VIOLENCE AGAINST HEALTH CARE

RESULTS FROM A MULTI-CENTRE STUDY IN KARACHI

VIOLENCE AGAINST HEALTH CARE MUST END

IT'S A MATTER OF LIFE & DEATH

ICRC

ICRC

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FOREWORD

Health Care in Danger (HCiD) is a global project of the International Committee of the Red Cross (ICRC) aimed at affording better protection to those who provide medical care, as well as their patients. Since 2011, the both the ICRC and the International Red Cross/Red Crescent Movement have been working on this crucial humanitarian issue in countries as different as Syria and Mexico, Brazil and South Sudan.

Within the HCiD framework, we engaged in humanitarian diplomacy with States and multilateral bodies, organized international expert workshops, produced a number of publications and provided concrete support to health-care structures in dire need of protection against violence. The introduction – with ICRC support – of improved safety management systems has led to a decrease in incidents targeting health-care staff and improved coverage of public health initiatives such as vaccination programmes. Notably, such interventions have been successful in some megacities of the South, where urban healthcare is one of the most important development indicators.

The ICRC has historically been and remains committed to supporting health systems in emergencies. In South Asia, we have been treating victims of the conflict in Afghanistan since the 1980s, evacuated wounded from the north of Sri Lanka during the civil war there, and provided artificial limbs to hundreds of thousands of amputees. More recently, in Karachi, the ICRC has been providing training and expertise on the management of mortal remains to local stakeholders, opened an orthoprosthetic centre in cooperation with Indus Hospital, and arranged seminars on emergency room trauma and war surgery.

The report which you are about to read is the main fruit of a year and a half of engagement on the issue of violence against healthcare in Karachi. The primacy given to research stems from our conviction that any meaningful public-health intervention in a complex metropolitan environment like Karachi must be based on a thorough understanding of the context.

During this time, we were lucky to work with cutting-edge professionals and academics, receptive government authorities, and active civil society. We are truly grateful to the Commissioner of Karachi, Mr. Shoaib Ahmed Siddiqui, for his support to this important humanitarian endeavour and his words of encouragement. The Dean of APPNA Institute of Public Health, Prof. Lubna Baig, has provided excellent leadership for the research, and Dr. Seemin Jamali, Joint Executive Director of JPMC, Prof. Kausar Saeed Khan and Prof. Syeda Kauser Ali from Aga Khan University, as well as Prof. Kamran Hameed from Ziauddin Medical University, have offered invaluable assistance and insight.

The ICRC, given its expertise of 150 years of providing medical aid in problematic areas and its role as part of the world's largest humanitarian network, is ready to share its experience and provide support. However, it is the people and institutions of Karachi that can come up with a lasting solution to the unfortunate problem of violence against health workers and patients.

Having witnessed the level of sincerity and professionalism that characterizes our partners in Karachi, I am hopeful that this crucial humanitarian issue can be tackled successfully.

One thing is certain: this is a complex problem that requires hard work by all of us. This research is just a beginning of a longer process of designing and implementing solutions, and I hope we can keep working on it together.

Reto Stocker,
Head of Delegation,
ICRC Pakistan

EXECUTIVE SUMMARY

Violence is a common feature of mega-city landscapes and health-care providers (HCPs) are not immune to it. This creates hindrances to the delivery of health care to the sick and needy. The International Committee of the Red Cross (ICRC), within the framework of its global project Health Care in Danger (HCiD), seeks to improve the protection of medical personnel from violence through humanitarian diplomacy, advocacy, the promotion of law and practical interventions. In order to pave the way for improving the safety of health-care professionals, facilities and ambulance services and hence also the patients, the ICRC, with the collaboration of APPNA Institute of Public Health, Jinnah Sindh Medical University, Karachi, conducted a research study on violence against health care from January 2015 to August 2015. The objectives of the study were to identify different types of violence and assess the perception, tolerance threshold and impact of violence on all types of stakeholders, thus contributing to the identification of policies to better protect health care from violence and its consequences.

Stakeholders included doctors, nurses, paramedics, security guards and other hospital staff, ambulance service drivers and staff, media and law enforcement agencies (CPLC, police and Rangers). A mixed-method (QUAN-QUAL) study approach was used. A total of 822 questionnaires were collected through consecutive sampling, and 17 focus groups and 42 in-depth interviews were conducted. Analysis was carried out by a team of academics meticulously adhering to appropriate methodological rigours.

Almost two thirds of the participants had either experienced or witnessed some kind of violence in the past year and one third reported having experienced any form of violence. Verbal violence was experienced more than physical violence. More commonly experienced or witnessed forms included abusive language, pushing and pulling, threats, and use of fists and feet. Multiple perpetrators were involved in almost half of the incidents. Patients' attendants were found to be the chief perpetrators, followed by unidentified persons. Emergency department and wards were the most common sites of violence.

The main reasons for violence included unreasonable expectations, communication failure, human error, unexpected outcomes, and perception of substandard care. The effects of violence included getting overly alert, feeling hopeless, and having repeated disturbing memories about the incident. Two thirds of the participants thought that the event could have been prevented. More than half of the affected did not take any action against the attackers. Almost one third considered it useless to report, while a few were afraid of the negative consequences of reporting the event. The majority were not aware of any specific institutional policy to deal with violence. More than half of respondents were not aware of any significant changes that had taken place in the last two years to deal with violence in their organization. The presence of metal detectors, panic button and patient screening methods were only reported by slightly more than one third of the respondents.

Physicians, security staff and ambulance staff reported significantly higher frequencies of verbal violence as compared to other job positions. Security and ambulance staff were significantly more likely to report experiencing physical violence. In comparison to public-sector hospitals and ambulance

services, private hospitals and NGOs were significantly less likely to report physical violence. Women were significantly less likely to experience physical violence.

Qualitative interviews revealed that there was general acceptance of HCPs and ambulance staff for verbal and even minor forms of physical offence. Law enforcement agencies (LEA) personnel reported tolerance among doctors for paying extortion money. While the HCPs and ambulance staff complained of unreasonable behavior and expectations of attendants, poor facilities and high workload, media and LEAs pointed to negligence in the behaviour of HCPs, poor quality of services, and low capacity of HCPs as contributing heavily to violent incidents. The deficiencies in preparedness to deal with violence included inadequate security staff, inadequate security facilities and a lack of training to manage violence by all stakeholders. HCPs and ambulance staff responded to violence mainly by counselling the attendants. Infrequently, in serious circumstances, FIRs were lodged and police help was sought.

Institutional recommendations included improvement in availability of facilities, improved clinical skills of HCPs, training of HCPs in communication skills, enhanced security facilities, restricted access of attendants inside the hospital, clear mechanisms of triage, and strict regulation of HCPs. Respondents also suggested societal reforms like improving awareness of respect for HCPs in emergency situations, awareness of respect for the law, performance of LEAs, literacy rate, judicial system and reduction in political interference in institutions. The importance of giving way to ambulances and respecting ambulance staff was emphasized by most of the stakeholders. Respondents emphasized the importance of media when it came to playing a positive role in raising awareness and accurately reporting on health-care issues.

In the light of the findings, the study proposes a framework for a multi-pronged response to the complex problem of violence against HCPs. Future projects should focus on designing interventions to decrease violence at multiple levels and implementation of a zero tolerance policy for any kind of violence against health care. We also propose capacity-building for HCPs in communicating with and counselling patients and improved security arrangements at the workplace. Awareness campaigns for respecting doctors and laws should be carried out. Health-care organizations should also actively lobby and advocate for autonomous health-care institutions without political influence.

1. INTRODUCTION

Violence in megacities has always been an observed element and is one of the significant public health dilemmas. It is among the leading causes of death globally.(1) According to the International Federation of Red Cross and Red Crescent Societies (IFRC), the basis of any violence is misuse of power.(2) The IFRC has defined violence as: "The use of force or power, either as an action or omission in any setting, threatened, perceived or actual against oneself, another person, a group, a community that either results in or has a high likelihood of resulting in death, physical injury, psychological or emotional harm, mal-development or deprivation."

The World Health Organization (WHO) defines violence as "the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, mal-development, or deprivation." This definition includes "the use of power" in itself and thereby expands on the conventional meaning of the word.(3)

Over the years, occupational violence has emerged as a major threat to health-care providers (HCPs). HCPs are the working officials who are engaged in delivering health to the needy population within and outside the health facilities. They may be doctors, nurses, paramedic staff, allied health professionals, ambulance service providers or health workers (especially community workers, etc.).

The 39th World Health Assembly specifically addressed the issue and agreed that HCPs are vulnerable to occupational violence ranging from blocking or interfering with timely access to care; discrimination in access to care, killing, injuring, kidnapping, harassment, threats, intimidation, and robbery to bombing, looting, forceful interference with the running of health-care services etc.(3) Regrettably, there seems to be a misplaced community expectation that HCPs—as members of caring professions—should continue to provide care regardless of the risks they may face.

The ICRC lists the following specific types of violence against health care prevalent in conflict and other emergencies:(4)

1. **Health-care facility**
    a. Violence includes bombing, shelling, looting, forced entry, shooting into, encircling or other forceful interference with the running of health-care facilities (such as depriving them of electricity and water).
    b. Health-care facilities include hospitals, laboratories, clinics, first-aid posts, blood transfusion centres, and the medical and pharmaceutical stores of these facilities.
2. **Wounded and sick**
    a. Violence includes killing, injuring, harassing and intimidating patients or those trying to access health care; blocking or interfering with timely access to care; deliberate failure to provide or denial of assistance; discrimination in access to, and quality of, care; and interruption of medical care.
    b. The wounded and the sick include all persons, whether military or civilian, who are in need of medical assistance and who refrain from any act of hostility. This includes maternity cases, newborn babies and the infirm.
3. **Health-care personnel**
    a. Violence includes killing, injuring, kidnapping, harassment, threats, intimidation, and robbery; and arresting people for performing their medical duties.
    b. Health-care personnel include doctors, nurses, paramedical staff including first-aiders, and support staff assigned to medical functions; the administrative staff of health-care facilities; and ambulance personnel.
4. **Medical vehicles**
    a. Violence includes attacks upon, theft of and interference with medical vehicles.

b. Medical vehicles include ambulances, medical ships or aircraft, whether civilian or military; and vehicles transporting medical supplies or equipment.

Violence against HCPs is a widespread phenomenon and has been condemned internationally. The developing countries have reported high incidences of physical and verbal violence in the emergency departments but that number is not even close to the proportions seen in Pakistan, particularly in Karachi, where it is a very common and to a certain extent acceptable phenomenon. The city has a profiled trend in relation to violence against health-care professionals. Over the years, several violent incidents occurred in which several innocent people lost their lives (and this does not include threats, verbal violence and extortions). The victims have ranged from doctors, nurses to ambulance drivers and security staff. The Pakistan Medical Association (PMA), an autonomous body that voices the issues of health-care providers, states that there have been almost 128 doctors killed from 1995 until 2015 across Pakistan. The highest number of incidents happened in 2014, when around 18 deaths were reported.(5) The violent events not only include human harm, but examples exist where health-care facilities (HCFs) and/or equipment (including ambulances) were damaged. The South Asia Terrorism Portal (SATP), an independent site, reports that between 2001 and 2014 some 40 doctors were killed due to terrorism.(5) This number is an understatement, as according to "The News" report, up until March 2, 2014 more than 130 doctors had been killed and 150 kidnapped in Karachi.(6)

Zarar Khan in 2002 had reported a hunger strike in Karachi on the targeted killing of 13 doctors in Karachi with an alarming number of 270 killings between 1997 and 2002.(7) The Pakistan Medical Association (PMA) used all possible platforms to protest against kidnapping and killing of HCPs, but to no avail.(8) Dr. Gadit wrote about the brain drain and migration of doctors (1000 – 1500/year) due to terrorism and the search for better quality of life.(9) A nationwide study conducted in 2009 in the emergency departments of the major hospitals reported that over the past two months, 76.9% of physicians had faced abuse (verbal or physical) from patients or their caretakers. Males were more likely than female physicians to be targeted for any kind of abuse. This in their opinion was at that time higher than such incidences reported globally.(10)

A recent study from Karachi's four major hospitals reported that 72.5% of HCP have experienced abuse (verbal and physical) in the past 12 months. Out of these, almost 30% reported physical attacks with 64% perpetrators being caregivers or attendants.(11) This study also reported that 86% of the HCPs thought that violence could have been prevented and 64% of them also said that no action was taken against the attackers.(11) All the studies recommended that HCPs should be informed of the types and possibilities of the violence in their area of practice.

Even though the issue has been identified in research and the most shocking events of violence have been reported in the media, the true extent of the problem clearly goes beyond what is publicly known. This is partly because of the incidents that are least likely to be reported, such as those not requiring medical attention, for example verbal abuse and incidents causing mental or psychological distress. Additionally, there is no reporting and registering agency that maintains statistics on all violent incidents in the country. To address this issue, the International Committee of the Red Cross (ICRC), within the framework of the project Health Care in Danger (HCiD) and working in collaboration with APPNA Institute of Public Health (AIPH), Jinnah Postgraduate Medical Centre and Ziauddin Medical University, supported this research aimed at investigating the major causes and different factors related to violent incidents involving HCPs and health-care facilities (HCFs). The ultimate aim was to acquire a nuanced image of violence against health care in Karachi in order to identify strategies for prevention and de-escalation.

2. METHODOLOGY

Introduction

Before developing the proposal one round-table conference, several meetings and a workshop was organized with all stakeholders in order to identify and finalize the questions for the study. The project was the first attempt of its kind to try and provide an in-depth understanding of the problem, its dynamics, scale and underlying reasons. Therefore, an effort was made to ensure that this investigation was well constructed to extract a maximum amount of knowledge. After the questions were identified through a consultative workshop which brought together more than 70 representatives of the medical profession, NGOs, Islamic charities, authorities and law enforcement agencies, the project partners jointly developed the research proposal with the study objectives given below.

Objectives

The objectives of the study were to:

1. Identify different types of violence against health-care professionals.
2. Gauge the magnitude of the problem.
3. Assess the perceptions and threshold of tolerance for violence among HCPs and all other stakeholders.
4. Identify the areas of Karachi that are more prone to violence and assess the causes.
5. Assess the impact of violence on health-care workers, patients and institutions.
6. Obtain the initial input of the stakeholders for future identification of remedies.
7. Assess the mutual expectations of stakeholders and local communities in terms of tackling the problem.

Study design

This was a mixed-methods study design with a QUAN-QUAL approach. Quantitative data was collected through a structured questionnaire which was completed by data collectors via direct interview on site including hospitals, non-governmental organizations (NGOs) and ambulance service providers (ASPs). Qualitative data was collected through in-depth interviews and focus group discussions conducted by trained surveyors and researchers themselves. Qualitative data was collected from hospitals, NGOs, ambulance service providers (ASPs), media; and other stakeholders with direct or indirect knowledge of violence against health-care professionals, including media, law enforcement agencies (LEAs), the Human Rights Commission of Pakistan (HRCP), and the Pakistan Medical Association (PMA). Respondents were asked about violent events they had experienced during the preceding 12 months. For qualitative data collection, semi-structured questionnaires were developed for all stakeholders.

Sampling

Sample size was calculated using the formula for categorical data and a cross-sectional study design using an open source online statistical software "Open Epi". Anticipated frequencies for verbal and physical abuse were taken from previous studies in Pakistan. The highest sample size came for an anticipated frequency of 72.5% for verbal abuse at a confidence level of 99%, with a minimum of 529 participants required for the study. However, as little was known and 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 posted/present in the institutions/organizations. We targeted to collect a minimum of 800 questionnaires from all consenting respondents available at the time of data collection using non-probability consecutive sampling. A total of 861 structured questionnaires were completed. A total of 17 focus groups and 42 in-depth interviews were conducted for the qualitative component. The amount of information we have collected allows us to say with great certainty that the situation depicted in the report is typical of Karachi as a whole.

Participating organizations/institutions

The quantitative data collection activity was carried out (using structured questionnaire) from hospitals, non-governmental organizations (NGOs) and ASPs. Qualitative data was collected from hospitals, NGOs, ASPs, media, PMA, HRCP and LEAs. The technique for data collection involved in-depth interviews and focus group discussions.

Data was collected from the following organizations/institutions:

Hospitals: Jinnah Postgraduate Medical Centre, Civil Hospital, Ziauddin Hospital, Sindh Government Hospital-Korangi, Sindh Government Hospital-Lyari, Sindh Government Hospital-Malir

NGOs: Al-Khidmat Foundation, Sina Foundation, Médecins sans frontières (MSF), Health Education and Literacy Programme (HELP), Health And Nutrition Development Society (HANDS)

Ambulance Service Providers: Aman and Edhi Ambulance Service

Media Groups: Geo TV, ARY News, Express News, Metro News, and Dawn News

Law enforcement agencies: Police, Citizens-Police Liaison Committee (CPLC). Other organizations: Human Rights Commission Pakistan (HRCP), Lady Health Workers Programme.

Process of data collection

1. Development and transformation of quantitative data collection tool

The thinking process and discussion with stakeholders helped us in transforming the variables of interest into the quantitative and qualitative questions used for the investigative process. The quantitative questionnaire was field-tested and after 10 iterations finalized for the project. The questionnaire also included Urdu translation for standardization across all data collectors. The translation was done by a certified translator.

A) The data collection tool included the following variables:

(a) Quantum of the problem
(b) Classification /types of violence
(c) Grade or intensity of the problem
(d) Perceived reason or triggering event
(e) Perceived motives of the perpetrators
(f) Result of the event
(g) Result of the intervention
(h) Any corrective or preventive action taken
(i) How could things be handled differently?

B) Hiring and training of data collectors: The field activity started with hiring ten data collectors and two field supervisors for the duration of two months. They were given complete training that involved in-depth knowledge of the research project and training on communication skills. The training also involved hands-on practice on questionnaire and interviews.

C) Piloting the field activity: The questionnaire underwent modifications on the basis of pilot testing. The pilot activity also helped us in assessing the capacity of data collectors, which was followed by extended training on several of the weaknesses identified among data collectors and their supervisors.

D) Team development for data collection: Separate teams were developed for quantitative and qualitative data collection components. A coordinating team helped with scheduling the visits to the organizations/institutions for data collection.

E) Data entry: In the field, the teams were accompanied by field supervisors, who checked the completeness of every form before submitting them to the data entry officers in the project office for data entry. The data entry officers entered the data in SPSS version 19 the same day: if any inconsistency was found, it was discussed with the team for clarification, and if necessary they went back to get clarification from the respondents the next day. The cleaning of data errors was carried out within the following week.

2. Development of a qualitative data collection tool

The semi-structured questionnaire developed for in-depth interviews (IDIs) and focus group discussions (FGDs) was tested during the training of the data collectors and supervisors. All the IDIs and FGDs were video- and audiotaped. For IDIs, the researcher or the supervisor guided the discussion, one data collector recorded the interview on paper, and the other recorded the nuances of the discussion and managed the recording.

3. Process of qualitative data analysis

The transcription of data started immediately after the IDI and/or FGD was conducted. Inductive analysis was done on six transcripts by the three researches independently. Consensus was reached on themes that were generated after discussion. These six transcripts were then added back to the entire data for further analysis. The thematic content analysis was done independently by the same three researchers and after frequent deliberations and meetings consensus was reached. This ensured rigor in the study for generalization to similar populations.

3. RESULTS

A. Quantitative findings

Statistical analysis

Descriptive statistics are being reported as frequencies and percentages. The relationship between predictor variables (age, gender, language, workplace, job position and job experience) and five major types of violence experienced (abusive language, pushing and pulling, threat to life or property, beating with fists or feet, and showing a weapon) was calculated using the Chi-Square test. A P-value of <0.05 was considered significant. After data cleaning, out of 861 questionnaires, only 822 that had no missing information were used.

A-1. Distribution of the study sites and participants

Fig: A-1.1 shows the distribution of data collection sites. Table A-1.1 shows the demographic characteristics of the study participants. The mean age of the participants was 34.51 years. Males (59.7%) outnumbered the females (40.3%). Almost one third were single (31.5%) and two thirds married (67.7%). The major language spoken by the participants was Urdu (60.3%), followed by Punjabi (13.5%) and Sindhi (8.8%), with 22.4% of the participants perceiving themselves as belonging to a minority group.

Table A-1.2 shows the job characteristics of the participants. Around one fifth (21.2%) were nurses, 15.8% were physicians and 15.1% were technicians. Other participants included security agents, administrators, ancillary and ambulance staff. The overwhelming majority (88.3%) had work experience of over one year. Almost half of the employees (48.6%) belonged to the public sector. The bulk of the data came from hospitals (70.7%), followed by ambulance services (18.1%) and non-governmental organizations (11.2%). Fig: A-1.2 shows the predominant places in the hospitals where the interviews took place. In the hospitals (n=581), interviews were predominantly conducted in Accident and Emergency Departments (41.8%) and Emergency Obstetrics (39.4%). Fig: A-1.3 shows the distribution of the number of participants from each site.

Fig A-1.1 Distribution of Data Collection Sites (n=822)

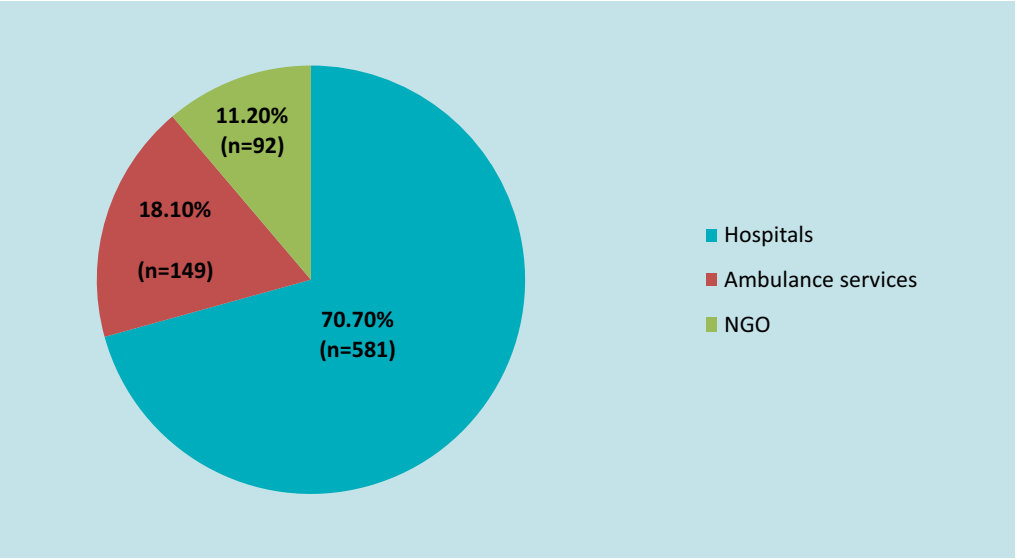


Fig A-1.2 Type of Place in the Hospitals (n=581)

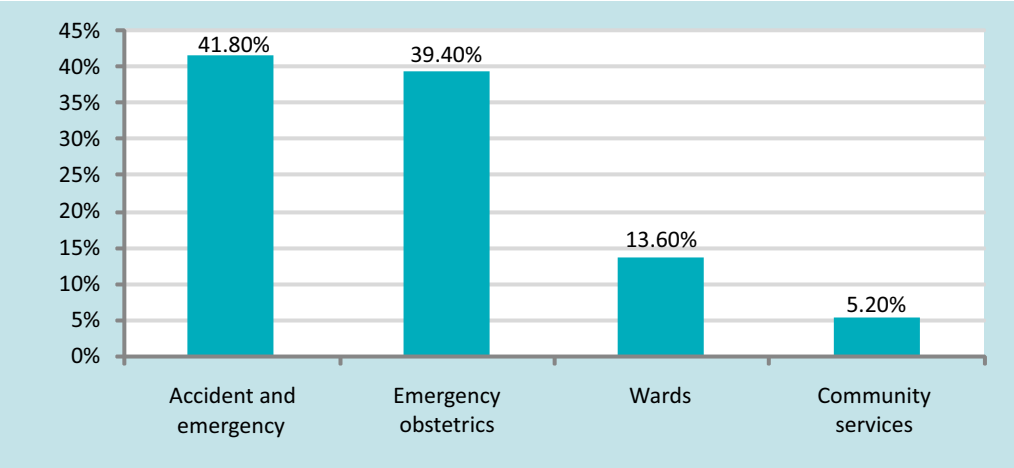


Fig A-1.3 Sites and number of HCP's interviewed at each Site

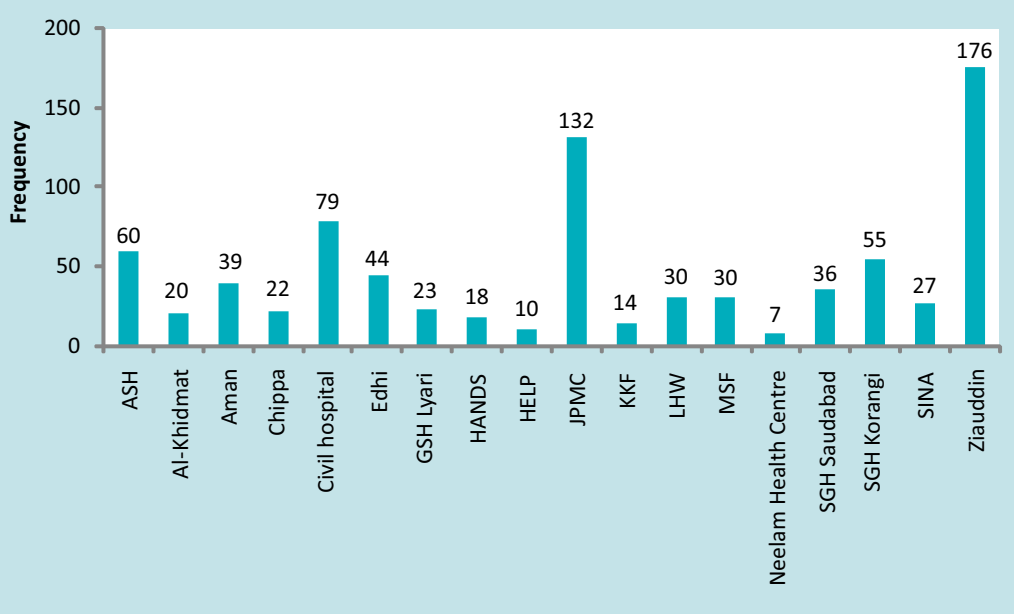


Table A-1.1 Demographic characteristics of research participants (n=822)

Age	Mean 34.51 SD 10.50
Gender	
Male	59.7% (491)
Female	40.3% (331)
Marital status	
Single	31.5% (259)
Married	67.7% (556)
Other (divorced/widowed)	0.8% (07)
Perception as minority	
No	65.1% (536)
Yes	22.7% (187)
Don't want to disclose	3.3% (27)
Don't know	8.9% (73)
Major language spoken	
Urdu	60.3% (496)
Sindhi	8.8% (72)
Punjabi	13.5% (111)
Pashto	8.4% (69)
Baluchi	3.3% (27)
Other	5.7% (47)

Table A-1.2 Job characteristics of research participants (n=823)

Nature of job	
Physician	15.1% (124)
Nurse	21.2% (174)
Auxiliary /ancillary	8.2% (67)
Administration/clerical	8.6% (71)
Professions allied to medicine	7.9% (65)
Technical staff	15.6% (128)
Security agent	9.5% (78)
Ambulance driver	10.1% (83)
Ambulance paramedic	1.8% (15)
Ambulance service administrator	2.1% (17)
Work experience	
Under 1 year	11.7% (96)
1-5 years	42.5% (349)
6-10 years	21.4% (176)
11-15 years	8.5% (70)
16-20 years	4.9% (40)
Over 20 years	11.1% (91)
Category of employment	
Private	31.4% (258)
Public	47.6% (391)
Don't know	21% (173)

A-2. Frequency, nature and characteristics of violence experienced or witnessed

Almost two thirds of the participants (65.6%) had either experienced or witnessed some kind of violence and one third reported having experienced some form of violence. Verbal violence was experienced or witnessed by 58.5%, while 30.5% themselves experienced verbal violence (Table A-2.1). Physical violence was experienced or witnessed by 28.6%, while 14.6% themselves experienced verbal violence. Fig. A-2.1 shows the predominant nature of violence experienced or witnessed by the participants. More commonly experienced or witnessed forms included abusive language (82.8%), pushing and pulling (40.6%), threats (34.7%), use of fists and feet (20.8%). Less common forms included damage to furniture (13.1%), showing of a weapon (9%), damage to access gates (7.2%), damage to equipment (5%), and use of explosives (1.3%). Fig. A-2.2 shows the frequency, number of perpetrators and number of victims in the violence experienced/witnessed. A large number (43.6%) of the participants had experienced or witnessed violence more than five times. Two to five perpetrators were involved in 51% of the events experienced or witnessed, while more than five perpetrators were involved in 30.6% of cases. Patients (58.1%) and the general public (26%) were found to be the chief perpetrators in the events of violence (Fig. A-2.3).

More than four fifths (81.7%) of the events took place inside the institution while the remaining events took place outside the facility or during field visits (Fig: A-2.4). Fig. A-2.5 shows the predominant location inside the hospital where the incidents took place. Emergency Departments (56.4%) and Wards (21%) were the most common sites of violence, while other less common sites included open spaces like parking or corridor (5%), OPD (3.8%), ICU room (3.45%), Labour room (3.4%), gate (2.5%), Investigation Laboratory or X-ray room (1.8%) and reception (1.4%). The events were spread across 24 hours of the day, with almost one third of the events taking place during the morning duty hours (Fig. A-2.6).

Table A-2.1 Nature of violence experienced or witnessed (n=822)

	Violence experienced or witnessed	Violence experienced
Verbal	58.5% (481)	30.5% (251)
Physical	28.6% (235)	14.6% (120)
Facility damage	11.1% (91)	6.2% (51)
Overall (any form of violence)	65.9% (542)	33.5% (275)

Figure A-2.1 Predominant nature of violence experienced or witnessed (n=542)

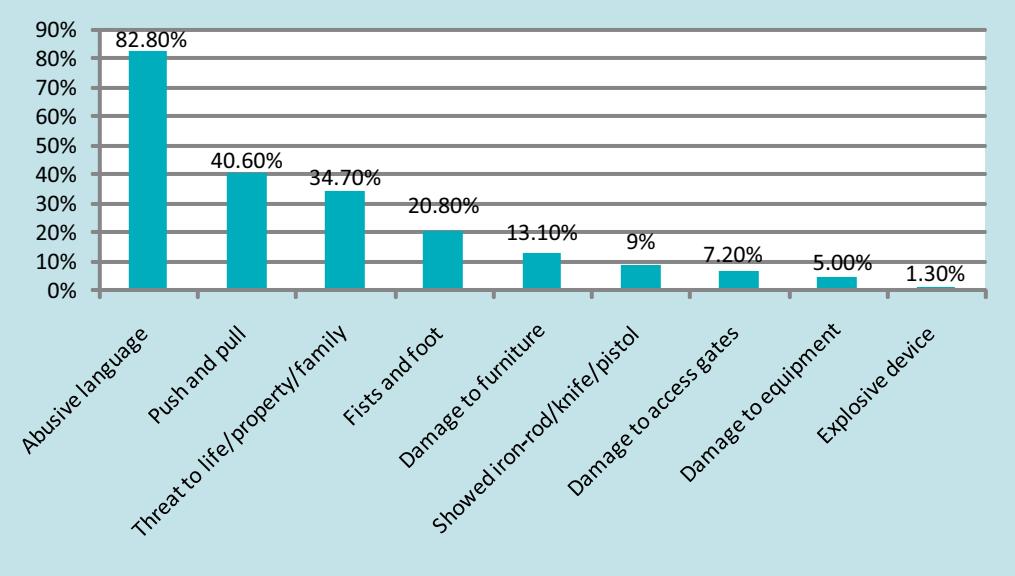


Fig A-2.2 Frequency, number of perpetrators and number of victims in the violence experienced/witnessed (n=542)

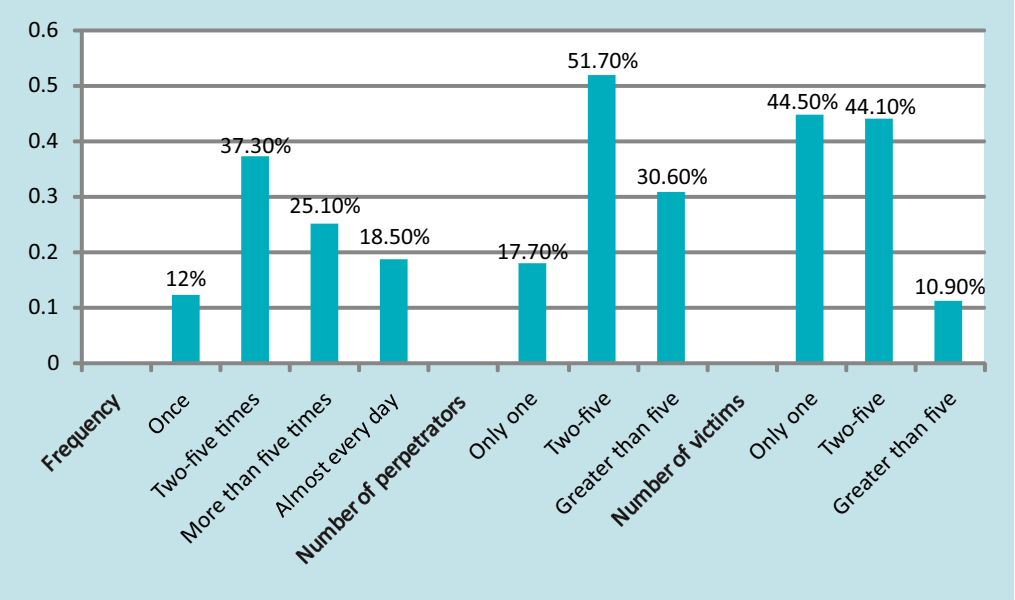


Fig A-2.3 Chief perpetrators in the events of violence experienced/witnessed (n=542)

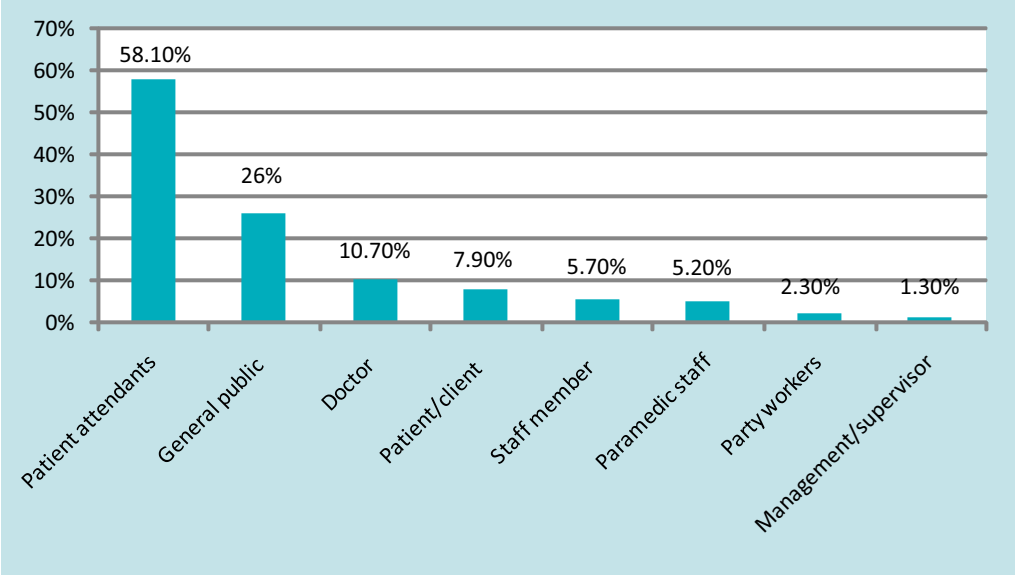


Fig A-2.4 Chief perpetrators in the events of violence experienced/witnessed (n=542)

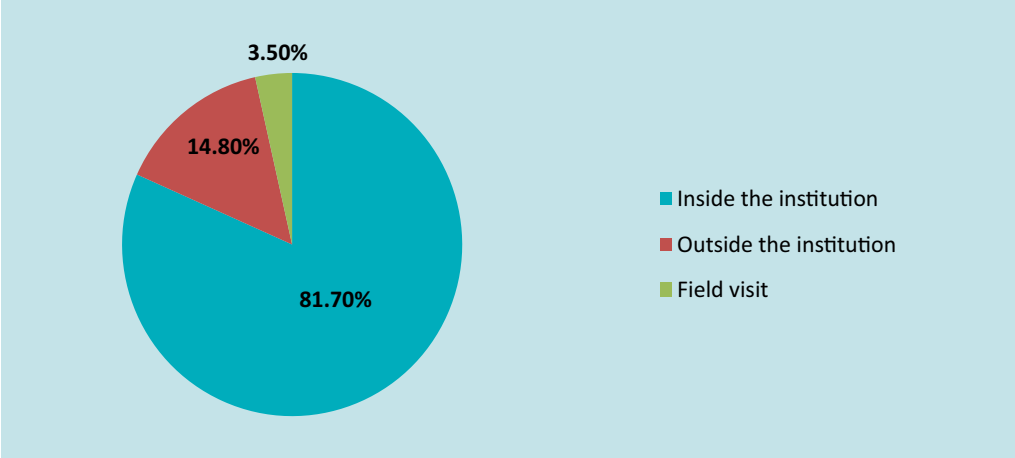


Fig A-2.5 Primary site inside the facility (n=443)

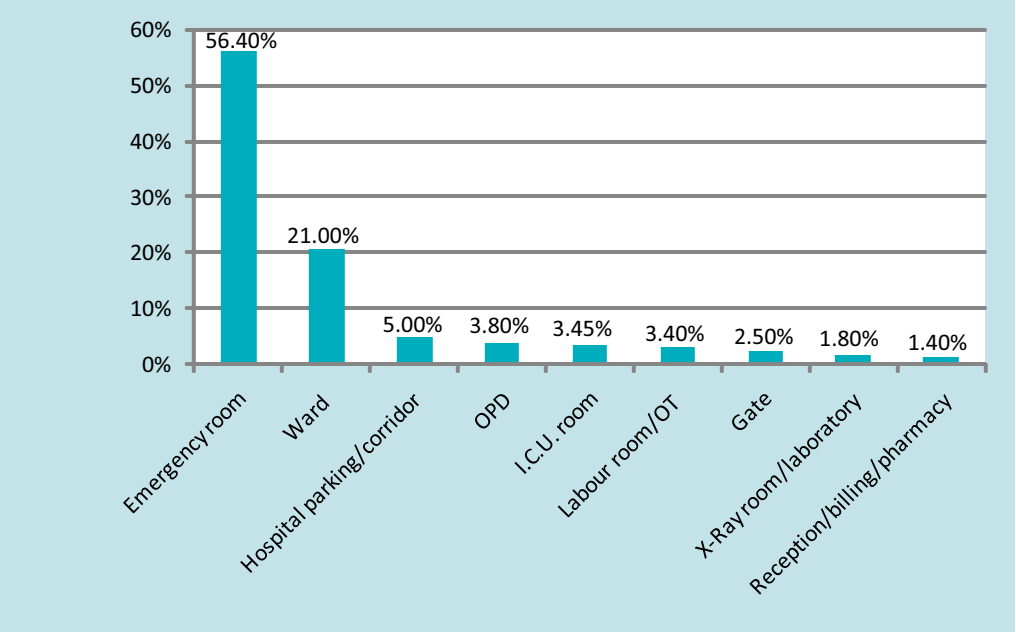
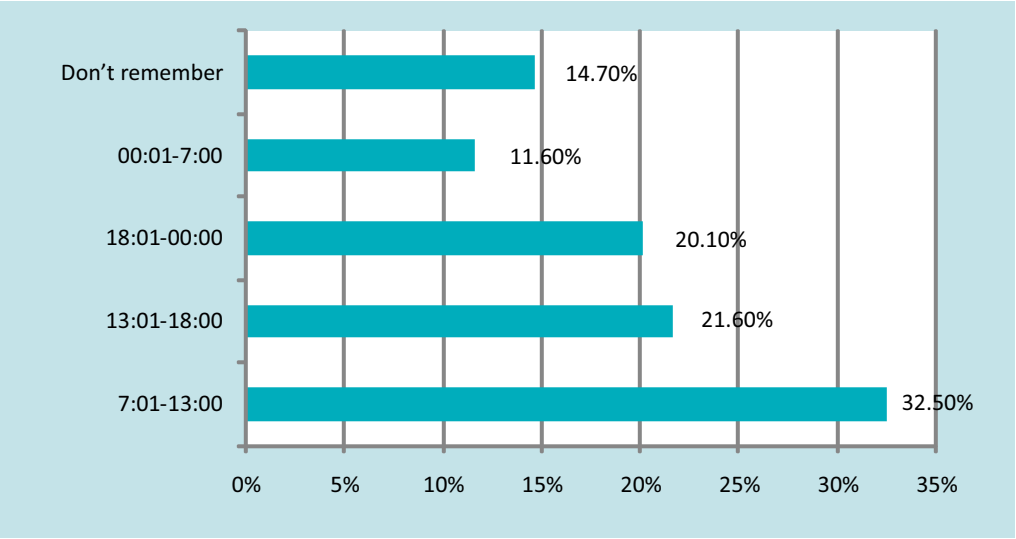


Fig A-2.6 Primary timing of the event (n=542)



A-3. Causes, consequences and effects of violence

The top five reasons for violence reported by the participants included unreasonable expectations (56.1%), communication failure (55%), human error (53.7%), unexpected outcome (42.6%) and substandard care (35%). Other important reasons that were reported by almost one third of the respondents included financial pressure, management failure, facility failure, and inadequate staffing (Fig. A-3.1).

Two percent (2%) of the victims died due to the events and 20.5% were injured (Table A-3.1). Among the injured, 84.7% required treatment and 46.8% had to take time off from their work. Among the predominant effects on the participant, problems getting over the incident were experienced by 73.4% (Fig. A-3.2). More than half of the participants also felt hopeless (50.3%), wanted to avoid talking about the incident (50.4%) and had repeated disturbing memories about the incident (58.7%). Two thirds of the participants thought that the event could have been prevented and one third were found to be highly worried about violence at workplace (Table A-3.2).

Fig A-3.1 Predominant factors that played a role in the development of incidents (n=542)

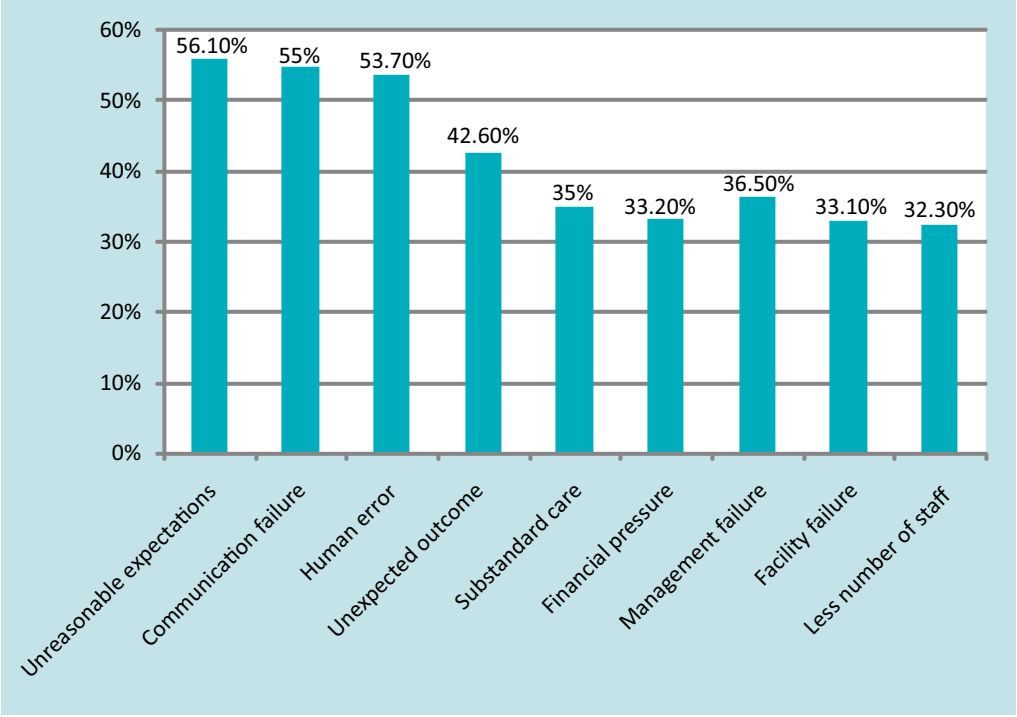


Table A-3.1 Consequences of violence

Injured or dead (n=542)		
Yes		20.5% (111)
No		71.6% (388)
Dead		2% (11)
Don't know		5.9% (32)
Injured required treatment (n=111)	84.7% (94)	
Injured took time off (n=111)	46.8% (52)	
Yes		
No		
Don't know		
Days off from work (n=52)		
One day	*17.3% (9)*	
2-3 days	*40.4% (21)*	
One week	*21.2% (11)*	
2-3 weeks	*11.5% (6)*	
1 month	*7.7%(4)*	
2-6 months	*1.9% (1)*	

Fig A-3.2 Predominant effect of violence on victim (n=549)

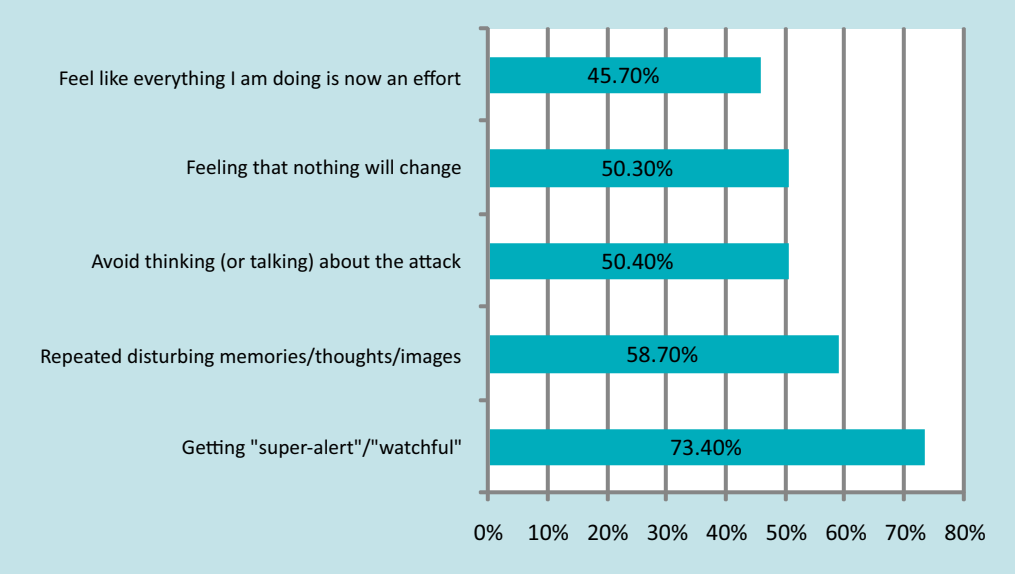


Table A-3.2 Perceptions of violence at the workplace

Level of worry about violence (n=822)	
Not worried at all	31.7% (260)
Not very worried	35% (288)
Very worried	33.3% (274)
Do you consider this to be a typical incident of violence in your workplace (n=542)	62.4% (338)
Do you think the incident could have been prevented (n=542)	65.7% (356)

A-4. Response to violence by victim and institution

More than half (51.3%) of those affected did not take any action against the attackers (Fig. A-4.1), 22.9% reported the incident to the seniors or the manager. Only 2.8% pursued legal prosecution. Out of 542 who experienced violence, 60.3% did not report the incident to anyone. Among those who did not report, almost half (45.7%) did not consider the event to be important enough to be reported (Fig. A-4.2), 31.1% considered it useless to report, while 13.4% were afraid of the negative consequences of reporting the event. Among those who reported the incident, the majority reported to the management of their organization (84.7%) followed by 7.9% reporting to security, police or the Rangers (Fig. A-4.3). No outcome was reported in 62.3% of cases, a warning was issued to the abuser in 29.8% of the cases, and care of the patient was discontinued 4.2% of the times. A minor proportion of abusers was either prosecuted (2.8%) or arrested (0.9%).

Fig A-4.1 Response to violence by the victim (n=542)

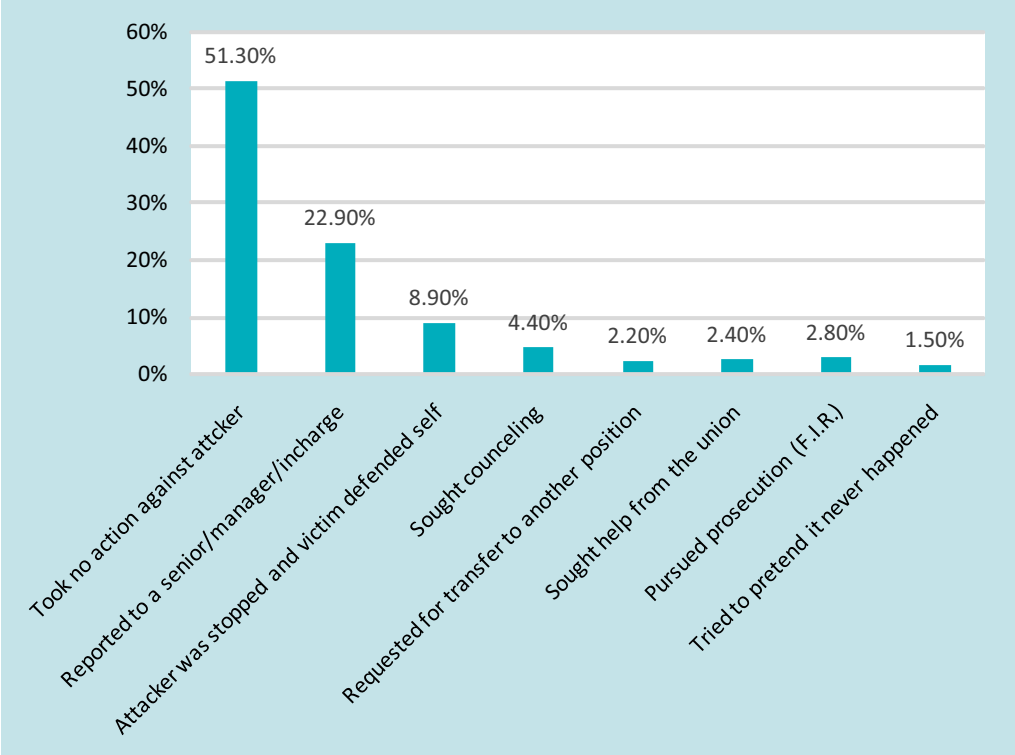


Fig A-4.2 Primary reasons for not reporting the violence (n=328)

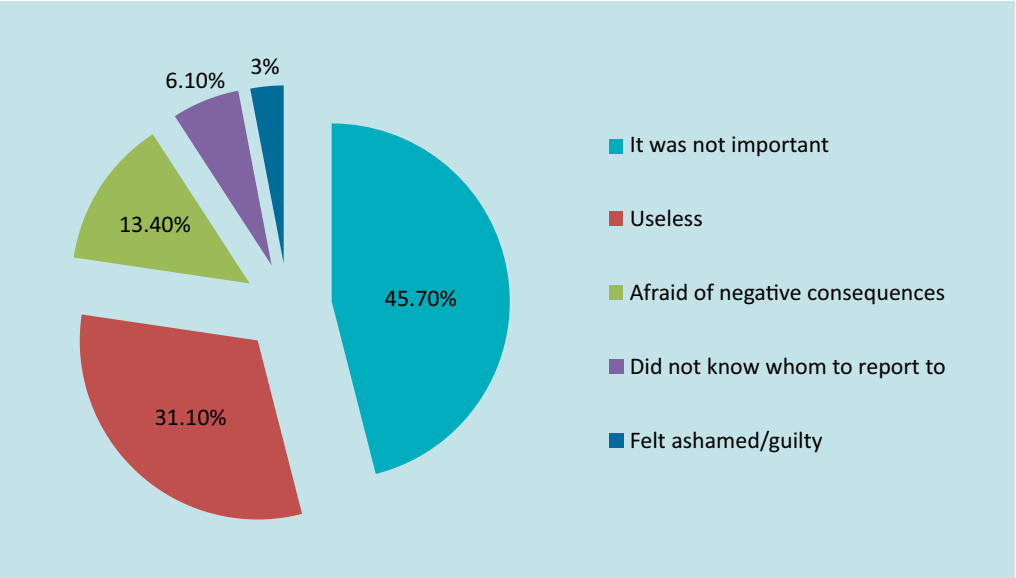
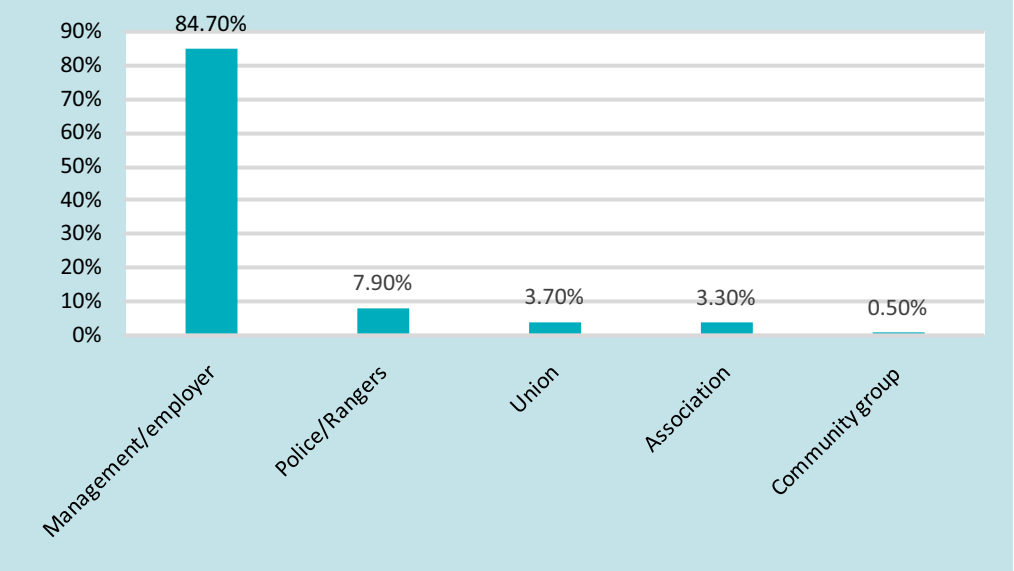


Fig A-4.3 Predominant source to whom the incident was reported (n=211)



A-5. Preparedness of the organization to deal with the violence

A large majority (87%) did not know about any specific institutional policy to deal with violence (Fig. A-5.1). In terms of institutional policy, 5.8% of the respondents were clear about calling security and reporting to management. Half of the organizations (50.9%) encouraged their employees to report violence, while a significant proportion of respondents (39.8%) said that their organization did not encourage reporting violence (Fig. A-5.2). More than half of the respondents (53.6%) did not know about any significant changes which had taken place over the last two years to deal with violence in their organization (Fig. A-5.3). Major institutional changes reported included restructuring (25.3%), increased staff (20.6%) and additional resources (19.8%). Organizations which underwent one of the above-mentioned changes showed an improvement as regards the situation of the staff (54%) and patients (32.5%), according to the perception of the respondents (Fig. A-5.4). Among the existing security measures, the presence of security guards (81%) and gates (70.1) were mentioned by a majority of respondents (Fig. A-5.5). Public access was restricted (55.5%) and staff numbers were reported adequate (54%) by slightly more than half of the respondents. Less than half of the respondents reported the existence of training of staff (46%), check-in procedures for staff (46.5%) and patient protocols (46.4%). The presence of metal detectors (39.9%), panic button (38.6%) and patient screening methods (38.4%) were only reported by slightly more than one third of the respondents.

Fig A-5.1 Existing specific policy to prevent violence (n=822)

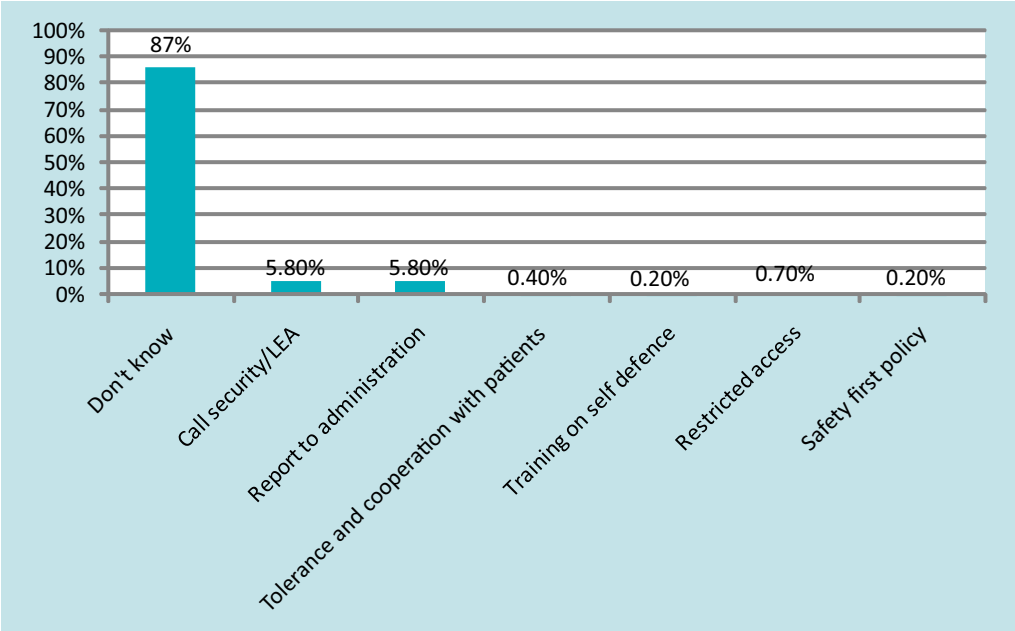


Fig A-5.2 Source of encouragement to report violence (n=822)

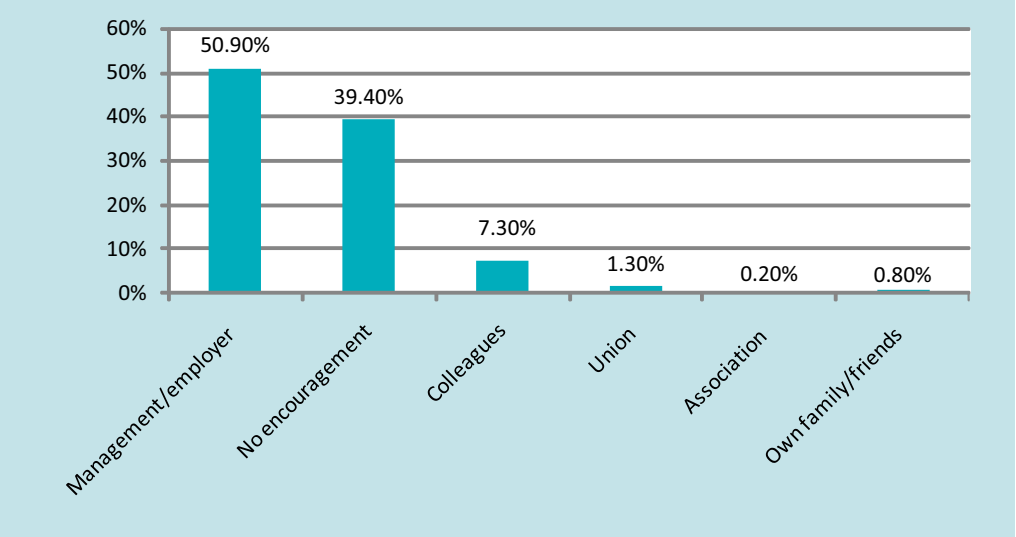


Fig A-5.3 Changes at workplace over the last two years (n=822)

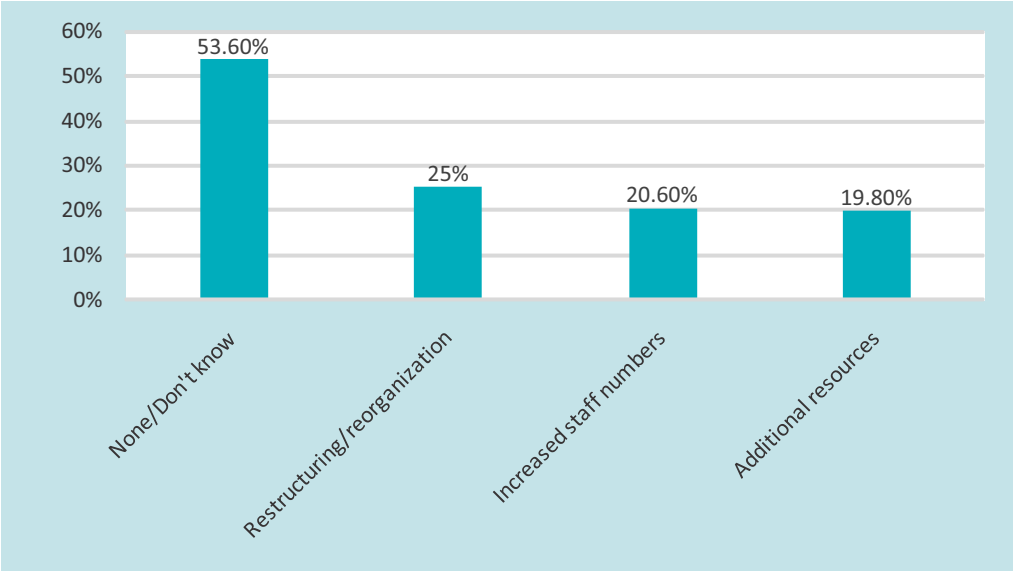


Fig A-5.4 Impact of the changes (n=390)

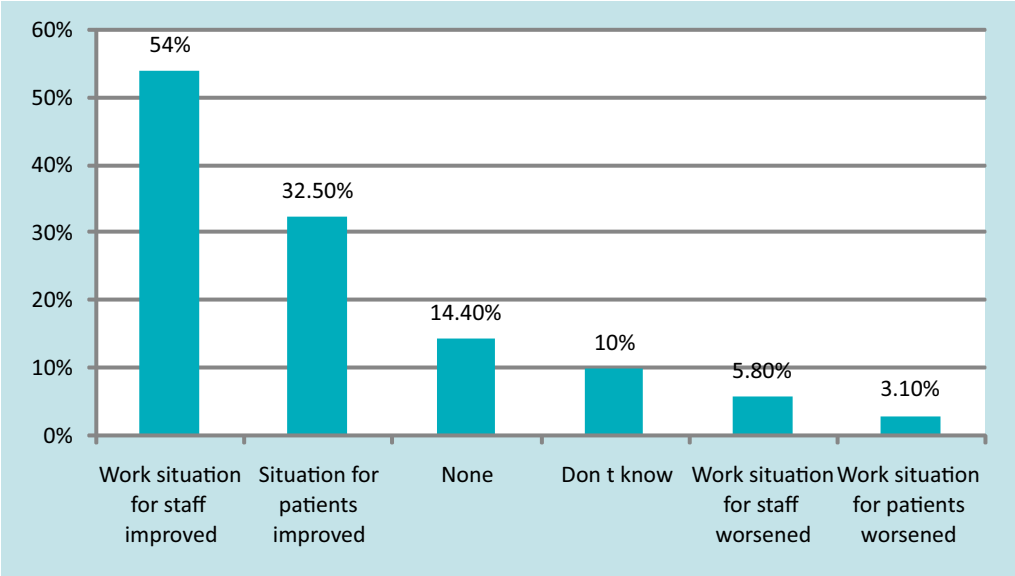
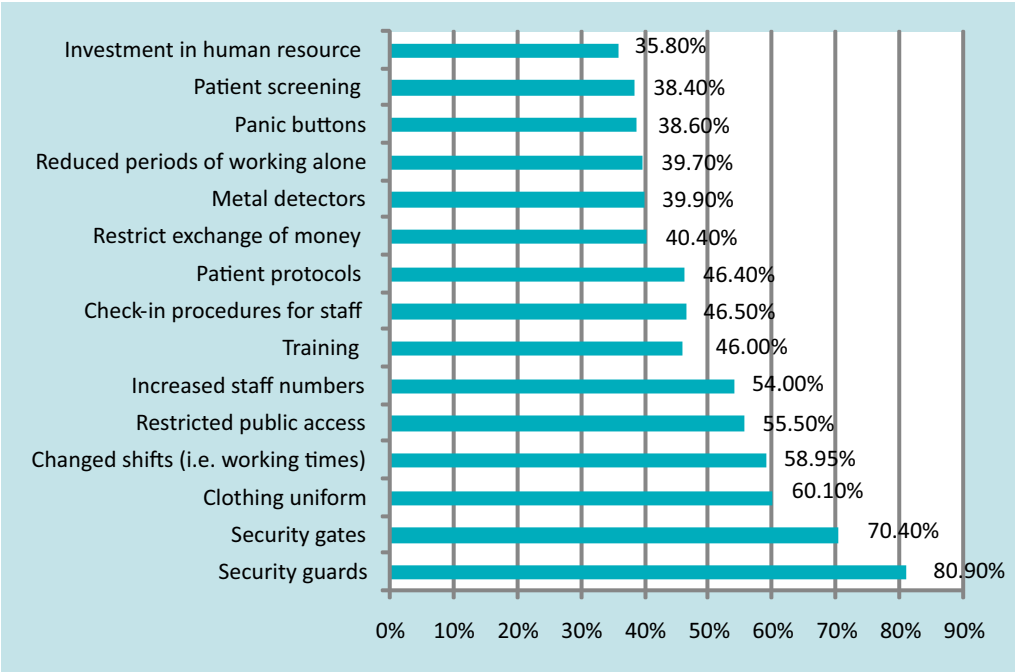


Fig A-5.5 Existing security measures at the workplace and respondents' perception of their importance (n=822)



A-6. Predictors of physical and verbal violence among different categories

Table A-6.1 shows the predictors of verbal and physical violence. There was no significant relationship of verbal violence with age, gender, ethnicity, worksite or work experience. Physicians, security staff and especially ambulance staff reported significantly higher frequencies of verbal violence as compared with other job positions (p=0.004).

No significant relationship of age or ethnicity was found with physical violence. Women were significantly less likely to experience physical violence (p=<0.001). Security and ambulance staff were significantly more likely to report experiencing physical violence (p=0.001). In comparison to public-sector hospitals and ambulance services, private hospitals and NGOs were significantly less likely to report physical violence (p=0.002). Having job experience of more than one year in the organization also showed a significant positive association with threat to life (p=0.002).

Table A-6.1 Predictors of verbal and physical violence among different categories (n=822)

	Verbal violence		Physical violence	
	% (f)	p-value	% (f)	p-value
Age				
18-39(n=581)	32.2%(187)	0.111	14.1%(82)	0.541
40 and above (241)	26.6% (64)		15.8% (38)	
Gender				
Male (n=491)	31.6% (155)	0.434	18.5% (91)	0.001
Female (n=331)	29% (96)		8.8% (29)	
Major language				
Urdu (496)	29.2% (145)		13.5% (67)	
Sindhi (72)	31.9% (23)		16.7% (12)	
Punjabi (111)	32.4% (36)	0.328	15.3% (17)	0.909
Pashto (69)	40.6% (28)		17.4% (12)	
Baluchi (27)	18.5% (5)		18.5% (5)	
Other (47)	29.8% (14)		14.9% (7)	
Nature of job				
Support staff (132)	22% (29)		11.4% (15)	
Physician (124)	38.7% (48)		15.3% (19)	
Nurse (174)	27.6% (48)		12.1% (21)	
Administration/clerical (71)	31% (22)		11.3% (8)	
Technical staff (128)	22.7% (29)		5.5% (7)	
Security staff (78)	38.5% (30)	0.004	24.4% (19)	0.001
Ambulance staff (115)	39.1% (45)		27% (31)	
Work experience				
Under 1 year (96)	22.9% (22)		4.2% (4)	
1-5 years (349)	30.9% (108)	0.157	12.9% (45)	0.002
6-10 years (176)	35.8% (63)		20.5% (36)	
11 and above (201)	28.9% (58)		17.4% (35)	
Worksite				
Public hospital (n=403)	30% (121)		15.4% (63)	
Private hospital (n=176)	27.8% (49)	0.341	9.1% (16)	0.002
NGO (n=92)	28.3% (26)		8.7% (8)	
Ambulance service (n=151)	36.4% (55)		22.5% (34)	

Table A-6.2 shows the predictors of two major forms of verbal violence, including abusive language and threat to life. There was no significant relationship of these two forms with age, gender or ethnicity. In comparison to support staff, physicians, nurses, security staff and ambulance staff were significantly more likely to be victims of abusive language (p=0.001) or receive a threat to life or property (p=<0.001). In comparison to government hospitals and ambulance services, private hospitals were significantly less likely to report verbal abuse (p=0.010). Having job experience of more than one year in the organization showed a positive association with threat to life (p=0.001).

Table A-6.2 Predictors of different types of verbal violence among different categories (n=822)

	ABUSIVE LANGUAGE		THREAT TO LIFE	
	% (f)	p-value	% (f)	p-value
Age				
18-39 (n=581)	56.5%(328)	0.101	23.6%(137)	0.452
40 and above (241)	50.2% (121)		21.2% (51)	
Gender				
Male (n=491)	55.2% (271)	0.689	22.4% (110)	0.697
Female (n=331)	53.8% (178)		23.6% (78)	
Major language spoken				
Urdu (496)	55% (273)		21% (104)	
Sindhi (72)	56.9% (41)		25% (18)	
Punjabi (111)	54.1% (60)	0.293	28.8% (32)	0.352
Pashto (69)	62.3% (43)		29% (20)	
Baluchi (27)	48.1% (13)		18.5% (5)	
Other (47)	40.4% (178)		19.1% (9)	
Nature of job				
Support staff (132)	45.5% (60)		11.4% (15)	
Physician (124)	68.5% (85)		35.5% (44)	
Nurse (174)	56.9% (99)		25.9% (45)	
Administration/clerical (71)	50.7% (36)	0.001	23.9% (17)	0.001
Technical staff (128)	43.8% (56)		13.3% (17)	
Security staff (78)	55.1% (43)		24.4% (19)	
Ambulance staff (115)	60.9% (70)		27% (31)	
Work experience				
Under 1 year (96)	50% (48)		8.3% (8)	
1-5 years (349)	55.9% (195)	0.107	25.8% (90)	0.001
6-10 years (176)	60.8% (107)		28.4% (50)	
11 and above (201)	49.3% (99)		19.9% (40)	
Worksite				
Public hospital (n=403)	58.8% (237)		25.3% (102)	
Private hospital (n=176)	44.3% (78)	0.010	19.3% (34)	0.165
NGO (n=92)	51.1% (51)		16.3% (15)	
Ambulance service (n=151)	57.6% (87)		24.5% (37)	

Table A-6.3 shows the predictors of three major forms of physical violence, including showing a weapon, being pushed or pulled, and being beaten. There was no significant relationship of these three forms with age or ethnicity. Women were significantly less likely to experience pushing or pulling (p=<0.001) and being beaten (p=<0.001). Security and ambulance staff were significantly more likely to report being shown a weapon (0.037), pushed or pulled (p=<0.001) or being beaten (p=0.001). In comparison to public-sector hospitals and ambulance services, private hospitals and NGOs were significantly less likely to report being shown a weapon (<0.010), pushed or pulled (<0.001) or being beaten (p=0.004). Having job experience of more than one year in the organization also showed a significant positive association with being pushed or pulled (p=0.002) or being beaten (p=0.004).

Table A-6.3 Predictors of different types of physical violence

	SHOWING A WEAPON		PULLED OR PUSHED		BEATEN	
	% (f)	p-value	% (f)	p-value	% (f)	p-value
Age						
18-39 (n=581)	5.5% (32)	0.394	25.1%(146)	0.100	12.4%(72)	0.080
40 and above (241)	7.1% (17)		30.7% (74)		17% (41)	
Gender						
Male (n=491)	6.7% (33)	0.262	33% (162)	0.001	17.5% (27)	0.001
Female (n=331)	4.8% (16)		17.5% (58)		8.2% (86)	
Major language						
Urdu (496)	6% (30)	0.890	25.6% (127)	0.827	12.7% (63)	0.534
Sindhi (72)	4.2% (3)		27.8% (20)		16.7% (12)	
Punjabi (111)	4.5% (5)		31.5% (35)		17.1% (19)	
Pashto (69)	7.2% (5)		29% (20)		17.4% (12)	
Baluchi (27)	7.4% (2)		22.2% (6)		7.4% (2)	
Other (47)	8.5% (4)		25.5% (12)		10.6% (5)	
Nature of job						
Support staff (132)	3.8% (5)	0.037	18.9% (25)	0.001	10.6%(14)	0.001
Physician (124)	7.3% (9)		25% (31)		10.5% (13)	
Nurse (174)	4.6% (8)		23.6% (41)		14.4% (25)	
Administration/clerical (71)	5.6% (4)		25.4% (18)		7% (5)	
Technical staff (128)	2.3% (3)		14.8% (19)		8.6%%(11)	
Security staff (78)	7.7% (6)		44.9% (35)		23.1% (18)	
Ambulance staff (115)	12.2%(14)		44.3% (51)		23.5% (27)	
Work experience						
Under 1 year (96)	4.2% (4)	0.407	14.6% (14)	0.002	3.1% (3)	0.007
1-5 years (349)	4.9% (17)		25.2% (88)		13.5% (47)	
6-10 years (176)	8% (14)		35.8% (63)		17.6% (31)	
11 and above (201)	7% (14)		27.4% (55)		15.9% (32)	
Worksite						
Public hospital (n=403)	6.5% (26)	0.010	28.3% (114)	0.001	15.4% (62)	0.004
Private hospital (n=176)	2.8% (5)		17% (30)		17% (30)	
NGO (n=92)	2.2% (2)		16.3% (15)		8% (14)	
Ambulance service (n=151)	10.6% (16)		40.4% (61)		19.9% (30)	

B. Qualitative findings

Coding of the transcripts was done by three independent experts and a consensus was reached on seven broad categories, including description of violence, acceptance of violence, causes of violence, lack of preparedness to deal with violence, sequelae of incidents of violence, recommendations, and positive experiences. Sub-themes were identified for each of the broad categories and their frequency was noted to identify the common and relatively uncommon sub-themes. Table B.1 gives a breakdown of organizations and participants.

Table B.1 Respondents and their respective organizations

	In-depth interviews		**Focus group discussions**	
Organization	Participants	No: IDIs	Participants	No: FGDs
Non-governmental organizations				
HELP	Community health supervisors	3	1.CHWs 2. Polio workers	2
HANDS	1.Administrator 2.Doctor	2	Community	1
SINA	1.Technician 2.Doctor	2	-	0
MSF	1.Nurse 2.Doctor	2	Nursing staff	1
HRCP	Administrator	1	-	0
PMA		0	Doctors	1
Liyari			Community	1
Law Enforcement agencies				
Police	1.Policeman 2.SP	2	Policemen	2
CPLC	CHIEF	1	Staff	1
Hospitals				
Malir	1.Doctor 2.MLO	2	-	0
GMH	LHS	1	LHWs	1
KGH	1.Doctor 2.Nurse	2	Technicians /Dispensers	1
LGH	Dispenser	1	-	0
JPMC	1.Director ER 2.Nurse 3.Ward Master 4.Vaccinator	4	Nursing staff	1
ASH	Doctor	2	Doctors	1
CHK	Doctor	1	Doctors PG trainees	1
ZH	Doctor	1	Nursing staff	1
Ambulance services				
AMAN	1.Doctor 2.Driver	2	Drivers	1
AL-KHIDMAT	Administrator	1	-	0
EDHI	1.Drivers 2.Shift Incharge	5	Drivers	1
MEDIA GROUP				
DAWN	Crime reporter	1	-	0
MAPP	Photographer	1	-	0
METRO	Cameraman	1	-	0
GEO	1.Cameraman 2.Crime reporter	2	-	0
ARY	Crime reporter	1	-	0
IPF	Press photographer	1	-	0
TOTAL IDIs		42	**TOTAL FGDs**	17

B-1. Description of violence

Table B-1.1 summarizes the participants' description of violence. Major forms of physical violence described included beating (punching/slapping/fist fighting/hitting/kicking) and throwing things (shoes/stones). Physical torture and manhandling were also pointed out by a few participants. Abusive language and threats were regarded as major forms of verbal violence, while speaking in a loud voice was also mentioned by some interviewees. Damage to building, furniture, vehicles and equipment was also described as violence by a majority of participants. Among other forms of violence, harassment, using weapons, killing and extortion were reported highly, while kidnapping and robbery/snatching was also mentioned by a few.

Table B-1.2 shows a comparison of description of violence among different stakeholders. While beating and abusive language were predominantly reported as the main forms of violence for HCPs, ambulance staff and media, the LEAs only considered an act violent if it was a cognizable offense. The explanation given by police was: "an act/incidence which leaves visible marks on the body". Also snatching was reported by those who were involved in fieldwork, i.e. by ambulance staff and media.

Table B-1.1 Description of violence by the participants

Physical violence	
Beating (includes punching/slapping/fist fighting/hitting/kicking)	(38)
Throwing things (includes shoes/stones)	(16)
Torture	(10)
Pushing/manhandling	(7)
Verbal violence	
Abusive language	(28)
Threat	(21)
Speaking in a loud voice(includes screaming/yelling/slogans)	(12)
Facility damage	
(Includes damage to building/furniture/vehicles/equipment)	(24)
Other	
Use of weapons (includes gun/knife/bomb/tear gas)	(25)
Harassment (includes forcing views/pressurizing)	(24)
Killing/burning alive	(19)
Bad behaviour (includes deception/belittling/bullying/rudeness)	(18)
Extortion	(11)
Kidnapping/holding hostage	(9)
Robbery/snatching	(8)

Table B-1.2 Comparison of description of violence among different stakeholders

Description of violence	Health-care providers	Ambulance workers	Media	Law-enforcement agencies
	Beating**** Abusive language*** Threat** Harassment (forcing)*** Pushing/manhandling* Facility damage* Kidnapping* Use of weapons* Killing ***"Violence can be both: verbal and physical." Doctor***	Beating**** Abusive language** Speaking in a loud voice Harassment** Facility damage** Use of weapons* Snatching* ***"Using abusive language, beating and forcing is violence." Ambulance driver***	Beating **** Abusive language* Threat*** Harassment** Facility damage*** Use of weapons*** Killing** Snatching Extortion* ***"Violence is violence. You may take it as hitting or firing or blast." Cameraman***	Beating **** Cognizable offence Threats*** Harassment* Pushing/manhandling** Facility damage*** Kidnapping* Use of weapons* Killing ** Extortion* Torture** ***"We only consider an act violent if it is a cognizable offence." Police officer***

B-2. Threshold of violence

The threshold of violence was sub-categorized into acceptance for the type of violence and reason for acceptance of violence.

Acceptance for verbal abuse was reported more as compared to acceptance for minor forms of physical violence. As expressed by the ER director of a government tertiary-care hospital, "Now people do not consider verbal violence as violence at all. They are so acclimatized to verbal abuse that they do not even consider that it is any sort of violence". (Table B-2.1). The main reasons for acceptance of violence included considering it the patient's right or part of the profession and fear of adverse consequences of reporting, including threat to life or job (Table B-2.2). One of the doctors working at a government hospital said, "Even if they speak to us harshly we have been trained to tolerate it."

Table B-2.3 shows a comparison of the threshold of violence among different stakeholders. There was general acceptance by HCPs and ambulance staff of verbal and even minor forms of physical abuse. Policemen reported tolerance among doctors for paying extortion money.

Table B-2.1: Acceptance for different types of violence

Acceptance of loud and harsh talk by patients or attendants	(10)
Acceptance of slapping/minor physical violence	(5)

Table B-2.2: Reason for acceptance of violence among the participants

Consider it the patient's right	(6)
Consider it part of the profession	(6)
Fear of adverse consequences of reporting (threat to life/job)	(5)
Lengthy procedures of investigation	(1)

Table B-2.3 Comparison of the threshold of violence among different stakeholders

Threshold of violence	Health-care providers	Ambulance workers	Media	Law-enforcement agencies
	Acceptance of verbal loud harsh talk **	Acceptance of slapping/minor physical violence*	Acceptance of loud and harsh talk *	Acceptance for giving extortion money*
		Consider violence as part of profession *		Reluctance to pursue lengthy procedures of investigation *
	"Even if they speak harshly to us, we have been trained to tolerate it." Staff nurse	***"We are told that even if someone abuses you, you need to be patient with them. Our job is to serve humanity and we can't fight anyone." Ambulance driver***	***"Doctors have to deal with all kinds of people; they ignore many things; they don't get harsh." Photographer***	***"Doctors take relief by paying 2-3 lacs. By doing this, they are not only doing wrong to themselves but also doing wrong to society."***

B-3. Causes of violence

Fig. B-3.1 summarizes the causes of violence as reported by interviewees. Causes were categorized as "behavioural", "institutional" and "socio-political".

Behavioural causes were further sub-categorized into client- and provider- related causes. Among the client-related causes, violence was predominantly seen as a natural reaction to adverse outcome or serious condition of a patient. Impatience and intolerance on the part of the consumer were also seen as major behavioural reasons. Other minor reasons included a habit of creating chaos, high expectations from the hospitals, and vested interests of the attendants, including expectation of getting wrong medical reports. On the part of providers, apathy, negligence and communication gap with the attendants were seen as violence-inciting factors.

Institutional causes were sub-categorized into capacity-related issues, resource constraints and institutional mechanisms. The low capacity of health-care providers to provide quality care and mishandling of cases were highlighted by many interviewees.

Among resource constraints, lack of facilities including equipment and medicines, lack of staff, a heavy workload and low incentives leading to protests by HCPs were frequently reported. Overcrowding due to easy access of attendants inside the hospitals and delayed response in treatment or rescue were also seen as major institutional reasons of violence. One of the staff nurses stated: "When there are only 1-2 attendants with a patient then the chance of violence also reduces".

In the field, competition among ambulance services was also seen as an important factor. A journalist while raising this issue said, "I don't know what they want but they fight over one dead body; three organizations fight to place their [branded] sheet over the body."

Major socio-political factors highlighted by the participants included a general lack of education and awareness in society. One of the community health supervisors commenting on people's misconception of polio vaccines said: "They say we do not want to give polio to our children; they can die from it; it causes infertility and restricts family growth."

Other factors highlighted included political influence in institutions, poor law and order, injustice and slow judicial system/no fear of punishment, poverty/inability to pay high cost of care, corruption/malpractice, religious extremism, sectarianism and ethnic nationalism. One of the doctors, while discussing the current law and order situation, said: "A person is so uncertain and insecure that when he goes on the road he doesn't know if he will come back alive or not."

Some participants believed that doctors were soft targets and could easily be exploited to get money. A member of LEAs said, "with the doctors, criminals have good experience because they get the ransom easily".

Some respondents also pointed to misconception of political groups about possible affiliation of certain organizations with politicial parties. One of the drivers expressed the opinion that, "The tragedy with us is that in some areas it is thought that our ambulances belong to "some committee" and in some areas it is thought that they belong to a political party".

Table B-3.1 shows a comparison of causes of violence among different stakeholders. While the HCPs and ambulance staff complained of unreasonable behaviour and expectations of attendants, media and LEAs pointed to negligence in the behaviour of HCPs.

Among institutional causes, HCPs complained about poor facilities and a heavy workload. In the field, delay in rescuing patients due to traffic was raised by ambulance staff, while media people said that delays were due to competition among ambulance services to take the patients. Law enforcement agencies thought that poor quality of services and low capacity of HCPs contributed significantly to violent incidents.

Among socio-political causes, while HCPs complained of poor law and order and easy acess to weapons by the public, LEAs blamed slow prosecution in courts as a major factor preventing the containment of violence.

Fig B-3.1 Causes of violence

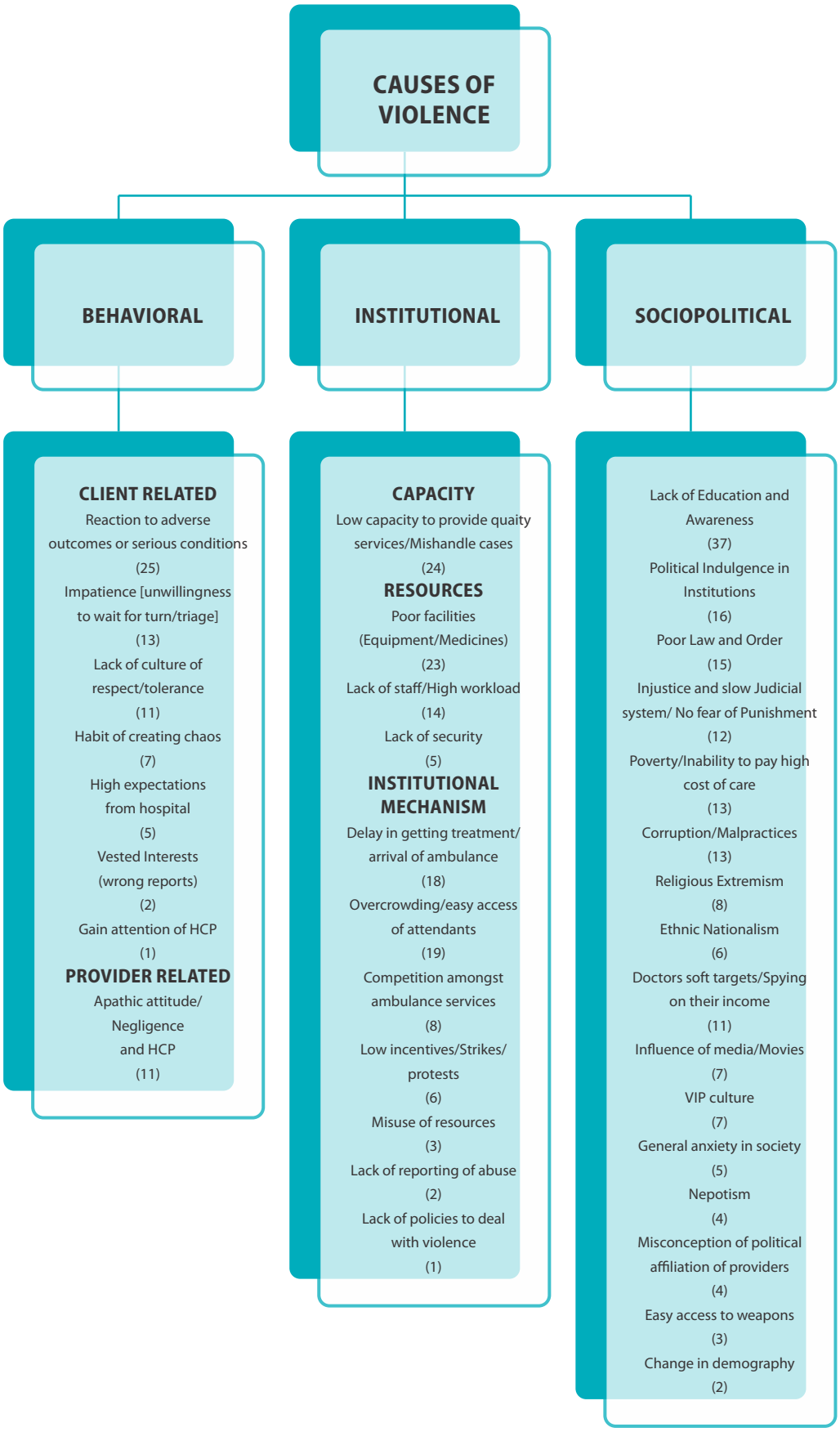


Table B-3.1 Comparison of causes of violence among different stakeholders

Causes of violence	Health-care providers	Ambulance workers	Media	Law-enforcement agencies
Behavioural	*Reaction to adverse outcomes and serious conditions**** *Lack of culture of respect*** *High expectations fromhospital*** *Communication gap b/w patient and HCP*** ***"Violence occurs when people get too demanding without communicating their concerns to doctor."*** ***Doctor***	*Reaction to adverse outcomes and serious conditions*** *High expectations of people** *Communication gap b/w patient and HCP*** ***"Attendants want that 4-5 of them should come with the patient on ambulance. We tell them to take 1-2 attendants but they don't listen."*** ***Ambulance driver***	*Reaction to adverse outcomes and serious conditions**** *Negligence of HCPs*** ***"Attendants tell us that deaths happen due to negligence of doctors."*** **ARY crime reporter**	*Reaction to adverse outcomes & serious conditions*** *Negligence of HCPs**** ***"Violence issues arise when doctors do not give proper attention to patients. They have become money-making machines."*** ***Police officer***
Institutional	*Overcrowding*** *Lack of staff/heavy workload** *Lack of facilities**** *Lack of security** ***"It becomes difficult to provide care to a patient with 10-12 attendants."*** ***Staff nurse*** ***"You know this is a government hospital and everything is not available here but attendants don't realize this." PG trainee***	*Overcrowding** *Low capacity to provide quality services**** *Lack of facilities** *Delay in treatment*** *Competition among Ambulance service** *Low incentives for HCPs** ***"Sometimes it is not possible to reach the victim on time, especially in traffic hours. Then people fight with us."*** ***Ambulance driver***	*Overcrowding*** *Low capacity to provide quality services**** *Lack of staff/heavy workload** *Lack of facilities*** *Delay in treatment** *Competition among ambulance services*** ***I don't know what they want but they fight over one dead body, three organizations fight to place their [branded] sheet on dead body."*** ***Photographer*** ***Ambulance drivers drive so fast. Ambulances do not have any facility to save lives; they are just carriers."*** ***Crime reporter*** ***"In our hospitals, proper treatments are not available, as a result people get frustrated."*** ***Crime reporter***	*Overcrowding*** *Low capacity to provide quality services*** *Lack of staff/heavy workload** *Lack of facilities**** *Delay in treatment*** *Competition among ambulance services** ***"Most of the hospitals and clinics do not meet the standard that they should."*** ***Policeman*** ***"Doctor do not give attention according to what patients want and expect."*** ***Policeman***

Table B-3.1 (contd.) Comparison of causes of violence among different stakeholders

Causes of violence	*Health-care providers*	*Ambulance workers*	*Media*	*Law enforcement agencies*
Socio-political	*Lack of education and awareness**** *Poor law and order*** *No fear of punishment/slow judicial system** *Poverty/inability to pay** *Easy access to weapons** *Negative role of media and LEAs** ***"Such are the conditions that people carry guns and walk freely in the hospitals." Doctor*** ***"Media and police pictured us bad; we are not as bad as they show us on TV that patient died due to Dr's negligence but they do not show that patient arrived in critical condition." PG trainee***	*Lack of education and awareness**** *Poor law and order** *No fear of punishment/slow judicial system** *Poverty/inability to pay** *Misconception about political affiliation*** *Ethnic violence** *Political indulgence in institutions*** ***"The tragedy with us is that in some areas it is thought that our ambulance belongs to a particular political group." Ambulance driver***	*Lack of education and awareness*** *Poor law and order** *No fear of punishment/slow judicial system** *Poverty/inability to pay** *Drs are soft targets*** *Sectarianism**** *Ethnic violence*** *Religious extremism*** *Political indulgence in institutions****	*Lack of education and awareness**** *No fear of punishment/Slow judicial system*** *Poverty/Inability to pay** *Drs are soft targets*** *Sectarianism*** *Religious extremism** *Political indulgence in institutions** *Corruption/malpractice*** ***"Weak prosecution and absence of witness is the major reason for freedom of criminals." Police officer*** ***"Doctors are soft targets, their time is money, therefore to get rid of the issue; they prefer to give money." Policeman*** ***"Why do doctors go to perform Umrah on the tickets provided by pharmaceutical companies and why do they ask them to put an AC in their office?" Policeman***

B-4. Lack of preparedness to deal with violence

Table B-4.1 shows the lack of preparedness of institutions to deal with violence, as expressed by interviewees. The deficiencies highlighted predominantly included inadequate security staff, inadequate security facilities and lack of training to manage violence by all stakeholders. One of the crime reporters interviewed said, "It is our bad luck that we are not given any training for these situations: we judge and manage these situations according to our experience". Lack of safety protocols and poor communication facilities were also emphasized by a few participants. One of the ambulance drivers said, "Sometimes the Command and Control does not know where we are."

Table B-4.1: Lack of preparedness of institutions to deal with violence

Inadequate security staff	(10)
Lack of training to deal with violence	(9)
Inadequate security facilities (equipment/safety doors)	(8)
No safety plans/protocols	(6)
Poor communication facilities	(4)

B-5. Sequelae

Fig: B-5.1 summarizes the sequelae of violence. Sequelae of violence were categorized as "response to violence" and "effect of violence" on victim and institution.

Reporting to the management or seniors and counselling the perpetrators were the two predominant immediate responses to violence that were reported. One of the doctors working in the emergency department of a government hospital said, "We have to choose who the intelligent person among them is. Who can mentally listen to us? If everyone is making noise, we cannot stand in between them and tell them. We will bring a single person to a side and will make them understand things".

A few interviewees pointed to calling the available security or law enforcement agencies and warning the perpetrators of discontinuation of care. Some of them mentioned escaping in such situations. Short-term responses included recovering damages and provision of incentives to victims in a few cases. In the long run, tighter security and pursuance of inquiry were reported in a few instances, while some participants complained of no response at all.

Violence affected the victims psychologically, made them scared and demotivated them at their job. It also led to damage of institutional property and closure of institutions in a few instances.

Table B-5.1 shows a comparison of sequelae of violence among different stakeholders. HCPs and ambulance service staff responded to violence mainly by counselling the attendants. Alternatively, if the situation worsened, they informed their seniors or facility security. In serious matters, they resorted to lodging FIR and got help from police. Media workers said that they tried their best not to disturb HCPs and LEAs while they are covering any event. A crime reporter also mentioned that violence not only affected HCPs but also terrified the patients.

Policemen responded to violence by reaching the spot as soon as possible, helping to rescue the victims and tracking the criminals in the long run.

Fig B-5.1 Sequelae of violence

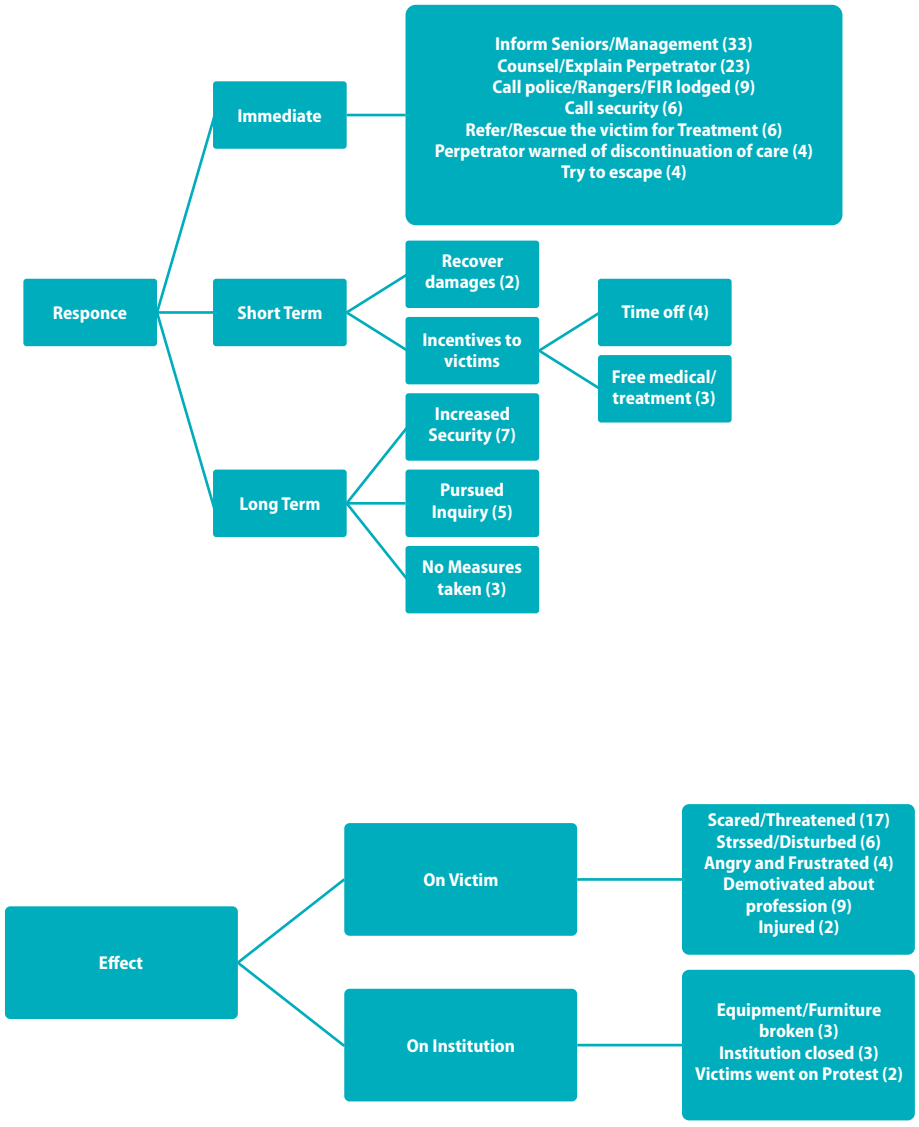


Table B-5.1 Comparison of sequelae of violence among different stakeholders

Categories	*Health-care providers*	*Ambulance workers*	*Media*	*Law enforcement agencies*
Response	Counsel the perpetrator** Inform seniors/management*** Call security Lodge FIR in serious matters* ***"If you counsel the patient's attendants and convince them, they will understand." Staff nurse***	Counsel the perpetrator*** Inform seniors/management*** Call police/Rangers** Refer/rescue the victim for treatment* **"We first inform control and they remain in contact with us; they also give us the address of the area's police station and their number." Ambulance driver**	Inform seniors/management** Let HCPs and LEAs do their work** ***"In an emergency situation doctors are doing their work, ambulance workers are doing their work. We try to do our work without disturbing them." Cameraman***	Counsel the perpetrator* Report to higher authorities* Refer/rescue the victim for treatment** Reach spot ASAP* Track and trace criminals* ***"Our first priority is to rescue them and for that we can do anything. We sometimes have to resort to shelling, use tear gas or do aerial firing." Policeman***
Effect	Feel insecure/scared Feel stressed/disturbed Anger/frustration Demotivated/Affects performance ***"You are giving care to patient on the one hand and you have to listen bad language from attendants on the other hand, this really makes me feel bad about my job." Staff nurse***	Feel scared* Feel stressed/disturbed Demotivated/affects performance Vehicle movement restricted in high-risk areas ***"We feel scared when someone is shot. We try to take the victim to hospitals as soon as possible. " Ambulance driver***	Patients are terrified ***"Already the injured are there under mental stress; they are further terrified by acts of violence." Crime reporter***	

B-6. Recommendations

Table B-6.1 summarizes the recommendations to improve safety and security of HCPs reported by interviewees. They were classified as institutional and societal.

Institutional recommendations were sub-categorized as capacity- and resource-related recommendations, improvements needed in rules and regulations, and need for building liaisons. Improvements in availability of facilities (including equipment, medicines and HCPs), training of HCPs in communication skills, and enhanced security facilities were highlighted by a majority of participants. An emergency physician at a public-sector hospital emphasized the importance of training in de-escalating violence and said: "A training module should be developed in which you teach HCPs how to deal with violent attendants or violent individuals".

Some of them also drew attention to improved professional skills of HCPs, working conditions, incentives for HCPs, and staff coordination and teamwork. Among improvements needed in institutional rules and regulations, participants recommended restricted access of attendants inside the hospital, mechanism of "triage", and strict regulation of HCPs. A weapon-free policy in institutions was also mentioned. A few participants also stressed community involvement and inter-sectoral collaboration as means of decreasing and improving response to violence.

Societal recommendations were sub-categorized into "awareness campaigns", "social reforms" and "role of stakeholders". The need for improving awareness for respecting HCPs in emergency situations was highlighted in particular. General awareness on respecting law and benefits of polio vaccines was also recommended. Major social reforms recommended included improvement in performance of LEAs, increased literacy rate, improved judicial system, and reduction in political interference in institutions. Banning religious hate speech was also recommended by a few.

Table B-6.2 compares the recommendation given by HCPs, media, ambulance workers and LEAs. Great emphasis was put on the media playing a positive role in raising awareness and reporting accurately on health-care issues. The institutional recommendations given were similar for all the respondent groups. The societal recommendations varied as HCPs and ambulance workers said that LEAs should perform better whereas the LEAs said that the Judicial system should improve so that culprits are punished. Ambulance workers also said that media should tell the truth.

Table B-6.1 Recommendations

A. Institutional	
Capacity and resources	
Adequate facilities (equipment/medicines/HCPs)	(26)
Training of HCPs in communication/counselling skills	(24)
Increased security personal and facilities	(21)
Training in managing violence	(12)
Improved clinical/professional skills of HCPs	(10)
Improved working conditions and incentives for HCPs	(9)
Improved staff coordination and teamwork among HCPs	(8)
Rules and regulations	
Restricted access of attendants	(10)
Rules for prompt response/triage	(6)
Regulate malpractice by HCPs	(5)
No entry of weapons inside the hospitals	(4)
Policy on violence	(2)
Complaint cells for patients	(2)
HCPs should be allowed to keep weapons for protection	(1)
Institutional liaisons	
Community involvement	(8)
Inter-sectorial collaboration (Health/LEA/NGOs/media)	(5)
B. Societal	
Awareness campaigns	
Awareness of general behaviour to respect HCPs esp. Emergency	(10)
Awareness of benefits of polio vaccine	(5)
Awareness for respecting the law	(4)
Awareness of giving way to ambulances	(2)
Social reforms	
Improved performance of LEAs	(11)
Improved judicial system and prompt action against culprits	(8)
Decreased political involvement in institutions	(7)
Improved literacy rate	(6)
Ban on religious hate speeches	(3)
Merit-based culture	(2)
Finish VIP culture	(1)
Role of stakeholders	
Media should raise awareness and tell the truth	(16)
People, LEAs and media should not interfere with rescue work	(3)
Clerics should spread the message of peace and unity	(2)
LEAs should support HCPs	(1)
Doctors' associations should highlight the issue of violence	(1)

Table B-6.2 Comparison of recommendations from different stakeholders

Domains	*Health-care providers*	*Ambulance workers*	*Media*	*Law enforcement agencies*
Institutional	Improved counselling, communication skills*****	*Improved counselling/communication skills***	*Improved counselling/communication skills***	*Improved counselling/communication skills***
	Improved clinical/professional skills**	*Improved clinical/professional skills**	*Mechanism of triage**	*Improved job conditions and incentives for doctors**
	Increased security personnel and facilities*	*Increased security personnel and facilities**	*Enhanced rescue response**	*Increased security personnel and facilities***
	Adequate facilities***	*Adequate facilities***	*Increased security personnel and facilities**	*Adequate facilities**
	Improved staff coordination and teamwork of HCPs*	*Everyone should let each other do their job***	*Adequate facilities***	*Everyone should let each other do their job**
	Community involvement*	*Restricted access to attendants/public/media***	*Everyone should let each other do their job**	*Reduce political influence in institutions**
	"It is the duty of nursing staff, consultants and doctors to keep contact with attendants and provide them continuous information." Doctor	*Process of picking up dead bodies to be mutually agreed upon by all ambulance services**	*Restricted access to attendants/public/media***	*Irresponsible HCPs should be punished***
	"Number of beds and number of wards should be increased." Doctor	***"The ambulance that come to help people should be allowed to do their work. General public needs to be far away." Ambulance driver***	***"Critical patients should be classified in A category and less serious ones in B category." Geo crime reporter***	***"We should have the latest technology for surveillance and investigation. Ambulances should be well equipped." Policeman***
			"LEAs should restrict the media from reaching the crime site and while taking pics interfering in rescue work." Crime reporter	***"Police checkposts should be installed in all hospitals so that police can respond timely during violent incidents."***
Societal	*Improved performance of LEAs**	*Media should raise awareness and tell the truth***	*Improved performance of LEAs***	*Improved literacy rate **
	*Media should raise awareness and tell the truth***	*Awareness of giving way to ambulances***	*Media should raise awareness and tell the truth****	*Improved judicial system and prompt action against culprits***
	*Awareness of respecting doctors**	*Improved literacy rate ****	*Awareness of respecting doctors**	*Awareness of first aid**
		*Ban on ethnicity-based parties**	*LEAs should support HCPs' fieldwork**	
		*Improved judicial system and prompt action against culprits***	*Ban on religious hate speeches**	
		*Improved coordination with media**	***"We need awareness through media that the doctor is here to save you and he will never kill you." Crime reporter***	***"People should know about first aid so that suffering victim does not suffer more due to mishandling" Policeman***
		"If someone hears the siren, they should automatically leave the fast track." Ambulance driver	***"The Ulema, media and leaders should spread messages about patience and humanity."***	
	"Role of media should be positive. They should tell that violence against paramedics, doctors and nurses should not take place." Doctor	***"We should all have coordination with media and other ambulance services. When there is coordination, there is less chaos." Ambulance driver***	***Crime Reporter***	

B-7. Positive experiences

The main institutional positive experiences mentioned by respondents included responsive management and seniors, adequate facilities, presence of security guards and a safety-first policy in some institutions (Table B-7.1). Respondents also emphasized that people can be calmed down with proper counselling and provision of quality treatment and building community liaisons. The positive impact of Rangers' operation in the city was also highlighted by some respondents. Some respondents also praised the role of LEAs in controlling the situation when required.

Table B-7.1 Positive experiences

Behavioural	
People understand if treated/counselled gently and urgently	(6)
People give way to ambulances	(2)
People apologize after misbehaving	(2)
Educated people cooperate	(2)
Ambulance services and paramedics cooperate	(1)
People respect female staff	(1)
Institutional	
Resources	
Presence of security guard/barriers/police checkposts	*(11)*
Adequate facilities (equipment and supplies)	*(7)*
Adequate and skilled staff	*(4)*
Capacity and coordination	
Supportive and responsive management/seniors	*(15)*
Trained in counselling/management of violence	*(7)*
Good staff coordination and communication	*(4)*
Mechanisms	
Safety-first policy	*(6)*
Community liaison	*(6)*
Mechanism of reporting	*(5)*
Restricted access of media inside ER	*(4)*
Good referral system	*(3)*
Registration system and information	*(3)*
Counselling services	*(3)*
Good collaboration with other organizations	*(3)*
No access of weapons inside instit ution	*(2)*
Staff appointment on merit	*(2)*
Media briefing sessions	*(1)*
Mechanism of triage	*(1)*
Policy on staff harassment	*(1)*
Socio-political	
LEAs respond and help when called	*(10)*
Rangers' operations have reduced violence	*(6)*
Media has increased awareness among people	(5)

4. DISCUSSION

This study, although not the first one to investigate the problem of violence against health care in Pakistan, stands out due to its scope, depth and orientation towards practical solutions. Out of three such studies that had been conducted in Pakistan before, none involved all the stakeholders that are directly or indirectly related to violence among HCPs. Inclusiveness remains a particularly salient feature, given that throughout the process of data collection and analysis, the findings were shared with all the stakeholders through consultative meetings and dissemination seminars.

The mixed-methods approach used for the first time in Pakistan for exploring this issue has yielded an in-depth understanding of the problem. Through the results of this study, we propose a framework for a multi-pronged response to this important problem.

During triangulation of data, we found that the major forms of violence described and experienced were similar in both the quantitative and qualitative components of the study and included abusive language, receiving threats, being beaten, being pushed or pulled, shown a weapon, and facility damage. Yet qualitative data also brought some other types of violence to the fore, namely harassment, behaving badly, extortion, kidnapping, and snatching. Almost two thirds of the participants either experienced or witnessed some form of violence at their workplace and one third had experienced some form of violence in the past year. Of these, 30.6% experienced verbal violence while 14.6% faced physical violence.

Our results are in conformity with three previous studies in Pakistan (10-12) that reported verbal violence ranging from 72.5% to 93.2%, and physical violence from 11.9% to 16.5%. Similar high proportions of verbal and physical violence among HCPs have been reported in developed as well as developing countries.(13-16) One possible reason for such high proportions for verbal violence in the other studies could be that only health-care physicians were interviewed who generally deal with patients in emergency departments of the hospitals, whereas the present study included multiple cadres of HCPs, such as technicians, administrators and ambulance drivers.

More than half of the incidents were reported inside emergency departments and another one-third inside the wards. In the majority of incidents, attendants were the main perpetrators and more than one perpetrator was involved. An important point that was mentioned by many was the presence of unknown perpetrators *(namaloom afrad)* roaming around in the hospitals and wards. This aspect should not be taken lightly, and highlights the importance of screening attendants and allowing the very close relatives of friends with the patient and also in limited numbers. The other aspect is that if there are more people in and around the patient, then the level of care may not be optimal and patient safety may be at stake. This shows how easy access of multiple attendants accompanying patients leads to overcrowding and results in violence inside hospitals, especially in emergency units. This aspect was again discussed in qualitative transcripts where the HCPs said that security should be heightened at the hospitals with an increase in the number of security guards and gates at all points of entry.

There was no significant relationship of verbal violence with age, gender, ethnicity, worksite and work experience. This is suggestive of the endemic nature of verbal violence across all sections of society. Most of the respondents related it to the general environment of violence in the country and more specifically in the city of Karachi with rampant political and ethnic rioting. Most of the respondents suggested that this can only be managed through building an environment of harmony and peace in the city through schools and media.

Women were significantly less likely to experience physical violence which is consistent with previous studies.(10,14,15) Security and ambulance staff reported a significantly higher proportion of physical

violence, as they are usually the first point of contact in emergency situations and are more exposed to attendants and mobs. In comparison to public-sector hospitals and ambulance services, private hospitals and NGOs reported a significantly lower proportion of physical violence. This is indicative of better institutional rules and security facilities in the private sector. The other reason could be that patients and attendants at private health-care institutions are slightly more educated and may be better informed compared to attendants and patients in public-sector health-care facilities. Having job experience of more than one year in the organization also showed a significant positive association, possibly because events tend to happen repetitively and the occurrence of events is directly related to time. This is consistent with a previous study conducted in four tertiary care hospitals of Karachi.(11)

A high threshold for acceptance of violence was observed in both public and private health-care facilities. Two thirds of the respondents considered incidents of violence as "typical" in the study. Some of the respondents in the IDIs and FGDs considered workplace violence in the medical profession as part of their job and the patient's right. More than half of the respondents did not report an incident because of previous experience of no action or because they did not consider the incident important enough to be reported. Lack of response and no action in the majority of incidents has also been reported in a previous study.(11) A few were reluctant to report due to possible adverse consequences on their job or family life. Lack of reporting due to adverse consequences of reporting has also been mentioned in studies conducted in hospitals of Palestine and Saudi Arabia.(15,17) An interventional study in the past had shown an improvement in reporting ability to deal with violence after the management recorded the violent events and provided structured feedback.(18) Our study findings suggest that minor forms of violence are considered a routine part of job and there is general apathy to discourage such incidents. None of the respondents mentioned any policy of the institutions that suggests zero tolerance for even the major forms of violence.

Causes of violence

Issues related to client, provider, capacity of HCPs and resources were consistently identified through both quantitative and qualitative data. Nevertheless, additional issues related to institutional mechanisms and socio-political factors were identified through in-depth interviews and focus group discussions.

Most respondents said that violence erupts as a consequence of emotional reaction by attendants (less frequently by patients themselves) due to patients' serious conditions or adverse outcomes. Another more frequently mentioned reason was unreasonable expectations of the patients and attendants from health-care institutions. Although emotional reaction is a natural response, interventions aimed at calming down the attendants through effective counselling especially in emergency situations can help in reducing the intensity of the anger and frustration of those affected. Many respondents suggested that HCPs should be trained in techniques of de-escalating violence and counselling, as this could effectively reduce the number of violent incidents.

A communication gap between HCPs and attendants of the patients was also reported as one of the major causes. It was suggested that HCPs should be trained in keeping the attendants and patients informed about the health status. Low competence of HCPs for provision of high-quality care leads to mismanagement of patients and could be a major inciting factor of violence. Poor quality of services has also been previously reported as a major cause of violence affecting HCPs in a previous study conducted in Karachi.(12) This can be resolved through merit-based appointment and continuous capacity-building of HCPs through trainings. Many respondents suggested that reducing corruption and nepotism could also effectively decrease the number of violent incidents.

Poor availability of essential equipment, lack of medicines and inadequate staffing were also mentioned as causes of violence by many respondents. Two thirds of the participants also pointed to a lack of security personnel and equipment. Resource-related issues have also been flagged in previous studies.(13,17,19) The way forward for this is to conduct cost estimation exercises for resources required to deliver a minimum standard of services and maintain adequate security levels.

Among institutional mechanisms, easy access of multiple attendants and delays in responding promptly to patients were seen as factors leading to violence against health care. Mechanisms are required to restrict access of multiple attendants inside the hospital. This could not only reduce mob violence but also help HCPs in providing better quality of care to the patients and ensure patient safety. Major socio-political factors mentioned included a lack of education, political indulgence in institutions, poor law and order, slow judicial system and corruption. This last set of factors would point to a strong link between the presence of ethno-linguistic conflicts and political violence in the city and the prevalence of minor forms of violence, like the ones experienced by many HCPs.

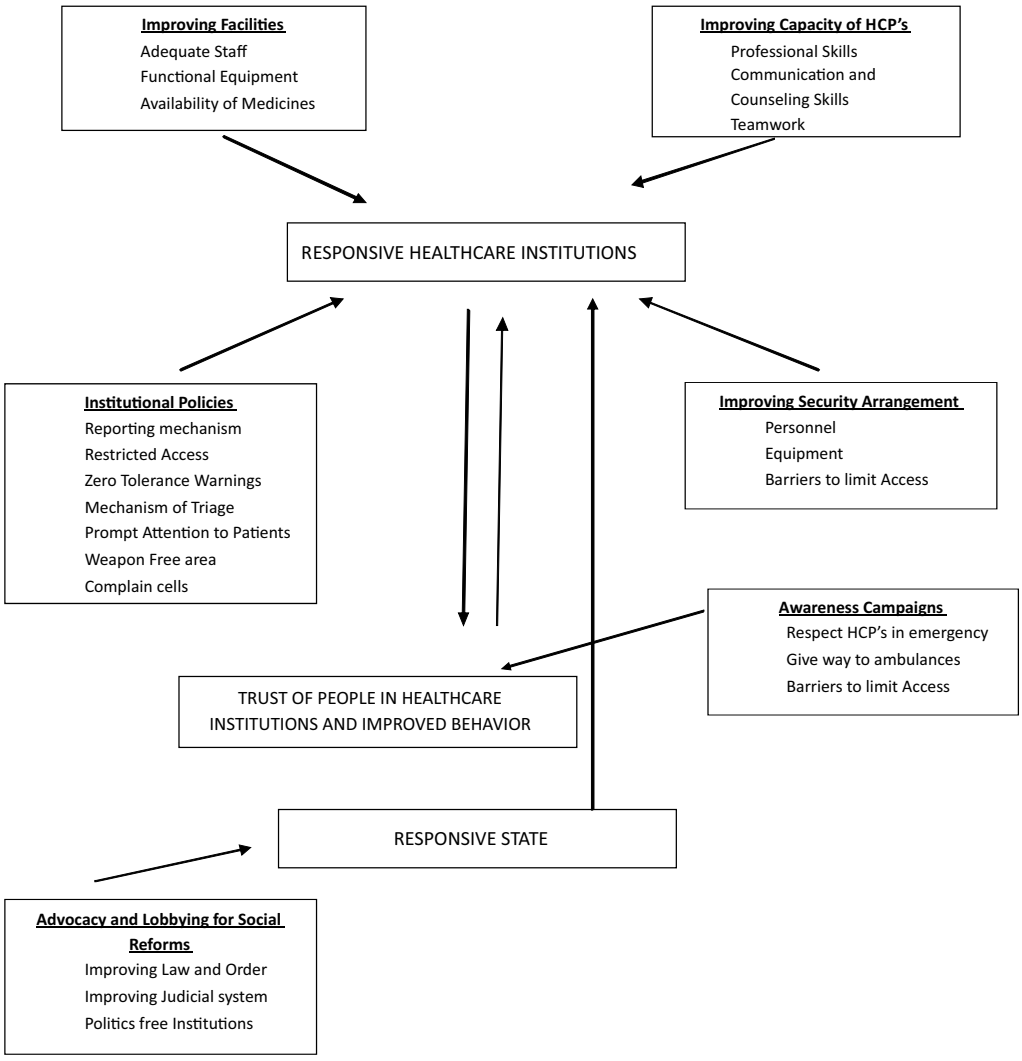
Effect of violence

Experience with violence affects not only the individual but also the family of the victim and his/her institution. More than half of the victims felt scared and threatened at their workplace. It also demotivated them at their workplace with feeling of helplessness and depression. Nabeel et al. have reported that violence reduces job satisfaction and affects the performance of victims. A study in Lebanon has also reported a high tendency to quit one's job as a consequence of violence.(19) Our study results are in conformity with international studies as well; henceforth we should learn from the international experience and develop strategies for decreasing/de-escalating violence against health care.

Conclusion

Violence faced by HCPs is a multifactorial complex issue. There is an urgent need to design interventions which can help in addressing the behavioural, institutional and socio-political factors promoting violence affecting HCPs. Future projects should focus on designing interventions to contain violence at multiple levels. We propose the following framework for interventions to contain violence (page 52).

PROPOSED FRAMEWORK OF INTERVENTIONS FOR DE-ESCALATING VIOLENCE



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معیاری سوالات پر مبنی انٹرویوز سے انکشاف ہوا کہ HCPs اور ایمبولینس سٹاف کے حوالے سے لفظی اور خاصی حد تک جسمانی تشدد کے بارے میں بھی ایک عمومی قبولیت یا بے اعتنائی پائی جاتی ہے۔ قانون نافذ کرنے والی ایجنسیوں، LEA نے آگاہ کیا کہ ڈاکٹرز حضرات بھتہ دینے میں زیادہ پس و پیش سے کام نہیں لیتے ۔ جبکہ HCPs اور ایمبولینس سٹاف نے لواحقین کے غیر معقول رویے اور توقعات، سہولیات کے فقدان اور HCPs کے ناقص معیار کو تشدد کی بنیادی وجوہات قرار دیا۔ تشدد کا سامنا کرنے میں حائل رکاوٹوں میں غیر مناسب سیکورٹی سہولیات اور تمام فریقین کی تشدد سے نمٹنے کی تربیت نہ ہونا شامل ہیں۔ HCPs اور ایمبولینس سٹاف نے تشدد کا جواب تیمارداروں سے گفت وشنید کے ذریعے دیا۔ چند ایک واقعات میں انتہائی سنگین صورتحال کے پیش نظر رپورٹ درج کروا کر پولیس کی مدد حاصل کی گئی۔

ادارہ جاتی سفارشات میں سہولیات کی بہتر دستیابی، HCPs کی طبی صلاحیتوں میں اضافہ، HCPs کی ابلاغ کی استعداد میں بہتری، بہتر حفاظتی اقدامات، تیمارداروں/لواحقین کی ہسپتال کے اندر حسب ضرورت محدود رسائی، ٹرائی ایج (Triage) کا واضح طریقہ کار اور HCPs کی کڑی ضابطہ بندی (Regulation) شامل ہیں۔ جواب دہندہ گان نے ہنگامی صورتحال کے دوران HCPs اور قانون کے احترام کا شعور بیدار کرنے، شرح خواندگی میں اضافے، عدالتی نظام کی اصلاحات اور اداروں میں سیاسی مداخلت کے تدارک پر مشتمل سماجی اصلاحات کی تجویز بھی پیش کی۔ زیادہ تر شرکاء کی طرف سے ایمبولینسوں کو راستہ دینے کی اہمیت اور ایمبولینس سٹاف کو احترام دینے پر زور دیا گیا۔

جواب دہندہ گان نے میڈیا پر شعور کی بیداری اور صحت عامہ کے معاملات کی ذمہ دارانہ رپورٹنگ کے لئے مثبت کردار ادا کرنے پر بھی زور دیا۔ ان سفارشات کی روشنی میں یہ مطالعہ HCPs پر تشدد کے خلاف ایک کثیر الجہتی منصوبے کی تیاری کے لئے ایک لائحہ عمل تجویز کرتا ہے۔ مستقبل کے منصوبوں کی تشکیل کے دوران کئی ایک سطحوں پر مداخلت اور شعبہ صحت کے خلاف تشدد کو کسی صورت برداشت نہ کرنے کی پالیسی پر عمل درآمد کو مرکز نگاہ بنایا جائے۔ ہم مریضوں کے ساتھ HCPs کی گفت وشنید اور بات چیت کی صلاحیتوں میں بہتری اور جائے ملازمت پر بہتر حفاظتی اقدامات کی تجویز پیش کرتے ہیں۔ ڈاکٹروں اور قانون کے احترام کا شعور بیدار کرنے کے لئے مہمات بھی چلائی جانی چاہییں۔ صحت عامہ کی تنظیموں کو بھی پوری تندہی کے ساتھ سیاسی مداخلت سے پاک صحت عامہ کے خودمختار اداروں کے لئے بھرپور آواز اٹھانی چاہیے۔

6. شعبہ صحت کے خلاف تشدد: کراچی میں ایک کثیرالجہت تحقیق کے نتائج

تشدد، بڑے شہروں کے منظر نامے میں ایک معمول کی بات ہے اور صحت عامہ کے کارکنان بھی اس سے مستثنیٰ نہیں۔ یہ بیمار اور ضرورت مند تک طبی امداد پہنچانے میں رکاوٹ کا باعث بنتا ہے۔ آئی سی آر سی اپنے عالمی پروگرام ''طبّی امداد خطرے میں'' (Healthcare in danger) کے دائرہ کار کے اندر رہتے ہوئے انسانی ہمدردی پر مبنی سفارت کاری، حمایت، فروغ قانون اور عملی مداخلت کے ذریعے صحت عامہ کے کارکنان کی حفاظت کا بیڑا اٹھاتی ہے۔ صحت عامہ کے کارکنان، مراکز صحت، ایمبولینسوں اور مریضوں کے تحفظ کی صورتحال بہتر بنانے کے لئے آئی سی آر سی نے جنوری 2015ء سے اگست 2015ء تک ''اپنا انسٹیٹیوٹ'' (ادارہ برائے صحت عامہ جناح سندھ میڈیکل یونیورسٹی کراچی) کے تعاون سے صحت عامہ کے کارکنان پر تشدد کے حوالے سے ایک تحقیقی مطالعہ کا انعقاد کیا۔

اس مطالعے کا مقصد تشدد کی مختلف صورتوں، عمومی تاثر، برداشت کے پیمانے اور تمام شرکاء مطالعہ پر تشدد کے اثرات کے ادارک کے علاوہ صحت عامہ کے کارکنان کو تشدد اور اس کے اثرات سے محفوظ رکھنے کے لئے ضروری پالیسیوں کی نشاندہی میں حصہ ڈالنا بھی تھا۔ شرکاء مطالعہ میں ڈاکٹرز، نرسیں، پیرامیڈیکل سٹاف، سیکورٹی گارڈ و ہسپتال کا دیگر عملہ، ایمبولینس ڈرائیورز و متعلقہ عملہ، میڈیا اور قانون نافذ کرنے والے ادارے (CPLC، پولیس اور رینجر) شامل ہیں۔ جائزہ کے دوران متفرق طریقوں پر مبنی (QUAN-QUAL) طریقہ سے استفادہ کیا گیا۔ مسلسل نمونہ سازی (Sampling) کے عمل سے 17 اجتماعی (فوکس گروپ) اور 42 تفصیلی انٹرویوز پر مشتمل 822 سوالنامے جوابات کے ساتھ جمع کئے گئے۔ تجزیے کا انعقاد تمام متعلقہ شعبہ جات پر گہری نظر رکھنے والے ماہرین کی ایک ٹیم نے کیا۔ تقریباً دو تہائی شرکاء نے پچھلے ایک سال میں تشدد کی کسی بھی قسم کا مشاہدہ یا تجربہ کر رکھا تھا اور ایک تہائی شرکاء نے کسی بھی قسم کے تشدد سے گزرنے کی روداد بیان کی۔ لفظی یا زبانی تشدد کا تجربہ جسمانی تشدد کی نسبت قدرے زیادہ تھا۔ تشدد کی زیادہ عمومی عملی شکلوں میں گالم گلوچ، دھونس دھمکی، دھکم پیل اور لاتوں اور مکوں کا استعمال شامل ہے۔ زیادہ تر واقعات میں گروہ یا ایک سے زائد افراد شامل تھے۔

مریضوں کے لواحقین/ تیمارداروں کے بعد نامعلوم افراد کو تشدد کے بنیادی ذمہ داروں کے طور پر شناخت کیا گیا۔ ہنگامی طبی امداد کے شعبہ جات اور وارڈز تشدد کی اہم ترین جگہوں میں شامل تھے۔ تشدد کی اہم ترین وجوہات میں غیر حقیقی توقعات، گفتگو کی ناقص صلاحیت، انسانی غلطی، غیر متوقع نتائج اور غیر معیاری دیکھ بھال کا تاثر شامل ہیں۔ تشدد کے اثرات میں ضرورت سے زیادہ احتیاط و ناامیدی کا احساس اور واقعہ سے متعلق مسلسل تلخ یادوں کی آمد شامل ہیں۔ 2 تہائی سے زیادہ شرکاء کا خیال تھا کہ تشدد کا یہ واقعہ روکا جا سکتا تھا۔ نصف سے زائد متاثرین نے حملہ آوروں کے خلاف کوئی کاروائی نہیں کی۔ تقریباً ایک تہائی نے واقعہ کی رپورٹ درج کروانے کو غیر مفید تصور کیا جب کہ کچھ رپورٹ کے اندراج کے سنگین نتائج سے خائف تھے۔ اکثریت کو تشدد سے بچاؤ کے متعلق کسی ادارہ جاتی پالیسی سے متعلق معلومات نہیں تھیں۔ نصف سے زائد متاثرین کو ان کے ادارے کی طرف سے گزشتہ دو سالوں کے دوران لائی گئی کسی بنیادی تشدد گریز پالیسی کا علم نہیں تھا۔ میٹل ڈیٹیکٹرز، پینک بٹن اور مریضوں کی نگرانی کے طریقہ کار کی موجودگی کے بارے میں صرف چند ایک شرکاء نے آگاہ کیا۔

دیگر شعبہ جات کے مقابلے میں فزیشنز، حفاظتی اور ایمبولینس عملے نے زبانی تشدد کے خاصی حد تک زیادہ واقعات کی نشاندہی کی۔ حفاظتی اور ایمبولینس عملے نے زیادہ تر جسمانی تشدد کی شکایت کی۔ سرکاری ہسپتالوں اور ایمبولینس سروس کے مقابلے میں نجی ہسپتالوں اور غیر سرکاری اداروں نے تشدد کی خاصی حد تک کم شکایت کی۔ خواتین کو نسبتاً کم جسمانی تشدد کا سامنا کرنا پڑا۔

7. THE HEALTH CARE IN DANGER PROJECT: WHAT NEEDS TO BE DONE?

Violence, both real and threatened, against health-care workers, facilities and beneficiaries must be recognized as one of the most serious and widespread humanitarian concerns of today. As this and other pieces of research have shown, there is an urgent need to secure the safety of the wounded and the sick, and of health-care personnel, health-care facilities and medical vehicles during emergencies. More must be done to ensure that the wounded and the sick have timely access to health care and that the facilities and personnel to treat them are available, adequately supplied with medicines and medical equipment, and secure. Safeguarding health care cannot be addressed by the health-care community alone. Governments, administrations, law enforcement authorities and armed forces must assume this responsibility as well.

To increase awareness of this issue and generate action to improve it, the ICRC is seeking support for the following initiatives:

1. **Building a community of concern**
   The ICRC aims to mobilize support for this issue from within the International Red Cross and Red Crescent Movement and among the health-care community, medical aid organizations, military forces, and governments around the world. Working together to enhance respect for the law, this community should cultivate a culture of responsibility among all concerned to safeguard health care.

2. **Regular and methodical information gathering**
   In order to better understand and react to attacks on patients, health-care workers and facilities, and medical vehicles, reports of incidents should be more systematically collected and centralized with the data of other organizations.

3. **Consolidating and improving field practices**
   The ICRC has undertaken many initiatives to improve access to and safeguard health care in the various contexts in which it is working. Experiences and best practice need to be shared more widely within the International Red Cross and Red Crescent Movement and broader health-care community to encourage more and better initiatives on this front.

4. **Ensuring physical protection**
   Hospitals and other health-care facilities in countries affected by armed conflict or other violence will be assisted in organizing the physical protection of the premises and in developing procedures for notifying others of their location and of the movements of their vehicles.

5. **Facilitating safer access for Red Cross and Red Crescent staff and volunteers**
   The ICRC will encourage greater involvement of Red Cross and Red Crescent staff and volunteers in collecting data on, and responding to, threats to patients, health-care staff, volunteers, health-care facilities and medical vehicles.

6. **Engaging with States**
   All States that have not yet introduced domestic legislation to safeguard health care in situations of armed conflict and other emergencies will be encouraged to do so. This includes enacting and enforcing legislation on limiting use of the red cross and red crescent emblems.

7. **Engaging with national armed forces**
   All national armed forces that have not yet incorporated provisions into their standard operating procedures with respect to safeguarding health care will be encouraged to do so. These standard operating procedures must address, among other issues, management of checkpoints to facilitate the passage of medical vehicles and entry into health-care facilities.

8. **Engaging with professional health-care institutions and health ministries**
   Increase dialogue with health ministries and health associations to generate solidarity on this issue and improve reporting on, and responses to, violence against health-care workers, facilities and beneficiaries.

9. **Encouraging interest in academic circles**
   Assist universities, other educational institutions and think tanks to incorporate modules on the implications of, and means to address, violence against patients and health-care workers and facilities into courses in public health, political science, law and security studies.

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