Screening for Intimate Partner Physical Violence against Women in Outpatient Clinics of a Nigerian Tertiary Hospital.

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SUMMARY

Objective: To determine the incidence and risk factors for intimate partner violence (IPV) against Nigerian women attending outpatient clinics in a tertiary hospital.

Methods: A cross-sectional questionnaire based survey of 332 women attending out-patient clinics for reasons apparently unrelated to physical violence.

Results: The response rate was 95.4%. The past year incidence of IPV was 14.5% while lifetime incidence was 20.2%. The risk factors were: belonging to the lower social class (P=0.03), level of education of the woman being primary school or no formal education (P=0.002), and secondary education (P=0.01), and the male partner having secondary education (P=0.02).

Conclusion: This study found a substantial incidence of IPV in Nigerian women attending outpatient clinics. Our findings suggest that most women attending outpatient clinics will be willing to provide information on experience of IPV if asked and therefore it is feasible to screen all women attending outpatient clinics for IPV. Health education programmes to increase awareness, to educate women, and to advocate for appropriate legislation against IPV need to be pursued to vigor.

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***Keywords*: intimate partner physical violence, women, incidence, risk factors.**

INTRODUCTION

Intimate partner phsyical violence (IPV) against women is an important public health problem worldwide, with consequences that can be severe and life long[1-6]. Recent studies have shown its association with increased risk of gynaecological and mental health disorders in women[7,8]. However, not much is known about the nature and extent of IPV against women in Nigeria and health professionals do not routinely screen women presenting to hospitals. Ezegui *et al*[1] reported an incidence of 37.2% in a hospital based survey in Enugu, Nigeria while Okemgbo *et al*[2] found a much higher incidence of 78.8% in a community based study in South Eastern, Nigeria. Studies in other West African countries show that it is prevalent with 66.7% of the women in a survey of Sierra Leonean women reporting ever being beaten by a n intimate partner[3,9].

Previous studies have examined the risk factors for intimate partner physical violence against women. While it has been shown to occur in all socioeconomic classes, reports indicate that it is more prevalent in lower socioeconomic groups[4,10]. High educational attainment of women and men has been reported be associated with lower levels of violence[4,10,11]. Most studies have found no relationship between age of either partner and physical violence[10,12,13].

The appropriate role of the health sector in addressing the problem of intimate partner physical violence is currently the subject of consideration, with differences in opinion on whether health professionals should screen all women for intimate partner violence[14,15]. Many organizations of health professionals and health administrators in the United Kingdom and North America emphasize the need for recognision, assessment and referral of victims of IPV within and beyond the health service and therefore recommend that clinicans screen all female patients for IPV[16-18]. The objective of this study was to determine the incidence of intimate partner physical violence among women attending outpatient clinics in a tertiary institution and its relationship with age and educational status of women and their partners, socioeconomic class and polygamy.

METHODS

Study setting: This study took place at the Baptist Medical Centre, Eku, Delta State, Nigeria. It has served as a major referral hospital in the Niger Delta, Nigeria for over 50 years. The hospital offers both outpatient and in-patient general and specialist medical care in Obstetrics and Gynaecology, Paediatrics, General and Orthopaedic surgery, and Internal medicine. It is accredited for the training of house officers and specialists in General medical practice.

Subjects: The study population consisted of 332 Nigerian women attending General practice, gynaecological, medical and surgical outpatient clinics for reasons apparently unrelated to physical violence over a 4-month period (August 1st to November 31st 2004). The Medical ethics committee of the hospital gave approval before the study started.

Procedure: The researchers developed a questionnaire based on the objectives of the study. The questionnaire had two parts. The first part requested information on the sociodemographic

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variables of the woman and her intimate male partner. The variables included age, marital status and setting, level of education as well as occupational of both couple. An initimate partner in this study was defined as a husband, a boyfriend, an ex-husband, or ex-boyfriend. The second part enquired about experience of physical violence in the past year and since the age of 18 years using close-ended questions. Physical violence was defined as receiving a blow, a slap, being hit with the limbs or an object, being flogged or being a victim of other acts aimed at inflicting physical injury on any part of the body by an intimate male partner. It took about 5-10 minutes to fill the questionnaires.

All women aged 18 years and above attending out patient clinics on Mondays, Wednesdays and Fridays between the hours of 9am and 2pm, who were not severely ill, were approached to participate in the study. Women accompained by their male partners or husbands were excluded from the study. Most of the women filled the questionnaires themselves while 82(24.7%) required help from the researchers and resident doctors that had been trained in the administration of the questionnaires. The respondents were stratified into two groups for comparison: Women that had experienced intimate partner physical violence and those that had not. Statistical analysis was with the INSTAT statistical package. Fisher's exact test was used to determine statistical significance between proportions. The Relative risk and 95% Confidence interval were also determined. The level of significance was set at P<0.05. Social class delineation followed the recommendations of Olusanya *et al*[19] using the woman's level of education and the partner's occupation.

RESULTS

A total of 348 women were approached but 332(95.4%) gave their consent to participate in the study. The reason given by all women who refused to participate in the study was the desire to leave the clinic early. Table 1 shows the distribution of the women who had experienced physical violence and those who had not according to age, level of education, marital status and settiing, and social class. Most were aged 20-29 years (34.6%) and 30-39 years (46.7%), had tertiary education (69.9%), and were married (92.2%). Six percent were single while 0.9% were separated or divorced and 0.9% widowed. More than half of the couples studied belonged to the upper social class (55.1%). Table 2 shows that majority of the male partners of the women surveyed were aged 30-39 years (44.3%) and equal to or greater than 40 years (53.6%) and had tertiary education (67.2%).

Incidence: Forty-eight women reported experience of intimate partner physical violenc in the previous year giving an incidence of 14.5% while 20.2% had experienced it at least once in their future.

Risk factors: Tables 1 and 2 show the risk factors for intimate partner physical violence in the study population. They included belonging to the lower social class (P=0.03), and women having less than secondary education (P=0.002) or secondary education (P=0.009). The male partner having secondary school education was also a risk factor (P=0.02). In contrast, the following characteristics placed the women at a statistically reduced risk of experience physical violence: belonging to the upper social class (P=0.01), having tertiary education (P<0.0001) and the male partner having tertiary education (P=0.01). No relationship was found between the age of the woman or her partner and physical violence in this study.

Table 1: Characteristics of the women, polygamy and intimate partner physical violence

Parameter	Women with violence (n=67) % (number)	Controls (n=265) % (number)	P-Value	RR	Cl
Age of women (years)					
<20	1.5(1)	1.1(3)	>0.05	1.2	01-12.9
20-29	28.4(19)	36.2(96)	>0.05	0.8	0.4-1.3
30-39	53.7(36)	44.9(119)	>0.05	1.3	0.8-2.4
>39	16.4(11)	17.7(47)	>0.05	0.6	0.4-1.9
Level of educational of women					
<Secondary	16.4(1)	4.5(12)	0.002*	2.6	1.7-9.9
Secondary	35.8(24)	20.0(53)	0.009*	1.9	1.3-4.0
Tertiary	47.8(32)	75.5(200)	<0.0001*	.04	0.2-0.5
Social class					
Upper	40.3(27)	58.9(156)	0.009	0.6	0.3-0.8
Middle	35.8(24)	28.7(76)	>0.05	1.3	0.8-2.5
Lower	23.9(16)	12.5(33)	0.03*	1.8	1.1-4.3
Polygamy	20.9(14)	13.2(35)	>0.05	1.5	0.9-3.5

Table 2: Age and educational status of the males and intimate partner physical violence

Parameter	Women with violence (n=67) % (number)	Women with no violence (n=265) % (number)	P-Value	RR	Cl
Male partner's age (years)					
20-29	4.5(3)	1.5(4)	>0.05	2.2	0.7-14.0
30-39	50.7(34)	42.6(113)	>0.05	1.3	0.8-2.4
>39	44.8(3.0)	55.8(148)	>0.05	0.7	0.4-1.1
Male partner's level of education					
<Secondary	11.9(8)	7.9(21)	>0.05	1.4	0.7-3.7
Secondary	35.8(24)	21.1(56)	0.02*	1.8	1.2-3.7
Tertiary	52.2(35)	70.9(188)	0.01*	0.5	0.3-0.8

DISCUSSION

Most women presenting for outpatient consultation during the study period consented to being part of the study suggesting that a similar proportion may be favorably disposed to giving information on intimate partner violence, if requested routinely. This is similar to findings among caucasian women[20,21]. The results of this study alos suggest that intimate partner physical violence against women is a prevalent problem among women attending outpatient clinics in the Niger Delta, Nigeria. The lifetime incidence of 20.2% found in the study is cause for much concern. However, it is lower than the findings of Ezegui *et al* among pregnant women reporting their experience before pregnancy[1]. The incidence falls within the range of 10-30% reported in women attending outpatient clinics in other parts of

the world[5,6,8].

Our study found that though Nigerian women experienced intimate partner physical violence across all social classes, being of the lower social class placed them at significantly higher risk of being victims. Similarly, women belonging to the upper social class were at significantly lower risk. This is in agreement with reports from both developed and other developiing parts of the world[4,10,13]. It has been suggested that this may be due to higher levels of stress experienced by poorer men[22]. Our finding that there was a significantly reduced risk of violence when either of the couple had tertiary education is of crucial importance. Other workers have similarly reported this[4,10,11]. It is probable that this may be due to the effect of education in conferring social empowerment, self-confidence, and ability to use information and resources available in society, and at times wealth on the educated woman[14]. In our setting, it is likely that education, with the attendant exposure to new ideas, helps break the prevalent traditional concepts of male dominance, therefore reducing the need to resort to violence to "enforce male authority". However, our findings differ with reports from the USA and South Africa that the relationship is U-shaped with women at the lowest levels protected too23,24. Most studies, as was found in this study, have not established any relationship between the age of either partner and physical violence[10,12,13]. Similarly, we did not note any relationship with polygamy, which is still relativley common in our setting. However, the proportion of women from polygamous settings in this study was low. Further studies with larger sample sizes are needed to better assess the effect of polygamy on intimate partner physical violence.

In this study, the vast majority of women were in the upper and middle social classes, which is not reflective of the general Nigerian population. This is may be because women in the upper and middle social classes are more likely to recognize the value of, and be able to afford orthodox medical care, the cost of which has escalated in Nigeria in recent years. With the finding that women in lower social class are at increased risk of intimate partner violence in this study, it is probable that the incidence in the community may be higher. Hence, our findings suggest that while routine screening for domestic violence against women by medical personnel will be of value, a significant proportion of victims may be missed because they do not utilize orthodox medical service. Hence hospital based screening must be complemented with community-based programmes aimed at identifying female victims of intimate partner phsyical violence. This is likely to apply also in most other African countries where the poor, for both cultural and economic reasons, do not readily utilizer orthodox medical care.

CONCLUSION

The findings of this study show a high incidence of IPV among Nigerian women attending outpatient clinics, willingness of the vast majority of women to give information on experience of IPV and that low socioeconomi class and low educational status of both partners are the risk factors. The results indicate a need for concerted multidisciplinary effort to reduce the prevalence of IPV against women in Nigeria. Community based programmes to enhance educational and economic empowerment of women should be pursued with vigour since this study suggests that this places them at lower risk of being victims of physical violence. The authors believe that the evidence available on the magnitude of intimate partner violence is enough to warrant health professionals screening all women presenting in outpatient clinics for intimate partner physical violence. This would provide opportunity to identify cases that may not present with complaints or with obvious trauma as well as a chance for counselling and providing information that will help reduce the sense of isolation and stigmatization the victims often feel.

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