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BRIDGING HEALTHCARE AND COMMUNITY BY EXPANDING THE SCOPE OF MEDICAL SOCIAL WORK IN PUBLIC HEALTH CARE IN SINDH, PAKISTAN: CHALLENGES AND SOLUTIONS

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ABSTRACT:

This research study aimed to bridge healthcare and community and to expand the scope of medical social work in public health care, specifically in Sindh, Pakistan, by identifying challenges and proposing solutions within this context. Using qualitative semi-structured interviews with a sample of 18 participants (or respondents), our study explored the opinions of psychiatric social workers who provide professional help to patients with psycho issues through their service delivery in mental care hospitals, clinics, and community centers. However, our research findings explored many challenges, as expressed by participants during qualitative interviews, including the role ambiguity of health social workers among communities, resource scarcity, community-public power imbalances, the shortage of physical infrastructure, prevalent diseases, cultural barriers to treatment, people with disabilities, the impact of public organizational culture on their service delivery, and patients' education and poverty. Our research suggests that health policymakers in Sindh address those challenges as solutions, thereby effectively enhancing the role and responsibilities of social workers in public health care at the provincial level.

KEYWORDS: Challenges, Communities, Public Health Care, Medical Social Work, Solutions

INTRODUCTION

Medical social work and services, a profession dedicated to enhancing the well-being of individuals and communities, have historically played a crucial role in the intersection of healthcare and societal welfare (1). Originating from late 19th-century efforts to address the social determinants of health, its evolution reflects a bidirectional influence between medicine and social work, profoundly shaping public health practices (2). This interdisciplinary approach recognizes that health outcomes are not solely determined by biological factors, such as child and maternal health, but are also significantly influenced by socioeconomic conditions, cultural contexts, and systemic inequalities (3). Hence, community health services are implicitly interconnected with public health care services in the current century.

In Sindh, Pakistan, this integrated approach is particularly pertinent, as the region grapples with significant disparities in healthcare access and pervasive socioeconomic challenges, especially in rural areas (4). In this context, this paper will explore the expanding scope of medical social work within Sindh province's public health care setting and thoroughly investigate the potential to bridge policy gaps between healthcare institutions and underserved poor communities, thereby fostering more equitable health outcomes.

A previously conducted study (1) concluded that the effectiveness of social work interventions, specifically in less developed regions such as Sindh province in Pakistan, significantly impacts public health policies and challenges the involvement of social workers in health care. Their findings will examine the specific challenges and opportunities for medical social workers in Sindh, advocating for their integral role in multidisciplinary healthcare teams and for the development of robust community-based health initiatives (5). The growing recognition of social workers' contributions in multidisciplinary teams within hospital settings further underscores their capacity to enhance holistic patient care and facilitate inter-professional collaboration, which is often lacking in many developing nations, like Mozambique, Tanzania, Malawi, Zambia, Zimbabwe, South Africa, and the Philippines (6,5,7). Furthermore, the implementation of medical social work in provincial hospitals in countries like Vietnam highlights its potential to significantly improve the quality and efficiency of healthcare services, especially when tailored to specific client needs (8). This becomes particularly vital in regions where social determinants of health, such as poverty, illiteracy, and low social capital, profoundly affect health outcomes and access to care (3). Hence,

the implementation of the Sustainable Development Goals (SDGs) is vital for bridging healthcare and communities as a solution, through efficiency in health services, improvement in health results, and advancement in community resilience, as the independent nature of SDGs only highlights the importance of integration of health care and communities within public health care (9). Hence, there is significant potential to integrate community health care services with public health care services.

Background of Medical Social Work

The historical trajectory of medical social work demonstrates a continuous adaptation to evolving healthcare paradigms, moving from initial efforts focused on individual patient advocacy to a broader public health orientation that addresses systemic inequities and promotes community well-being (10). This evolution has been critical in solidifying the profession's role in addressing the complex interplay between social determinants of health care, particularly evident during global health crises such as the COVID-19 pandemic-related health challenges, where social workers provided crucial interventions, support, and advocacy for vulnerable populations (1). The expansion of medical social work into public health care services in low-income countries like Mozambique further underscores its critical role in promoting health equity and addressing multifaceted challenges through collaboration with public health professionals, thereby advancing the Sustainable Development Goals (SDGs) as elaborated by (6). Thus, the increasing complexity of patient needs and the growing recognition of integrated care necessitate the continued involvement and expansion of medical social work within diverse healthcare systems in Mozambique (11). This integration is essential because medical social workers provide individualised, client-centred support that addresses patients' psychosocial needs, complementing the routine clinical care provided by nurses and physicians and ultimately enhancing treatment adherence and patient satisfaction (12). Various recent studies, amongst others, highlight that the integration of social work in Karachi's public hospitals serves as a vital strategy for patient welfare, yet the efficacy of these services is often undermined by the "stigmatized labour" and high stress levels experienced by frontline workers (1, 13). Furthermore, (13) previously noted that the prevailing perception of these professionals as mere "charity distributors" rather than skilled clinical practitioners limits their role to financial gatekeeping, thereby preventing the provision of standard professional services required to address the complex psychosocial needs of vulnerable populations. This narrow mandate is particularly problematic in Karachi's major facilities like Jinnah Hospital, where the daily influx of 2,500 to 3,000 patients creates an acute demand for counselling and guidance that existing officers, crippled by financial constraints and a lack of local knowledge components in their training, are unable to meet (14). This resulted in a critical disconnect, with non-social work graduates frequently appointed to these roles, further diluting the professional standards necessary for effective interprofessional collaboration within the healthcare system (6). The systemic dysfunction is compounded by a lack of clear career progression beyond the director level and a deficiency in clinical supervision, both of which demotivate practitioners and hinder the proper application of direct practice methods. In addition to these structural deficits, (13) also report that the lack of private counselling rooms in public hospitals compromises patient confidentiality, while the absence of official transport prevents social workers from conducting essential field visits for follow-up care. The authors explain that the professional environment is further constrained by an entrenched hierarchical structure that prioritizes the medical model, positioning physicians as the primary authority figures while often disregarding the specialized competencies of social case workers in patient recovery. Beyond these internal hierarchies, practitioners are increasingly subjected to external interference from political and religious factions when managing sensitive cases like domestic violence or sexual assault, which often compromises their ability to provide impartial advocacy for vulnerable patients (13). This environment is further complicated by the fact that many Social Welfare Officers hold degrees in sociology rather than specialized social work, leading to a profound lack of familiarity with assessment methodologies necessary for clinical case management (13). This study was a qualitative study designed to explore challenges in medical social work in a limited resource region of Sindh, Pakistan.

METHODS

Study Design, Methods and Sampling

This research utilizes a qualitative descriptive approach, conducted during March to May 2025, employing semi-structured face-to-face interviews to capture respondents' perceptions, opinions, and socio-economic descriptive data (15) related to the effective involvement of social workers in bridging psychiatric health care for communities with their enhanced role in public medical care across Sindh,

Pakistan. Using purposive sampling, a qualitative questionnaire was administered to interview 18 psychiatric social workers, working in different types of community health centers, and non-governmental organizations (NGOs), like social service agencies, in collaboration with diverse public or private health institutions, such as psychiatric hospitals and mental health clinics, to evaluate their professional satisfaction and the specific barriers they face with implications of theoretical frameworks in clinical settings to ensure holistic care for patients (16). Following a previous study (6), during the final survey, the semi-structured questionnaire was tested with four respondents to ensure the validity of questions related to the aim of this study and to make minor modifications immediately.

Data Collection and Analysis

Using semi-structured interviews mirroring the aim of the study was to collect qualitative data on a comprehensive range of topics from respondents (or psychiatric social workers) on the role ambiguity of health social workers among communities, resource scarcity, community-public power imbalances, the shortage of physical infrastructure, prevalent diseases, cultural barriers to treatment, people with disabilities, the impact of public organizational culture on their service delivery, and patients' education and poverty. Our qualitative survey results indicate that there were 11 male and 7 female participants, as the number of female social workers is usually lower than that of male social workers due to socio-cultural constraints on women across Pakistan. Furthermore, the results show that the average age of respondents was 35 years, with most holding certificates in university and social work training. On average, psychiatric social workers had 5 years of experience in the field.

RESULTS

A total of 18 participants were included in this study including 11 males and 7 females, aged between 20 to 60 years. A summary of the demographic characteristics is given in Table 1.

Table 1: Socio-economic characteristics of participants (social workers)

Characteristics (Variables)	Statistics/ Number	Average
Age (years)		
20 – 30	4	35
31 – 40	11	
> 40	3	
Education / Training		
Primary education	1	
Secondary education	3	-------
University education	6	
Social training or a degree certificate	5	
Psychology training or a degree certificate	3	
Years of Social work experience (years)	-----	5 years
Total Sample (n) = No. of respondents	**18**	-------

Most the participants had university level education (n=6) or a social training (n=5), only a small number had early education (Table 1). The findings of the study indicate that medical social work in Sindh is severely compromised by a lack of specialized supervisory personnel, as many hospital placements are currently managed by non-professional staff who lack the necessary social work educational background to provide clinical oversight.

Various social workers' opinions are explained as follows;

Oh … many community members don't even know the social worker's status. They perceive social workers as nice human beings who help patients, even without proper education and training. Sometimes, they give some money to social workers as a gift (Respondent 9).

Another respondent was interviewed and explained.

Communities and NGOs have inadequate resources. They rely heavily on donations or charity coming from middle-class and/or poor people. As a result, it affects our health delivery services (Respondent 4).

Many participants expressed that the public organizational health care culture, cultural barriers, patients' education and poverty mainly affect psychiatric social workers' performance. This research, therefore, also explored these issues to bridge the gap between communities and health care with an effective involvement of public health care in Sindh province of Pakistan.

Regarding the above issue, a few participants expressed.

…. We don't see appropriate or supportive consideration from health professionals in the public health sector when performing this social work, on the one hand, especially in marginalized areas. On the other hand, communities have cultural barriers, a lack of education, and poverty, which affect our role and responsibilities (Respondents 2, 6 and 13).

Regarding a question raised about the professional silos and unequal power dynamics that often relegate social workers to secondary status within multidisciplinary teams, various interviewees expressed.

Umm …. We social workers have often found that there is a power inequality, specifically when we perform in multidisciplinary teams. We also found inadequate physical infrastructure and insufficient counselling space for dedicated staff and patients in most hospitals in Sindh province. As a result, these issues stop us from performing private counselling sessions effectively (Respondents 10, 17, 18).

The two interviewees revealed.

Oh . . . shortages of finances are a big challenge in conducting this social work. Low salaries and a shortage of service delivery inputs and infrastructure adversely affect our social work performance (Respondents 1 and 14).

DISCUSSION

Our research findings from Sindh province of Pakistan mirror organizational challenges observed in Saudi Arabia and Iran, where medical social workers are increasingly recognized as vital human resources for national health strategies yet remain constrained by a semi-professional status that triggers high levels of work-related stress and exhaustion (18,19). Driven primarily by the fact that many practitioners are forced to perform non-specialized tasks, such as medicinal procurement and price auditing, for which they have no formal pharmacological training (18). This displacement from clinical practice to clerical oversight is symptomatic of a top-down bureaucratic structure (or power imbalance) where practitioners often follow orders rather than exercising professional discretion, a reality reflected in reports that a significant portion of their daily labor is dictated by administrative mandates rather than patient-centered psychosocial needs (19). This erosion of professional autonomy is further compounded by the communities or public's limited understanding of social casework's specialized reputation in developing countries, like in Sindh, Pakistan, where extreme poverty and inadequate healthcare financial resources currently representing only 2.8% of Pakistan's GDP often reduce the perceived role of the psychiatric social worker to a mere facilitator of financial aid rather than a trained clinician capable of managing complex psychological and economic anxieties (13). This professional distress is further intensified in the Sindh context as practitioners must navigate a "hybrid" role, where they are pressured to adapt to externally dictated organizational policies that favor administrative efficiency over the core clinical values of social inclusivity and patient advocacy (13). In contrast to the private sector, where specialized welfare services for non-affording patients are virtually non-existent, the authors further elaborate that social workers in Sindh's public hospitals must single-handedly manage the "Parchi fee" (or money gift) system and navigate a landscape devoid of any formal government monitoring mechanism to audit service quality or clinical standards. Also, a shortage of infrastructure and space in medical centers poses a big obstacle for social workers when they do psychiatric counselling. Due to a lack of education and specialized training of social workers, in addition to patients' cultural barriers, illiteracy and poverty are other equivalent issues to be addressed if public health policy makers in Pakistan make a health policy in the future, aiming at bridging healthcare and community and expanding the scope of medical social work in public health, specifically in Sindh, Pakistan. Following previously reported stuides (6) and (19), that specifically addressed the professional silos and unequal power dynamics that often relegate social workers to secondary status within multidisciplinary teams, our study also explores that this power imbalance is further intensified by a critical shortage of physical infrastructure, as the lack of dedicated office space in many Sindh province's hospitals prevents social workers from conducting

private counseling sessions, thereby compromising the dignity and confidentiality of patients during sensitive psychosocial assessments.

Moreover, the lack of professional field supervisors in many Sindh hospitals forces students and practitioners to navigate complex psychosocial cases without adequate clinical mentorship, a situation exacerbated by gendered perceptions that frame social work as a welfare-oriented female profession rather than a technical healthcare discipline (20). This perception is deeply rooted in a national cultural ethos that continues to view social work as a voluntary, unpaid activity of a "selfless sort" rather than a paid professional practice, leading to a systemic abhorrence toward the idea of professional social workers receiving wages for what the public considers inherently noble service (14). Consequently, this cultural preference for unpaid sacrifice undermines the development of professional social work education in Pakistan, which struggles to establish a distinct indigenous identity while relying heavily on American philosophical frameworks and techniques that may not fully align with the local socioeconomic reality (21). This theoretical disconnect is further exacerbated by the absence of a "National Council for Social Work Education and Training," leaving the province without standardized licensing or a governing body to distinguish qualified professionals from non-specialized humanitarian actors (14). The above statements align with previous literature, such as studies reported previously (6) and (19), which specifically address professional silos and unequal power dynamics that often relegate social workers to secondary status within multidisciplinary teams. Thus, our study also explored that this power imbalance is further intensified by a critical shortage of physical infrastructure, as the lack of dedicated office space in many hospitals in Sindh province prevents social workers from conducting private counselling sessions, thereby compromising the dignity and confidentiality of patients during sensitive psychosocial assessments. Consequently, the lack of professional authority and institutional autonomy within the broader healthcare hierarchy prevents these workers from executing complex tasks, as their contributions are frequently overshadowed by administrative constraints and the dominance of medical practitioners (19). This systemic marginalisation is further evidenced by data showing that nearly two-thirds of social workers feel they lack the same level of professional authorisation as their medical colleagues, a disparity that actively discourages them from introducing innovative psychosocial interventions or grief counselling techniques (19), (22). The authors further explain that this absence of mentorship is linked to a rigid centralization of authority and outmoded hospital hierarchies that prevent practitioners from participating in key organizational decisions or establishing formal linkages with another medical unit.

The statements of respondant 10, 17 and 18 were aligned with previous literature, such as studies by (6) and (19), which specifically address professional silos and unequal power dynamics that often relegate social workers to secondary status within multidisciplinary teams. Thus, our study also explored that this power imbalance is further intensified by a critical shortage of physical infrastructure, as the lack of dedicated office space in many hospitals in Sindh province prevents social workers from conducting private counselling sessions, thereby compromising the dignity and confidentiality of patients during sensitive psychosocial assessments. Consequently, the lack of professional authority and institutional autonomy within the broader healthcare hierarchy prevents these workers from executing complex tasks, as their contributions are frequently overshadowed by administrative constraints and the dominance of medical practitioners (19). This systemic marginalization is further evidenced by data showing that nearly two-thirds of social workers feel they lack the same level of professional authorization as their medical colleagues, a disparity that actively discourages them from introducing innovative psychosocial interventions or grief counseling techniques (19), (22). The authors further explain that this absence of mentorship is linked to a rigid centralization of authority and outmoded hospital hierarchies that prevent practitioners from participating in key organizational decisions or establishing formal linkages with another medical unit. The research results reveal that the challenges as mentioned above are exacerbated by a significant budgetary shortfall (or shortage of financial resources), with current funding allocations for professional development often amounting to less than 200 dollars per worker, rendering specialized training in advanced psychosocial interventions (17). In addition to these financial constraints, the professional growth of social case work in Sindh has been significantly stunted by a fifteen-year government ban on new appointments that lasted until 2016, a policy gap that forced existing staff to manage Patient Welfare Association funds from sources like Zakat and Bait-ul-Maal without sufficient manpower (13). This personnel deficit is compounded by rigid bureaucratic protocols, as more than half of the surveyed practitioners expressed that inflexible hospital policies and the requirement to refer all minor procedural matters to higher-level administrators severely restrict their ability to respond effectively to immediate social issues (19). The research results reveal that the challenges as mentioned above are exacerbated by a significant

budgetary shortfall (or shortage of financial resources), with current funding allocations for professional development often amounting to less than 200 dollars per worker, rendering specialized training in advanced psychosocial interventions (17). In addition to these financial constraints, the professional growth of social case work in Sindh has been significantly stunted by a fifteen-year government ban on new appointments that lasted until 2016, a policy gap that forced existing staff to manage Patient Welfare Association funds from sources like Zakat and Bait-ul-Maal without sufficient manpower (13). This personnel deficit is compounded by rigid bureaucratic protocols, as more than half of the surveyed practitioners expressed that inflexible hospital policies and the requirement to refer all minor procedural matters to higher-level administrators severely restrict their ability to respond effectively to immediate social issues (19). In detail, the systemic lack of professionalization, coupled with inadequate infrastructure and pervasive resource scarcity, contributes significantly to psychological distress and burnout among healthcare workers, particularly female professionals, in Sindh. This phenomenon is particularly pronounced among women doctors who face significant work-life conflicts, gender discrimination, and an unsafe work environment, leading to high attrition rates within the Pakistani healthcare system (26). Furthermore, medical students themselves frequently report elevated levels of anxiety, depression, and a diminished sense of accomplishment, underscoring a broader systemic issue of mental health challenges within the medical education and practice pipeline (27). These pervasive stressors, compounded by hierarchical institutional structures that limit voice and autonomy, create a challenging environment for fostering a robust professional identity and patient advocacy (28).

The consistent exposure to these demanding conditions, including long working hours and emotional labor, significantly contributes to the elevated burnout rates and mental health issues observed among medical professionals, particularly women in gynecology and emergency departments, across Pakistan (29). This professional burnout is further exacerbated by systemic issues such as poor healthcare infrastructure, high patient loads, and limited career progression opportunities, which are prevalent in many low- and middle-income countries (30). The absence of adequate mental health facilities and the pervasive stigma surrounding mental illnesses exacerbate these issues, with mental health conditions often attributed to supernatural causes (31). These factors collectively contribute to a higher susceptibility to stress, anxiety, and depression among medical students and practicing professionals, hindering the effective provision of patient care and often leading to devastating outcomes such as physician suicide (32,33). Therefore, addressing the root causes of burnout and psychological distress among healthcare workers, especially women, through comprehensive support systems and improved working conditions is crucial for maintaining the well-being of the healthcare workforce and enhancing the resilience of the healthcare system in Sindh. The challenges faced by female healthcare professionals, including medical students, are particularly acute, with studies indicating higher rates of depressive symptoms among them, suggesting a need for gender-specific interventions to mitigate disparities and address the unique stressors they face (35,36).

Our research overall suggests that the combination of social work in Karachi's public hospitals serves as a vital strategy for patient welfare, yet the efficacy of these services is often undermined by the "stigmatised labour" and high stress levels experienced by frontline workers. Keeping in view the above challenges faced by social workers in their roles and responsibilities, while working in parallel with the affected communities, and the challenges they confront, besides their appropriate recognition, the provincial health department, the government of Sindh, Pakistan, must address these challenges appropriately, which already offer solutions, in their health policy in the near future.

CONCLUSIONS:

Our study aimed to bridge healthcare and community and expand the scope of medical social work in the public health sector, specifically in Sindh, Pakistan. Using qualitative semi-structured interviews, with a sample of 18 respondents, our study explored the opinions of psychiatric social workers, working to professionally help psycho patients using their service deliveries, like transportation, patients' admission at public and private hospitals and clinics, psycho social counselling. However, many challenges, as expressed by participants during qualitative interviews, were recognized, including the role ambiguity of health social workers among communities, resource scarcity, community-public power imbalances, the shortage of physical infrastructure, prevalent diseases, cultural barriers to treatment, people with disabilities, and impact of public organizational culture on their service delivery, and patients' education and poverty.

Conflict of Interest

Authors declare no conflict of interest.

Ethical consideration

The study was approved by local Research Ethic Committee.

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