TRENDS OF VIOLENCE AGAINST HEALTH-CARE WORKERS AND FACILITIES IN PAKISTAN

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Abstract

Violence against healthcare workers and facilities is a pervasive global issue, transcending boundaries and escalating internationally. This paper addresses the concerning trend of violence within the healthcare sector in Pakistan, surpassing rates observed in other fields and receiving insufficient attention. Conducting in-depth interviews in both urban and rural settings, the research identifies a people-centered perspective, exploring causes such as inadequate communication skills, emotional stress, disparities between government and private facilities, and more. The paper challenges existing one-dimensional literature and offers pragmatic recommendations. The research emphasizes the need for a comprehensive, multidimensional study to understand and address the root causes of violence.

Keywords: Healthcare violence, People-centered approach, Urban-rural, Causes of violence, Healthcare workers safety.

Introduction

Violence against health care workers and facilities is a global issue, transcending regional boundaries and escalating on an

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international scale. This pervasive problem encompasses a spectrum of direct attacks, ranging from threats, kidnappings, and murders to robberies, obstruction of ambulances, and coerced discriminatory actions by doctors favoring one patient over another. This phenomenon is not exclusive to a specific income level, affecting low-, middle-, and high-income countries alike. The World Health Organization (WHO) defines violence as the intentional use of physical force or power, whether actual or threatened, resulting in injury, death, psychological harm, maldevelopment, or deprivation (World Health Organization, 2002). In the context of health care, violence manifests as behavioral or verbal threats directed at health care providers, encompassing both sexual and physical assaults, with the perpetrators typically identified as patients, their relatives, and other individuals (WHO, 2002).

Research conducted in Pakistan and internationally underscores a concerning trend of violence within the health care sector, surpassing rates observed in other fields and yet receiving insufficient attention. Salminen notes that, following prison guards and police officers, psychiatric nurses constitute the third professional group most exposed to violence (Salminen, 1997). Among health care professionals, emergency service employees emerge as the most vulnerable to violence (Fernandes, 1999). Elliot further emphasizes that the risk of encountering violence in

the health sector is 16 times higher than in any other field (Elliott, 1997).

The impact of violence against health care extends beyond immediate consequences, causing lasting harm to both individuals and the healthcare system. In addition to physical injuries, loss of life, and infrastructure damage, such violence disrupts access to healthcare services, resulting in a profound and catastrophic effect on public health (ICRC, December 2018). Developing countries report high incidences of physical and verbal violence against health care, particularly in emergency departments. However, the scale of this issue in Pakistan, especially in urban areas, surpasses the proportions observed elsewhere and, to some extent, is normalized. Pakistan exhibits a longstanding trend of violence against healthcare professionals, with potential consequences encompassing negative impacts on their mental and physical well-being, as well as their job and professional lives if not adequately addressed.

This paper identifies a gap in the existing global and Pakistani literature concerning violence against health care workers and facilities, emphasizing the deficiency in a people-centered perspective. While healthcare providers are highly regarded as *messiahs* by the people in Pakistan, there is a paradoxical occurrence of violence against them. The central question this paper addresses is why individuals, who generally hold health

care workers in high esteem, resort to violence against them. Without understanding and addressing the root causes of this issue, it is likely to persist indefinitely. The paper undertakes the unique approach of delving into the perspectives of the people themselves, conducting 20 in-depth interviews with individuals, including patients and attendants. Despite existing literature discussing the causes of violence against health care workers, this paper argues that the lack of a people-centric viewpoint has been a notable gap. By focusing on this unique dimension, the study aims to contribute valuable insights that have been overlooked in previous research. The findings not only shed light on the reasons behind violence but also offer recommendations to efficiently address the issue. Furthermore, the paper contends that the dynamics of violence against health care workers in Pakistan exhibit variations between urban and rural settings.

Literature Review and Gaps in the Literature

Violence against healthcare workers is a global issue, with statistics from the World Health Organization (WHO) indicating that the prevalence of physical violence among these workers ranges from 8% to 38%, and verbal violence is even more widespread. The primary perpetrators of such violence are often patients or their attendants. Those most at risk include nurses, paramedics, and those directly involved in patient care, particularly within emergency services (WHO, April 2019).

In a 2011 study conducted in the U.S. emergency services, it was revealed that 78% of physicians experienced some form of violence, with reported incidents of physical violence at 21% and verbal violence at 75% (Behnam et al., 2011). The British Medical Association reported that one-third of doctors in 2007 faced verbal or physical attacks within a one-year period (British Medical Association, 2008). Similarly, in Jamaica in 2005, a significant number of health workers were exposed to verbal (38.6%) and physical violence (7.7%) (Jackson and Ashley, 2005). In Iran, the emergency service department witnessed substantial exposure to violence, with 71% experiencing verbal violence, 38% facing physical violence, and 4% enduring physical attacks resulting in serious injuries (Rahmani et al., 2012).

A study in Canada reported that 60% of emergency service employees were exposed to violence, including verbal violence (76%) and physical attack or threat (86%), leading to decreased job satisfaction (Fernandes et al., 1999). In Japan, a study involving 19 hospitals in 2011 found that 36.4% of respondents faced various types of violence at their workplaces, with verbal violence at 29.8%, physical violence at 15.9%, and sexual violence at 9.9%. The highest incidence of violence was recorded in the intensive care unit and psychiatric clinic (Fujita et al., 2012).

The situation in Pakistan, within the South Asian context, differs due to its complex security environment marked by conflict/post-conflict situations, extreme poverty, environmental disasters, and weak governance. The people of Pakistan, affected by economic and political instability, express impatience, frustration, and anger, leading to increased crimes and violence. Over the years, the country has witnessed numerous incidents of violence resulting in the loss of innocent lives, including healthcare providers such as security staff, ambulance drivers, nurses, and doctors. According to the Pakistan Medical Association, between 1995 and 2015, approximately 128 doctors were killed, and more than 150 doctors were kidnapped in Karachi alone, along with damage to health facilities and equipment (Khan, March 20, 2014; The News, March 20, 2014). The International Committee of the Red Cross (ICRC) conducted four studies comprehensively examining violence against healthcare workers and facilities in Pakistan. These studies identified the types, reasons, and consequences of violence, citing factors such as unreasonable expectations, communication failure, human error, unexpected outcomes, and perceptions of substandard care (ICRC, October 2015).

While the existing literature has identified several reasons for violence against healthcare workers and facilities, such as unmet expectations, communication failure, human error, unexpected outcomes, perception of substandard care, lack of institutional

mechanisms/policies, and awareness of healthcare workers regarding these mechanisms, it predominantly presents the causes from the perspective of health providers/workers. The current knowledge fails to delve into the root cause of the issue—why people resort to violence against healthcare workers—from the people's perspective. Recognizing that every action has a reaction, it becomes crucial to explore why individuals adopt violence against healthcare providers, who are revered as their Messiahs. The gaps in the existing literature justify further exploration of the issue from a people-centered (bottom-up) approach.

The identified gaps in the existing literature are outlined as follows:

1. The current literature overlooks the complex security environment in Pakistan, marked by violence, extreme poverty, environmental disasters, and weak governance.
2. The predominant focus of existing literature on institutional, legal, and healthcare provider perspectives neglects a critical analysis of the issue from society or people's viewpoints. The lack of examination from the people's perspective leads to a biased and unscientific approach.
3. There is a lack of a holistic approach in the existing literature on how a largely poor, uneducated, and

economically challenged state should respond to the issue in a radicalized and sensitive society with institutional disparities and security challenges. The paper aims to suggest ways forward for addressing the issue effectively.

4. While many cases of violence against healthcare providers have been studied, there is a dearth of research on the societal-public (patient) perspective. The indifferent and inhumane treatment of patients by healthcare providers and staff remains an overlooked issue.
5. Rural-urban differences in violence against healthcare providers and facilities are scarcely addressed in existing literature. Rural areas often adore healthcare providers, considering them as messiahs, while urban areas with educated populations may pay less attention to the medical profession.
6. The existing literature fails to examine the government's failure to develop strategies for training healthcare providers on medical ethics and educating the public on facility usage and behavior towards healthcare providers. This gap exacerbates the issue as both doctor behavior and public lack of awareness contribute to the problem.
7. There is a lack of insight in existing literature regarding the social status, education, and economic conditions of the people, coupled with an examination of government

policies and programs and their capacity to serve the population. This oversight contributes to heightened violence against healthcare providers in situations where social services are inadequate.

8. The commonality of violence against healthcare workers and facilities across Pakistan is acknowledged, but existing literature lacks an in-depth exploration of this trend in urban and rural settings. Rural areas may revere healthcare providers as messiahs, but urban areas face higher risks of violence due to heterogeneous populations and demographic affiliations.
9. Violence against common healthcare providers, such as doctors and vaccination providers, is not adequately addressed in existing literature. Vaccination programs, in particular, become targets of violence due to misconceptions, while doctors, especially in rural areas, are adored and respected.

Addressing these gaps through a people-centered approach can contribute to a more comprehensive understanding of violence against healthcare workers and facilities. The gaps identified in the existing literature on violence against health providers and facilities underscore a lack of in-depth analysis and understanding of the issue. The current literature is often characterized by bias and predominantly presents the perspectives of health providers. To address these shortcomings, this paper

takes a people-centered approach, recognizing the need for a more comprehensive understanding that includes the societal viewpoint. Additionally, the paper acknowledges and explores the rural-urban differences in the manifestation of violence, aiming to contribute to a more nuanced and balanced perspective on this critical issue.

Causes of Violence against Health Care Workers and Facilities: People-Centered Approach

The people-centered approach contributes a unique perspective to the existing knowledge on the causes of violence against healthcare providers. For this purpose, in-depth interviews conducted in both urban and rural settings which, explores the various factors contributing to violence against health-care workers and facilities in Pakistan.

3.1 Inadequate Communication Skills and Patient Education

Healthcare providers often neglect medical ethics and fail to educate patients and their attendants, lacking proper communication skills. The importance of providing information about the disease, expected healing times, and treatment procedures is often overlooked. Respondents in field interviews expressed concerns that healthcare workers' failure to communicate effectively leads to doubts about the adequacy of

provided medication or treatment, triggering violent reactions towards them from patients and their attendants.

3.2 Emotional Stress of Patients and Attendants

During times of illness or serious health issues, patients and their attendants experience heightened stress and emotions. Understanding and addressing their suffering is crucial for health workers to prevent potential violence. Respondents emphasized that healthcare professionals should be mindful of these tense situations, and handle patients with care, as the perceived lack of concern from doctors often leads to violent incidents.

3.3 Lack of Oversight on Health Care Workers' Duty Hours

Healthcare workers in Pakistan, particularly senior doctors, are often perceived to lack accountability for their government duties. Instead, they prioritize private clinics, having agents at government facilities who guide patients to their private facilities. This lack of commitment to public health services contributes to frustration among the public and increases the likelihood of violent incidents.

3.4 Disparities between Government and Private Health Facilities

Public perception holds that the behavior of health workers differs between government and private facilities. Respondents

noted that senior doctors in government hospitals may not communicate effectively with patients, while they exhibit more professionalism and empathy in private clinics. Patients often experience neglect, leading them to seek private healthcare where doctors provide better care and empathy. This disparity contributes to a lack of trust in government health facilities and thus make the patients and attendant aggressive against these doctors. The behavior, apathy, and lack of attention by health care providers in government facilities contribute to public irritation and violence.

3.5 Kidnapping of Health Care Workers

Despite being generally respected, healthcare workers, especially those perceived as exploiting patients in private practice, become targets for kidnapping by militants and outlaws. This violence is directed towards doctors who prioritize private clinics thus earning in millions, neglecting patients in government facilities.

3.6 Rural-Urban Differences in Attitudes towards Health Care Workers

Urban populations, more educated and accustomed to healthcare services, tend to perceive health workers as routine service providers. In contrast, rural areas hold health workers in high regard, with the only exception being misconceptions about family planning and polio workers. Rural communities generally

respect health care providers. But due to the misperception they have about these family planning, vaccination program, thus they target and get violent against these vaccination health providers.

3.7 Public Trust in Private Health Institutions over Government Facilities

Due to factors such as perceived inattention, rude behavior, and lack of ownership in government facilities, people trust private health institutions more. Despite higher fees, private hospitals are seen as providing better treatment, attention, and respect to patients and their attendants. That's why the respondent opined that the people then doubt the health facilities provided in government hospitals and are thus become violent if they find these facilities not fulfilling their needs.

The respondents informed that there is lack of ownership by health workers in government facilities which, contributes to a sense of mistrust among patients. The respondents highlighted issues such as dysfunctional machines and the frequent referral of patients to private laboratories instead of using available government resources.

3.8 Struggle between Strong Doctors and a Weak State

The absence of effective policies to control doctors' private practices leads to conflicts between strong doctors and the state. Doctors' reluctance to adhere to government policies, particularly

regarding private practices, indicates their prioritization of personal interests over public service.

3.9 Promotion of Low-Quality Drugs

Pharmacy companies often use incentives such as foreign trips, cash commissions, and other benefits to promote their low-quality drugs. This practice generates mistrust among educated patients who recognize the use of substandard medications, leading to resentment and potential violence against those doctor who proscribe these medicines.

3.10 Substandard Emergency Services

Issues such as the absence from duty and substandard emergency services contribute to public anger and violence against healthcare professionals. The lack of proper and satisfactory treatment during emergencies exacerbates tensions between patients, attendants, and medical staff.

3.11 Misuse of Ambulances for Personal Services

Public distrust of health care providers leads to suspicion about the misuse of ambulances for personal transportation. This perception prevents easy passage for ambulances on the road, reflecting a lack of trust in the integrity of healthcare services.

3.12 Dissatisfaction with Treatment at Government Hospitals

Patients and their attendants experience dissatisfaction and humiliation in government hospitals due to substandard care, inefficient services, and dismissive attitudes from healthcare practitioners. The ill-equipped nature of government hospitals further erodes public trust in these facilities.

3.13 Inadequate Management at Government Hospitals

The lack of adequate management in government hospitals, particularly in rural areas, forces patients to manage on their own. This contributes to frustration and resentment, further diminishing trust in government health facilities.

3.14 Disregard for Medical Ethics by Health Workers

A general disregard for medical ethics, including gaps in empathetic communication and the absence of universal education on medical ethics, contributes to patient dissatisfaction. The imbalance in the treatment of privileged and less privileged patients fosters mistrust in the medical profession as a whole. The practice of demanding preferential treatment from doctors by the privileged exacerbates these issues, undermining the impartiality of healthcare services.

Therefore, to tackle the overarching concern of violence against health care personnel, it is imperative to get to the root of the matter and address the issues which create that problem.

Conclusion

Violence is a pervasive issue globally, particularly within the realm of healthcare, as evidenced by numerous studies conducted both worldwide and in Pakistan. Recent years have witnessed an alarming surge in reported incidents of violence against healthcare workers, specifically targeting polio vaccination and family planning workers and programs. Consequently, there is a pressing need for more stringent penalties within healthcare institutions to deter such acts.

However, despite the evident increase in media reports on violence, there is a notable absence of scientific studies that can precisely quantify the extent of this issue and its escalation against healthcare workers and institutions. Government organizations or ministries also lack concrete data to ascertain the growing trend of violence in the healthcare sector, particularly in Pakistan.

The patterns of violence against healthcare workers and facilities exhibit variations from one country to another and within different settings, such as urban and rural areas in Pakistan. While some studies in Pakistan provide partial data on the

subject, neither these studies nor government reports offer a comprehensive, multidimensional exploration of the issue. The existing literature remains one-dimensional, failing to present a holistic understanding of the problem.

There is an urgent and compelling need for a comprehensive, multidimensional study that examines violence against healthcare workers from all perspectives. Such a study should be representative of the entire country of Pakistan and encompass all healthcare workers. Moreover, it should be conducted at regular intervals to identify trends in the incidence of violence, enabling the formulation and implementation of effective measures by healthcare workers and relevant organizations to minimize these occurrences.

Recommendations with Strategies

This paper challenges the recommendations proposed by existing studies, which are often deemed impractical and based on wishful thinking. Instead, our research offers pragmatic and achievable recommendations accompanied by a strategic discussion on implementation.

1. Conducting awareness campaigns in rural areas about vaccination is crucial for dispelling misconceptions. Beyond mere campaigns, practical evidence should be

presented to the people to effectively eliminate these misconceptions.

2. Engaging stakeholders and rural elders, including village elders (*masharan*), is essential to eradicate these misconceptions permanently. Misinformation, often propagated by religious figures, can be countered by logical discussions, sensitization on the importance of polio vaccines, and training these influencers to convey the vaccine's benefits during their Friday sermons.
3. While recommending the banning of religious hate speech, it is acknowledged that such a measure may face resistance in Pakistani society. Instead, involving religious leaders, engaging them in logical discussions, proving the importance of the polio vaccine, and training them to advocate for vaccination during their sermons can be a more acceptable and effective approach.
4. Providing healthcare workers with adequate opportunities for professional training, including techniques to deescalate violent situations, is essential to address aggression against healthcare facilities.
5. Identifying the root causes of aggression against healthcare facilities, such as perceived unsatisfactory treatment and overcrowding, and addressing these issues through improved healthcare facility planning and management.

6. Urgently raising awareness among the general public regarding the respect and protection of the healthcare community, emphasizing the rights, roles, and responsibilities of all stakeholders. Behavioral change communication campaigns should be implemented to reinforce these principles.
7. Engaging religious and community leaders to play a more active role in changing perceptions, creating awareness, and enhancing respect for healthcare.
8. Advocating for violence against healthcare as a pressing public health issue, requiring coordinated efforts from healthcare communities, administrations, law enforcement authorities, civil society, international organizations, media, and armed forces.
9. Enhancing the skills of healthcare personnel in communication, ethical principles, managing violence, and dealing with its consequences.
10. Encouraging universities and educational institutions to incorporate modules on addressing violence against healthcare in public health, political science, law, and security studies curricula.
11. Maintaining continuous engagement with the media to promote responsible, balanced, and informed reporting on healthcare issues.

12. Raising awareness among the general public about the respect and protection of healthcare against violence, spreading awareness about existing laws, and continuous advocacy with lawmakers and policymakers.
13. Providing training to healthcare personnel in communication skills and techniques to de-escalate violence.
14. Ensuring the provision of healthcare services tailored to the population's needs and reducing the workload on healthcare staff.
15. Leveraging media and engaging religious and community leaders to change perceptions regarding healthcare.
16. Developing a training module to educate healthcare workers on dealing with violent attendants or individuals.
17. Implementing restricted access for attendants inside hospitals, adopting a triage mechanism, and enforcing strict regulation of healthcare providers.
18. Emphasizing community involvement and inter-sectorial collaboration as crucial elements in decreasing and improving responses to violence against healthcare.

Way forward: Future Research

Moving forward, it is imperative to undertake a comprehensive national representative study, utilizing a people-centric approach as delineated in this paper, to comprehensively understand the magnitude, patterns, and dynamics of violence against healthcare

workers and facilities in Pakistan. The proposed research aims to quantify the frequency and severity of such incidents, adopting in-depth interviews and surveys to directly capture the perspectives of individuals involved or witnessing these acts. Additionally, it seeks to explore the root causes, assess the impact on healthcare workers, examine regional variations, and identify effective intervention strategies. With a focus on community engagement, education, and policy implications, this research endeavors to contribute substantively to addressing and preventing violence against healthcare workers, fostering a safer and more supportive environment for healthcare providers across the nation.

References

Behnam M, Tillotson RD, Davis SM, and Hobbs GR. (2011) Violence in the emergency department: a national survey of emergency medicine residents and attending physicians .J Emerg Med. ;40(5): 565579.

British Medical Association (BMA). (2008). Health Policy & Economic Research Unit. Violence in the workplace - The experience of doctors in Great Britain. http://www.bma.org.uk/images/violenceintheworkplace_tcm4137871.pdf,

Carmi-Iluz T, Peleg R, Freud T, and Shvartzman P. (2005). Verbal and physical violence towards hospital- and community-based physicians in the Negev: an observational study. BMC Health Services Research 2005;5:54.

Elliott PP. (1997). Violence in health care. What nurse managers need to know? Nurs Manage; 28:38-41.

Esmaeilpour M, Salsali M, and Ahmadi F. (2011). Workplace violence against Iranian nurses working in emergency departments. Int Nurs Rev. 58(1):130-7

Fernandes CM, Bouthillette F, Raboud JM, et al. (1999). Violence in the emergency department: a survey of health care workers. CMAJ;161:1245-8.

Fujita S, Ito S, Seto K, Kitazawa T, Matsumoto K, and Hasegawa T. (2012). Risk factors of workplace violence at hospitals in Japan. J Hosp Med.7: 79-84.

Hahn S, Hantikainen V, Needham I, Kok G, Dassen T, and Halfens RJ. (2012). Patient and visitor violence in the general hospital, occurrence, staff interventions and consequences: a cross-sectional survey. J Adv Nurs. 68(12): 2685-2699.

International Committee of the Red Cross (December 2018), Addressing violence against health care in Peshawar a mixed methods study.

International Committee of the Red Cross (October 2015). Towards protecting health care in karachi a legal review - A Report by the Research Society of International Law, Pakistan;

Jackson M, and Ashley D. (2005). Physical and psychological violence in Jamaica's health sector. Rev Panam Salud Publica. 18(2): 114-21.

Owen C, Tarantello C, Jones M, Tennant C. (1998). Violence and aggression in psychiatric units. Psychiatry Services.;49:1452-1457.

Rahmani A, Hassankhani H, Mills J, Dadashzadeh (2012). A. Exposure of Iranian emergency medical technicians to workplace violence: A cross-sectional analysis. Emergency Medicine Australasia ;24:105-110.

Sahar Haroon (2017). Protecting health care in Khyber Pakhtunkhwa - a legal analysis, ICRC ICRC Study on Violence in Karachi.

Salminen S. (1997). Violence in the workplaces in Finland. J Safety Res;3: 123-31

The News. (March 20, 2014). Aaj Kamran Khan Kay Sath. Karachi: 130 doctors killed, 150 kidnapped in two years. The News. March 20, 2014. DOI:http://www.thenews.com.pk/Todays-News-2-239349-Karachi-130doctors-killed-150-kidnapped-in-two-years.

Wealth Health Organization (WHO), (April. 2019). Retrieved from: https://www.who.int/violence_injury_prevention/violence/workplace/en/

World Health Organization (2002). World report on violence and health: summary. Geneva. p 4.