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Violence: Recognition, Management and Prevention

VIOLENCE AGAINST HEALTH CARE PROVIDERS: A MIXED-METHODS STUDY FROM KARACHI, PAKISTAN

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Abstract—Background: Violence against health care providers (HCPs) remains a significant public health problem in developing countries, affecting their performance and motivation. **Objectives:** To report the quantity and perceived causes of violence committed upon HCPs and identify strategies intended to prevent and de-escalate it. **Methods:** This was a mixed-methods concurrent study design (QUAN-QUAL). A structured questionnaire was filled in on-site by trained data collectors for quantitative study. Sites were tertiary care hospitals, local nongovernmental organizations (NGOs) providing health services, and ambulance services. Qualitative data were collected through in-depth interviews and focus group discussions at these same sites, as well as with other stakeholders including media and law enforcement agencies. **Results:** One-third of the participants had experienced some form of violence in the last 12 months. Verbal violence was experienced more frequently (30.5%) than physical violence (14.6%). Persons who accompanied patients (58.1%) were found to be the chief perpetrators. Security staff and ambulance staff were significantly more likely to report physical violence ($p = 0.001$). Private hospitals and local NGOs providing health services were significantly less likely to report physical violence ($p = 0.002$). HCPs complained about poor facilities, heavy workload, and lack of preparedness to deal with violence. The deficiencies highlighted predominantly included inadequate security and lack of training to respond effectively to violence. Most stakeholders thought that poor

quality of services and low capacity of HCPs contributed significantly to violent incidents. **Conclusion:** There is a great need to design interventions that can help in addressing the behavioral, institutional, and sociopolitical factors promoting violence against HCPs. Future projects should focus on designing interventions to prevent and mitigate violence at multiple levels. © 2017 Elsevier Inc. All rights reserved.

Keywords—violence; health care providers; preventive strategies

INTRODUCTION

The World Health Organization defines violence as “the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, which either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation” (1). Violence was declared a major public health problem in the Forty-Ninth World Health Assembly in 1996 (2). The Assembly recommended that Member States give urgent consideration to the problem of violence and set up public health activities to prevent and mitigate it. Almost one-fourth of workplace violence occurs within the health care sector. Within health care, emergency care is the sub-sector

most impacted by violence that occurs in the workplace (3). Fear of violence affects the performance of health care providers and decreases their responsiveness to patients' health care needs, especially in emergency situations (2). Moreover, ineffective security also decreases the confidence of the patient that they will be able to obtain health care services safely, without experiencing violence perpetrated by other patients or those who accompany those patients (4). As effective security services are an important contributor to a hospital's reputation, hospitals with the means to do so, and hospital leadership motivated to do so, will allocate sufficient resources to enable a safe environment in hospitals (5). Violence against health care providers (HCPs) at the workplace is an alarming problem in both developed and developing countries. Although developed countries have made significant progress in providing a safe work environment for their HCPs, it remains a significant public health challenge in developing countries (6–10).

In Pakistan, violence against health care staff such as sectarian killings of doctors, extortion threats, execution of patients, and targeting of HCPs due to possession of sensitive information have been widely reported by the print and electronic media (11). This study aimed to report the quantity and perceived causes of violence committed upon HCPs and identify strategies intended to prevent and de-escalate it. It was conducted in Karachi, which is one of the world's top 10 most populous cities, with an estimated population of 18 million (12). Although reported events of violence like terrorism, militant attacks, target killings, and security operations have declined, the city still remains the most violent place in the country (13). More importantly, it is widely believed that many low-level incidents of verbal and physical violence remain hidden and unreported. The city's health care system comprises a mix of 134 public and private hospitals providing health care services to the locals, with a significant number of referred patients from other parts of the country (14). Previous studies in the health care settings in the city have also shown frequent experience of physical and verbal abuse of varying intensity by HCPs (15,16).

MATERIALS AND METHODS

This was a mixed-methods concurrent triangulation design (QUAN-QUAL).

Quantitative Methods

Quantitative data were collected from HCPs at hospitals, nongovernmental organizations (NGOs), and ambulance services. We interviewed all cadres of HCPs, including doctors, nurses, technical staff, support staff, administra-

tive/clerical staff, security staff, and ambulance staff. As data were being collected from multiple stakeholders without an accurate estimate of the target population, we decided to collect data from at least 50% of the staff present in the institutions. Data were collected from all consenting respondents using nonprobability convenient sampling.

A structured questionnaire was adapted from previous studies and finalized after discussions with stakeholders after 10 iterations. It included questions on the quantity of the problem, classification/types of violence, perceived reason or triggering of event, and consequences of the event. It was translated into the local language (Urdu) by a certified translator and was piloted prior to the formal start of the survey. A broad definition of violence was adopted for the study to capture all types of violence affecting the health care system, ranging from low-intensity verbal violence to armed attacks. Violence was defined as any act of verbal abuse (speaking in loud voice, threatening, abusing), physical abuse (pushing, beating, throwing things), and other acts, including use of weapons or damage to facility. The questionnaire was completed by trained data collectors. The field teams were accompanied by the supervisors, who checked the completeness of every form prior to submission to the project office for data entry. The data were entered in SPSS version 19 (IBM, Armonk, NY) on the same day.

Statistical analysis. Descriptive statistics are reported as frequencies and percentages. The relationship between predictor variables (age, gender, language, workplace, job position, and job experience) and two major types of violence (verbal and physical) was calculated using the chi-squared test. A p -value of < 0.05 was considered significant.

Qualitative Methods

The qualitative data were collected through 42 in-depth interviews (IDIs) and 17 focus group discussions (FGDs) conducted by researchers, which included senior faculty of the Institute of Public Health who had training in qualitative research and had previous experience of conducting IDIs and FGDs. Qualitative data were collected from hospitals, local NGOs providing health services, ambulance service providers (ASPs), and other stakeholders including media, law enforcement agencies (LEAs), and the Pakistan Medical Association. All the stakeholders were formally approached, official permission was taken, and face-to-face interviews were conducted. All participants were informed about the aims and objectives of the interview and the process of the interview. Purposive sampling was done to identify participants for IDIs and FGDs, which included service

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