



ORIGINAL ARTICLE

Barriers for domestic violence screening in primary health care centers

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Received 12 May 2012; accepted 9 July 2012

Available online 9 August 2012

KEYWORDS

Battered women;
Screening;
Barriers;
Primary health care

Abstract *Backgrounds:* Violence against women is an important public health problem that draws attention of a wide spectrum of clinicians. However, multiple barriers undermine the efforts of primary health care workers to screen battered women.

Objectives: Reveal barriers that might impede screening of women for domestic violence and compare the list of barriers of physicians and nurses.

Methods: An observational cross-sectional study was carried out in primary health care centers located in two randomly selected health regions in Kuwait. The study involved all available physicians (210) and nurses (464) in the selected centers. The overall response rate was 54.3%. A self-administered questionnaire was used for data collection.

Results: Barriers related to the battered woman herself topped the list of ranks for both physicians ($92.9 \pm 19.7\%$) and nurses ($85.9 \pm 17.6\%$), $P = 0.02$, followed by women culture in general ($89.5 \pm 17.2\%$ for physician and $83.8 \pm 20.8\%$ for nurses, $P = 0.38$), then health administration

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Peer review under responsibility of Alexandria University Faculty of Medicine.



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barriers ($78.7 \pm 22.4\%$ for physician and $72.5 \pm 26.4\%$ for nurses, $P = 0.04$). Barriers related to the examiner appeared at the bottom of the list ($67.8 \pm 26.9\%$ for physician and $69.9 \pm 28.6\%$ for nurses, $P = 0.01$).

Conclusion: Medical staff face major barriers in screening for domestic violence against women in the primary health care centers. Specifically tailored programs are required to enhance both knowledge and skills of the health care staff about the screening process. Infrastructure and physical environment needs modification to facilitate screening of women.

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1. Introduction

Intimate partner violence (IPV) is defined as physical or sexual violence or threats of violence made by one partner to another, often accompanied by controlling behaviors.¹ IPV is common and has serious impacts on the health of affected women.^{1,2} Early identification of abuse has been a priority in efforts to improve health care response to intimate partner abuse.³ Collecting these data will uncover the scope of the problem and illuminate the social conditions associated with this harmful behavior.⁴

Several medical organizations recommended screening for intimate partner abuse.⁵ A systematic review reported that most studies on screening for IPV in health care settings found that screening detected more abused women than non screening.⁶ Surveys indicate that 43–85% of female respondents consider screening in health care settings acceptable, although only one third of physicians and half of emergency department nurses favored screening.⁶

There are many factors that might interfere with screening of women for violence. The evidence on how to screen and effectively intervene once problems are identified is limited, and few clinicians routinely screen patients who do not have apparent injuries.^{7–10} Although, direct inquiry by physicians facilitates disclosure,^{10,11} yet physicians often fail to inquire about IPV risk owing to lack of time, more pressing acute medical problems, discomfort, fear of offending the patient, and lack of familiarity with resources.^{12–14} What adds to the complexity of the problem is refraining of many women, despite frequent visits to the health care centers, to disclose their experience of IPV to the health care staff due to feelings of shame.^{15–18} All these factors, combined, may result in a missed opportunity to intervene and even prevent multiple types of harm that women could suffer. Thus, the current study was formulated to reveal barriers of screening battered women in the primary health care (PHC) centers and compare the list of barriers with the opinion of physicians and nurses.

2. Methods

An observational cross-sectional study design was adopted for this study. The study was carried out in the PHC centers located in two randomly selected health areas (Capital and Jahra) out of five in Kuwait. The total number physicians and nurses working in the selected centers was 239 and 510 respectively. All available physicians (210) and nurses (464) during the field work of the study in the selected centers were the target population of this study. Out of these, only 366 (128 physicians and 238 nurses) agreed to share in the study with an overall response rate of 54.3% (61.0% and 51.3%,

respectively) The study covered the period from August 2011 to February 2012. Data were collected over three months starting from September to December, 2011.

Data of this study were collected through a specially designed questionnaire. This questionnaire consisted of several sections. The first section dealt with socio-demographic characteristics, including age, sex, nationality, marital status, educational qualification, and current job. The suggested screening tool consisted of 26 statements covering four domains. The first domain dealt with barriers related to women culture and involved 7 statements. The second aspect consisted of six statements about barriers of examiners. Eight statements were assigned for barriers related to the health administration system. The last part consisted of five statements and dealt with barriers related to the victim herself. Participants were asked if they agree or not about these statements. For each statement score “1” was given for positive answer and score “0” for negative answer. The total percentage score for each domain was calculated as well as the overall score.

A pilot study was carried out on 30 physicians and nurses (not included in the final study). This study was formulated with the following objectives: test the clarity, applicability of the study tools, accommodate the aim of the work to actual feasibility, identify the difficulties that may be faced during the application. Also, the time needed for filling the questionnaire by the staff was estimated during this pilot study. The necessary modifications according to the results obtained were done, so some statements were reworded. Also, the structure of the questionnaire sheet was reformatted to facilitate data collection.

A pre-coded sheet was used. All questions were coded before data collection. This facilitates both data entry and verification as well as reduces the probability of errors during data entry. Data were fed to the computer directly from the questionnaire without an intermediate data transfer sheet. The Excel program was used for data entry. A file for data entry was prepared and structured according to the variables in the questionnaire. After data were fed to the Excel program; several methods were used to verify data entry. These methods included simple frequency, cross-tabulation, as well as manual revision of entered data. Percent score was calculated for the total attitude score as well as for each domain of attitude.

All the necessary approvals for carrying out the research were obtained. The Ethics Committee of the Kuwaiti Ministry of Health approved the research. A written format explaining the purpose of the research was prepared and signed by the physician before filling the questionnaire. In addition, the purpose and importance of the research were discussed with the director of the health center.

2.1. Statistical analysis

Before analysis; data were imported to the Statistical Package for Social Sciences (SPSS) which was used for both data analysis and tabular presentation. Descriptive measures were utilized (count, percentage, arithmetic mean and standard deviation) as well as analytic measures (Chi square for qualitative variables and Student's *t* test for normally distributed quantitative variables). Mann–Whitney test was used for non parametric variables. Multiple linear regression was used to identify significant factors after controlling for the confounding effect of other variables. The level of significance selected for this study was $P \leq 0.05$.

Stepwise multiple regression analysis was utilized to identify the significant factors correlating with the overall percent score of barriers for screening. Age, duration at work, nationality, gender, and marital status were used as co-variates. A score of one was used for physician and a score of 2 was used for being a nurse.

3. Results

Table 1 shows socio-demographic characteristics of the studied physicians and nurses. Physicians were significantly older than nurses (40.6 ± 9.0 years compared with 34.0 ± 7.0 years, $P < 0.001$) and spent more years at the current job (13.4 ± 8.1 years compared with 9.5 ± 7.1 years, $P < 0.001$). Physicians also, had higher educational qualification than nurses (71.9% had high qualification compared with 11.3%, $P < 0.001$). The majority of nurses were of Non Arab nationality (68.9%) while the majority of physicians were Arabs (58.6%) and Kuwaitis (35.9%), the latter nationality constituted only 5.0% of nurses, a difference that was a statistically significant. Singles were more likely encountered among nurses (15.1%) than physicians (10.9%) while currently married constituted 89.1% of physicians compared with 84.9% of nurses. However, these differences were not statistically significant, $P = 0.27$.

Tables 2 and 3 show barriers for screening women for domestic violence (DV) as stated by physicians and nurses. Barriers related to the battered woman topped the list of domains

of barriers followed by barriers related to status of women, while barriers related to the examiner can be seen at the bottom followed by health administration barriers. Also, physicians tended to have higher scores on all the domains except for the domain dealing with barriers of the examiners, where the nurse had a higher mean% score however, the difference is not statistically significant ($69.9 + 28.6\%$ compared with $67.8 + 26.9$, $P = 0.384$). However, the individual statements constituting this domain showed significant differences between the two groups. Nurses were more likely to admit that they were not convinced with the importance of screening (76.1% compared with 50.8%, $P < 0.001$) as well their lack of experience that impeded screening (63.9% compared with 46.1%, $P = 0.001$), while physicians stated that they were insufficiently trained (82.8% compared with 69.3%, $P = 0.005$). Physicians tended to have a significantly higher score on the health administration barriers than nurses ($78.7 + 22.4\%$ compared with $72.5 + 26.4\%$, $P = 0.038$). Generally speaking, the same pattern can be observed for the barriers related to women culture with an overall mean percent score of $89.5 + 17.2\%$ for physicians and $83.8 + 20.8\%$ for nurses, $P = 0.023$. Also the barrier domain dealing with the victim herself showed similar patterns to the previous ones with an overall percent score of $92.9 + 19.7\%$ for physicians and $85.9 + 27.6\%$ for nurses, $P = 0.007$. Overall, physicians tended to have a higher mean percent score for the grand total barrier domain than nurses ($81.9 + 15.6\%$ compared with $77.5 + 20.1\%$), however, the difference is not statistically significant $P = 0.112$.

Stepwise multiple regression analysis revealed that, after confounding for the effect of other variables, the job (physician or nurse) was the only factor associated with the barrier score for screening women for DV. The model produced the following equation: screening barrier score = $86.18 - 4.33$ (physician/nurse job).

4. Discussion

Identification of and intervention in domestic violence are critical to providing comprehensive patient care.¹⁹ Several national medical organizations have developed practice guidelines for IPV that encourage routine screening and interventions.²⁰ In the US, the Family Violence Prevention Fund Consensus Guidelines recommended that all adolescent and adult patients should be routinely asked about DV.²¹ Although, there is ongoing debate about the evidence for screening or routine enquiry, there is unquestionably a need for clinicians to ask about DV more often than they currently do.⁶

A study of women attending general practices in east London found that only 17% of women experiencing IPV reported that their doctor had asked them about DV.²² It is known that women who are experiencing violence want to disclose this to trusted doctors and get support,¹⁸ but that a high proportion of women who are experiencing abuse do not disclose this spontaneously in clinical consultations.²²

The current study was designed to reveal the barriers that might impede PHC medical staff to screen battered women and to reveal the differences between physicians and nurses. The results of this study showed that there are real major barriers facing the medical staff to screen for DV against women in the PHC centers. Physicians tended to admit a higher mean percent score of overall barriers than nurses. However, this

Table 1 Socio-demographic characteristics of physicians and nurses.

Characteristics	Physicians (<i>n</i> = 128)		Nurses (<i>n</i> = 238)		<i>P</i> -value
	No.	%	No.	%	
<i>Age (years)</i>					
<30	12	9.4	70	29.4	<0.001*
30–	22	17.2	74	31.1	
35–	29	22.7	48	20.2	
40–	27	21.1	23	9.7	
>45	38	29.7	23	9.7	
<i>Sex</i>					
Male	68	53.1	23	9.7	<0.001*
Female	60	46.9	215	91.3	
<i>Nationality</i>					
Kuwaiti	46	35.9	12	5.0	<0.001*

Table 2 Barriers for screening women suffering from domestic violence stated by physicians and nurses at primary health care units.

Type of barriers	Physicians		Nurses		P χ^2 test
	No.	%	No.	%	
<i>Barriers related to women culture (B1)</i>					
–Feudal and traditional families	116	90.6	213	89.5	(0.733)
–Religious factors	98	76.6	199	83.6	(0.100)
–Low education level	110	85.9	195	81.9	(0.327)
–Fear from husband	117	91.4	188	79.0	(0.002) ^a
–Feeling of embracement	121	94.5	208	87.4	(0.031) ^a
–Fear from insult and failure	116	90.6	189	79.4	(0.006) ^a
–For the sake of children and her life	124	96.9	204	85.7	(0.001) ^a
<i>Barriers related to the examiner (B2)</i>					
–Insufficient training	106	82.8	165	69.3	(0.005) ^a
–Feeling of embracement	99	77.3	162	68.1	(0.061)
–Fear of revenge by the husband or relatives	89	69.5	167	70.2	(0.899)
–Not convinced with screening importance	65	50.8	181	76.1	(< 0.001) ^a
–Personal experience impedes interference	59	46.1	152	63.9	(0.001) ^a
–Lack of staff	102	79.7	172	72.3	(0.119)
<i>Barriers related to health administration (B3)</i>					
–Lack of training	113	88.3	192	80.7	(0.063)
–Lack of knowledge on legality of violence	118	92.2	205	86.1	(0.086)
–Time constraints	116	90.6	191	80.3	(0.010) ^a
–Heavy workload of health care workers	117	91.4	191	80.3	(0.005) ^a
–Health staff can not help	93	72.7	135	56.7	(0.003) ^a
–Health staff experience the same abuse	68	45.3	127	53.4	(0.142)
–Need of increased authorization	103	80.5	179	75.2	(0.254)
–Shame of asking questions about abuse	88	68.8	160	67.2	(0.766)
<i>Barriers related to the victim (B4)</i>					
–Hide and endure abuse despairingly	121	94.5	205	86.1	(0.014) ^a
–Turning back to the same environment	121	94.5	198	83.2	(0.002) ^a
–Afraid of the repeat of abuse	118	92.2	203	85.3	(0.055)
–Lack of knowledge on legal rights	115	89.8	206	86.6	(0.361)
–Shame	120	93.8	210	88.2	(0.091)

^a Significant, $P \leq 0.05$.

Table 3 Total percentage scores of barrier domains for screening women suffering from domestic violence in by physicians and nurses at primary health care units.

Type of barriers	Physicians	Nurses	P Mann Whitney Test
Barriers related to women culture (B1)	89.5 ± 17.2	83.8 ± 20.8	0.023 ^a
Barriers related to the examiner (B2)	67.8 ± 26.9	69.9 ± 28.6	0.384
Barriers related to health administration (B3)	78.7 ± 22.4	72.5 ± 26.4	0.038 ^a
Barriers related to the victim (B4)	93.0 ± 19.7	85.9 ± 27.6	0.007 ^a
Grand total% barrier score (B) (Mean and SD)	81.9 ± 15.6	77.5 ± 20.1	0.112

^a Significant, $P \leq 0.05$.

difference is not statistically significant. Among the four studied barrier domains, those related to the victim (battered women) topped the rank for both physicians. The individual questions of this domain included hiding abuse, turning back to the same environment, shame, and lack of knowledge on legal right. Factors as shame, embarrassment, fear of partner's retaliation and perception that it is the doctor's role to screen and then intervene were revealed by some authors to prevent abused women from seeking help from health care providers.^{23,24} Women wanted to be able to progress at their own pace and not to be pressured to disclose, leave the relationship, or press charges against their partner or ex-partner.¹⁸ Traditional beliefs regarding the family privacy, family unity and

gender role were found to have posed difficulties to health care providers in their screening and dealing with DV.²⁵ However, multiple studies revealed that many abused women do not mind being asked about violence and would like health care providers to be more pro-active in asking questions on abuse.^{23,24,26,27}

The second barrier revealed by this study is that related to culture of women that may prevent disclosure of the event to health care providers. Still, the lack of disclosure is consistent with reports from abused women who stated that they often refused to disclose abuse in health care settings.¹⁰ Interestingly, the same women advice health care professionals to ask about intimate partner violence because it gives abused women

support and information.²⁸ Patient-provider relationship may affect women's disclosure of IPV.²⁹ Studied physicians selected for the sake of the woman and her children followed by embarrassment as the leading barriers for screening in this domain, while nurses mentioned traditional families and embracement as the leading barriers.²⁹

Barriers related to the examiner appeared at the bottom of the list of barriers with no significant differences between physicians and nurses. Physicians admitted that insufficient training to screen battered women was the main barrier that undermined their capacity to deal with this issue. Unfortunately, nurses stated that non convincing with the importance of screening (76.1%) is the main barrier that impedes them to screen for DV against women. A meta-synthesis of qualitative studies identified appropriate health care provider training as a basic expectation that women have if they are going to be asked about abuse.¹⁸ Based on the synthesis and interpretation of data from 25 studies that explore women's experiences of disclosure to health care providers, the authors concluded that, prior to inquiry about abuse, women require that health care providers have a full understanding of the issue of DV, including knowledge of community services and appropriate referrals.³⁰ The healthcare providers' insufficient knowledge and training in screening have been suggested to be among the multiple causes of non screening for violence by the health care staff.^{30,13} Other factors such as roles governing the provider-client relations and healthcare provider's individual attitudes toward interpersonal violence may influence screening for violence in healthcare.^{31,32} Also, health care providers need to be aware that DV is indeed a major medical problem and they have important roles to play in its detection and management. Health care providers possess certain opinions and prejudices based on their own upbringing, culture and religious beliefs. These biases can affect their professional behavior including their intention to ask about abuse and create errors in clinical judgment in DV cases.³³

Reluctance on the part of health professionals to inquire about abuse owes to factors such as lack of time and training, lack of effective interventions and the complexities of providing whole family care.^{34,35} The current study revealed that barriers related to health administration ranked third by both physicians and nurses. Time constraints and heavy workload were stated by 90.6% and 91.4% of physicians and nurses in this study as barriers for conducting violence screening.

Differences of barriers to screen battered women between nurses and physicians were also revealed in other studies, however no clear explanation was provided for these differences.³⁴ The current study revealed that being a nurse or a physician was the only significant factor related to the overall barrier percent score when the confounding effect of other variables is controlled. Despite the differences between nurses and physicians on three out of the studied four domains of barriers, univariate analysis revealed non significant difference with regard to the overall barrier percent score.

National practice guidelines for intimate partner abuse that encourage routine screening and interventions must be developed. The frequency and circumstances of clinical use should be clearly defined so that health care professionals adhere to them. In addition, clinically based training of PHC workers about violence screening and empowering them with the required administrative skills and knowledge about the legal

aspects of violence seem urgent. Providing suitable places for screening and enhancement of the communication skills of physicians and nurses can add value to screening women exposed to DV.

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