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WORKPLACE HARASSMENT AND SECURITY THREATS AGAINST COMMUNITY BASED HEALTH CARE PROVIDER IN DISTRICT OKARA

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Abstract

This study investigates the prevalence and impact of workplace harassment and security threats faced by community-based healthcare providers in District Okara. Utilizing quantitative methods including chi-square tests, factor analysis, and ordinal logistic regression, the research identifies various dimensions of harassment, such as psychological, verbal, sexual, and physical threats, alongside institutional inadequacies like the absence of safety training and emergency response mechanisms. The results reveal a strong association between these threats and negative outcomes, including reduced job satisfaction, deteriorated mental health, avoidance behavior, and diminished work performance. The study emphasizes that such challenges not only affect the providers' well-being but also compromise the quality and accessibility of healthcare services, particularly in rural and underserved regions. The findings call for urgent structural reforms to create safer, more supportive working environments for frontline healthcare professionals.

Keywords: Health, Healthcare Providers, Harassment, Workplace, Job Satisfaction

Introduction

Violence has a pervasive impact on individuals across every part of society and can appear in a variety of settings, including households, streets, educational institutions, occupational environments, and other establishments. Violence has historically been disregarded as a public health issue because it lacks a precise definition, but it is indisputably a multifaceted and dispersed problem. Defining violence is not as straightforward as correlating it with scientific facts; rather, it involves assessing suitable and permissible actions shaped by culture, beliefs, and social conventions. The World Health Organization (WHO) defines "violence as the deliberate use of physical force or power, whether threatened or real, towards oneself, another individual, or a group or community, which has the potential or is highly likely to cause injury, death, mental anguish, mis development, or deprivation". According to the Occupational Safety and Health Administration (OSHA), "workplace violence includes any intentional or potential physical violence, harassment, intimidation, or other disruptive behaviour that occurs inside the workplace" (Map, 2015). Physical violence at the workplace includes beating, pushing, slapping, biting, kicking, and stabbing. There has been a lack of concerted efforts to address the same psychological problem as (Lippel, 2016). Harassment, categorized as a form of violence, is defined as any behaviour that reduces, humiliates, creates irritation, or raises worry. Bullying is verbal insults in which the actors uses unpleasant language and bully others through their communication, gestures, and actions of intimidation (Mannella, 2023).

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Harassment against female healthcare providers and workplace security threats have become substantial in several health facilities; this is especially the case for healthcare provider women residing in low-resource settings. They have experienced incivility from the public, implemented in both verbal abuse and physical violence or psychological intimidation, not only affecting their work environment but also contributing to compromising their health (Saand et al., 2023).). These include patriarchy, which primes Indian society; inadequate workplace safety and reporting mechanisms, compounded by a lack of legal protections, thus adding to hardship already experienced by women in such fields (Shah et al., 2021). Ending this issue is very important to provide protection and a conducive environment for female workers and to help ensure that these health workers better contribute toward patient care without fear of harassment or harm. There is no excuse for violence towards healthcare workers who are working hard to ensure the care they provide is of a high standard. The nurse alarmingly opines that this violence has significant impacts on the physical and psychological well-being of healthcare employees (World Health Organization [WHO] 2022). Victims are more likely to feel devalued and depressed, have poor self-esteem and experience helplessness and post-traumatic symptoms such as sleep disturbances, irritability, attention problems, flashbacks, and emotional distress (Zafar et al., 2013; Gerberich et al.,2004; Kvas & Seljak, 2014)

Workplace violence is multifactorial in origin and involves an interaction of factors associated with perpetrators as well as the health workers themselves. The setting in which health care services occur can provide conditions that foster occupational violence. In many cases, it is perceived that violence represents part and parcel of a healthcare worker's job (Gerberich et al., 2004; Kvas & Seljak, 2014); they were just at the wrong place in incorrect timing. Fear of punishment often exists, which is whether the offenders will care and do something with it (Gates, 2004 Some fears reporting lead to go through a lot before things start moving forward due to stigma as well as legal obstacles about change process “bureaucracy/maze” issues (Bartol et al.) Incidents might not be reported by healthcare workers out of fear of further harassment, violence, or threats to them and their families (Arnetz et al., 2015). The World Health Organization (WHO, 2022) reported that in many healthcare settings, especially in high-risk and conflict areas, female workers are attacked for being not only healthcare providers but also because they are women. These threats encompass physical harm, sexual assault scares, or general security risks that make women think twice about careers in healthcare. Jafree et al. Dawn (2019) reported that female nurses in Pakistan were being intimidated and harassed constantly at work, leaving many of them fearing for their lives. These security threats had been largely exacerbated due to a lack of institutional support and insufficient reporting mechanisms identified in the study. It can be difficult for female healthcare workers to report abuse without feeling vulnerable because they frequently find themselves in precarious situations with no legal protection. Ethiopian healthcare settings also observed the presence of security threats to female health workers, more commonly so in rural areas where facilities were less connected with other sectors (Abeya et al. 2019).

Significance of the Study

This study holds substantial significance in District Okara, Punjab, Pakistan's healthcare system, particularly in addressing the safety and well-being of community-based healthcare providers (CBHCPs), the backbone of primary healthcare delivery in rural and underserved areas. By exploring the nature, prevalence, and impact of workplace harassment and security threats these frontline workers face, the research sheds light on a critically underexamined aspect of occupational health in the public sector. The findings provide empirical evidence highlighting systemic gaps in protection, institutional response, and mental health support for CBHCPs. These insights are essential for health policymakers, administrators, and stakeholders to formulate effective safety protocols, legal frameworks, and training programs that ensure a

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secure working environment for these workers. Additionally, the study emphasizes the gendered dimensions of workplace violence, offering a valuable lens for feminist and sociological inquiry into the intersection of gender, power, and occupational vulnerability. This research contributes to the global discourse on decent work and human rights in the healthcare sector by advocating for safer working conditions and the psychological well-being of community-level healthcare providers.

Objective of the Study

1. To identify the different forms of workplace harassment and security threats faced by community-based healthcare providers.
2. To examine the psychological, physical, and sexual harassment experiences and their impact on job satisfaction and mental well-being.
3. To explore the relationship between workplace threats and healthcare providers' performance, stress levels, and area avoidance behaviors.
4. To analyze the influence of demographic and job-related factors (e.g., location, access to safety training, emergency protocols) on the experience of workplace harassment.

Literature of Review

Increasing attention has been paid to workplace harassment in healthcare settings over the last 20 years due to its often-serious consequences for employees and patient care quality. Healthcare personnel (HCPs) are especially susceptible to different kinds of transgressions, such as verbal abuse, physical aggression, bullying, and sexual harassment. The incidence of workplace harassment in healthcare is well above that in most other industries, at least partly because the work environment and relationships with patients are so emotionally laden for workers (Gates, 2020). Because our health care system is built on individual practitioners and small entities that are typically removed from larger organizations, community-based providers with fewer support systems or in the communities themselves possess certain characteristics that make them more targeted to workplace harassment. This harassment has a wide-ranging influence on not only the mental health and job satisfaction of healthcare workers but also leads to negative patient outcomes and impacts care delivery (Joubert & Bhagwanjee, 2011).

Healthcare work is inherently stressful, emotionally demanding, and involves frequent interactions with people in crisis, these conditions foster harassment, according to a recent study. When the situation is urgent, emotions are high, and healthcare workers often suffer verbal or physical violence from patients… (Zhang, Li & Zhang, 2021). These interactions can often evolve into more dangerous forms of harassment and even violence. Workplace harassment can be so prevalent because of the hierarchical power structure within healthcare institutions. Because doctors traditionally have more power in a hospital system, and because the implicit bias can be tied to lower self-awareness among them (Felsenstein et al., 2019), this could result in them being less likely to notice these microaggressions happening around them against nurses if an unhealthy balance of power between both parties is maintained (McPhaul & Lipscomb, 2014). It also affects community-based health workers, who are even more often unsupported and supervised by the faceless sort of institution that permits its members to harass others with a click.

Common forms of harassment healthcare workers in community settings face, on top of what would be considered normal workplace harassment behavior, happen both inside and outside their work environment. Healthcare providers in communities could automatically locate their practices in high-threat locations, such as rural regions and neighborhoods with high crime prices. These environments not only jeopardize healthcare workers with physical violence but also expose them to security threats like theft, vandalism, and environmental hazards (Ferri et al., 2016). To be addressed, these risks must have physical security measures taken in such places (Fukushima et al., 2020) and are not implemented in many community healthcare

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settings. These environments create the opportunity for 'humorous' "joking around" and targeted harassment.

In the field of healthcare, particularly in this time and age where safety is more than just a concern but has become an issue that continues to exist despite discussions about how workplace harassment can have such profound consequences. However, research evidence demonstrates that harassment is one factor significantly and positively correlated with higher levels of stress, anxiety, depression, and burnout among healthcare workers (Abed et al., 2016). Those mental health effects often manifest themselves in lower satisfaction on the job and deeper rates of staff turnover, both issues that can have devastating impacts on healthcare systems. Poor quality of patient care and increased costs in hiring and training new personnel are all consequences of declining commitment from harassed healthcare professionals to continue working. Additionally, part of the hostility between team members is because workplace harassment issues are causing a hostile workplace and reducing teamwork support to provide effective health care delivery (Gates).

They must deal with frequent harassment as they work in isolation and are unavailable for any institutional support at the time of distress. Community health workers form the backbone of primary healthcare in many low- and middle-income countries, delivering first-line care to communities with limited or no access to such services (Sharma et al. 2018). However, their work often puts them at risk and navigating cultural norms and social-gender dynamics may lead to unwanted attention or, worse yet, physical violence. There is an additional layer of vulnerability that female healthcare workers face, which would be gender and workplace harassment. Sexual harassment and gender-based violence remain pressing issues in healthcare, with women at higher risk that compound further if they are working within community-based roles (Rodriguez et al., 2018). This form of gender-based harassment can present itself in many ways, such as name-calling and sexual invitations; according to studies that show that this type of abuse haunts women for years after it occurs. Workplace harassment is a widespread problem in healthcare settings, and it can take many different forms, including verbal abuse, physical violence, and even sexual harassment. Moreover, the healthcare industry provides unique working conditions that may be experienced as more stressful and demanding than in other sectors because of proximity to patients with their families or under public scrutiny (Zhang et al., 2021). The high-stress environments, emotional demands, and unpredictable nature of patient care can add fuel to the fire by creating charged situations where healthcare workers are vulnerable targets for aggression or abuse.

Verbal harassment is one of the most common types of abuse suffered by health workers. This may or may not include name-calling, insults, threats, and derogatory comments. This harassment is often triggered by patient dissatisfaction, misconceptions, and sometimes anger over medical outcomes. Healthcare workers in emergency rooms and intensive care units, where a higher level of stress is experienced when managing life-threatening or stressful situations, face an increased risk of being aggressed verbally (Ferri et al., 2016). In such high-pressure environments, patients and their families might lash out at healthcare providers due to the anxiety or fear they are feeling. The near-constant presence of verbal abuse can cause emotional burnout and less satisfaction in work, ultimately resulting in a higher rate of burnout among healthcare providers.

There have been serious issues concerning physical harassment in healthcare contexts as well. Physical Aggression: Patients or family members may physically assault ED staff in a variety of ways, including, but not limited to, pushing and shoving up to more severe acts of violence. A study by Rosenthal et al. A study published in 2017 showed that physical violence is not reported as frequently because this type of event tends to be seen as a normal act within the health service (2017). Health workers — nurses and those based in communities, most

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especially, subjected to physical abuse on the job take it as one of those things that further entrenches this cycle. Due to factors such as cognitive impairments or mental health conditions (Wu et al., 2019), the healthcare workforce, particularly those working in psychiatric units or geriatric care, has a greater Than average risk of encountering violent patients. The problem is compounded by the fact that many healthcare settings, community-based care environments—are not built with adequate security measures.

Indeed, sexual harassment is a widespread problem in healthcare. In the case of female health workers, they are often subject to sexual harassment, especially while working in far-flung community settings or during night hours. Patients can inflict sexual harassment on their families or colleagues, and it may take many forms, including attempts to form inappropriate relationships such as suggestive remarks or touching. For one, research has demonstrated that the hierarchical nature of healthcare organizations and resulting power differentials among doctors versus nurses or other staff positions can foster a climate where sexual harassment is condoned or otherwise left unaddressed (Sharma et al., 2018). These can cause enormous psychological harm, and they also entrench gender inequities in the medical system.

The problems stemming from workplace harassment in healthcare are deep and wide. More alarming is the fact that caregivers who experience hazing, discrimination, and bullying are more prone to developing anxiety disorders or depression, which directly impacts the quality of healthcare service delivered. It can further strain already burdened healthcare systems from increased absenteeism, job dissatisfaction, and high turnover rates when exposed to frequent harassment (Zhang et al., 2021). Healthcare organizations need to go a step further in addressing ground causes of workplace mistreatment through specific prevention measures while focusing on staff training, standardizing clear mechanisms for reporting incidents, and upkeeping anti-harassment policies.

Providing essential services to geographically isolated and socioeconomically deprived populations would be unsustainable without community-based healthcare providers. However, the risk often faced by these providers can put their well-being and safety in significant danger. One of the most imminent is sheer physical violence from patients or just someone down in your neighborhood research by Wu et al. Several factors, such as lack of proper security mechanisms and poor infrastructure, make health workers in isolated areas more prone to violence (2019). Given the emotional and psychological strain that patients, as well as their families, experience, often in high-pressure healthcare settings, aggressive behaviors aimed at healthcare providers have become more common. Such violence carried by the hands of police officers presents immediate threats, but also systems change that negatively impacts the welfare and, on top, long-term trauma for those who are suffering.

Another is the dimension of environmental hazards in community-based healthcare security threats. Many healthcare providers work in high-crime neighborhoods where the chance of being robbed, beaten, or killed is much greater. The workplaces do not always have the minimum necessary safety infrastructure to protect healthcare workers, including lightening and surveillance or even security systems that enable an emergency response. Fukushima et al. (2020) highlight that these areas' socio-economic conditions make making for the m even more difficult, as it is low resources and poverty laden. The absence of secure health facilities and safe transportation creates an environment of intimidation for healthcare workers and can hamper service delivery.

The lack of infrastructure support and environmental and physical threats further compound the vulnerabilities of community-based healthcare providers. Most health care facilities have almost no security presence and nothing to protect staff. There is indeed a gap in knowledge and resources, which renders healthcare providers vulnerable when faced with potential attacks (Fukushima et al., 2020). This failure to uphold and commit to safety impacts not only the risk

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associated with violence but can drastically affect the morale as well as the mental health of staff. Additionally, existing training programs relating to de-escalation techniques and safety preparedness are subpar or nonexistent, resulting in most staff being under-prepared for appropriately dealing with such uncalled-for events.

the security challenges faced by providers in community-based health care services are complex, including physical and environmental threats and a lack of institutional backing. Chief among them is the issue of achieving holistic safety strategies designed to safeguard further healthcare workers, which, in an ideal world, requires a joint effort from both caregivers' organizations and policymakers as well community stakeholders. Ensuring that healthcare workers are safe and well can go a long way to improving care delivery within our health system, thus leading to better population-level public health.

Community-based health care providers suffer high levels of harassment and security threats in the workplace, which are linked to job satisfaction problems and mental ill-health resulting into lasting professional, social & personal impacts. To such an extent, over physical assault or verbal abuse and even the subtle psychological harassment in many ways breeds a hostile work environment for any healthcare worker that can cause them to feel unsafe and so negative affect their recovery as well. Research has also consistently documented the strong link between exposure to harassment and violence and poor mental health outcomes, including anxiety, depression, and stress burnout. As Joubert and Bhagwanjee (2011) suggest, healthcare workers who are exposed to frequent harassment can become psychologically distressed, which in turn hurts their behavior over time. This emotional burden reduces the satisfaction of work, leading to frustration and helplessness which in turn spirals eventually into professional dystrophy.

The broader implications of harassment are not limited to the psychological well-being of individual health care providers; it can also have a detrimental effect on patient care. Healthcare staff who are at risk of violence or intimidation may not always be able to deliver a high standard of care as they have used up their emotional energy and feel distressed. Yields High Absenteeism and Turnover: The fear of harassment/assault causes a low–skilled workforce to stay home cause the absentee rate; turnover also remains high, especially in environments faced with incidents too frequently. According to Abed et al., 2016, the organization failed in reducing workplace violence and harassment levels resulting a sharp decrease of staff retention and morale. Healthcare workers in these settings may also feel underappreciated or unsupported leading to them seeking employment elsewhere, which can worsen a healthcare professional shortage in vulnerable communities.

continued exposure to harassment is associated with burnout a condition that includes emotional exhaustion, cynicism and a loss of confidence in one's ability. Burnout has been one of the key contributors to low job satisfaction of healthcare workers especially working in high pressurized settings like community-based care. This ultimately leads to a negative cycle in which healthcare workers experiencing poor mental health and job satisfaction are less effective at providing care, consequently feeling more frustrated and dissatisfied with their work. The consequences of workplace harassment on community-based healthcare providers are significant, which includes their mental health and job satisfaction as well as the ability for entire healthcare systems to deliver high-quality care. Solutions to these issues are multifactorial and need to include systematic changes that focus on safety for workers, mental health support services, while also combatting sexual harassment culture within practices.

Women are disproportionately represented in the community-based healthcare workforce, especially those of lower and middle-income countries. Sadly, they frequently face higher risks of being harassed and mistreated based on their gender within workplaces in these instances because of verbal or sexual harassment, which will extend to physical assault. For many female healthcare providers, additional obstacles exist due to the deeply ingrained gender norms.

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Research by Sharma et al. (2018) highlights that female community health workers, especially those working in lower and middle-income countries, are vulnerable to harassment. All too often, these women work in patriarchal environments with inadequate and unenforced workplace policies to support them.

Sexual harassment is one of the worst forms of gendered workplace violence that women suffer in high proportions, including health workers. Comments touches, and advances that can take an inappropriate turn by the colleagues or superiors of patients on female health workers are well documented. This harassment type is associated with the larger societal norms of gender-based violence acceptance or normalization, especially in societies where women are traditionally placed as subordinated (Nakao et al., 2020). The lack of a legal framework, avenues for implementation, or a mechanism for enforcement further complicates this by limiting the redressal options available to women seeking justice and security. As noted by Kumar et al. According to Fitzgerald et al. (2017), the lack of institutional accountability fosters a culture of impunity that not only provides little consequential discouragement for committing harassment but often leaves victims in fear upon reporting due to potential retaliation or stigmatization.

Sexual harassment is not the only form of gender-based violence that female healthcare providers face in community settings. The isolated, unsafe working environment in which many community health workers operate frequently makes this violence, which can range from verbal threats to physical assault, worse. As many female healthcare providers visit homes, especially in highly marginalized or high-crime areas, they become much easier targets of violence. Gender-based violence against female healthcare workers is also prevalent in such settings as cultural norms, social stigmatization, and normalization of gendered violence (Dye et al., 2019) and has an under-reported rate of reporting. These guilty feelings not only take a toll on health workers' mental and emotional well-being but also affect their capacity to provide quality healthcare, contributing to even wider inequities when it comes to access to care for these populations.

We found that how healthcare systems are structured contributes to gendered dimensions of workplace harassment. Still, female healthcare workers are more likely to be lower-tier (though not necessarily low-status) staff than their male colleagues, and hence the power dynamic remains for those further up in the chain. Sharma et al. The institutionalization of gender hierarchy into healthcare systems and the absence of strong reporting mechanisms were two key reasons why harassment is so widespread. Due to fear of their professional reputation being damaged, this population is less likely to report incidences that can have long-term effects on career and financial stability (García-Moreno et al., 2015).

The resolution of gendered barriers to workplace harassment in the healthcare sector demands systemic solutions. Examples include enforcing better legal controls that prevent the abuse of women, creating zero-tolerance policies for gender-based violence, and ensuring our healthcare facilities provide decent backup services and health personnel in a safe workplace. It calls for training that also addresses harmful gender norms and challenges them, plus more gender-sensitive training throughout the whole education process of health workers.

Methodology

The methodology of this study employed a quantitative research design to examine the relationship between parental conflict, emotional security, academic self-efficacy, and educational aspirations among students' community-based healthcare providers (CBHPs) actively serving on the frontline in District Okara from January 2023 to June 2023 was the population of the study n=300 community-based healthcare providers were selected through Yamane's formula. Data were collected using standardized questionnaires.

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Results

Table 1

Demographic profile of the respondent

	Valid	Frequency	Percentage
Age	18–25 years	54	18.0
	26–35 years	74	24.7
	36–45 years	114	38.0
	46 or above	58	19.3
Gender	Male	72	24.0
	Female	228	76.0
Role	Lady Health Worker	74	24.7
	Midwife	56	18.7
	Vaccinator	170	56.7
Experience	<1 year	56	18.7
	1–5 years	148	49.3
	6–10 years	37	12.3
	>10 years	58	19.3
Residence	Rural	110	36.6
	Urban	190	63.3

The demographic profile of the respondents reveals a diverse sample across various categories. Regarding age, the majority of respondents fall within the 36–45 years range, comprising 38.0% of the total sample. This is followed by individuals in the 26–35 years age group (24.7%), the 18–25 years age group (18.0%), and the 46 or above group (19.3%). Gender distribution shows a dominant female representation, with 76.0% identifying as female and 24.0% as male. In terms of professional role, the majority of respondents were vaccinators, making up 56.7% of the sample, followed by Lady Health Workers (24.7%) and midwives (18.7%). When considering work experience, most respondents (49.3%) had between 1 and 5 years of experience, while 18.7% had less than a year, 12.3% had between 6 to 10 years, and 19.3% had more than 10 years of experience. Lastly, the residence distribution shows that 63.3% of respondents live in urban areas, while 36.6% reside in rural areas.

Table 4.21

Component Matrix of Workplace Harassment and Security Threats Among Community Based Healthcare Providers

	Component					
	1	2	3	4	5	6
Psychological harassment (e.g., humiliation, blackmail).	.027	-.341	.612	-.112	.491	-.084
Aggression from patients/relatives (e.g., physical violence).	-.064	-.292	-.120	-.058	.391	.059
Threats from local influential figures.	.180	-.532	.154	.145	-.203	-.059
Harassment/security threats have reduced my job satisfaction.	.811	.085	-.093	-.087	-.180	.134
I feel anxious or stressed during fieldwork.	.746	.056	.141	-.259	-.073	.403
These incidents have affected my work performance.	.098	.599	-.233	.124	.363	.071

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I avoid certain areas/patients due to safety concerns	.145	.194	-.199	.499	.497	.157
My mental health has deteriorated due to workplace risks.	.153	.362	.455	.203	-.035	-.570
Availability of safety training programs.	-.442	.410	.092	.108	-.429	.086
Access to emergency response protocols.	-.409	.200	.559	-.106	.082	.439
Verbal abuse (e.g., shouting, insults) from community members.	-.480	-.224	-.220	-.017	-.038	.361
Sexual harassment (e.g., unwelcome advances, inappropriate remarks).	.163	.007	.430	.598	-.151	.351
Physical intimidation or threats.	.033	-.381	-.176	.609	-.113	-.032

The PCA with six components selected reflects several important factor loadings that underscore the diverse experiences of CHPs in community workplaces with harassment and security threats. "harassment/security threats have reduced my job satisfaction" (0.811) and "feeling anxious or stressed during fieldwork" (0.746) in Component 1, which seems to be working in the direction of emotional impact and job satisfaction, show the highest loadings; this, in turn, means that workplace risks affect very much the emotional and job satisfaction. Performance-related stressors are the focus of Factor 2 and the factors "these occurrences have affected my work performance" (0.599) and "availability of safety training programs" (0.410), which load heavily, indicating that performance decrease is associated with a lack of institutional support. Component 3: The psychological dimension and lack of support mechanisms are the elements related to this component displaying high loadings for "psychological harassment" (0.612) and "access to emergency response protocols" (0.559), indicating that lack of resources to address psychological distress is related to lack of ability to report to emergency, as for component 4, which consists mainly of physical security and harassment, the largest factors are the following: "sexual harassment" (0.598) and 'physical intimidation or threats' (0.609), reflecting direct threats in the field. Component 5 combines avoidance behavior with psychological stress, as in "I avoid certain places/patients for fear of safety" (0.497) and "psychological harassment" (0.491) are clear drivers here, suggesting that behaviors have been modified due to perceived threats. Finally, Component 6 is negatively loaded with "my mental health has been poorer from the risk to my job" (-0.570) and positively loaded with "access to emergency response protocols" (0.439), suggesting that at the same time that mental health suffers, access to support structures can offer a buffer. Together, these elements demonstrate how various types of harassment and organizational responses are intertwined with emotional distress, avoidance of work performance problems, and overall safety perceptions among healthcare employees working in the community.

Table 4.22

Association Between the Role of Community-Based Healthcare Providers and Their Experience of Workplace Harassment

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	17.748[a]	6	.007
Likelihood Ratio	19.586	6	.003
Linear-by-Linear Association	1.992	1	.158
N of Valid Cases	300		

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The Chi-Square test results show a statistically significant association between the role of community-based healthcare providers and their experience of workplace harassment. The Pearson Chi-Square value of 17.748 with 6 degrees of freedom and a p-value of 0.007 indicates that the experience of harassment is significantly related to the specific roles individuals occupy within the healthcare setting. Similarly, the Likelihood Ratio (19.586, p = 0.003) confirms this significant relationship. This means that different roles such as Lady Health Workers (LHWs), vaccinators, or midwives experience workplace harassment at differing rates or intensities. The result is statistically reliable, as all cells met the assumption of adequate expected counts (minimum expected count = 7.65).

Discussion

This study indicates that CBHCPs in Pakistan experience a range of complex forms of workplace harassment and security threats, having a substantial impact on their psychological well-being, job satisfaction, and ability to perform services. The findings of the component matrix and ordinal logistic regression highlight the six main workplace threat dimensions of psychological harassment, verbal abuse, physical intimidation, and lack of institutional safety measures. These findings are consistent with previous research which concluded that community-based healthcare workers from different HMIC, are at higher risk of exposure to WPV, that of exposure to WPV due to scarce access to institutional support and due to cultural stigma (WHO, 2020; ILO, 2022).

A characteristic pattern found in this survey is the prominent correlation of threats in the workplace with lower job satisfaction among CBHCPs. This is in line with findings from earlier studies by Kumar et al. (2021), who established that repeated exposure to threats and aggression in community health settings markedly reduces motivation and heightens feelings of burnout. Similarly, the decline in mental well-being described by the participants is consistent with the literature in low- and middle-income countries, which found that workplace hostility and inadequate protective facilities among frontliners contributed significantly to occupational stress (Jalil et al., 2019; Siddiqui et al., 2022).

The findings also suggest that influential people's threats to abuse (a special dimension of harassment in a Pakistani socio-political culture) render CBHCP powerless to ask for justice or report the violence. This cultural dimension focuses on an interplay of gender, power and occupational susceptibility, especially for working women in the conservative rural backdrop (Ali & Khan, 2018). Also, the result that the CBHCPs tended to avoid high-risk areas, and patients in these areas, for fear of their safety, has implications for equitable healthcare access and maintaining service provision in underserved areas.

The lack of institutional emergency protocols and safety training was also reflected in factor loadings. This is consistent with the apprehension of Abbas et al. (2020) and by Shaukat et al. Furthermore, the significant impact of harassment on work performance and psychological health also advocates the global demand to include mental health support and safety standards in health workforce policy (WHO, 2021).

The chi-square testing also revealed that the type of work and harassment experience were significantly related, which means a field-oriented, socially visible role was the risk status factor. This result highlights the need to distinguish security policies by occupational exposure level. The study contributes to the emerging literature on occupational safety in healthcare, grounded in the experiences of CBHCPs working in Pakistan. It highlights the pressing demand for focused policy action, legal remedies and social engagement mechanisms to ensure a safer working environment for community health workers.

Conclusion

The findings of this study highlight a critical and alarming reality faced by community-based healthcare providers in District Okara. The data reveal that these frontline workers are

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frequently subjected to various forms of workplace harassment, including psychological and verbal abuse, physical intimidation, and, in some cases, sexual harassment. Security threats particularly from patients, local influential figures, and community members have been shown to significantly reduce job satisfaction, increase workplace stress, and negatively affect overall work performance. The results of the component analysis and ordinal logistic regression further demonstrate that lack of access to safety training, emergency protocols, and support systems exacerbates these challenges. Harassment and insecurity not only compromise the personal well-being of these providers but also hinder the delivery of essential healthcare services, especially in vulnerable and underserved communities. These findings underscore the urgent need for targeted policy interventions, improved workplace protections, and institutional accountability to safeguard the dignity, mental health, and professional functioning of community-based healthcare workers.

1.1 5.3 Recommendations

1. Health departments must regularly conduct mandatory safety training sessions to equip healthcare providers with strategies for managing hostile situations and personal threats during fieldwork.
2. Quick-response teams, emergency hotlines, and community safety protocols should be developed to provide immediate support during threatening incidents.
3. There is a need for strict enforcement of workplace harassment laws, including clear reporting channels, investigation protocols, and legal consequences for perpetrators.
4. Counseling services and stress management programs should be made available to help healthcare providers cope with the psychological effects of workplace violence and harassment.
5. Public awareness campaigns should be launched to sensitize local communities about the roles and rights of community-based healthcare providers, aiming to reduce stigma and aggression.
6. Supervisory bodies must ensure regular monitoring of field conditions, with structured feedback mechanisms to identify and mitigate risks to staff security and well-being.

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