Review Article

# Workplace violence against community health workers in Lower Middle Income Country-India

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**Abstract**

**Introduction**: Violence against Community Health Workers (CHWs) is a severe issue, as it impacts their safety and services. The various forms of violence that CHWs encounter are discussed. Also, the incidents of violence against CHWs in India, emphasizing the causes are discussed. **Material and Methods:** This was a cross-sectional study of local online media reports analyzed between August 2020 to March 2023. **Results:** A total of 31 incidents were identified, with perpetrators of violence being relatives of the patients. Mistrust of CHWs was the reason reported. **Conclusion:** By understanding violence against CHWs, we can protect CHWs' safety and wellbeing. The repercussions of violence in healthcare provision are examined, and strategies are recommended.

**Keywords:** Workplace violence, Community health workers, Frontline health workers, abuse, harassment

## Introduction

Community Health Workers (CHWs) are essential healthcare workers who provide primary healthcare services directly to their communities, living in the same geographical areas. They receive specialized training, but they do not obtain official certifications. Their crucial role is to deliver culturally appropriate healthcare tailored to the community's specific requirements[(1)]. CHWs act as primary healthcare providers, bridging the gap between formal health systems and communities, significantly contributing to community development and improving healthcare accessibility, especially in resource-constrained settings. The World Health Organization (WHO) recognized the vital importance of CHWs in achieving universal health coverage, as expressed at the Alma Ata conference in 1978[(2)]. CHWs are predominantly female residents, essential in promoting and improving community health. They receive instruction in health-related knowledge and acquire skills to provide healthcare services directly to the community.

The National Rural Health Mission (NRHM) was launched in 2005 to improve healthcare access in rural areas, with a particular emphasis on community health[(3)]. The primary goal of the NRHM was to enhance healthcare services by establishing Accredited Social Health Activists (ASHAs) to rectify shortcomings in healthcare provision. Auxiliary Nurse Midwives (ANMs) and ASHAs work together to provide healthcare services in rural areas[(4)]. CHWs, primarily women, have a vital role in delivering healthcare services and have significantly contributed to the progress of maternal and child health in India. The Ministry of Health and Family Welfare (MoHFW) and the Ministry of Women and Child Development (MoWCD) oversee CHWs, with a particular focus on disease prevention and improving the health of mothers and children. CHWs have been instrumental in achieving notable advancements over the past decade, such as increased rates of hospital deliveries, expanded immunization coverage, and reduced maternal and child mortality[(5)].

"*Community health workers should be members of the communities where they work, should be selected by the communities, should be answerable to the communities for their activities, should be supported by the health system but not necessarily a part of its organization, and have shorter training than professional workers*"[(6)].

A serious problem that jeopardizes the safety of CHWs and impairs the provision of healthcare is violence against CHWs. CHWs are crucial in providing essential healthcare services to underserved communities worldwide. For countries to meet Sustainable Development Goal-3 (SDG-3) of achieving universal health coverage, community health workers have been positioned as a critical component in partially resolving the global health workforce shortage[(7,8)]. CHWs serve as a bridge between the healthcare systems and the communities. CHWs, often the first point of contact for healthcare, offer culturally sensitive and accessible care. Despite being vital in tackling health disparities, they encounter aggression from patients, families, and

communities[9]. Violence against CHWs is a global public health problem, according to global data showing that between 8% and 38% of CHWs experience physical violence at some point in their careers. The most common forms of violence include verbal abuse, threats, physical assault, and sexual harassment[10,11]. Even more vulnerable to violence are CHWs who operate in areas of significant poverty or conflict[12,13].

CHWs are a practical way to achieve universal health coverage, lessen inequalities, and enhance health outcomes. They have been critical in tackling a variety of health challenges, including violence against CHWs in India, which has become a growing problem over the last several decades. Existing studies from international and national show that 32% of female CHWs had suffered sexual violence and 26% had experienced physical assault; this violence occurred both at home and at work and included violence committed by relatives of the families they served[14-16]. In addition to prejudice from the community and their own families, Mumtaz et al. reported that female CHWs in Pakistan frequently endure harassment and abuse from superiors and fellow workers. Numerous situations have been observed when community members and supervisors were involved in discrimination, sexual harassment, and gang rape[17,18]. Psychosocial stressors and a toxic workplace are associated, with sex being a significant factor for increased stress levels. Both the International Labour Organization (ILO) and scholars investigating violence in the workplace concur that hierarchy plays a critical role in fostering a workplace that encourages and sustains harassment and violence at work[19,20].

Workplace Violence (WPV) impacts job satisfaction and has been demonstrated to be a vital predictor of the effectiveness and quality of the health systems in developed and developing nations[21]. The hiring process for health professionals still needs a sufficient understanding of the obstacles and vulnerabilities faced by CHWs working in fragile and conflict-affected circumstances, even though existing worldwide literature guides optimizing CHW effectiveness and performance. More research must be conducted to determine the factors influencing CHW performance in fragile and conflict-ridden situations.

Concerns about violence against CHWs are also rising. To fully utilize the capabilities of CHWs, achieve fair healthcare for everyone, and protect their safety and well-being, these issues must be addressed.

## Materials and Methods

This was a cross-sectional study of local online media reports and their analysis. All the reported incidents of violence against CHWs by the English and Telugu online media from all Indian states from August 2020 to March 2023 were searched, included, and analyzed. These incidents were selected through the Google search engine using keywords such as "violence on community health workers," "violence against ANM," "workplace violence against ASHA workers," and" violence against *Anganwadi* workers (AWW).

### *Data Collection*

To carry out a comprehensive examination of the violent incidents portrayed in the media, information was collected from websites (Free Press, logical India, Opindia Latestly, Telugu. samayayam, News Click), Newspapers in both languages (English-Siasat, Indian Express, Times of India, Hindustan Times, Deccan Chronicle, India Today, The Hans India and Telugu-Andra Jyothi, Eenadu, Disha daily) and news (Sheth people, ANI, Times Now, Asianet News) classified and aggregated for the analysis of the study. The primary rationale for selecting these sources is their inclusion of data about protests involving CHWs and instances of WPV.

### *Study criteria*

After collecting the data, we classified the media reports according to defined criteria. At first, we looked at specific terms in the medical field and community settings, such as ANMs, ASHAs, AWWs, healthcare professionals, hospitals, violence, aggression, attack, and workplace violence. Moreover, we classified the articles based on their titles. We excluded any items that do not directly relate to WPVs but rather to other healthcare professionals such as doctors and nurses. We also removed subjects such as medical education and income among Healthcare Professionals (HCPs).

### *Data Analysis*

The variables, including state, place, target, type, and preparator of violence, were extracted from the selected media articles, and simple descriptive analyses were carried out.

## Results

The research for this study turned up 302 news items linked to major mass media and published in Telugu and English on news channels, newspapers, and websites. Of these, 259 fell beyond the study's scope, 12 were duplicates because they did not meet our inclusion requirements, and 31 were included for analysis (Figure 1)

Study data shows that Telangana reported the highest number of violent occurrences, with 25.8%. Furthermore, Uttar Pradesh and Karnataka have a significant number of cases. In all other regions, reported incidences are lower (Table 1).

**Table 1: Geographical distribution of newspaper articles regarding incidents of violence against Community Health Workers**

| Sr. No | Region | n (%) |
|---|---|---|
| 1 | Andhra Pradesh | 3 (9.6) |
| 2 | Chhattisgarh | 1 (3.2) |
| 3 | Delhi | 1 (3.2) |
| 4 | Himachal Pradesh | 1 (3.2) |
| 5 | Karnataka | 6 (19.3) |
| 6 | Kerala | 1 (3.2) |
| 7 | Madhya Pradesh | 2 (6.4) |
| 8 | Maharashtra | 1 (3.2) |
| 9 | Odisha | 1 (3.2) |
| 10 | Tamil Nadu | 1 (3.2) |
| 11 | Telangana | 8 (25.8) |
| 12 | Uttar Pradesh | 4 (19.9) |
| 13 | West Bengal | 1 (3.2) |

The incidents of workplace violence against community health workers, including ANMs, ASHAs, and AWWs, were included.

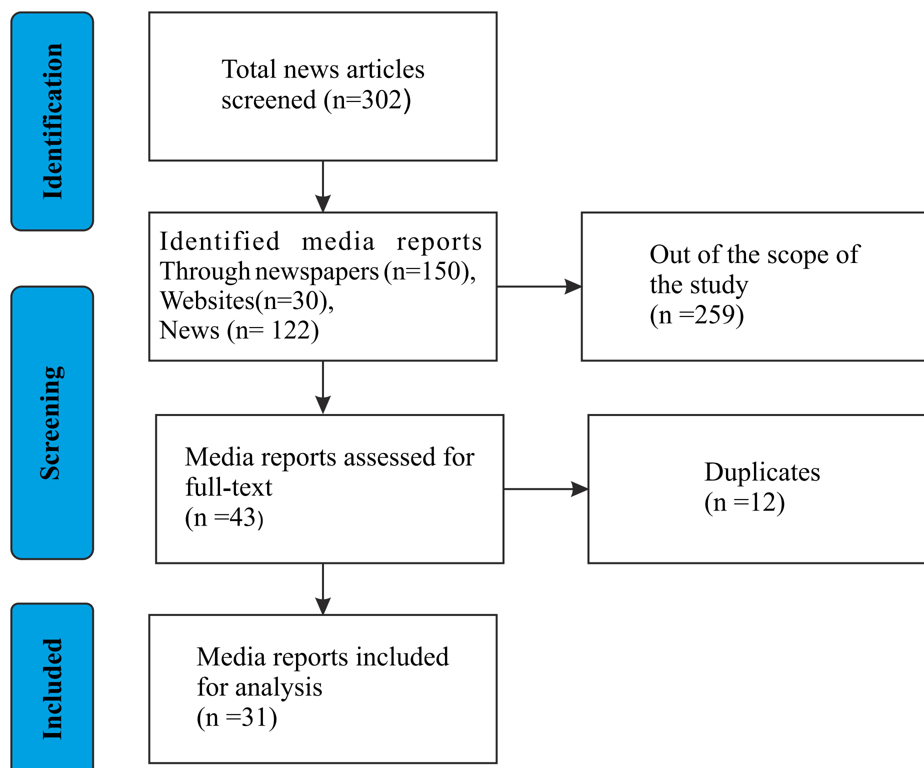


**Figure 1: Flow diagram of selection of eligible media reports on Workplace Violence against CHWs**

The incidents reported were physical violence 56%, psychological violence 29% and sexual harassment 15% (Table 2).

**Table 2: Proportion of Workplace Violence incidents by type (N=31)**

| Sr.No | Types of Workplace Violence | n (%) |
|---|---|---|
| 1. | Physical violence | 17.36 (56) |
| 2. | Psychological violence | 8.99 (29) |
| 3. | Sexual harassment | 4.65 (15) |

The severe recent violence against community health workers in India is a reflection of the subpar management systems in place at the time and the low regard for community health workers in contemporary society. The study found multiple causes of violent attacks (Table 3). And also, study data showed that patients, family members, community members, and police personnel were the perpetrators of violence against CHWs.

**Table 3: Causes of Workplace Violence against CHWs (Based on Media Reports)**

| Category | Cause | Example |
|---|---|---|
| Beneficiary related variables | Lack of health literacy | Pregnant women received COVID-19 vaccinations from the ANM. However, the expectant mothers' family believed the vaccine killed the babies and attacked the ANM. |
| Societal Factors | Disease-related- Lack of trust | A woman refused to have her childrenvaccinated, claiming that the ANM was administering vaccines coercively to meet their quota. |
| Systematic Issue | Lack of vaccines | A young man verbally abused and threatened ASHA and ANM due to not providing services. |
| Workplace | Lack of security measures | Facilities without sufficient security protocols: A man rejected a love proposal, and following a rejection, ANM's brother-in-law sought revenge by arriving at PHC and assaulting her with a knife. |
| Communication Issues | Disparities in cultural norms, attitudes, and beliefs generate miscommunication. | While collecting data, a Muslim family suspected that the ASHA personnel were gathering information for the National Register of Citizens, and therefore, they assaulted and refrained from providing their information. |
| Worker Factors | Working and traveling alone | CHWs who engage in home visits or work in isolated areas face verbal, physical, and sexual harassment. |

**Discussion**

Workplace violence against CHWs is one of the global public health problems, which is often aggravated by emergencies. CHWs are facing many challenges apart from that 56% of CHWs reported experiencing violence in a particular period, which indicates a high incidence of violence in this research. Physical violence (56%) and psychological violence 29% sexual violence (15%) all contributed to the high levels of violence. These problems are faced both during work hours and outside of them. Female CHWs were especially at risk because of their gender, social status, and the economic conditions that first motivated them to look for a job. People in the community were aware of their precarious condition and frequently felt free to treat them harshly since they knew there would probably be no repercussions. Closser et al. stated several accounts of workers being the victims of unpunished[10]. ASHAs often encounter sexual assault in the family and have encountered stalking, sexual remarks, etc. Many ASHAs experienced verbal abuse from the relatives of their beneficiaries. ASHA workers experienced more violence, followed by AWWs and ANMs[22,23]. Previous studies examined how caste affects ASHAs' and AWWs' function[24-27]. This study aimed to identify the characteristics of WPV reported online against CHWs. Our results of the community's WPV victims and perpetrators, as well as its spatial and temporal distribution, its nature, and its results, were all disclosed by CHWs in Indian states. It should be emphasized that in this study, physical violence was the most prevalent kind of WPV, followed by psychological violence and sexual violence[28], which was presumably related to entering phrases into search engines.

Additionally, more human resources must be needed to contribute to the demanding daily healthcare activities CHWs perform. As a result, there needs to be more opportunities or hours in the day to get the training you need. This might lead to health workers providing patients with inadequate humanistic care and needing more empathy. This will further harm how well patients and CHWs communicate. There are currently very few CHW communication training offered to healthcare professionals by the government and institutions. violence may occur when a patient thinks that CHWs are treating them poorly. A study by Rao et al. reported that ASHAs were frequently held accountable by the families of their beneficiaries for events beyond their control. When their beneficiaries were denied compensation for giving birth at a hospital or when other medical employees improperly charged them fees, ASHAs were held accountable[14].

Given that recipients were community members, a lack of respect from their families probably reflects the community as a whole[14]. There is a substantial healthcare hierarchy inside India's public health system. Because ASHAs are at the bottom of the healthcare structure, they have little power to

confront individuals in positions of authority. ASHAs reported that higher-ranking coworkers treated them with a great deal of contempt, which frequently led to violence of various kinds. To handle harassment and violence in the workplace, the ILO and WHO advise organizations to establish clear, zero-tolerance policy statements of belief, additionally "a readiness to engage in support of any action aimed at fostering an environment free from violence"[29]. Efforts also need to be taken to address the root cause of violence and to reduce prejudice and hatred in the community towards CHWs[30]. The study highlights a concerning trend of rising violence against CHWs in India. The perpetrators of violence against CHWs, as well as the situations that led to these episodes, were all covered in this study. Using this media examination, the study also made recommendations on ways to reduce violence against CHWs.

**Recommendations**

1. Put in place meticulous policies and procedures for preventing workplace violence. These policies should include precise definitions of violence, reporting guidelines, and penalties for perpetrators. Along with defusing potentially violent situations, they should also cover how to support CHWs who have experienced brutality.
2. Instruct CHWs on acknowledging and dealing with potentially violent circumstances. This instruction should cover risk assessment, effective communication with patients or visitors who may be violent, and de-escalation techniques.
3. Develop and upkeep secure work environments and have defined protocols for reporting suspicious activity.
4. Take steps to address the root causes of violence against CHWs. This entails tackling issues like disparities in wealth, poverty, and mental health care access. It also entails making efforts to lessen prejudice and hatred towards CHWs.

**Limitations**

The primary drawback of this study was that it relied on internet reports, whose objectivity and veracity were affected by elements like government laws, the geographical locations of the stories, the motivations of public media and internet firms, the journalistic ethics of the reporters, and the reliability of the sources. Additionally, only a small number of samples (31) were included in this study, and the years covered mostly the period from August 2020 to March 2023.

**Conclusion**

Violence against CHWs is currently an issue that calls for the immediate attention of all stakeholders. There is not enough research on violence towards community health workers. The degree and forms of violence encountered by CHWs, as well as the corresponding perpetrators of this violence in Indian states; this study looked at the working conditions of CHWs. According to the media, violence against CHWs is common, takes many different forms, and often originates from the CHW's close social circles. The study's findings clarify the problems CHWs encounter and show how local social structures might help create a more supportive workplace for CHWs. A multi-level strategy may be needed for interventions to reduce violence against CHWs, with cooperative elements acting at the individual, interpersonal, healthcare institution, and societal levels.

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**Ethical consideration**

In this study no human participants are involved. Since it's a review article, Ethics approval is not required.

**Authors' Contribution**

SG: Conceptualization and designing of the research study, data collection, implementation, data analysis, interpretation and manuscript writing, and review; SR: Conceptualization and designing of the research study, Interpretation and manuscript writing, Supervision, Reviewing, and approving the final version.

**Data availability statement**

Data used for the present study is available in public domain.

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