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Management of Intimate Partner Violence: Physician's Readiness in Southwestern Nigeria (Management of Intimate Partner Violence)

Olaleye Atinuke O[1], Jagun Omodele O[2]*, Ajose Adeola A[1], Sokeye Elizabeth O[3], Omotosho Adebola[3] and Ekor Oluwayemisi[2]

[1]*Department of Obstetrics and Gynecology, Babcock University Teaching Hospital, Ilishan-Remo, Ogun, Nigeria*
[2]*Department of Surgery, Babcock University Teaching Hospital, Ilishan-Remo, Ogun, Nigeria*
[3]*Department of Community Medicine, Babcock University Teaching Hospital, Ilishan-Remo, Ogun, Nigeria*

Introduction

Intimate partner violence [IPV] also historically called domestic violence(D), describes any physical, sexual or psychological harm by a current or former intimate partner or spouse with the intent of causing pain, distress or injury [1]. It is an issue of global concern that violates the law of basic human rights because many cultures still accept harmful traditional practices towards women e.g. marital rape, female genital mutilation [2]. Domestic violence forms a pattern of behaviour and control which takes a variety of forms. These include physical assault [ranging from bruises, major injuries and homicide], psychological abuse (threats, intimidation, and degrading humiliating behavior), sexual coercion and controlling behaviour (isolation from family or friends and restriction of freedom of movement or control over resources) [3].

UNICEF applies the term "domestic violence," for family and intimate partner violence. It includes violence that is perpetrated by intimate partners and other family members, and that is manifested through physical abuse, sexual abuse, psychological abuse, economic abuse, and acts of omission [4]. Traditionally, domestic violence is committed against females; however, both women and men experience domestic violence but the prevalence and impact, particularly of sexual and severe physical violence, is higher among women [5].

Domestic violence is widespread and the common forms of violence against women in Nigeria are rape, acid attacks, molestation, wife beating, and corporal punishment [6]. In a nationwide survey on crime victimization and safety, the CLEEN Foundation reported that 1 in every 3 respondents (30%) admitted to being a victim of domestic violence. The survey also found a nationwide increase in domestic violence over 3 years from 21% in 2011 to 30% in 2013 [7]. It was further revealed that domestic violence ranks among the top four most common victimizations in Nigeria [7].A recent community-based survey of IPV among married women in an urban area of Lagos, Nigeria revealed lifetime prevalence for physical violence, sexual violence and psychological violence of 50.5%, 33.8% and 85.0% respectively [8].

A hospital-based retrospective survey of DV survivors in Lagos, Nigeria showed that none of them were referred for psychotherapy nor had forensic specimens collected in cases of rape after seeing a physician even though 73.1% knew their assailants [9]. Previous studies have indicated a low prevalence of screening amongst health care specialists, and in one of such studies only 6% physicians indicated screening for IPV when suspected and 10% said they have never screened for IPV [10]. A meta-analysis of several studies has highlighted some common barriers which may be the cause for this low screening as time constraints indicated by 82% of physicians, lack of knowledge or training on the issue [68%] and inadequate follow up resources and support staff [63%] [11].

The medical community is one of the institutions most likely to see women victims and as such constitutes a frontline of identification and intervention. Women experiencing abuse have frequent contact with primary care clinicians [12], and the prevalence of domestic violence among women seeking health care is also higher than in the general population [13]. Battered women often visit primary care physicians for a variety of medical complaints, such as abdominal pains, headaches, and sleep disorders. Pregnancy in particular appears to be a high risk factor for abuse [14]. Hence, health care workers constitute an important potential source of help and support for these women.

Domestic violence often leads to chronic physical and mental health problems, such as depression, anxiety, posttraumatic stress disorder and suicide [15], but historically, the quality of care for women experiencing abuse has been poor worldwide [16]. In addition, physicians and other medical staff are rarely provided with training or specific protocols to aid in dealing with these cases. Thus they lack knowledge on management, thereby consequently providing sub-optimal care to domestic violence survivors [17]. Many clinicians agree that domestic violence is a healthcare issue, but are often reluctant to ask about abuse or do not respond appropriately if domestic violence is disclosed [18]. Such ambivalence is attributed to a number of factors but commonly cited barriers include the lack of knowledge, training, patient disclosure, self-efficacy, system level support, and time [18].

The cost of the failure to identify and intervene in violence is incalculable, particularly in violence by intimates, since assaults tend to be repeated over time, produce more injuries than assaults by strangers, and have complicated sequel with implications for further morbidity [19] Domestic violence affects women's ability to engage in safe sexual relations, free from coercion or disease, make choices regarding pregnancy or fertility regulation, go through pregnancy safely or seek appropriate healthcare for self or family [20]. In a survey that asked 836 rural and urban dwelling women in South Eastern Nigeria to state the people to whom they made reports of domestic violence, physicians had the lowest ranking behind family/in-laws, law enforcement officers and clergy [21].

Consequently, this study is being conducted to assess the knowledge and preparedness of physicians in Ogun state, South Western Nigeria on the management of IPV, and to identify barriers encountered by them in screening for IPV. It is expected that findings from this study

***Corresponding author:** Jagun Omodele O, Department of Surgery, Babcock University Teaching Hospital, Nigeria, Tel: 234 8023184198; E-mail: omodelly@yahoo.com

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will serve as a platform for the development of appropriate protocols for the management of IPV, and also contribute to the improvement of physicians' skills for managing victims of IPV.

Justification

Although violence against women is pervasive, there are only few studies documenting the magnitude of the problem with regards to screening and management from the physicians' perspective in Nigeria [22].

Despite the growing interest about DV, studies on the magnitude, precipitating factors and consequences for women and their families remains scarce in most developing countries including Nigeria. In the absence of such data, many policy makers including those in the health institutions have been reluctant to address the issue, given that it touches on what has traditionally been viewed as a highly personal and sensitive aspect of family life. The paucity of information has similarly impeded the formulation of sound and effective programs to address it, most notably in the area of training and institutional protocols for managing victims of IPV.

It is not known to what extent medical doctors in South Western Nigeria are trained to respond to female patients experiencing DV. Thus this study seeks to fill this knowledge gap by determining the knowledge and perception of physicians regarding intimate partner violence in Ogun State, Nigeria. Specifically it will assess the knowledge and preparedness of physicians in Ogun state, south western Nigeria on the management of IPV, and identify barriers encountered by them in screening for IPV.

Objectives

- To assess the knowledge of physicians on intimate partner violence.
- To evaluate physicians' readiness for the management of intimate partner violence.
- To identify barriers encountered by physicians in screening for intimate partner violence in Ogun state, Nigeria.

Materials and Methods

Study location

Ogun state is one of the thirty six states in the Federal Republic of Nigeria. The state is located in South West Nigeria with its capital in Abeokuta and covers an area of 16,762 square kilometres [sqkm], between latitude 6.20N and 7.80N and longitude 3.00E and 5.00E. It is bordered by Lagos State to the South, Oyo and Osun States in the North, Ondo State to the East and the Republic of Benin to the West [23].

Sampling technique

A cross-sectional survey was conducted among all the medical doctors working in the four tertiary hospitals in Ogun State i.e.: Babcock University Teaching Hospital, Ilishan, Olabisi Onabanjo University Teaching Hospital, Sagamu, Federal Medical Centre, Abeokuta and Neuro-Psychiatric Hospital, Abeokuta.

Data collection was done with a standardized self-administered structured questionnaire which consisted of the PREMIS toolkit and modified DVHPSS questionnaires. The instruments were adapted for use in the study environment after pre-testing on physicians in the secondary health facilities. A convenience sampling of 200 doctors was done in the four tertiary health facilities, during the clinic days of each specialty in addition to the laboratory specialties. Descriptive statistics and multivariate analysis were carried out at 0.05% level of significance. All data collected was entered and analyzed using the SPSS version 17 package.

The Physician Readiness to Manage Intimate Partner Violence Survey (PREMIS) is a questionnaire developed and validated in the USA [24]. It comprises five sections: Respondent profile, Background (including perceived preparedness and knowledge), Actual knowledge, Opinions, and Practice issues [25]. The section of opinions was modified based on a shortened version of the Domestic Violence Healthcare Providers' Survey Scales [DVHPSS] questionnaire which was developed and validated in Sweden and Nigeria [26,27]. The items on physician readiness opinions were grouped into five factors namely: Perceived self-efficacy, Fear of offending patients, Victim personality/trait, Professional role resistance and Victim disobedience. Responses to the questions on these factors were scored on a 5-point Likert scale of agreement.

For this study, knowledge of IPV was categorised based on number of correct answers into: Good knowledge (7-9), Fair knowledge (4-6) and Poor knowledge (0-3).

This study was conducted in accordance with the regulations of the Health Research Ethics Committee of Babcock University Teaching Hospital, Ogun State, Nigeria. (NHREC/17/12/2013, BUHREC084/15)

Results

Two hundred out of about 280 doctors who work in the four tertiary hospitals were randomly given the self-administered questionnaires. However, 155 (77.5%) responded, out of which 140 were completely filled and were thus analysed. The demographic distribution of the respondents is as shown in Table 1. Most of the respondents were male (65%), married (68.6%), Christian (88.6%) and from the Yoruba ethnic group (81.4%). The mean age of respondents was 34.5years, with about half (53.6%) of them being within the 31-40year age group.

The junior residents comprised the majority of the respondents (57.9%), while the mean number of patients seen weekly was 38, and 11.4% of the respondents did not directly attend to patients in their

Variable	Frequency	Percent
Gender		
Male	91	65
Female	49	35
Ethnicity		
Yoruba	114	81.4
Igbo	21	15
Hausa	--	--
Other	5	3.6
Religion		
Christianity	124	88.6
Islam	15	10.7
Other	1	0.7
Marital status		
Single	43	30.7
Married	96	68.6
Divorced/separated	1	0.7

Table 1: Socio-demographic details of respondents.

Variable	Frequency	Percent
Designation		
Consultant	16	11.4
Senior resident	20	14.3
Resident	81	57.9
Senior Medical Officer	7	5
Medical/Dental Officer	11	7.9
House officer	5	3.6
Mean number of patients seen weekly		
Not seeing patients	16	11.4
<20	21	15
20-39	49	35
40-59	24	17.1
60-79	15	10.7
80-99	6	4.3
≥100	9	6.4

Table 2: Occupational profile of respondents.

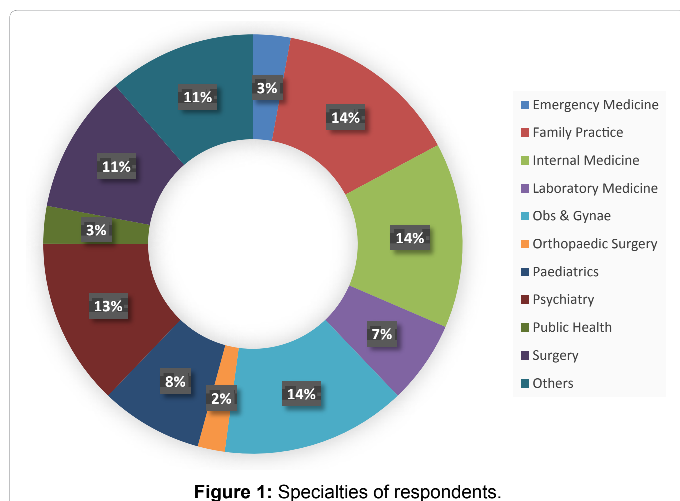

Figure 1: Specialties of respondents.

Variable	Frequency	Percent
Poor knowledge (≤ 3 correct)	43	30.7
Fair knowledge (4-6 correct)	93	66.4
Good knowledge (≥7 correct)	4	2.9

Table 3: Level of actual knowledge of respondents.

Cadre	Poor (%)	Fair (%)	Good (%)	Total
Consultant	5 (31.3)	10 (62.5)	1 (6.3)	16
Senior resident	6 (30.0)	13 (65.0)	1 (5.0)	20
Resident	24 (29.6)	55 (67.9)	2 (2.5)	81
SMO	1 (14.3)	6 (85.7)	0	7
MO	5 (45.5)	6 (54.5)	0	11
House Officer	2 (40.0)	3 (60.0)	0	5

Table 4: Actual knowledge of respondents about IPV according to cadre.

practice (Table 2). The average duration of practice of the respondents was 8.1years. The specialties majorly represented were Internal medicine, family practice, and Obstetrics & Gynaecology were mainly represented (14.3% each). (Figure 1)

Physicians had very low levels of IPV/DV training. Only one respondent had received training in domestic violence (DV) within the preceding 6 months of the survey. Furthermore, 40.8% of the physicians had received no form of IPV/DV training, and of those who had, it was mainly during the residency/ postgraduate (8.0%) and undergraduate/ medical school (15.5%) programs.

Concerning actual knowledge about IPV, about two-thirds of the physicians (66.4%) had a fair knowledge of IPV, while 30.7% and 2.9% had poor and good knowledge respectively (Table 3). This finding was similar among the different cadre of staff (Table 4) The majority of clinicians had a good understanding of the clinical documentation of reasons for IPV concerns, occurrence of strangulation injuries in IPV and ensuring safety for IPV victims during consultation. However, less than half (40%) of respondents knew that being supportive of a patient's choice to remain in a violent relationship does not condone the abuse, while only 9.3% knew that the greatest risk for injury is when women experiencing abuse are leaving the relationship.

Levels of perceived preparedness to manage domestic violence patients were low for all items. Notably, only about one-third of respondents reported feeling well prepared to ask appropriate questions about IPV (Figure 2). Clinician's scores for perceived knowledge also reflected those for their perceived preparation (Figure 3).

Concerning the perceived self-efficacy of the physicians regarding IPV, majority of the respondents (78.6%) felt they had strategies to help IPV victims, that they (62.1%) could make appropriate referrals for such victims and that they (65%) had time to ask about IPV in their practice. However, information detailing IPV management was not perceived to be readily accessible by 53.5% of the respondents. In addition, though most of the physicians (85.7%) agreed that medical social work personnel can help manage IPV patients, only about half of the respondents (49.3%) had ready access to medical social workers or community advocates to assist in the management of IPV (Table 5).

Fear of offending the patient or invading their privacy was not seen as a barrier to IPV screening by most of the respondents. More than a quarter of physicians attributed the victim's personality/trait to occurrence of abuse. 32.1% agreed people are victims only if they choose to be. 61.4% even agreed that there are patients whose personalities cause them to be abused. (Table 5)

There was little professional role resistance among the respondents, as most felt that investigating IPV is a part of medical practice. A sizeable proportion of respondents also either agreed or was uncertain about the fact that women who choose to step out of traditional roles are a major cause of IPV (42.1%). Psychiatric support in the form of institutional mental health services was perceived to be readily accessible and adequate for IPV victims by majority of the respondents (62.8%). (Table 5)

The perceived preparedness of the respondents regarding the management of IPV victims was significantly predicted by the level of their perceived knowledge of the issue. Other factors such as respondents' age, duration of practice, gender, specialty, previous DV training and actual knowledge of IPV were not significant predictors of their level of perceived preparedness. (Table 6)

Discussion

Intimate Partner Violence (IPV) against women is now recognized as a problem of global magnitude, owing to its detrimental consequences on the health, social and economic welfare of women and their children.1-3 It is a life-threatening problem primarily affecting women and girls and it has been documented as the third leading cause of mortality among females of reproductive age [28,29] Indeed, it often

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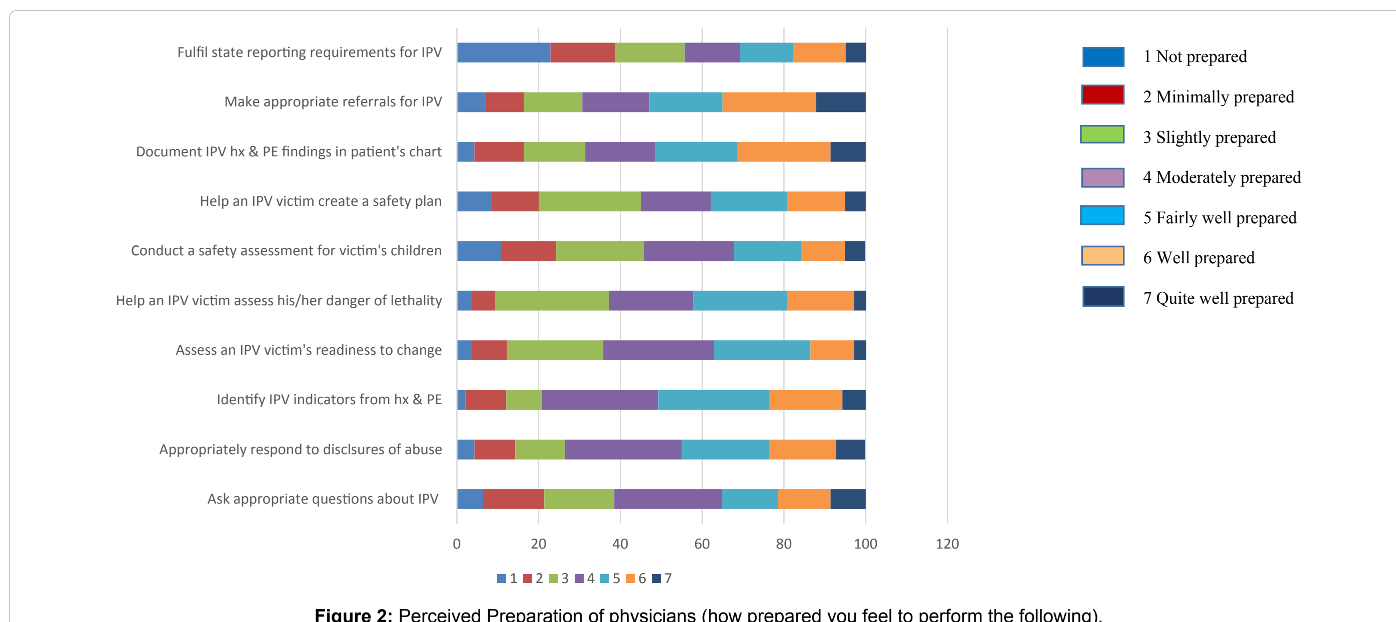

Figure 2: Perceived Preparation of physicians (how prepared you feel to perform the following).

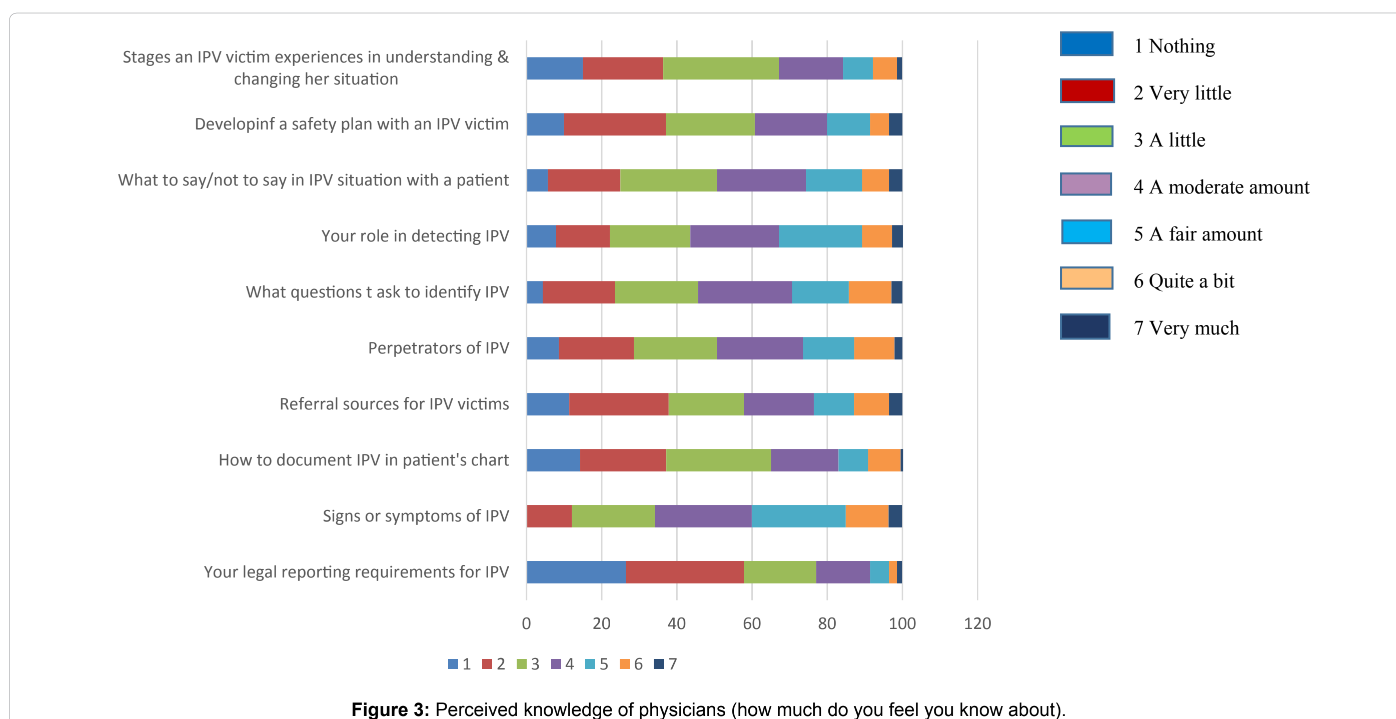

Figure 3: Perceived knowledge of physicians (how much do you feel you know about).

has grave consequences for the individuals involved, their family and the society at large.

In this study, most of the respondents were male, married, Christian and from the Yoruba ethnic group. The registrars constituted a large proportion of the respondents, and they are also usually the first line physicians seen by the patients in the tertiary hospitals. Specialties of family practice, internal medicine and Obstetrics & Gynaecology are also common locations for presentation of IPV victims, after the emergency room.

Physicians in this study had low levels of IPV pre- and post-qualification training. In-service training was also poor as only one person had received such training in the 6 months preceding this survey. Similar low levels of DV/IPV training has been reported amongst health providers in previous studies [17,25] though an inverse high level of 80% was reported in one study [10]. A key recommendation of WHO regarding IPV training is the inclusion of first-line response competence in the curriculum for all clinicians before and after qualification. There is evidence of the effectiveness of training, particularly when linked with referral pathways to support programs for women experiencing IPV [30]. In Nigeria, however, this subject is still basically absent from the curricula of most medical schools, at both undergraduate and postgraduate levels.

A significant proportion of respondents agreed that they had time

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Factor	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
I have no time to ask about IPV in my practice	1.4	16.4	17.1	53.6	11.4
There are strategies I can use to help victims of IPV change their situation	20	58.6	20.7	0.7	0
I feel confident that I can make the appropriate referrals for abused patients	15.7	46.4	32.1	5	0.7
I have ready access to information detailing management of IPV	5	17.1	24.3	46.4	7.1
I have ready access to medical social workers or community advocates to assist in the management of IPV	10.7	38.6	18.6	28.6	3.6
I feel that medical social workers can help manage IPV patients	20	65.7	10	3.6	0.7
Fear of offending patients					
I am afraid of offending the patient if I ask about IPV	1.4	8.6	5.7	62.1	22.1
Asking patients about IPV is an invasion of their privacy	0.7	5.7	7.1	56.4	30
If I ask non-abused patients about IPV,they will get very angry	0.7	6.4	29.3	47.1	16.4
Victim personality/ trait					
A victim must be getting something out of the abusive relationship, or else s/he will leave	1.4	27.1	17.9	34.3	19.3
People are only victims if they choose to be	7.1	25	8.6	44.3	15
When it comes to DV victimization, it usually "takes two to tango"	5.7	35.7	15	32.1	11.4
I have patients whose personalities cause them to be abused	9.3	52.1	18.6	16.4	3.6
Victim's passive-dependent personality leads to abuse5.7	51.4	21.4	18.6	`	2.9
Professional role resistance					
It is not my place to interfere with how a couple chooses to resolve conflicts	3.6	15	17.9	48.6	15
Investigating the cause of IPV is not part of medical practice	3.6	5	10.7	53.6	27.1
If patients do not reveal abuse to me, then they feel it is none of my business	2.1	25	18.6	42.1	12.1
Victim disobedience					
Women who choose to step out of traditional roles are a major cause of IPV	1.4	21.4	19.3	40.7	17.1
The victim has often done something to bring about violence in the relationship	0	14.3	19.3	47.1	19.3
Psychiatric support					
I have ready access to mental health services Should our patients need referrals	22.1	50	8.6	15.7	3.6
I feel that the mental health services at my hospital can meet the needs of IPV victims in cases where they are needed	21.4	41.4	18.6	14.3	4.3

Table 5: Opinions of respondents regarding IPV (modified DVHPSS).

Variables		Standard Error	Wald	df	Sig.	Odds Ratio (OR)	95% C.I.	
							Lower	Upper
Previous training	0.234	0.428	0.3	1	0.584	1.264	0.546	2.925
Age	1.022	0.701	2.126	1	0.145	2.778	0.703	10.969
Duration of practice	-0.595	0.71	0.704	1	0.401	0.551	0.137	2.215
Actual knowledge	-0.25	0.426	0.345	1	0.557	0.779	0.338	1.795
Perceived/Felt Knowledge	2.639	0.529	24.873	1	0	14.001	4.963	39.501
Specialty (ref non-clinical)	-0.056	0.524	0.012	1	0.914	0.945	0.338	2.641
Sex (ref Female)	0.199	0.439	0.205	1	0.651	1.22	0.516	2.884
Constant	-0.501	0.615	0.662	1	0.416	0.606		

Table 6: Logistic regression table on Perceived preparedness of respondents.

to ask about IPV in their practice. This finding differs from previous studies where time constraint was often reported as a provider barrier to IPV screening [31,32]. The low mean number of patients seen weekly by the physicians in this study may account for this response. However, this finding underscores the fact that physicians in this environment may consider incorporating screening for domestic violence into their clinical consultations if other barriers are tackled.

Actual knowledge about IPV was quite low, as only 2.9% of the total respondents had good knowledge of the questions asked although majority (66.4%) had a fair level of knowledge. This low level of IPV knowledge has also been reported by other researchers [17]. Evidence from various studies shows that the high prevalence of violence against women brings them into regular contact with physicians. However, physicians frequently treat the injuries but fail to recognize the underlying abuse [14] Treating only the injuries and symptoms of abuse will not address the ongoing family violence that predicates the women's health issues. When physicians do not diagnose abuse, it is quite likely to persist or even worsen [11].

The majority of clinicians had a good understanding of the clinical documentation of reasons for IPV concerns, occurrence of strangulation injuries in IPV and ensuring safety for IPV victims during consultation. However, physicians in this study lacked the confidence to manage victims of IPV, as the levels of perceived preparedness to manage domestic violence patients were generally low for all the items studied. These included issues such as asking appropriate questions about IPV, appropriately responding to disclosures of abuse, safety assessment and plans for IPV victims and their children as well as fulfilment of state reporting requirements for IPV. This low result is corroborated by the

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research of Ramsay and colleagues [25] among general practitioners and nurses in the UK.

The significant predictor of the respondents' level of perceived preparedness to manage IPV victims was the level of their perceived/felt knowledge about IPV, while the actual knowledge of the respondents did not significantly predict this. It thus implies that more effort needs to be put into the training of physicians at all levels regarding IPV, to ensure that the knowledge imparted is applied in their practice. Moreover, the confidence level of the physicians for managing IPV may be boosted by increased access to practical rather than theoretical resources such as IPV-specific protocols and referral sources.

With the repetitive nature of IPV in most instances, the traditional medical model of management comprising short term patient compliance with the treatment of acute problems may not suffice. In the management of patients with chronic diseases such as cardiovascular disease and diabetes mellitus, a documented successful approach is that of a disease and care management (D&CM) model with the introduction of "care manager" nurses, trained to serve as a bridge between physicians, specialists, and patients, while ensuring a patient-centred care. Results show that the approach was feasible and highly effective in increasing patient health knowledge, self-management skills, and readiness to make changes in health behaviors [33]. Adaptation and integration of the care manager into the management of IPV victims may help to empower such clients to change or improve their situation. Further studies are however required to establish this potential opportunity.

Limitations

There were some incompletely filled questionnaires which were excluded from the study. However, the respondents affected were of similar characteristics to those who filled the questionnaires completely.

The use of structured questionnaires precluded the assessment of the factors underlying the personal opinions of the respondents. However, this approach was used due to the number of respondents in the survey and the busy nature of their profession. Thus, further exploratory studies would be required to elucidate such issues.

Conclusion

Physicians in Ogun state have inadequate knowledge of IPV, and require more access to information on its management. Though their attitude towards IPV victims is generally positive, further education is necessary to correct misconceptions. The development and dissemination of institutional protocols for IPV management and state legal reporting procedures will help improve physicians' competence for managing IPV victims.

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