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Workplace violence against women nurses working in two public sector hospitals of Lahore, Pakistan

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ABSTRACT

Background: Cultural and structural forces help sustain workplace violence (WPV) against feminized professions like nursing in Pakistan.
Purpose: The purpose of this study was to identify the prevalence and patterns of workplace violence (WPV) against women nurses (more than 95% of entire nursing population) in two hospitals of Pakistan.
Methods: A standardized international survey developed by the World Health Organization was used to collect cross-sectional data. Descriptive statistics, chi-square tests, and multivariate regression were used for data analysis. A total of 309 nurse respondents were sampled from two public sector tertiary care hospitals of Lahore.
Results: Findings show that 73.1% of nurses reported experiencing some sort of violence in the last 12 months; with 53.4% suffering from physical violence, 57.3% from verbal violence, and 26.9% from sexual violence. The main perpetrators were reported to be male coworkers, patients, and attendants. Higher risk for WPV includes single status, non-Punjabi provincial belonging, Islamic faith, staff and student nurse designations, temporary government contract, and working additional hours in the evening and night. The primary response to violence included not doing anything and remaining silent. It was also reported that nurse victims experienced moderate levels of emotional grievances after facing violence.
Conclusion: The results of this study suggest that public sector hospitals in the region need to improve their policy for the protection and monitoring of WPV against female nurses. Reporting and counseling bodies need to be installed to encourage both complaints and the seeking of medical attention after victimization.

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Introduction

The World Health Organization (WHO) describes workplace violence (WPV) as incidents in which employees at work are abused, threatened, or assaulted, with consequences to their safety, well-being, and health (Wynne et al., 2000). The four different types of WPV include verbal, physical, sexual, and horizontal violence. The latter includes verbal or nonverbal hostility, verbal harassment, and bullying. Across the world, WPV has been recognized as a serious detriment to worker productivity, organizational efficiency, and public health. WPV prevails at one-third

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the rate of non-WPV (Harrell, 2011) and is the third leading cause of occupational hazards and the second leading cause of women's mortality (Findorff, McGovern, Wall, & Gerberich, 2005).

Serious implications of WPV exist for developing nations where prevalence statistics and costs are not being measured and policies are not being targeted to improve workplace safety. WPV can cause economies to suffer billions of dollars because of loss of productivity, low occupational commitment, increased employee health care costs, and the decline in patient safety (Gerberich et al., 2004). Sixty percent of all WPV occurs in the health care sector; with nurses identified as being three times more at risk of experiencing violence than any other professional group (Chapman, Perry, Styles, & Combs, 2008). Recent research indicates that as many as 95% of nurses experience some form of WPV (O'Connell, Young, Brooks, Hutchings, & Lofthouse, 2000). Common perpetrators of WPV against nurses include patients, family attendants, coworkers, and supervisors. Coworkers of nurses in the health sector include other nurses, physicians, surgeons, administrators, therapists, paramedical staff, and pharmacists. Men are recognized as predominant perpetrators of violence in the health sector (Hader, 2008; Kamchuchat, Chongsuvivatwong, Oncheunjit, Yip, & Sangthong, 2008). In addition, in patriarchal societies like Pakistan, men are even more aggressive and violent against working women (Tarar & Pulla, 2014). The victims of WPV have been found to face deterioration in overall quality of life, health and well-being, and family relations. Deteriorating job satisfaction and inadequate care delivery of nurses facing WPV can also lead to increased workplace errors and subsequent risks for patient safety and mortality (Arnetz & Arnetz, 2001).

Causes of WPV against nurses include low professional status, frontline exposure with patients and family attendants, long hours spent in the hospital setting, and feminization of the nursing profession (Kim & Motsei, 2002). Poor perception of health services by the patient altered or disturbed the mental state, and the exposure to prolonged physical or psychological discomfort also contributes to patient and family attendant precipitated violence (Perrone, 1999). WPV against women nurses is more common in male-dominated wards and when men occupy the top administrative and supervisory jobs in the hospital organization.

Nursing is a feminized profession in Pakistan, with more than 95% of the 76,244 nurses in the country comprising women (WHO, 2012). Pakistan is facing multiple and complex problems related to the nursing profession, including critical shortages, unfavorable organizational culture, and a lack of structural protection against WPV (Khowaja, Merchant, & Hirani, 2005). Public hospitals in the region predominantly serve illiterate patients who have little knowledge of medical treatment or the importance of nurse care practices. Role delivery of frontline women nurses is further complicated by multiple family attendants being constantly present with patients. It is difficult for public hospital administrations in the region to limit the number of family attendants within the hospital settings because of fears of community backlash and risk of family honor in leaving blood relatives alone during times of illness.

Some scholars claim that WPV has been overshadowed by domestic violence, and it goes undetected because there is no coordinated data collection system (Kelly, 2005). The major dearth in scholarship is the research of WPV in developing nations and among minority populations, such as nurses. Developing regions are predicted to have critically high rates of WPV prevalent against women (Karega, 2002). Actual prevalence figures for WPV are near to nonexistent in Pakistan (Parveen, 2011). Pakistani society is patriarchal in nature, with oppressive attitudes against women's independence and male hierarchies dominant at work organizations. The predominant cultural belief is that women should not work outside the home and consequently that WPV against such women is acceptable (Karmaliani et al., 2012). There are few constitutional laws protecting women from domestic and WPV in Pakistan (Niaz, 2003). Although the criminal law related to sexual harassment at the workplace was passed in 2009, very few women actually turn to courts and police when they are victimized. This is because of cultural restrictions, fear of family dishonor, and the lack of accountability provided by the police authorities and judicial system.

The aim of this study was to supplement the dearth in scholarship regarding WPV faced by women nurses in the country through ascertaining prevalence, perpetrators, and consequences. Attempt was also made to understand associations and predictors of WPV in relation to nurse sociodemographic and employment characteristics.

Methods

Study Design

A descriptive design using cross-sectional data was used. The findings reported here are part of a larger study that explored the organizational cultures and violence faced by nurses in public sector hospitals of Pakistan (Jafree, Zakar, Fischer, & Zakar, 2015; Jafree, Zakar, Zakar, & Fischer, 2016).

Setting and Sample

The study was conducted in Lahore, the capital of the province of Punjab. Lahore is the second largest city of Pakistan with an estimate population of more than 10 million people. Two large tertiary care public hospitals were selected randomly for the study sample from an official list, by the Pakistan Institute of Medical Sciences, containing names of all 11 hospitals in the city. Public

hospitals in Pakistan have large staffs and extremely high patient turnovers because they are the only affordable options for most of the poor population. The public hospitals of Lahore are frequented by patients from several neighboring rural zones who have limited access to health care facilities. Both the sampled hospitals have affiliated medical and nursing colleges. Combined, the average daily patient turnover of the sampled hospitals is 3,800, with an average in-patient bed capacity of 1,890. All registered women nurses, who had been working in the hospital setting for more than 1 year, were sampled randomly. Each nurse designation was sampled, including supervisors, instructors, ward heads, staff nurses, and student nurses. Student nurses with more than 1 year experience of clinical work were included in the sample. In public sector hospitals of Pakistan, student nurses work in the clinical setting after 3 months of their training because of shortages.

Ethical Consideration

Ethics committee approval was taken from the Punjab University Ethics Board and the Ethics Review Committees of both the hospitals and the affiliated teaching schools where the nurses were interviewed. Nurse respondents were assured that no hospital names will be provided in any publications so that individual nurse participants in low frequency designations (e.g., nurse superintendents) could not be traced. All survey respondents were informed by attaching a cover letter to the questionnaire, describing the objectives of the research, and no names or contacts were asked for to preserve confidentiality and anonymity. Respondents were given the contact number of the author with the assurance that free services for psychiatric consultation would be provided to any respondent who may feel emotionally disturbed after completing the survey.

Instrument

Instrument validity was assured by using an international standardized scale, the WHO Workplace Violence Questionnaire (WHO, 2003), which has been frequently used by scholars to measure WPV against nurses in many countries (Esmaeilpour, Salsali, & Ahmadi, 2011; Kwok et al., 2006; Pai & Lee, 2011). A total of 39 questions from the original survey were used, such that only questions relevant to nurses working in Pakistan were retained. Definitions for types of violence and description of what constitutes violence were clearly stated in the survey and taken from the WHO report (World Health Organization & Krug, 2002). Physical violence (PV) was described as including beating, kicking, slapping, stabbing, shooting, pushing, biting, and pinching. Verbal violence (VV) was described to respondents in terms of behavior that humiliates, degrades, or otherwise indicates a lack of respect for the dignity and worth of an individual. Sexual violence (SV) was described with reference to any unwanted, unreciprocated, and unwelcome behavior of a sexual nature that is offensive to the person involved and causes that person to be threatened, humiliated, or embarrassed. Respondents were able to select more than one of the three types of WPV they had suffered from in the last 12 months. Questions also addressed the perpetrators of WPV and the victim response and health or psychological consequences after facing WPV. The survey was printed in English as it is the official working language and also the academic language in Pakistan.

Data Collection

Data were collected during a 5-week period between the months of November 2013 and January 2014. Both hospitals combined have 2,270 practicing women nurses. A total of 804 surveys were distributed across wards to interested nurse participants. All nurse designations visit ward's head offices daily to sign the attendance register, and thus, this was the place deemed suitable for communication of research aims, study cover letter, and permission for questionnaire completion. A total of 309 nurses agreed to complete the survey at a response rate of 34.8%. Nursing school rooms were reserved for data collection from 15 to 30 nurses at a time, with the author present to answer any questions during this process. Completed surveys were returned in sealed envelopes by nurses in a dropbox placed in both the nursing schools.

Data Analysis

Raw data were entered into Excel (Elliott, Hynan, Reisch, & Smith, 2006). It was then transferred into SPSS 17.0 (IBM Corporation, Armonk, NY) for statistical analysis (Nie, Bent, & Hull, 1970). Descriptive statistics were used to ascertain the prevalence of WPV, perpetrators of WPV, types of responses by victims and, the emotional consequences to nurses after experiencing WPV. Chi-square tests of significance were run to assess associations between experiences of WPV and sociodemographic and employment characteristics of nurse respondents (Hahn et al., 2010; McKenna, Smith, Poole, & Coverdale, 2003; Ryan & Maguire, 2006). p values of $<.05$ were considered statistically significant. Multivariate regression has been used to determine higher odds of facing WPV in relation to sociodemographic and employment characteristics of nurses (Estryn-Behar et al., 2008; Jiao et al., 2015; Kitaneh & Hamdan, 2012). For analytical purposes, facing WPV was scored 1 and not facing WPV was scored 0. The enter method was used. Odds ratio with 95% confidence levels and p values were calculated, and the significance was assigned at 0.5%. All variables in the model were controlled for age (as a continuous variable), literacy, and monthly income.

Findings

Respondents varied between the ages of 20 and 59, with the mean age at 34.8 years (standard deviation = 10.13).

Most nurses were married or had been married (56.6%), and nearly half (49.5%) earned between PKR 20,000 to 39,000. The average income was PKR 31,581/- or USD 303.2/- per month (FOREX, 2016). This value is above the average monthly wages at national level but below the average wage for specialist graduates and other medical practitioners like surgeons and physicians in Pakistan (Irfan, 2008). Most respondents belonged to the Punjab region (97.4%) and were Muslims (77.8%). Most of the nurses had attained either a basic nursing degree (56.3%) or earned a BSc in Nursing degree (38.3%); 65.7% were staff nurses, 17.8% were student nurses working as adjunct staff in the clinical wards, 12.3% were ward heads, and 4.2% were either instructors or supervisors. More than half of the nurses were on permanent contract (56.0%), and nearly all listed having to work additional hours at the workplace without additional pay (81.6%).

In all, 73.1% of nurse respondents faced some form of violence in the last 12 months; 53.4% were subjected to PV, 57.3% to VV, and 26.9% to SV. The frequency and percentage of WPV faced by nurse respondents is shown in Table 1. Chi-square tests revealed significant association between the frequency of PV, SV, and VV with the variables of age, marital status, religion, degree, designation, government contract, and extra hours worked. Predictors of WPV were found through multivariate regression analysis (Table 2). Nurses were more likely to suffer SV if they were single (adjusted odds ratio [AOR], 1.98; 95% confidence interval [CI], 0.41–2.35), non-Punjabi (AOR, 1.69; 95% CI, 0.11–3.30), and Muslim (AOR, 1.95; 95% CI, 0.43–2.12). Staff and student nurses had higher odds of facing PV (AOR, 1.06; 95% CI, 0.25–2.07), VV (AOR, 1.53; 95% CI, 0.76–2.71), and SV (AOR, 1.75; 95% CI, 0.59–2.55). The odds were higher for nurses on temporary government contract for facing VV (AOR, 1.59; 95% CI, 0.82–2.94) and SV (AOR, 1.76; 95% CI, 0.32–2.78). Finally, nurses having to work extra hours in the evening or night also had higher odds of facing VV (AOR, 2.08; 95% CI, 1.70–3.23) and SV (AOR, 2.14; 95% CI, 0.96–3.88).

The type of WPV faced by nurse respondents, type of perpetrator, and the response of victims are listed in Table 3. With regard to perpetrators of violence, findings indicated that nurses were more likely to face PV from coworkers (31.9%) and patients (34.7%), VV from patients (33.6%) and family attendants (38.5%), and SV from coworkers (32.8%). The most frequent response of victims after facing PV, VV, and SV was none (62.3%, 46.7%, and 51.8%, respectively). Responses for reporting to seniors, pursuing legal action, seeking counseling, union help, or medical attention were not as considerable as they should have been to secure the health and well-being of women nurses.

The emotional problems and complaints suffered by nurse respondents after suffering WPV have been shown in Table 4. A significant number of nurse respondents indicated suffering from moderate experiences of repeated, disturbing memories, thoughts, or images of the attack (40.9%); avoiding thinking about or talking about the attack or avoiding having feelings related to it (51.1%); becoming super alert or watchful and on guard (43.1%); and feeling like everything they did was an effort (53.3%).

Discussion

Despite religious and cultural barriers, the employment of women in Pakistan has steadily risen from 13% in 2000 to 22% in 2011 (Statistics, 2012). However, women in the region have few employment benefits, inadequate workplace protection, and are restricted to joining feminized professions like teaching and nursing. WPV is estimated to be high in the country, which undermines the assumption that employment is supporting working women for their autonomy and well-being. International literature indicates that WPV against nurses has serious negative repercussions on the victim's health and mental well-being, role delivery for care provision to the patient, team work in the hospital setting, and overall patient safety (Roche, Diers, Duffield, & Catling-Paull, 2010).

All nurse designations in public hospitals of the country were represented in the sample for this study. In this study, most (73.1%) nurses were found to have faced some type of violence in the last 12 months. More than half of the respondents indicated facing PV and VV, whereas nearly one-third had faced SV. Previous local research has also estimated that nurses work in extremely unsafe and violent work environments (Somani, 2012). The literature from developed regions predicts that nurses face up to 80% of PV and VV from patients (O'Connell et al., 2000). The findings report that the main perpetrators of WPV include patients, family attendants, and coworkers. It is worth considering that if coworkers, patients, and family attendants are commonly imposing violence on women nurse practitioners in hospital settings, they may also be imposing violence against women within their homes. This is because domestic violence, by husbands and in-laws, is an easier crime to get away with because of lack of witnesses, privacy of the home environment, and the seclusion of women victims at homes (Garcia-Moreno, Jansen, Ellsberg, Heise, & Watts, 2006). It has also been suggested by researchers that men who are openly violent in public places and those who have adopted an overt culture of violence are more likely to commit violence in the private domestic setting (Krug, Mercy, Dahlberg, & Zwi, 2002).

The findings suggest that unmarried nurses in Pakistan face more of all types of violence. Recent research from another developing region also confirms that unmarried women nurses face more SV at the work setting (Boafo, Hancock, & Gringart, 2016). This may be because younger and unmarried women are more vulnerable and inexperienced and less likely to report SV. In addition, reporting SV may lead to victim blaming, loss of family honor, and inability to secure a

marriage proposal in a community that upholds the arranged marriage system (Critelli, 2010). Staff nurses, student nurses, and nurses working on temporary government contracts have greater chance of suffering all types of violence; as confirmed by other research (Alameddine, Kazzi, El-Jardali, Dimassi, & Maalouf, 2011). This may be because nurses with lower designations and on lower status contracts have less experience and influence in reporting violence. The findings of this study show that Muslim nurses may face more SV compared with the minorities, and this is contrary to what previous research had suggested (Ballard, 2012). It may be that the few respondents from minority backgrounds were less willing to report violence. Alternatively, it may be that Muslim nurses face greater WPV as perpetrators, following Islamic

Table 1 – Experience of PV, VV, and SV in the Last 12 Months

Socio-demographic and Employment Variables	PV		VV		SV	
	Did	Did Not	Did	Did Not	Did	Did Not
Age						
20–29	115 (70.1%)	49 (29.9%)	85 (51.8%)	79 (48.2%)	28 (17.1%)	136 (82.9%)
30–39	20 (23.3%)	66 (76.8%)	18 (20.9%)	68 (79.1%)	39 (45.3%)	47 (54.7%)
40+	30 (50.8%)	29 (49.2%)	29 (49.2%)	30 (50.8%)	16 (27.1%)	43 (72.9%)
X^2	17.899		2.701		7.112	
p	<.001		.100		.008	
Marital status						
Never married	93 (69.9%)	40 (30.1%)	75 (56.4%)	58 (43.6%)	21 (15.8%)	112 (84.2%)
Ever married	71 (40.6%)	104 (59.4%)	57 (32.6%)	118 (67.4%)	62 (35.4%)	113 (64.6%)
X^2	21.785		18.125		15.204	
p	<.001		<.001		<.001	
Nurse income (PKR)						
5,000–19,999	22 (38.6%)	35 (61.4%)	20 (35.1%)	37 (64.9%)	24 (42.1%)	33 (57.9%)
20,000–39,999	90 (58.5%)	63 (41.5%)	66 (43.1%)	87 (56.9%)	32 (20.9%)	121 (79.1%)
≥40,000+	51 (53.1%)	48 (46.9%)	45 (46.9%)	54 (53.1%)	27 (28.1%)	72 (71.9%)
X^2	6.827		2.043		9.505	
p	.063		.360		.069	
Province						
Punjab	141 (46.8%)	160 (53.2%)	129 (42.9%)	172 (57.1%)	82 (27.2%)	219 (72.8%)
Sindh	02 (33.3%)	06 (66.7%)	03 (50.0%)	05 (50.0%)	01 (16.7%)	07 (83.3%)
X^2	2.450		1.624		1.074	
p	.063		.645		.783	
Religion						
Islam	143 (59.8%)	96 (40.2%)	112 (46.9%)	127 (53.1%)	54 (22.6%)	185 (77.4%)
Minority (Christian/Hindu)	22 (31.4%)	48 (68.6%)	20 (28.6%)	50 (71.4%)	29 (41.4%)	41 (58.6%)
X^2	17.544		7.402		9.776	
p	<.001		.007		.002	
Nursing degree						
Diploma	76 (43.7%)	98 (56.3%)	112 (64.4%)	62 (35.6%)	60 (34.5%)	114 (65.5%)
BSc Nursing	78 (65.0%)	42 (35.0%)	54 (45.0%)	66 (55.0%)	20 (16.7%)	100 (83.3%)
MSc Nursing	11 (23.3%)	04 (76.7%)	11 (23.3%)	04 (76.7%)	03 (20.0%)	12 (80.0%)
X^2	14.803		3.742		9.668	
p	<.001		.002		.003	
Nurse designation						
Student	20 (56.4%)	35 (43.6%)	36 (65.5%)	19 (34.5%)	25 (54.5%)	30 (45.5%)
Staff nurse	118 (58.1%)	85 (41.9%)	110 (54.2%)	93 (45.8%)	41 (20.2%)	162 (79.8%)
Head nurse	20 (32.6%)	18 (67.4%)	23 (30.5%)	15 (69.5%)	13 (34.2%)	25 (65.8%)
Nurse instructor/supervisor	07 (33.8%)	06 (66.2%)	08 (31.5%)	05 (68.5%)	04 (30.8%)	09 (69.2%)
X^2	2.339		3.742		1.444	
p	.041		.002		.001	
Government contract						
Contractual	73 (42.2%)	63 (57.8%)	115 (66.5%)	21 (33.5%)	26 (36.1%)	110 (63.9%)
Permanent	32 (54.4%)	141 (45.6%)	47 (65.3%)	126 (34.7%)	57 (32.9%)	116 (67.1%)
X^2	30.721		22.550		21.255	
p	<.001		<.001		<.001	
Work extra hours in evening or night						
Yes	132 (66.0%)	120 (34.0%)	84 (74.5%)	64 (25.5%)	45 (42.2%)	207 (57.8%)
No	31 (29.0%)	26 (71.0%)	93 (46.5%)	30 (53.5%)	38 (19.0%)	19 (81.0%)
X^2	40.164		22.603		19.601	
p	<.001		<.001		<.001	

Note. PV, physical violence; SV, sexual violence; VV, verbal violence.

Table 2 – Multivariate Regression Results for Odds of Facing Workplace Violence

Socio-demographic and Employment Variables	AOR for Facing PV (95% CI)	p	AOR for Facing VV (95% CI)	p	AOR for Facing SV (95% CI)	p
Marital status						
Never married	1.56 (0.42–2.86)	n/s	1.94 (0.31–1.87)	n/s	1.98 (0.41–2.35)	<.01
Ever married	1		1		1	
Province						
Minority	1.99 (0.51–2.92)	n/s	1.78 (0.77–3.78)	n/s	1.69 (0.11–3.30)	<.1
Punjab	1		1		1	
Religion						
Islam	1.84 (0.25–1.82)	n/s	1.38 (0.12–1.89)	n/s	1.95 (0.43–2.12)	<.5
Minority	1		1		1	
Nurse designation						
Student or staff nurse	1.06 (0.25–2.07)	<.5	1.53 (0.76–2.71)	<.1	1.75 (0.59–2.55)	<.1
Manager or instructor	1		1		1	
Government contract						
Contractual	1.10 (0.35–2.42)	n/s	1.59 (0.82–2.94)	<.5	1.76 (0.32–2.78)	<.5
Permanent	1		1		1	
Work extra hours in evening or night						
Yes	1.39 (0.22–1.81)	n/s	2.08 (1.70–3.23)	<.1	2.14 (0.96–3.88)	<.01
No	1		1		1	

Note. AOR, adjusted odds ratio; CI, confidence interval; n/s, not specified; PV, physical violence; SV, sexual violence; VV, verbal violence.

codes of patriarchy, are intentionally penalizing women for participating in the workforce, and going against socioreligious norms (Sadruddin, 2013). Also, non-Punjabi provincial minorities from Baluchistan, KPK, and Sindh face more SV. This may be because provincial ethnicity and minority status, evident through language and accent, encourages perpetrators in Punjab to impose violence against women who have less family connections and networks to seek justice. International research confirms that minority ethnic nurses from different regions may face diverse forms of violence (Alexis, Vydelingum, & Robbins, 2007). Finally, nurses working extra hours in the evening and night faced increased risk of VV and SV. Previous research confirms that postdusk hours of work for women nurses places them at higher risk for WPV because administration and security is not at its full strength at evening and night (Estryn-Behar et al., 2008).

Table 3 – Types of WPV Experienced, Perpetrators, and Responses of Victims

Nurse Respondents, $N = 309$
Exposure to Any Kind of Violence in the Last 12 mo, $N = 226$ (73.1%)

	PV	VV	SV
	f (%)		
Type of violence experienced in the last 12 mo	165 (53.4)	177 (57.3)	83 (26.9)
Perpetrator of WPV			
Coworker	46 (31.9)	03 (02.5)	45 (32.8)
Patient	50 (34.7)	41 (33.6)	35 (25.5)
Family attendant	44 (23.0)	31 (38.5)	07 (05.1)
Combination (patients, family attendants, & coworkers)	04 (02.8)	47 (25.4)	35 (25.5)
Response of victim			
None	76 (62.3)	57 (46.7)	71 (51.8)
Told person to stop	46 (37.7)	05 (04.1)	70 (51.1)
Told colleague	01 (0.8)	09 (07.4)	10 (07.3)
Reported to senior nurse	17 (13.9)	19 (15.6)	11 (08.0)
Told colleagues and senior nurse	14 (11.5)	14 (11.5)	28 (20.4)
Tried to prevent it	63 (46.0)	05 (04.1)	70 (51.1)
Sought union help	01 (0.8)	05 (04.1)	—
Sought counselling	03 (02.5)	05 (04.1)	—
Pursued legal action	05 (04.1)	03 (02.5)	—
Sought medical attention	—	—	—

Note. PV, physical violence; SV, sexual violence; VV, verbal violence; WPV, workplace violence.

With regard to nurse responses after facing WPV, the findings reflect specific shortfalls. Most nurses indicated not responding in any way to facing physical, verbal, or sexual assault. It was reported by some nurses that colleagues and senior nurses were told about the experiences of WPV; but vital course of actions like legal retribution, seeking counseling and medical attention, and attempt to gain union support were almost negligible. In this way, findings suggest that WPV is not being reported, victims are not being compensated, counseled, or given medical attention, and more importantly, the perpetrators are free to repeat actions of WPV without accountability. International research also suggests that one of the main causes of WPV is that women choose to keep quiet and to not report victimization (Gates, Gillespie, & Succop, 2011). Reasons for victim preference to not report violence include fears of job loss and of provoking more assault, shame, and self-blame, and an absence of legislative laws or the presence of bodies to report to (Felblinger, 2008).

Table 4 – Emotional Problems and Complaints After Experiencing WPV

Repeated, disturbing memories, thoughts, or images of the attack	
Not at all	63 (46.0%)
Moderately	56 (40.9%)
Extremely	03 (02.2%)
Avoiding thinking about or talking about the attack or avoiding having feelings related to it	
Not at all	44 (32.1%)
Moderately	70 (51.1%)
Extremely	08 (05.8%)
Being super alert or watchful and on guard	
Not at all	20 (14.6%)
Moderately	59 (43.1%)
Extremely	43 (31.4%)
Feeling like everything you did was an effort	
Not at all	20 (14.6%)
Moderately	72 (53.3%)
Extremely	29 (21.1%)

Note. WPV, workplace violence.

A considerable number of nurse respondents indicated suffering from repeated images of violence, disturbed memories and sleep, becoming alert and weary at the workplace, and having to put in extra effort to continue with job. Suffering WPV silently has been found to be detrimental for nurse role delivery and patient safety (Roche et al., 2010). In addition, not adopting help-seeking behavior by nurse victims has been found to cause multiple problems, such as psychological and physical troubles, not feeling competent, and suffering emotional complications that may have spillover effects on the home and family relations.

This study has a number of limitations, including a response rate less than 50% and the consequent inability to generalize findings. The sensitive nature of the topic may have influenced the willingness of female nurses to honestly share their experiences of violence in a male-dominated work organization. However, this research has significant strengths. It is one of the few studies attempting to present data for the prevalence, consequences, and predictors of WPV in the region. Findings highlight that policymakers need to assure security and protection for women nurses. It is hoped that this study helps mobilize longitudinal nationwide data collection regarding WPV against nurses and other working women.

Conclusion

The results of this study indicate that structural policies and protection mechanisms are not in place securing the safety of nurses working in public sector hospitals of the region. Legislative reforms for hospital governance pertaining to zero tolerance for violence are needed. Nurse managers and hospital administration can successfully adopt policies to mitigate WPV, including training employees to recognize and report violence, avoiding delays, increasing security during postdusk working hours, preventing overcrowding and shortage of resources, limiting the number and timings of family attendants, and monitoring use of drugs and alcohol in hospital premises. Independent monitoring, reporting, and penalizing bodies within public hospital settings need to be initiated at the state level by the health ministry to encourage reporting and deter perpetrators. Conveniently accessible and anonymous reporting avenues for women would also help to encourage reporting. Medical attention and counseling for victims is also recommended. Also, collaborative community efforts would help alter the culture of patriarchy and reduce violence against women nurses, such as the raising of voices by nurse unions (e.g., Pakistan Nursing Council), increasing support for working nurses (e.g., media), and improving awareness about the public role and status of women nurses (e.g., religious leaders).

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