence against HCWs is still understudied. The current findings are in agreement with literature reporting a high rate of post-traumatic stress disorder (PTSD)-associated symptoms and burnout amongst HCWs experiencing violence.[10,18,19] Hence, violence not only reduces job satisfaction, but also affects a healthcare worker's performance and efficiency.[20-22]

The current study's limitations include the use of quota sampling within the clusters, which reduced the generalisability of the findings. Besides, the study was done in only four districts, and there can be intercultural variability, like the Tharparkar district having a culture that is entirely different from other districts.

In the light of the findings, the current study recommends holding training of HCWs in essential communication skills and de-escalation of aggressive/violent behaviour. Many studies have proven the positive role of such trainings.[9,23,24] The role of media is also essential in the context of increasing social awareness.[25]

Mechanisms for reporting violence also needs to be improved to prevent violence because an inadequate reporting system, and discouraging violence reporting increases violence.[25]

Conclusion

Violence is a significant concern for HCWs in Pakistan, and it acts as a major barrier towards providing effective healthcare. The rural areas of Sindh are less privileged, with a low literacy rate and high poverty rate. HCWs in rural Pakistan not only work with limited resources, but also provide culturally competent care that is within the confines of the religious and cultural boundaries of the region. There is an urgent need to address violence against HCWs in the rural areas. With assistance from police, media outlets, and local leaders, a campaign to protect HCWs in the rural areas is necessary.

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