Detection of Indices of Violence Against Women by Health Professionals in a Nigerian Teaching Hospital

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Abstract

Context: Violence against women (VAW) is the commonest form of violence existing in human race and is a major reproductive health issue of our time because of its many negative reproductive health consequences.
Health care providers have important roles to play to build capacity of their employees to meet the challenges of diagnosing, managing and preventing this societal problem. This can be started by assessing their training needs.
Objective: To determine the extent to which Health Professionals can recognize some indices that may suggest VAW.
Design, Setting and Subjects: This is a descriptive study. Using a structural questionnaire a survey was done among a randomly selected Doctors, Nurses and Social Workers in OAUTHC, Ile-Ife in Osun State of Nigeria. Information on their socio demographic characters were obtained and they were also asked to identify the degree of association between a set of signs and symptoms in relation to violence against women.
Results: Divorce/separation during pregnancy, alcohol and drug abuse in women, attempted suicide were the indices (with scores of 85.8% and 79.9% respectively) that would mostly prompt suspicion of VAW. About 31.1% of the respondents may not appropriately detect VAW. There is no significant difference in the ability with regard to sex, years of experience and the professional group.
Conclusion: Health Professionals in OAUTHC will benefit from training and retraining programme on how to detect VAW. Similar baseline surveys are recommended for other Health Institutions as the first step in meeting this great challenge of the twenty-first century.

Key Words: Violence Against Women, Suspicion Indices, Health Professionals. [Trop J Obstet Gynaecol, 2005, 22: 27-32]

Introduction

Violence against women (VAW) has been defined as any act that results in or likely to result in physical, sexual, psychological harm or suffering to another person including threats of such acts, coercion or arbitrary deprivation of liberty[1] Domestic violence is one the commonest types of violence existing in human race and violence against women (including the girl-child), in various forms, constitutes the bulk. VAW occurs in all forms of social interactions in the home, work places, social gatherings and religious settings[2,3]. Violence against women has been observed as resulting in negative health consequences, including significant level of morbidity, debility and mortality among women world-wide[4] and it has become a major issue in contemporary discourse within the health and development sectors[5]. Surveys around the world showed an alarming VAW prevalence of between 20% and 50%. The few studies reported from Nigeria so far also lend credence to the high prevalence of various forms of VAW[6,7]. Common types of VAW identified in Nigeria include verbal abuse, battering, acid bath, spousal murder, incest, neglect and abandonment, sexual harassment and violence[7].

The World Health Organisation (WHO) in 1996 recommended increased research, data collection, appropriate definitions and classification, advocacy, collaboration and training of health professionals for quality intervention and control of VAW[8].

Health Professionals have become a major focus and critical partners for definitive action and programmes as they have important roles in primary, secondary and tertiary prevention, with possible activities including education, advocacy, prompt diagnosis and care. However, health workers can only be effective if well sensitized and trained on the issue of VAW. Training programmes to raise awareness, and help them acquire appropriate skills for quality management are not yet widely implemented in developing countries[9].

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Violence against women has been linked with high propensity for grandmultiparity, unwanted pregnancy, high risk sexual behaviour, sexual dysfunctions, affective disorders among others[10,11]. Many women exposed to VAW would present with signs and symptoms that may not be easily appreciated as coming from violence in the home unless the health and social service professionals have become highly sensitized to such possibility. Apart from being instruments of positive change in the society, health care providers are expected to assist in alleviating the sufferings of women exposed to domestic violence through physical support, medical treatments, counseling and prompt referral approved by clients to other social agencies where other assistance could be offered[12,13].

Policy formulations and implementation in this direction are being effected in many parts of the world[14,15,16]. As a preliminary survey to planning definitive action programmes to improve the knowledge base, skills in diagnosis and provision of holistic care of women exposed to violence, this study was conducted to achieve four objectives; namely:

(a) determine the extent to which health care workers are conscious of behaviours, signs and symptoms in women that may raise suspicion of experiences of violence by such clients;
(b) determine association between selected socio-demographic factors and levels of awareness of suspicious signs and symptoms of VAW;
(c) determine the diagnostic indices that health workers would use in identifying female clients experiencing violence;
(d) determine training needs of the health workers with respect to detection and management of VAW.

Materials and Methods

The survey was carried out at the Obafemi Awolowo University Teaching Hospital Complex in Ile-Ife, in the South-west geo-political zone of Nigeria. The institution serves as the Federal referral health facility for Osun, Ondo, and Ekiti states. Data were collected between March and July, 2002 using a questionnaire after the due processing and approval by the ethical committee of the institution.

The respondents were randomly selected from the hospital's staff list of doctors and nurses, while all the social workers were enlisted because they were few in number. Consent of every respondent was duly and freely obtained before enrolment into the study. A self-administered structured questionnaire, developed through review of literatures[12, 17, 18, 19, 20, 21], was used to collect data. The questionnaire has three sections. The first section was designed to collect socio-demographic data of respondents while the second part elicited responses on acts perceived to be forms of violence against women. The third part of the questionnaire consists of list of 27 symptoms found to have been associated with violence against women to which respondents were asked to respond to. Each respondent was to tick a response for each symptom out of 4 choices (to a large extent, to some extent, undecided, no relationship) depending on the degree of agreement with the statement. For analysis, agreement either to a "large extent" or "some extent" were grouped as positive options, "undecided" or "no relationships" were regarded as negative responses and scores. The questionnaire was pilot tested among health care workers in a nearby State Hospital. Scores of 4, 3, 2 and 1 were respectively assigned to agreement to a large extent, to some extent, uncertain and no relationship in order to be able to calculate the total score for an individual and make other comparisons. This makes the maximum score possible to be 108 and the lowest score 27. An individual is taken to have inadequate knowledge if the score is less than 70%, while individuals with 70% or more of the total maximum possible mark were reckoned as having "adequate" knowledge. The group with adequate knowledge was further classified into two groups: "good" knowledge if the score is between 70% and 79% (75.6 points) of the maximum points, and "excellent" knowledge if the score is 80% (86.4 points) or more of the maximum. Data was analyzed the using the SPSS 9.0 statistical package, and Computer Program for Epidemiologic Analysis (PEPI).

For each of the 27 symptoms, indicating behaviour or symptoms of VAW the percentage of the total respondents that recognize it as having positive association with VAW were noted and tabulated in order of decreasing frequency. Based on the categorization of individuals according to their level of knowledge into inadequate, good and excellent (as discussed above) and Chi-square was applied as test of significance to assess the relationship between respondents' level of knowledge and selected socio-demographic characteristics (sex, profession and years of experience). In the t-test, with the use of PEPI, a sum of 0.0000001 was added to the cell with zero value to permit computation.

Results

There were 134 randomly selected respondents out of a population consisting of 245 doctors, 315 nurses and 5 social workers. Out of 134 questionnaires given to respondents, 132 were fully completed and among these were 61 medical doctors, 66 nurses, and 5 were medical social workers. The age range was 24 to 58 years with a mean of 39.3 ($\pm$ 9.5 standard deviation) years. The post qualification experience varied from 3 months to 35 years. Majority of the respondent (83.3%) were from the

Yoruba ethnic group the dominant group in South-western Nigeria (Table 1). Majority of the respondents were married (67.5%) and were Christians (91.7%). In terms of sex distribution, 75.4 % of physicians were males while 77.3 % of the nurses were females, and 66% of the medical social workers were females.

Table 1
Frequency Distribution of respondents by their demographic characteristics

Variables	Physicians (n=61)	Nurses (n=66)	Medical Social (n=5)	Total	% of N
Age in Years					
20-30	29 (47.5)	6(9.1)	2(40)	35	26.5
30-39	17 (27.9)	20(30.3)	3(60)	39	29.5
40-39	12 (19.7)	23(34.8)	0(0)	38	28.8
50-59	3 (4.3)	17(25.8)	0(0)	20	15.2
Sex					
Female	15(24.6)	51(77.3)	3(60)	69	52.3
Male	46(75.4)	15(22.7)	2(40)	63	47.7
Marital Status					
Single	36(59)	5(7.6)	0(0)	41	31.1
Married	24(39.4)	60(90.9)	5(100)	89	67.4
Widow	1(1.6)	1(1.5)	0(0)	2	1.5
Post Qualification Years					
1-5 years30	(49.2)	6(9.1)	0(0)	36	27.3
6-10 years	16(26.2)	7(10.6)	0(0)	23	17.4
11-15 years	11(18)	9(13.6)	2(40)	22	16.7
16-20 years	2(3.7)	13(9.8)	2(40)	17	12.9
21-25 years	1(1.6)	15(22.7)	1(20)	17	12.9
26 years &above	1(1.6)	16(24.2)	0(0)	17	12.9
Religion					
Christianity	53(86.9)	63(95.5)	5(100)	121	91.7
Islam	7(11.5)	3(4.5)	0(0)	10	7.6
Traditional Religion	1(1.6)	0(0)	0(0)	1	0.7
Ethnic Group					
Yoruba	47(77)	59(89.4)	4(80)	110	83.3
Ibo	11(18.)	3(4.5)	1(20)	15	11.4
Efik	2(3.7)	4(6.1)	0(0)	6	4.6
Itsekiri	1(1.6)	0(0)	0(0)	1	07
Total	61(100)	66(100)	5(100)	132	100

Three-quarters of the physicians (75.4%) and all the medical social workers were below the age of 40 years while 60.6% of the nurses were aged 40 years and above. This observed variation in age distribution by profession is also reflected in the marital status of the respondents, with majority of the physicians still single while 90.9% of the nurses were married. Compared to 75.4 % of physicians who have been in practice for ten years or less, 70.3% and 100% of the nurses and medical social workers respectively have been in professional practice for over 10 years.

Following up from recognition of what constitutes VAW, responses to behaviours, signs and symptoms that would raise suspicion of VAW in clients are as summarized in Table 2. Divorce or separation during pregnancy (87.1%) alcohol and drug abuse in women (86.4%) and history of attempted suicide or suicidal thoughts (81.1%) were the most regarded indicators that would make health care workers suspicious of VAW. Chronic pelvic pain (47.7%), extreme obesity (50.8%) and chronic irritable bowel syndrome (53.8%) were the least frequently recognized as symptoms that may be indicators of VAW.

Table 2
Frequency of identification of behaviour/symptoms by the health workers as possible indicators of violence against women in decreasing order.

	Symptoms	Frequency of positive Responses (n= 132)	%
1.	Divorce or separation during pregnancy	115	87.1
2.	Alcohol and drug abuse in a woman	114	86.4
3.	History of attempted suicide or suicidal thoughts	107	81.1
4.	Loss of self confidence	103	78
5.	Injury not matching explanation	102	77.3
6.	Miscarriages	102	77.3
7.	Lack of pleasure in sexual intercourse	102	77.3
8.	Chronic vague complaints with no physical signs	102	77.3
9.	Physical injury during pregnancy	98	74.2
10.	Insomnia or other sleep problems	98	74.2
11.	Delay between injury and the time of seeking treatment	98	74.2
12.	Teenage pregnancy	92	69.7
13.	Self induced or attempted abortions	91	68.9
14.	Sexually transmitted disease in children or young girl	91	68.9
15.	Chronic unexplained physical symptoms	90	68.2
16.	Vaginismus	86	65.2
17.	Very attentive partner at woman's side (not willing to leave client) during consultation	84	63.6
18.	Menstrual irregularities	83	62.9
19.	Multiple abortions	76	57.6
20.	Vaginal itching and bleeding	76	57.6
21.	Chronic abdominal pain	76	57.6
22.	Client avoiding pelvic examination	76	57.6
23.	Painful micturition or defecation	72	54.5
24.	Chronic irritable bowel syndrome	71	53.8
25.	Extreme obesity	67	50.8
26.	Chronic pelvic pain	63	47.7
27.	Anxiety, depression and self destructive behavior	39	29.5

Using a VAW suspicion scale with possible scores ranging from 27 to 108 points, as described in the material and method section, the mean average score for all the health workers is 72.37 (± 17.0 SD). Among the 3 professional groups studied, medical social worker had higher scores (78.4 ± 13.8 SD) compared to doctors (71.9 ± 17.5) and nurses (72.3 ± 16.9). Further statistical analysis to determine association between selected socio-demographic characteristics of the health care worker (years of experience in practice, sex, and scores on the VAW suspicion scale, as shown in Table 3, indicated no significant difference on the performance on the VAW suspicion scale based on the socio-demographic factors of interest.

Table 4 summarises the responses of the respondents to five indices which they would use as basis of making positive diagnosis of experiences of abuse and VAW compared by sex and professional grouping. Obvious physical findings and clients direct history would be used by majority of the health workers to make diagnosis of VAW.

Discussion

It is obvious from this study that significant proportion of health workers in our environment (31.1%) lack adequate knowledge to suspect VAW when they present with any of the known clinical features and 34.8% had just adequate knowledge while 34.1% was adjudged as having good knowledge based on our previously discussed criteria. This is a matter of serious concern where this social problem seems to be on the increase[7] and also translates to the fact that victims cannot receive adequate and proper care. The reliability on obvious physical findings and history volunteered by the victims to make diagnosis in this study as against the little use of emotional or psychological problems show inadequate understanding of how violence affect women's reproductive health and sexual well being.

Table 3

The performance of Health Workers in the rating of symptom/Sign based Suspicion of VAW.

Variables	Mean	sd	Level of Knowledge			
			Inadequate Knowledge (<70%) N (%)	Good Knowledge (70-79%) N (%)	Excellent Knowledge (>80%) N (%)	*P*
Profession (N)						0.58
Doctor (61)	72.0	17.5	22(36.1)	18(29.5)	21(34.4)	
Nurses (66)	72.3	16.9	18(27.3)	25(37.9)	23(34.8)	
Social Worker(5)	78.4	13.8	1(20.0)	3(60.0)	1(20.0)	
Post Qualification Years (N)						
< 10yrs (53)	72.1	17.1	17(32.1)	19(35.8)	17(32.1)	0.36
11-20 Yrs (40)	72.2	17.7	12(30.0)	17(42.5)	11(27.5)	
21-30 (32)	71.7	17.1	10(31.3)	10(31.3)	12(37.5)	
> 30 Yrs (7)	84.0	4.9	-	3(42.9)	4(57.1)	
Sex (N)						
All Males (61)	71.6	18.0	19(31.1)	22(36.1)	20(32.8)	0.95
All Females (71)	73.0	16.2	22(31.0)	24(33.8)	25(35.2)	
All Respondents(132)	72.4	17.0	41(31.1)	46(34.8)	45(34.1)	

Table 4

Distribution of respondents by indices that they would use in making a diagnosis of VAW in clients by sex and profession:

Index of Positive Diagnosis	Sex		Profession		
	n = 63 Male n(%)	n=69 Female n(%)	n=5 Social Worker n(%)	n=66 Nurses n(%)	n=61 Physicians n(%)
From clients direct history of VAW	47(66.7)	54(78.3)	4(80.0)	50(75.8)	96(72.7)
Physical findings on examination	52(82.5)	66(95.7)	5(100.0)	58(87.9)	55(90.1)
Emotional or Psychological Problems	29(46.0)	31(44.9)	3(60.0)	24(36.4)	33(54.1)
Alcoholism in client	8(12.7)	23(33.3)	0(0.0)	16(24.2)	15(24.6)
Patients' disclosure after systematic probing	36(57.1)	26(37.7)	1(20.0)	18(27.3)	43(70.5)

While many of the indicators used for this research were developed initially in the Western World it has been found applicable in many other cultures[5,6,20]. Moreover, the careers of the Health Professionals under study have to a large extent been influenced by both the African and the Western cultures, so the instruments of the survey have the necessary validity.

This study showed that the health workers in the Nigerian environment perceive divorce of a pregnant woman as the greatest evidence (85.8% of respondents) of violence against women. This rating perhaps has to do with the cultural set-up in our environment where it is generally believed that the most crucial time for a man to tolerate his wife is when she is pregnant, and that one of the worst act of neglect a man can put up is to shirk his responsibility to or abandon his pregnant wife. Routine intake of alcohol by women is not a common practice in our setting, and therefore, a woman with drinking problem is often regarded as someone with severe underlying problems, one of the common suspicions is marital stress: this may account for its high rating as symptom of VAW. Affective disorders like attempted suicide, suicidal thought, or depressive illness were rated by 79.9% of the health workers as symptoms of VAW. This response may be partly due to the educational background of the health professionals as most must have been taught during their psychiatric posting to look inward into the family first for precipitating factors for affective disorders especially depressive illness. It is noteworthy that injury not matching explanation was rated by 76.7% of respondent as a symptom that is associated with DV.

Chronic pelvic pain is rated to have the least (47.7%) association with VAW but it is suspected that the

situation might be different if this rating were to be done in Western set-up. There is no doubt that somatisation of an emotional problems have cultural pattern. Any health worker with adequate knowledge is expected to score 70% and above of the total points for he or she to be effective, and this means scoring more than 75.6 points out of a maximum of 108 points. The mean score of the population under study is below expectation (72.37 points).

From Table 2, many of the respondents may be assumed to be sensitized to behaviour and symptoms that should raise suspicion of VAW. The expectations would be that all health care providers should be able to pick all causes of VAW. However, with less than 50% considering chronic pelvic pain, anxiety, depression, and self destructive behaviours as possible indicators of VAW, the degree of sensitization to reproductive and mental health indicators of VAW would be considered inadequate.

The perception of what constitutes domestic violence is determined by culture, social background and the level of health education the person had received. To many people, the only case that society regard as domestic violence is wife battering but in actual fact a lot of practices go on in the society that are ignored or tolerated but are of sufficient gravity to impair the mental, physical and social health of women. Since many of these acts of VAW are not direct physical forces, physical injury may not be seen but then the emotional scars may last for a prolonged period: healing of minds takes much longer than the skin wound, which usually heals within 2 weeks.

VAW in family set-up may range from denying woman her basic needs, use, of coercion to force her to do things against her personal wishes, withdrawal of privileges, verbal abuse or harassment, to wife battering. Other detrimental activities include denial of inheritance to widows, discrimination in appointments to posts, dowry, female genital mutilation, female infanticide, relative neglect of girls' education and lack of authority of women to make reproductive decisions, among others.

In many instances the victims do not complain about such problems in their interactions with health professionals in order to conceal their private affair or, sometimes, out of fear of the spouse getting to know and provoking more acts of aggression. Hence the treatment they receive for their ailment is less effective since the root of the problem still persists and a lot of money and time will be wasted in the management with poor dividends.

It is recommended that the institutions should organise a short-term training programmes for the workers in form of seminars and workshops. On a long time basis, efforts should be made to incorporate topic related to domestic violence, sexual and reproductive rights of women into the syllabus of doctors, and nurses currently being revised. It is after these have been achieved that Health Professionals can become catalyst of transformations of cultural, social, religious and legal milieu that condone and perpetrate VAW.

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