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PAMJ One Health

Research

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Received: 19 Feb 2024 - **Accepted:** 16 Apr 2024 - **Published:** 26 Apr 2024

Keywords: Domestic violence, knowledge, practice, healthcare professional

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Cite this article: Olufemi Aworinde et al. Knowledge and attitude of health care providers towards the identification and management of domestic violence victims. PAMJ-One Health. 2024;13(20). 10.11604/pamj-oh.2024.13.20.43013

Available online at: https://www.one-health.panafrican-med-journal.com/content/article/13/20/full

Knowledge and attitude of health care providers towards the identification and management of domestic violence victims

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PAMJ One Health

Abstract

Introduction: *domestic violence (DV) can affect anyone; however, the majority of victims are females. The aim of this study was to assess the knowledge, attitude, and practice of health care providers (HCP) towards the identification and management of domestic violence victims.* ***Methods:*** *this descriptive cross-sectional study was carried out among 281 HCP working at Bowen University Teaching Hospital (BUTH) and LAUTECH Teaching Hospital (LTH), Ogbomoso. A structured questionnaire was administered to participants. Ethical approval was obtained from the ethical committee of BUTH.* ***Results:*** *most of the respondents were doctors (47.0%) with the majority being females. About 30% of them thought that chronic unexplained pain and substance abuse were warning signs of domestic violence. Most of the respondents believed that the fear of retaliation by the perpetrator, financial dependency, sociocultural and religious beliefs and love for the perpetrator were the reasons victims of domestic violence were not willing to leave the relationship. With the diagnosis of domestic violence, 73.7% of the healthcare professionals conducted a safety assessment for the woman; 78.9% counseled the woman about options, while 53.7% helped the woman develop a safety plan; 91.8% of the healthcare professionals did not have a protocol for dealing with domestic violence.* ***Conclusion:*** *the ability of the HCP to identify victims of DV was found to be adequate, however, their ability to manage victims and give appropriate referrals was poor.*

Introduction

Domestic violence (DV) also referred to as "intimate partner violence", is defined by the World Health Organization (WHO) as behaviour by an intimate partner or ex-partner that causes physical, sexual, or psychological harm including physical aggression, sexual coercion, physical abuse, and controlling behaviours [1]. Domestic violence can affect anyone regardless of age, race, sexual orientation, socio-economic status, religion, or gender; however, the major percentage of victims are of the female gender [2]. Twenty-seven pecent (27%) of ever-partnered women aged 15-49 years were estimated to have experienced a form of intimate partner violence in their lifetime, with 13% experiencing it in the past year before the survey [3]. Low socio-economic status, use of drugs or alcohol, seeing or being a victim of violence as a child and unemployment are risk factors for domestic violence [1,2]. Domestic violence has also been found to be significantly associated with the financial disparity in favour of the female, influential in-laws, educated women, and couples within the same age group [4].

Various norms and beliefs support domestic violence in the African culture. These beliefs abound in Nigerian society, and they include the belief that: a man is socially superior to the woman and has a right to physically discipline her for ´incorrect´ behavior; sexual intercourse is a man´s right in marriage; a woman should tolerate violence in order to keep her family together and there are times a woman deserves to be beaten to keep her in check [2]. Considering the permissive attitude of Nigerian society towards domestic violence, it is difficult to ascertain the magnitude of the problem. A study conducted among civil servants in Oyo State, South Western Nigeria, found the prevalence of wife beating to be about 31 percent. While this study projects the picture of the problem across various socio-economic strata, it examined only wife beating, just one aspect of domestic violence against women [5]. The sequelae of domestic violence are numerous; the most feared of which is death. It is thus of utmost importance that healthcare professionals be knowledgeable about domestic violence as well as harness their clinical skills to appropriately provide adequate care to the victims to reduce long-term effects and mortality [1].

Studies have shown that healthcare professionals (HCP) are cautious when discussing domestic violence with victims [6]. This may be because healthcare professionals think that women are not

favourably disposed to speaking about violence, so they prefer not to ask probing questions about their experiences. This has however been disproved by studies that found out that victims of intimate partner violence (IPV) were eager to discuss their experiences with health care professionals especially when the HCP initiates the discussion about domestic violence, and were assured of confidentiality and their privacy [7]. The knowledge, clinical skills, and attitude of healthcare professionals towards domestic violence are important, as most victims do not willingly divulge complete information about the surrounding events following unexplained injuries. The reasons for this include fear of further harm, loss of their children, arrest of their perpetrator, and previous poor response by healthcare providers [6]. Positive attitudes and practices of health care professionals towards domestic violence can help in primary prevention of domestic violence, prompt recognition of victims of domestic violence as well as delivery of adequate care and avoidance of complications [8].

The objective of the study was to assess the knowledge and attitude of healthcare providers towards the identification and management of domestic violence victims in Ogbomoso town, South Western Nigeria. The barriers to screening of patients for domestic violence as perceived by the health care providers as well as the ability of the health care providers to give appropriate referrals were also assessed. Research question: do healthcare workers in Ogbomoso, Southwestern Nigeria have adequate knowledge to identify and manage domestic violence victims?

Methods

Study design: this is a descriptive, non-experimental cross-sectional study.

Setting: the study was carried out at both Ladoke Akintola University of Technology Teaching Hospital (LTH) and Bowen University Teaching Hospital (BUTH), Ogbomoso. Ladoke Akintola University of Technology Teaching Hospital (LTH) is a government-owned tertiary health institution that was founded in 2011. It caters for all specialties of medicine. BUTH is a mission-owned tertiary health institution founded by the Baptist mission in Nigeria. It also caters for various specialties and has all cadres of staff. Ogbomoso is the second-biggest city in Oyo state, Southwestern Nigeria with a population of about 655,000 people. It is a predominantly Yoruba-speaking city.

Participants: all healthcare professionals working in hospitals-doctors, dentists, nurses, midwives, and physiotherapists who gave consent.

Variables: variables included the level of knowledge of the participants regarding the identification and management of domestic violence victims; the attitude of the participants toward domestic violence victims and the practice of the participants about management of victims of domestic violence.

Data sources/measurement: data were collected using a pretested, structured, self-administered questionnaire. The questionnaire consisted of 50 multi-item questions divided into four sections. Section A consisted of questions related to the sociodemographic characteristics of the respondents; section B consisted of questions related to the knowledge of the respondents about domestic violence; section C consisted of questions related to HCPs attitude towards patients suffering from domestic violence and; section D consisted of questions related to HCPs practice concerning domestic violence.

Bias: bias was addressed by including all healthcare workers who come in contact with potential domestic violence victims. In addition, the questionnaire was self-administered with nothing to identify the respondents.

Sample size: the sample size of 281 participants was determined using the Kish Leslie formula for single proportions [9].

$$N = \frac{z^2 p(1-p)}{d^2}$$

Where N= minimum sample size, z= standard normal deviation of 1.96 at a 95% confidence interval p= 21%, d= maximum allowable margin of error at 10% putting the power of the study at 80%. Stratified random sampling was employed in selecting participants from each cohort of professionals. A list of the healthcare workers in both institutions was obtained. The participants were selected from each cohort according to their proportion in the total workforce. For example, medical doctors made up 47% of the total population of healthcare workers and thus that of the participants. The study was carried out in October 2023.

Data analysis: data obtained was processed using the Statistical Product and Service Solutions (SPSS) version 22. Frequency tables were generated for univariate variables.

Ethical clearance:the work was approved by the ethics committee of Bowen University Teaching Hospital, Ogbomoso with number NHREC 12/04/2012. Subjects gave informed consent to the work. Refusal to participate in the study was respected.

Results

Participants/descriptive data: most of the respondents, 162 (57.7%), were between the ages of 20-29 years. The majority were doctors (47.0%), 40.5% nurses/midwives, 3.9% dentists, 5.0% pharmacists and 3.6% physiotherapists. Most of them were Christians, 231 (82.2%); with the majority being females, 182 (64.8%). One hundred and ninety-four (69.0%) of them had less than ten years of working experience.

Outcome data/main results: twenty-six questions were used to assess their knowledge of DV. Twenty of these questions were true statements. One hundred and forty-eight (52.7%) of the respondents got between 20-26 correct (good knowledge); 40 (14.2%) got 14-19 (moderate knowledge) and 93 (33.1%) got less than 14 questions correct (poor knowledge). About 30% of them thought that chronic unexplained pain and substance abuse were warning signs of abuse. Most of the respondents (about 90%) believed that the fear of retaliation by the perpetrator, financial dependency, sociocultural and religious beliefs, catering to the children´s needs, and love for the perpetrator were the reasons victims may not be willing to leave a relationship with the abuser. Nineteen-point-nine percent (19.9%) felt it was wrong to inquire about domestic violence from patients if the information is not volunteered. Sixty-six-point-two-percent (66.2%) of the respondents had not been diagnosed with any domestic violence cases 6 months before the study. With the diagnosis of domestic violence, 73.7% conducted a safety assessment for the woman; 78.9% counseled the woman about options, while 53.7% helped the woman develop a safety plan. Seventy-one-point-two percent (71.2%) of respondents think that they don´t have adequate knowledge of referral resources in the community, while 91.8% of the respondents do not have a protocol for dealing with domestic violence.

Discussion

Most of the respondents were between 20-29 years of age. This is probably due to a preponderance of a young workforce in most teaching hospitals in the country. The junior doctors are in the majority, while most of the nurses are young as well. This age distribution impacted the years of experience noted in this study. The preponderance of the female gender is like findings in previous studies [10-12]. The finding of most of the respondents being physicians was also like findings in earlier studies [6,7,11,12]. Most of our respondents were Christians which is not surprising considering the demography of Ogbomoso town whose population is predominantly Christians. About

two-thirds of the respondents had moderate to good knowledge of DV. However, less than a third of the respondents thought that chronic unexplained pain and substance abuse were warning signs of an abused victim. This disagrees with the findings of Ramsay *et al.* in London, where 73.2% of the respondents felt chronic unexplained pain and 91.5% believed that frequent injuries were warning signs of abused victims [12]. This might be explained by cultural differences between both societies.

Most of the respondents correctly identified the reasons why victims were unwilling to leave an abusive relationship. These included the fear of retaliation by the perpetrator, financial dependence on the perpetrator, religious beliefs, and children's needs. The result agrees with the findings of Ramsay *et al*. but does not agree with the findings of Baraldi *et al*. in Brazil, where 80% of nurses and 65.8% of physicians believed there were no justifiable reasons for a victim to remain in an abusive relationship [11,12]. Regarding the ways to inquire about domestic violence, 61.6% of our respondents agreed to the idea of asking the victim directly, if they were victims of domestic violence, while 19.9% believed there was no need to inquire about DV when suspected. The findings of the study are different from the findings of most Western studies, where most respondents believe it is inappropriate to ask the patient directly, while preferring to ask indirectly [10-13]. As regards the causes, 60.1% believed that alcohol consumption is the greatest single predictor of the likelihood of domestic violence. This is in line with the findings in a study done in Brazil, in which 94.1% of the respondents agreed to alcohol as being a major cause of domestic violence, but it was in dissonance with the result in London, where just 27.2% agreed with the fact that alcohol is the single most likely predictor of domestic violence [11-13]. Most of the respondents felt clinicians should not pressure female patients to acknowledge that they are living in an abusive relationship. This they felt was tantamount to invading their privacy.

Only a third of our respondents had managed a case of domestic violence in the six months preceding the study. With this result, it can be said that the cases of domestic violence being reported are not many, probably because they are truly not occurring because they are not being reported by the victims to the health facilities, or because healthcare practitioners miss the diagnosis [6,13]. Most of the respondents believed that DV is associated with both social problems and psychiatric disorders. This supports the position of previous authors that regard DV in some instances as being due to factors beyond what can be controlled by the aggressor, and thus should be treated as a medical problem [4,6,11,14,15]. Most of the respondents disagree that aggression toward a woman or a man by her husband or wife is considered an intimate and private matter. This is like findings in similar studies [6,10,12].

Regarding the role of health care professionals concerning domestic violence, 74% believed that victims should be helped to get out of the situations of violence and 78% feel they should be provided the addresses of places they can also receive care for proper improvement of their wellbeing physically and psychologically. This agrees with the findings of Ramsey *et al*. and Baraldi *et al*. in their studies [11,12]. This suggests that HCPs have a bigger role to play than just diagnosing domestic violence. They are to assist the victims where possible with linkages to support groups and other help resources. The high prevalence and health effects of intimate partner abuse make it important for healthcare professionals to ask directly about domestic violence. A large proportion of the populace encounters HCPs yearly. This places HCPs in a good position to help identify and diagnose domestic violence and help link them to help resources [6,11,12]. Most of the health professionals in this study could not provide women who had experienced abuse with domestic violence education or resource materials because of inadequate referral resources and counseling aids in their community. In addition, almost all the

respondents agreed that there was no management protocol in place for domestic violence in their health institutions. These two inadequacies will in no small measure negatively impact the management of the few women diagnosed with domestic violence in these centres.

Conclusion

The knowledge and attitude of the healthcare professionals toward identifying victims of domestic violence were found to be inadequate. Neither hospital had any documented protocols for the management of domestic violence victims.

What is known about this topic

- *Domestic violence is seen mostly amongst women;*
- *Health care practitioners are weary of managing victims of domestic violence due to medicolegal reasons.*

What this study adds

- *The knowledge of healthcare practitioners about the management of DV is poor;*
- *Attitude to identification of DV victims is poor;*
- *Protocols need to be put in place to aid the management of DV victims.*

Competing interests

The authors declare no competing interest.

Authors' contributions

Olufemi Aworinde: conceptualization, methodology, software, data curation, writing-reviewing and editing. Adebayo Adekunle, Musa Ayinde, Matthew Fijabiyi, Medinat Aliu-Ayinde: software, visualization, investigation, data curation, writing-original draft preparation. Adewale Adeyemi: software, validation, supervision, writing, reviewing and editing. All the authors have read and agreed to the final manuscript.

Acknowledgments

We acknowledge the contributions of the staff members of both hospitals.

Tables and figures

Table 1: sociodemographic characteristics of respondents

Table 2: knowledge of respondents about domestic violence (DV)

Table 3: attitude of respondents towards domestic violence (DV)

Table 4: practice of healthcare professionals

References

1. World Health Organization. Violence and Injury prevention: Intimate partner and sexual violence. WHO. 2012. **Google Scholar**
2. Aihie ON. Prevalence of domestic violence in Nigeria: Implications for counselling. Edo Journal of counselling. 2009;2(1): 1-8. **Google Scholar**
3. Sardinha L, Maheu-Giroux M, Stöckl H, Meyer SR, García-Moreno C. Global, regional, and national prevalence estimates of physical or sexual, or both, intimate partner violence against women in 2018. The Lancet. 2022 Feb 26;399(10327): 803-13. **PubMed**| **Google Scholar**
4. Obi SN, Ozumba BC. Factors associated with domestic violence in South-East Nigeria. Journal of obstetrics and Gynaecology. 2007;27(1): 75-78. **PubMed**| **Google Scholar**

5. Fawole OI, Aderonmu AL, Fawole AO. Intimate partner abuse: wife beating among civil servants in Ibadan, Nigeria. Afr J Reprod Health. 2005;9(2): 54-64. **PubMed**| **Google Scholar**
6. Procentese F, Di Napoli I, Tuccillo F, Chiurazzi A, Arcidiacono C. Healthcare Professionals' Perceptions and Concerns towards Domestic Violence during Pregnancy in Southern Italy. Int J Environ Res Public Health. 2019;16(17): 3087. **PubMed**| **Google Scholar**
7. Silva T, Agampodi T, Evans M, Knipe D, Rathnayake A, Rajapakse T. Barriers to help-seeking from healthcare professionals amongst women who experience domestic violence - a qualitative study in Sri Lanka. BMC Public Health. 2022 Apr 11;22(1): 721. **PubMed**| **Google Scholar**
8. Gerbert B, Moe J, Caspers N, Salber P, Feldman M, Herzig K, Bronstone A. Physicians' response to victims of domestic violence: toward a model of care. Women Health. 2002;35(2-3): 1-22. **PubMed**| **Google Scholar**
9. Kish L. Survey sampling. New York: Wiley Interscience Publication. 1965. **Google Scholar**
10. Vieira EM, Dos Santos MA, Ford NJ. Seizing an Opportunity to Help Knowledge and Attitudes of Doctors and Nurses Towards Women Victimized by Intimate Partner Violence in Brazil. Health Care for Women International. 2012;33(3): 228-249. **PubMed**| **Google Scholar**
11. Baraldi PAC, de Almeida AM, Perdoná G, Vieira EM, Dos Santos MA. Perception and Attitudes of Physicians and Nurses about Violence against Women. Nurs Res Pract. 2013;2013: 785025. **PubMed**| **Google Scholar**
12. Ramsay J, Rutterford C, Gregory A, Dunne D, Sharp D. Domestic violence: knowledge, attitudes, and clinical practice of selected UK primary healthcare clinicians. Br J Gen Pract. 2012;62(602): e647-e655. **PubMed**| **Google Scholar**
13. Ramsay J, Richardson J, Carter YH, Davidson LL, Feder G. Should health professionals screen women for domestic violence? Systematic review. BMJ. 2002 Aug 10;325(7359): 314. **PubMed**| **Google Scholar**
14. Lahav Y. Painful bonds: Identification with the aggressor and distress among IPV survivors. Journal of Psychiatric Research. 2021;144: 26-31. **PubMed**| **Google Scholar**
15. Rakovec-Felser Z. Domestic Violence and Abuse in Intimate Relationship from Public Health Perspective. Health Psychol Res. 2014;2(3): 1821. **PubMed**| **Google Scholar**

Table 1: sociodemographic characteristics of respondents	
Characteristics	**Frequency**
Age	30.95±9.826
20-29	162 (57.7%)
30-39	59(21.0%)
40-49	42(14.9%)
50-59	16(5.7%)
≥60	2(.7%)
Sex	
Female	182(64.8%)
Male	99(35.2%)
Occupation	
Dentist	11(3.9%)
Medical doctor	132(47.0%)
Nurse/midwife	114(40.5%)
Pharmacist	14(5.0%)
Physiotherapist	10(3.6%)
Religion	
Christian	231(82.2%)
Muslim	47(16.7%)
Others	3(1.1%)
Years of experience	
1-10	194(69.0%)
11-20	71(25.3%)
>20	16(5.7%)

Table 2: knowledge of respondents about domestic violence (DV)			
Warning signs of abuse	**Agree**	**Not sure**	**Disagree**
Chronic unexplained pain	87(31.0%)	34(12.1%)	170(60.5%)
Substance abuse	59(21.0%)	52(18.5%)	170(60.5%)
Depression	222(79.0%)	20(7.1%)	39(13.9%)
Frequent unexplained injuries	168(59.8%)	62(22.1%)	51(18.1%
Reasons why a victim may not be willing to leave an abusive relationship			
Fear of retaliation by the perpetrator for leaving	267(95.0%)	01(0.4%)	13(4.6%)
Financial dependence on the perpetrator	266(94.7%)	11(3.9%)	04(1.4%)
Religious belief	259(92.2%)	13(4.6%)	09(3.2%)
Children's need	268(95.4%)	09(3.2%)	04(1.4%)
Love for the perpetrator	249(88.6%)	02(0.7%)	30(10.7%)
Fear of isolation	225(80.1%)	05(1.8%)	51(18.1%)
Right ways to inquire about domestic violence			
Are you a victim of domestic violence	63(22.4%)	85(30.3%)	133(47.3%)
Has your partner ever threatened you	74(26.3%)	68(24.2%)	139(49.5%)
Have you ever been hit or hurt by your partner	36(12.8%)	79(28.1%)	166(59.1%)
True statements concerning domestic violence			
Alcohol consumption is a strong predictor of domestic violence (DV)	169(60.1%)	89(31.7%)	23(8.2%)
Document reasons for concern about DV	129(45.9%)	92(32.7%)	60(21.4%)
Being supportive of a victim's choice to remain in a violent relationship would condone the abuse	190(67.6%)	12(4.3%)	79(28.1%)
Strangulation injuries are rare in cases of DV	95(33.8%)	18(6.4%)	168(59.8%)
The presence of partners at consultation is ideal	104(37.0%)	15(5.3%)	162(57.7%)
Do not be judgemental of DV victims	105(37.4%)	34(12.1%)	142(50.5%)
Women being abused can make appropriate choices about how to handle their situation	125(44.5%)	13(4.6%)	143(50.9%)
Clinicians should not pressure female patients to acknowledge that they are being abused	201(71.5%)	12(4.3%)	68(24.2%)
Women who have experienced domestic violence are at greater risk of injury when they leave the relationship	134(47.7%)	09(3.2%)	138(49.1%)
Even if the child is not in immediate danger, clinicians have a duty of care to the child witnessing DV	229(81.5%)	14(5.0%)	38(13.5%)
DV is caused by social factors	208(74.0%)	46(16.3%)	35(12.5%)
DV is caused by psychiatric problems	224(79.7%)	40(14.2%)	25(8.9%)

Table 3: attitude of respondents towards domestic violence (DV)			
Attitude of healthcare professionals	**Agree**	**Not sure**	**Disagree**
The role of HCPs in abused women should be the same as their role with abused children	208(74.0%)	29(10.3%)	52(18.5%)
DV should be considered and treated as a medical problem	159(56.6%)	68(24.2%)	62(22.1%)
Abusive partners should be shown compassion	75(26.7%)	43(15.3%)	171(60.9%)
Abusive partners should be imprisoned	79(28.1%)	56(19.9%)	154(54.8)
Child abuse is an intimate and private matter	49(17.4%)	52(18.5%)	188(66.9%)
DV is an intimate and private matter	47(16.7%)	35(12.5%)	207(73.4%)
HCPs should encourage victims to leave abusive relationship	214(76.2%)	40(14.2%)	35(12.5%)
HCPs should link up victims of violence with support groups	228(81.1%)	33(11.7%)	28(10.0%)
HCPs should be alert towards diagnosing DV	225(80.1%)	28(10.0%)	36(12.8%)
HCPs should not inquire about DV if information is not volunteered	56(19.9%)	35(12.5%)	198(70.5%)
HCPS; health care providers, DV; domestic violence			

Table 4: practice of healthcare professionals	
Which group of patients do you routinely ask about domestic violence?	
Do not routinely ask	156(55.5%)
Patients in whom I am suspecting DV	123(42.6%)
All patients	10(3.6%)
Did you diagnose DV in the last 6 months?	
Yes	95 (33.8%)
No	186 (66.2%)
When you were diagnosed DV, which of the following actions did you take? N=95	
Conducted a safety assessment for the woman	41(43.2%)
Counselled the woman about her options	41(43.2%)
Helped the woman develop a safety plan	41(43.2%)
Conducted safety assessment for the woman's children	10(10.5%)
Referred to other agencies	10(10.5%)
Do you routinely provide women who have experienced abuse with domestic violence education or resource materials? N=95	
Yes	10(10.5%)
No, due to inadequate referral resources in the community	67(70.6%)
No, because I do not feel these materials are useful	18(18.9%)
Is there a protocol for dealing with domestic violence where you practice?	
Yes	0
No	258(91.8%)
Not sure	23(8.2%)
Do you have adequate domestic violence referral resources at your work site?	
Yes	0
No	258(91.8%)
Not sure	23(8.2%)
DV; domestic violence	