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Screening for intimate partner violence in healthcare in Kano, Nigeria: barriers and challenges for healthcare professionals



Imaobong'09

Ime Akpan John

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1810 – 2010 *Years*



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Cover photo: On the cover page is a painting '*romantiska*', by my daughter Imaobong when she was nine years of age. When asked to explain what the painting meant, she said '*romantiska*', is a Swedish word for romance. When probed further, she explained that her painting indicated problems in relationships. It seems to me that the uncoordinated coloured lines and curves depict conflicts within romantic relationships which may as well represent violence among intimate partners- Ime A. John

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*Dedicated to:
The healthcare professionals in Nigeria*

ABSTRACT

Background

Though there has been increased advocacy for screening for Intimate partner violence (IPV) in healthcare over the past decades, data from developed country context suggest that only one in ten healthcare providers routinely screen for this phenomena suggesting barriers. Knowledge on the screening activity, with regard to IPV, and related barriers among healthcare providers in Sub-Saharan Africa is lacking.

Aims

The aim of this dissertation is to scrutinize provider-related as well as client related barriers to screening for Intimate Partner Violence in healthcare in the Sub-Saharan African context, using data from healthcare facility in Kano, Northern Nigeria

Methods

The cross-sectional studies were based on three questionnaires assessing readiness to screen and screening activity, satisfaction with care and preferences for screening among patients. Domestic Violence Health Care Provider Survey Scale was utilised to measure healthcare providers' readiness to screen for IPV as well as actual screening activity (Study I-III). Structured interviews were conducted with women attending the General Out-patient department, maternal and child health clinics of the participating hospital to probe their preference for screening and their satisfaction with care using the pyramid patient questionnaire (Study IV). Data were analysed using relevant univariate and multivariate statistical methods.

Results

The instruments utilised illustrated a stable structural validity (study I) and internal consistency (Studies I, II, III & IV). Barriers to screening were eminent both from the provider and the client perspective. Majority of Health Care Provider (HCP) did not inquire about the possibility/occurrence of IPV from their clients (74%) and scored on average moderately on readiness to screen indicator (i.e. self-efficacy, system support, attitudes towards screening, professional roles and victim/provider safety subscales) suggesting barriers (Study III). Readiness to screen for IPV as well as screening for IPV was associated with several demographic and occupational characteristics of the healthcare provider (Study II). Social workers perceived a higher self-efficacy and a better support network to refer victims of violence than other professions. Gender and profession were significantly associated with blaming the victim with males and doctors less likely to blame the victim. Age, ethnicity and profession impacted significantly on professional roles related to screening for IPV where younger care providers, of Yoruba ethnicity and social workers were less likely to perceive conflicting professional roles related to screening than older providers, of Hausa ethnicity and doctors respectively. HCP from the Yoruba ethnicity were more likely to inquire about the possibility of IPV among their clients than peers from other ethnic affiliation (Study III). Majority of Women had a preference for being probed about IPV in healthcare (76%) while 20% regarded such inquiry as unacceptable. However, only 7% of the interviewed women had been probed on the possibility of IPV. Women of Hausa ethnicity (9%) and Islamic religion (8.2%) were more likely to have been screened for IPV during their latest contact. Participants who had been probed on IPV expressed a higher satisfaction with care than peers who had not been probed. (Study IV).

Conclusion

There remain barriers to screening for IPV as expressed in the moderate scores of readiness to screen as well as actual screening statistics. Occupational and socio-demographic characteristics of HCP may account for differences in readiness to screen as well as actual screening activity, warranting interventions e.g. training, education and policy interventions. From the clients' perspective, majority preferred being probed about IPV in healthcare. Moreover, women who had been screened expressed a higher satisfaction with care than colleagues who had not. These findings warrant introduction of routine screening in healthcare settings in this region. The ethnic and religious disparities in screening for IPV warrant further investigation.

List of Original papers

This thesis is based on the following publications, which will be referred to in the text as study and enumerated in roman numbers.

- I. John, IA; Lawoko, S. Assessment of the Structural Validity of the Domestic Violence Healthcare Providers' Survey questionnaire: using a Nigerian sample. *Journal of Injury & Violence Research* (In the press)
- II. John, IA; Lawoko, S; Svanström, L; Mohammed, AZ. Health Care Providers readiness to screen for Intimate Partner Violence in Northern Nigeria. *Violence & Victims*, Volume 25 (4) (In the press)
- III. Ime Akpan John; Stephen Lawoko; Leif Svanström. Screening for Intimate Partner Violence in Healthcare in Kano, Nigeria: extent and determinants – *Journal of family violence*. (In the press)
- IV. John, IA; Lawoko, S; Oluwatosin, A. Acceptance of screening for Intimate partner violence, actual screening and satisfaction with care among female clients visiting a health facility in Kano, Nigeria (submitted)

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1.0 INTRODUCTION

The prevention and elimination of intimate partner violence (IPV) against women is a complex subject that has engaged multidisciplinary competence, including human rights and women's rights advocates, scientists and policy-makers. The healthcare delivery sector has been recognised as one of the critical arenas in which to address IPV. Over the past decades, researchers have advocated the screening of intimate partner violence against women in healthcare in a further to understand its extent, nature, consequences, risks and triggering factors, and also potential barriers to intervention (Emenike et al., 2008; ACEP, 1995; Waalen et al., 2000). Yet, clinicians have only recently responded to such advocacy in some parts of the world (Waaen et al., 2000), and the results indicate that only a few healthcare providers routinely screen for IPV. These findings are indicative of the likely existence of barriers to screening. This dissertation attempts to understand these barriers in a sub-Saharan African context through examination of a Nigerian health facility.

2.0 BACKGROUND

2.1. Intimate partner violence against women (IPV) – definitions, extent, health consequences, risk factors and prevention

2.1.1. Definitions of intimate partner violence (IPV)

IPV has been defined in several ways. Some authors have treated it in terms of physical assaults, including sexual assaults that occur in intimate relationships (Golding, 1999; Rothman et al., 2003). Others have, in addition to physical assaults, included intention to physically hurt one's partner without actual physical abuse (VMS, 2006). The latter is in line with World Health Organisation (WHO) general definition of violence as "the intentional use of physical force or power, threatened or actual, against one self, another person, group or community that may or may not result in injury, death, psychological harm, maldevelopment or deprivation" (WHO, 2001). Article 1, item (j) of the protocol to the African Charter on Human and People's Rights, like the WHO definition, adopts a holistic definition: "all acts perpetrated against women which cause or could cause them physical, sexual, psychological and economic harm, including the threat to take such acts, or to undertake the imposition of arbitrary restrictions on or deprivation of fundamental freedoms in private or public life, in peace time and during situations of armed conflict or of war" (ACHPR, 2005).

Thus, IPV is gender-based violence against women that manifests itself in physical, sexual and emotional abuse. In this study, the operational definition of IPV captures these aspects.

2.1.2. Extent

Intimate partner violence against women is a global phenomenon that cuts across culture, race, social status and nation, with no major variations according to the economic status of countries, as shown in Table 1. Globally, yearly prevalence ranges between 20% and 60% and lifetime prevalence between 11% and 74%. Consequently, IPV against women constitutes a potential public health problem.

Table 1. Yearly and lifetime prevalence of physical and sexual abuse among intimate partners in selected countries.

	Regions/ Classification	Country	Yearly prevalence %	Lifetime prevalence %	Source
PHYSICAL ABUSE	Low and middle income	Korea	27		WHO
		Kenya	40		DHS; Raikes, 1990
		Nicaragua	52		WHO
		Poland	60		UNICEF
		India	22	22-75	Rao 1997; Mahajan, 1990
		Nigeria	39	11-52	DHS
		Sri Lanka	60	51-60	Sonali, 1990
		Papua New Guinea	56	56-62	Toft, 1987
		Malaysia	39	15-22	Raj-Hashim, 1993
		Colombia	20	20-50	Profamilia, 1992; DHS
		Costa Rica	35	35-51	UNICEF/PAHO
		Guatemala	49	49-74	UNICEF/PAHO
		Chile	26.2	70	Larrain, 1993
		Ecuador	60	37	CEPLAES, 1992
		Palestine	52	22-52	WHO
		Tajikistan	23		WHO
	Mexico	33-57		Ramirez & Vasquez, 1993; Santiago & Cox, 1990	
	High Income	Antigua	30	50	Handwerker, 1991
		Australia			
		Barbados	30	50	Handwerker, 1993
Canada		3			
Norway		25		Schei & Bakketeig, 1989	
New Zealand		20	58	Mullen et al., 1988	
USA		28	28-40	Straus & Gilles, 1986; Grant et al., 1991	
SEXUAL ABUSE	Low and middle income	Colombia, Korea	19-27	10	DHS, WHO
	High income	Canada, Estonia, New Zealand, United Kingdom, USA	12-25	12	Grant et al., 1991; Schei & Bakketeig, 1989

2.1.3. Health consequences

Intimate partner violence (IPV) has been associated with several problems that not only affect the victim but society at large, e.g. development, labour force and productivity. However, our

discussion will focus on the health consequences, which include both fatal and nonfatal outcomes, as summarised in Table 2.

Table 2. Health consequences of intimate partner violence and sexual violence by any perpetrator.

Fatal Outcomes	Non fatal outcomes		
	Physical injuries and chronic conditions	Sexual and reproductive sequelae	Psychological and behavioural outcomes
Femicide	Fractures	Gynaecological disorders	Depression and anxiety
Suicide	Abdominal/thoracic injuries	Pelvic inflammatory disease	Eating and sleep disorders
AIDS-related mortality	Chronic pain syndromes	Sexually transmitted infections, including HIV	Drug and alcohol abuse
Maternal mortality	Fibromyalgia	Unwanted pregnancy	Phobias and panic disorder
	Permanent disability	Pregnancy complications	Poor self-esteem
	Gastrointestinal disorders	Miscarriage/low birth weight	Post-traumatic stress disorder
	Irritable bowel syndrome	Sexual dysfunction	Psychosomatic disorders
	Lacerations and abrasions	Unsafe abortion	Self-harm
	Ocular damage	Gynaecological disorders	Unsafe sexual behaviour
	Burns	Pelvic inflammatory disease	
	Ear injuries		

Adapted from Heise & Gracia Moreno, 2002; Heise, Ellsberg & Gottemoeller, 1999.

A substantial proportion of physically assaulted women sustain injuries, ranging in severity from bruises to fractured bones (Koenig et al., 2003; Aimakhu et al., 2004; Fawole et al., 2005), and exhibit various symptoms of psychological morbidity, manifested in depression, anxiety and post-traumatic stress disorder (Golding, 1999; Heise et al., 1999; Tjaden & Thoennes, 2000; Petersen et al., 2001; Tolman & Rosen, 2001; Aidoo & Hapham, 2001; Plichta, 2004; Campbell 2002; Campbell et al., 2002; Mayeya et al., 2004). As well as suffering physical and psychological problems, female victims of IPV, to a greater extent than peers in non-abusive intimate relationships, adopt health-risk behaviours, such as unhealthy eating, substance abuse, alcoholism and suicidality (Heise et al., 1999; Silverman et al., 2001; Roberts et al., 2005; Lee & Hadeed, 2009). Evidence suggests further that abused women of reproductive age encounter reproductive health problems, including terminated pregnancies, undesired pregnancies and child loss during infancy to a greater degree than peers in non-violent intimate relations (Rose et al., 2000; Kishor & Johnson, 2004; Garcia-Moreno et al., 2005).

Women experiencing IPV, by contrast with non-abused peers, tend to use community and healthcare services more sparingly, and have a more restrained bond with healthcare providers and employers (Plichta, 2004; Heise & Garcia-Moreno, 2002). It remains unclear, however, whether this is a reflection of loss of self-confidence or whether they in fact are victims of social and institutional marginalisation. Whatever the case, screening could improve the institutional detection and management of IPV.

2.1.4. Determinants of IPV against women

The determinants of intimate partner violence are multifaceted and often are a result of complex inter-play between factors at the individual, relationship, community and societal level, as depicted in the ecological model (Fig. 1).

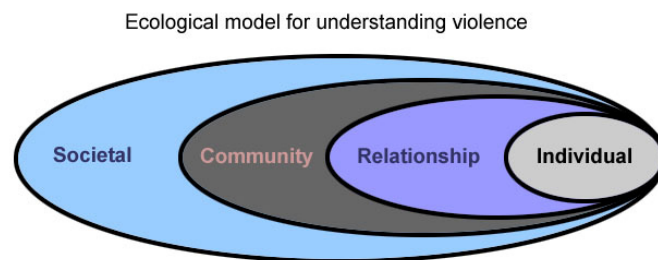


Figure 1: The ecological model (Heise, 1998).

The *individual level* represents biological and personal experience. Sex role expectations become an intrinsic part of children as they grow up. A male child is expected to be aggressive, risk-taking and bold, while a female child is expected to be calm and submissive (Scheresky, 1976; Zukerman & Sayre, 1982). Witnessing IPV as a child can impact negatively on a child, who might learn to adopt violence as a method of resolving conflict (Margolin & Gordis, 2000; Fantuzo & Mohr, 1999). Other factors associated with an increased risk of IPV perpetration, and also being a victim, are abuse of alcohol and drugs (Hotaling & Sugarman, 1986; Kantor & Straus, 1989; Klostermann & Fals-Stewart, 2006). At the *relationship level*, men's control of wealth and decision-making autonomy in the household render women dependent on their husbands (Lawoko, 2007). Differences between partners in age, education, etc. are likely to increase the risk of conflict between them (Lawoko et al., 2007; Archer, 2006; Efoghe, 1989). Likewise, women's behaviours that are considered to infringe expected gender norms are likely to be perceived as an abuse of "family honour", increasing the risk of abuse by the family as a whole and husbands in particular (Campbell, 1985; Niaz, 2003).

At the *community level*, women's isolation and social neglect, and also community tolerance of violence against them, puts women at the disadvantage. In communities with a collectivist orientation, there may be unsympathetic treatment of 'out-groups', for example the

maltreatment of a wife by her in-laws who expect her to be an obedient servant (Triandis, 2001). Traditional norms in some communities control women's sexuality, and women may be killed by husbands and family members for suspected infidelity. Divorce and remarrying are not options, since they are seen as impeding family honour (Kulwicki, 2002; Douki et al., 2003)

At the *societal level*, failures of institutional structures and policies in addressing IPV may in fact promote such practices. Gender roles are skewed to give men the advantage, and implemented in all institutions, including educational facilities, offices and hospitals. The legal system in some countries is unfavourable to women. The customary laws and penal codes are a reminder that societal norms are deeply rooted in institutional regulations. In northern Nigeria, for example, the Penal Code (29 Section 55) states that: "*Nothing is an offence which does not amount to the infliction of grievous hurt upon any persons which is done ... d) by a husband for the purpose of correcting his wife, such husband and wife being subject to any native law or custom in which such correction is recognized as lawful*" (Domestic Violence, Nigeria 2000; Bamgbose, 2005; Eze-Anaba 2006). Physical violence against women by their spouse is clearly endorsed as a means of settling domestic conflict. Male dominance becomes the acceptable norm in many institutions, where equity and other gendered regimes operate to place women at a disadvantage. Violence against women is not improved by policies that endorse and maintain economic and social inequalities against women. Corporal punishment of women and limitation of their fundamental human rights remain operational in societies with such an inclination.

2.1.5. Intimate partner violence against women in a multi-cultural, ethnic and religious societal context – an example from Nigeria

Culture in the Nigerian context incorporates beliefs and norms that assign and regulate power relationships in society, including marital relationships. Social and sex roles expectations are predicated on sex differences being a result of a division of labour in which there are distinct masculine or agentic roles and feminine or communal traits (Ridgeway & Correll, 2004). Such gender identification is reinforced as male children develop. The aggressive role, which includes discipline and control of the wife, is constructed as an expected practice of manhood (Connell & Messerschmidt, 2005). The expected patterns of behaving as a man or woman are transmitted to future generations through socialisation processes (Wood & Eagly, 2002). Belief in the inherent superiority of males and a patriarchal society give men proprietary rights of ownership of women especially, where bride price is a valued demand from in-laws.

By accepting a monetary dowry in exchange for their daughter, the parents seal a transaction or contract supported by the customary laws of Nigeria (Bamgbose, 2002). Some cultures within Nigeria also view wife-beating as normative behaviour in matrimonial relations, tolerated even by the victims (Fawole et al., 2005; Odunjinrin 1993). This feature is also observed elsewhere in sub-Saharan Africa (Lawoko, 2006; Lawoko, 2008).

Ethnicity is defined as a socio-cultural concept that involves the common consciousness of shared origins and traditions of a people, which may provide the basis for social interactions in norms, belief and behaviours. Ethnicity, therefore, may assign certain behaviours to people of certain groups, as proposed in the health behaviour model (Dressler, 1993). Thus, certain ethnic groups may be more prone and receptive to violence than others (Nickens, 1986; Murdaugh, et al. 2004). Studies from Nigeria indicate a higher prevalence of abuse among women in the Yoruba ethnic group (Okenwa et al., 2009). Whether or not acceptance and delivery of screening may vary according to ethnicity is further investigated in this work.

Religion is defined generally as a personal or institutionalised system grounded in belief in, worship of and reverence for a supernatural power or powers regarded as a creator or creators (Answer.com, 2010). Religion has provided solace for several behaviours that have either promoted or damaged well-being (Hackett 2003; Rostas, 1999; Hummer et al., 2004).

Women's disclosure of abuse has been found to be affected by religion and culture (Kershner & Anderson, 2002, Okenwa et al., 2009), with such disclosure being less common among Asian Americans (Preisser 1999; Sorenson & Taylor, 2003). How religion influences healthcare providers' readiness to screen for IPV against women is still not clear. The current work is intended to fill this gap in research.

2.1.6. Primary prevention of intimate partner violence

Prevention in public health can be categorised into primary, secondary and tertiary. This section will focus on the primary prevention of IPV, since this has implications for the dissertation as a whole.

2.1.6.1. Legal reforms and strengthening responses from the criminal justice system

Although it has been suggested that legal reforms positively influence IPV incidence in some developing countries, in others its realisation (i.e. the move from proposal to implementation) remains a problem. This might stem from difficulties in changing traditional norms that are deeply rooted in the society (Eze-Anaba, 2006; Bott et al., 2005; UN, 2004; Baobab for Women's Human Rights, 2003; UNICEF, 2001; McNutt et al., 1999; Wijma et al., 2003; Xu

et al., 2005; Okenwa et al., 2009; Rubertsson, 2010). Such norms are cultural and religious as well as ethnic (as discussed in the previous sections).

2.1.6.2. Education

The effect of education on intimate partner violence reduction remains contentious. While in some societies education of both men and women may reduce IPV, in others the opposite has been observed, which suggests that there is an inverted U-shaped association between the two (Jewkes, 2002). For example, a higher level of education has been shown to confer protection against violence to women in the USA (Jones et al., 1999). But, although in Kenya education of women has been associated with a lower likelihood of abuse, in Zambia the opposite has been observed (Lawoko, 2008). Also, women can be empowered by addressing school safety and best practice, and effecting attitudinal change among students and adolescents towards women's rights (Bott et al., 2005). On the other hand, less violence was found to be associated with the withdrawal of young girls from schools in sub-Saharan Africa and south Asia (UNICEF, 2004; Mensch & Lloyd, 1998). These discrepancies warrant re-assessment and consequent revision of the educational programs delivered to women. Also, there may be a need to include men, the potential perpetrators, in such educational initiatives if the desired impact of educational interventions is to be achieved (Lawoko, 2006; Lawoko, 2008).

2.1.6.3. Health sector approaches

Women come into contact with healthcare for various reasons pertaining to their own reproductive, physical and psychological health; there are, for example, routine controls and child health issues. Accordingly, the health sector offers a unique opportunity routinely to inquire about the possibility of abuse from women themselves.

Health sector intervention has been recognised as crucial to promoting remedies to the scourge of intimate partner violence against women. The former Director General of the World Health Organisation, Dr Gro Harlem Brundtland, added her voice to the global call for action: "National health policies, institutions and programs must pay attention to gender-based violence not only as a public health problem but a key component of the HIV/AIDS pandemic. We have some of the tools and knowledge to make a difference – the same tools that have successfully been used to tackle other health problems. Violence is often predictable and preventable" (Krug et al., 2002).

Interventions to address IPV in high income countries have focused on training for healthcare providers and developing protocols and tool for identifying and referring victims of IPV.

There is overwhelming evidence showing that healthcare providers do not inquire into the possibility of IPV against women despite obvious signs of abuse and the knowledge that it is abused women who use health services more than their non-abused peers (Plichta & Weisman, 1995; Campbell, 2002; Ramsay et al., 2002). The reluctance of healthcare providers to probe abuse may be for fear of offending the woman, or for fear of opening a ‘Pandora’s box’ of cases that they may not be well equipped to manage (Velzeboer et al., 2003). Other factors preventing abused women from disclosing violence include fear of the perpetrator and lack of support from family members and society. More recently, socio-demographic characteristics of abused women have been found to impact on their acceptance of inquiry, yet a majority of women do accept being screened (Gerbert, 1999; Stenson et al., 2001; Dowd, 2002).

However, there are emerging approaches that – when well implemented – should provide a better guide to achieving better health for women, which are summarised in Table 3 (Bott et al., 2005). These include broadly addressing population attitudes and practices, community mobilisation to counteract gender-based violence, law reforms, and strengthening institutional capacity to identify and control IPV. This dissertation focuses primarily on understanding the latter aspect, by studying barriers to screening for IPV in a Nigerian context.

Table 3. Examples of objectives and initiatives from the health sector.

Levels	Objectives	Specific initiatives
Individual and relational behaviour change	<p>To improve the knowledge, attitudes and practices of key groups and the broader population</p> <ul style="list-style-type: none"> • Promote gender-equitable, nonviolent sexual partnerships • Increase women’s ability to make decisions about the timing and nature of sexual relationships • Decrease tolerance for violence by raising awareness of gender-based violence as a public health problem • Encourage victims of abuse to seek help and to disclose violence to service providers 	<ul style="list-style-type: none"> • Clinic and community-based education efforts (theatre, videos, pamphlets, talks, etc.) • Mass and multi-media behaviour change campaigns, such as edutainment programs (e.g. Soul City and Sexto Sentido) • Programs for men aimed at promoting gender equitable relationships and changing norms, attitudes and behaviours • Gender-based violence prevention within HIV/AIDS and adolescent reproductive health programs
Community mobilisation	<p>To increase community mobilisation to address gender-based violence as a public health problem</p> <ul style="list-style-type: none"> • Strengthen community support for survivor services • Strengthen coalitions and networks • Improve attitudes, norms, practices and resources at the community level 	<ul style="list-style-type: none"> • Coalitions for public health research and advocacy • Community level prevention and mobilisation initiatives • Community-based awareness campaigns aimed at mobilising journalists, policy-makers, and opinion leaders
Institutional reform	<p>To strengthen the response of healthcare and public health institutions to gender-based violence</p> <ul style="list-style-type: none"> • Raise awareness of the links between violence and health among service providers, managers, and public health policy-makers • Improve the quality of care for survivors of violence, including identification, treatment, documentation, information referrals and follow-up • Increase coordination with other sectors that provide services or work on violence prevention 	<ul style="list-style-type: none"> • Policies, procedures and protocols to improve the healthcare response • Sensitisation and training of health professionals • Routine screening and referral systems • Development of information systems such as epidemiological surveillance, and morbidity statistics on violence • Specialised survivor services (counselling, support groups) • Improved coordination and referrals to NGOs and other sectors • Curricular changes in training of nurses and medical personnel
Laws and policies	<p>To improve laws and policies</p> <ul style="list-style-type: none"> • Clarify providers’ legal responsibilities 	<ul style="list-style-type: none"> • Reforms of laws and policies regulating the medico-legal system (e.g. introduction of forensic nurses)

	<ul style="list-style-type: none"> • Encourage a better health sector response to #gender-based violence (GBV) through national, regional, and municipal policies regarding screening, referral, documentation and counselling for victims of violence • Ensure survivors' rights to services (e.g. emergency contraception, STI prophylaxis, etc.) 	<ul style="list-style-type: none"> • Reform of laws and policies regulating healthcare providers' obligations vis-à-vis victims of gender-based violence • Mandatory reporting laws/policies • National health policies and protocols • Laws/policies governing forensic medicine, provider obligations, abortion, EC and patient confidentiality
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Source: Bott S, Morrison A & Ellsberg M. 2005. World Bank Policy Research Working Paper 3618.

3.0 Screening for intimate partner violence in healthcare

Researchers and experts have advocated screening for IPV in healthcare because of its adverse impact on the health of women and children. Routine screening of women during visits to clinics, irrespective of the medical conditions that brought them there, has been practised in high income countries, such as the USA and some European countries (ACOG, 1998). However, reciprocal screening routines are yet to be implemented in many middle and low income countries.

3.1. What constitutes screening for IPV?

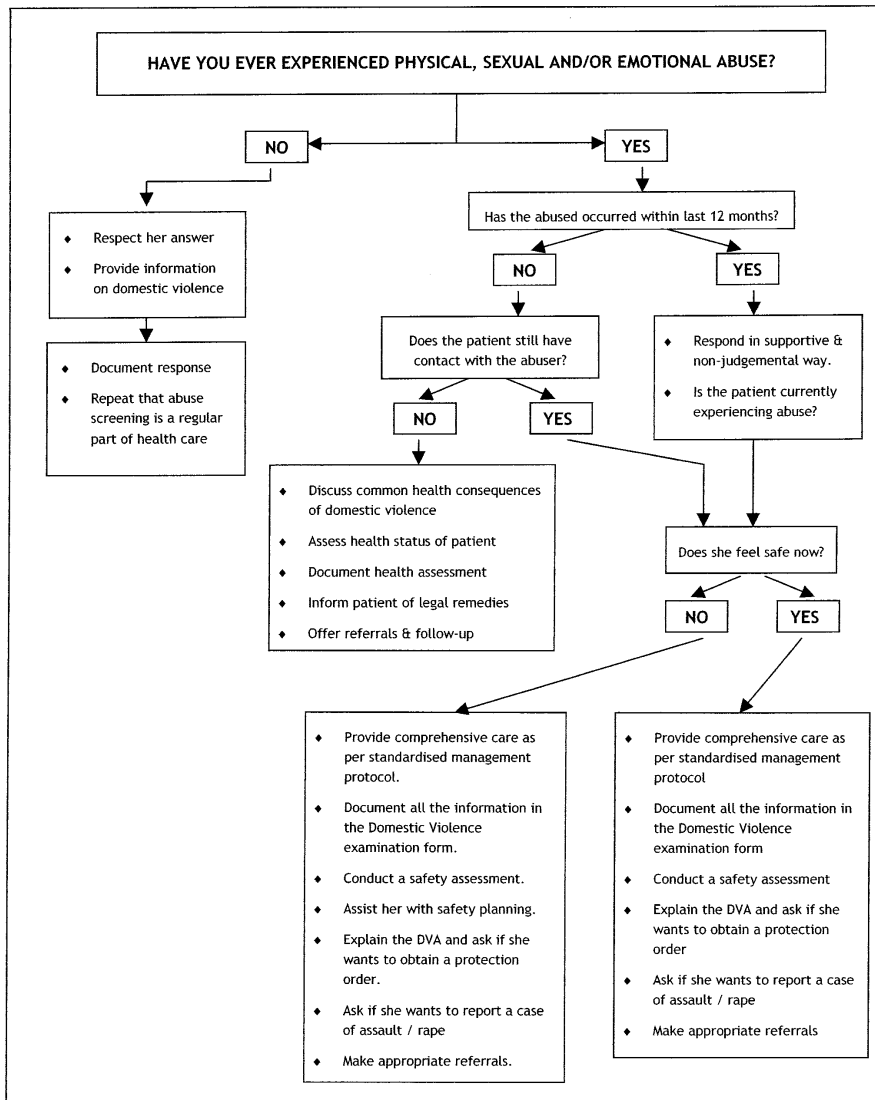
Screening in medical practice is defined as a process designed to identify previously unrecognised disease or defect using tests, examinations or other procedures that are applied rapidly. Screening aims to sift out apparently healthy people from those who may have the disease. Screening is not usually diagnostic (Last, 1995; Beaglehole et al., 1993). It can be performed for the whole population (mass screening), involve a variety of tests on the same occasion (multiple or multiphase screening), and/or aim at the early detection of a specific condition in presumably healthy individuals (prescriptive screening).

For the purpose of this dissertation, however, screening for the 'disease' – in this case IPV – is the process of questioning patients or clients visiting health facilities about a possible history of physical, sexual or psychological violence from their intimate partners. Thus, clinicians are tasked routinely to raise the possibility of abuse with clients, regardless of the reason for their visit (McNutt et al., 1999). This process, which is routine in several countries, is acceptable to women, and is regarded as good practice (Friedman, 1992; Caralis & Musialowski, 1997).

A number of instruments have been developed and utilised to screen women for IPV, mostly within industrialised high-income countries (Hudson & McIntosh, 1981; Marshall, 1992; Mcfarlane et al., 1992; Smith et al., 1995; Brown et al., 1996; Feldhaus et al., 1997; Sherin et al., 1998; Straus, 1979; Swahnberg & Wijma 2003; Weiss et al., 2003; Swahnberg & Wijma, 2007; Sohal et al., 2007).

Attempting definitions of the behaviours that constitute intimate partner violence has raised the question of having ‘gold standards’ that would determine an acceptable instrument to be used for its screening. However, the basis of a screening tool lies in its capacity to identify potential victims and meet the World Health Organisation’s screening principles (Wilson & Jungner, 1968). Thus, a protocol that is simple, yet comprehensive enough to offer referrals and prompt management of IPV, is to be preferred. A universal screening protocol developed by the Taskforce on Health Effects of Woman Abuse, London, Ontario, Canada meets this criterion. The protocol aims to identify physical, sexual and/or emotional abuse and offers steps to be taken to manage them. In general, the protocol probes clients on whether they are experiencing abuse, offers information on domestic violence, offers support for victims of abuse, informs patients of legal and other remedies, enables the performance of a safety assessment, and makes access to referrals easy.

UNIVERSAL SCREENING PROTOCOL



Adapted from: Task Force on the Health Effects of Woman Abuse, Middlesex-London Health Unit (2000).

3.2. Benefits of screening for IPV

The benefits of routine screening have been questioned by several authorities (Ramsey et al., 2002; Wathen & MacMillian, 2003; Nelson et al., 2004), since there is only limited evidence in the research to demonstrate such benefits. Nonetheless, self-reports from women in developed countries indicate that they feel comfortable responding to questions about violence in healthcare settings (Stenson et al., 2001; Stenson et al., 2005). Reciprocally, healthcare professionals themselves acknowledge that routine screening is likely to improve the identification of IPV (Bair-Merritt et al., 2006; Furniss et al., 2007).

The overall gains of screening may better be attainable if healthcare providers are put through the following steps; they are not necessarily ends in themselves, but constitute an ongoing process (McLeer et al., 1989; Davidson et al., 2001):

- Training of HCP;
- Provision of a comprehensive screening protocol;
- Regular follow-up of HCP;
- Continuous campaigns on IPV screening within the hospitals and community
- Feedback from HCP;
- Improvement of screening procedure by regular evaluation;
- Close supervision of the process by a coordinator situated at each facility.

3.3. Barriers to screening for IPV

Despite the potential benefits of screening, studies have abundantly indicated that few healthcare providers screen their clients for IPV, which suggests that there are barriers to implementation (Erikson et al., 2001; Roelens et al., 2006). Such barriers may stem from individual, organisational and socio-cultural factors (Thurston et al., 1998). These factors are likely to affect inquiry into IPV (barriers from the care provision perspective) as well as response to inquiry (barriers from the client perspective). The focus of this dissertation is on scrutiny of these barriers.

3.3.1. Barriers and challenges to screening for IPV – care provision factors

Disclosure of IPV is likely to be affected by the methodology used to collect information on it. Screening protocol design issues, e.g. the formulation of questions etc, are likely to affect respondents' feelings of security and privacy, thereby affecting disclosure of abuse (Ellsberg et al., 1999; Krug et al., 2002; Swahnberg & Wijma, 2007). Thus, healthcare providers' knowledge and training are likely to play a major role in accurate screening. A failure to

provide competency among professionals has only recently been acknowledged as a significant barrier to screening for IPV in industrialised societies (Waaen et al., 2000; Erikson et al., 2001). Moreover, professional roles governing provider-client relations (e.g. mutual respect) and attitudes towards IPV in general may hinder healthcare providers from inquiring about private issues, such as abuse. Indeed, the evidence from industrialised societies indicates that only between 8% and 10% of healthcare personnel routinely screen for IPV (Erikson et al., 2001) despite the fact that women feel comfortable in responding to exposure-to-violence questions in healthcare settings (Stenson et al., 2001; Stenson et al., 2005; Swahnberg & Wijma, 2007).

Such evidence notwithstanding, assessment of healthcare providers' skills and capabilities in screening, attitudes towards screening and access to support systems to which victims can be referred has not received attention in the research literature, particularly in the context of developing countries. Moreover, studies of the possible demographic and occupational factors that may account for differences in IPV screening between individual healthcare providers are generally lacking. For example, it may be hypothesised that women are more prone than men to inquire about IPV, since – as potential victims – they are more likely to identify with the problem of violence. Nurses may be more prone to inquire about IPV as they are more often at the forefront of care provision. And experienced personnel may be more likely to probe for IPV, than their less experienced colleagues, etc. An assessment of how such factors are related to screening is useful for, among other purposes, the identification of potential groups requiring further skills in screening. The current work will assess care provision characteristics likely to affect screening for IPV in a Nigerian context.

3.3.2. Barriers and challenges to screening for IPV – client features

Though evidence in developed societies suggests that women in general feel comfortable in responding to IPV questions in clinical settings (Stenson et al., 2001; Stenson et al., 2005; Swahnberg & Wijma, 2007), it remains unclear whether such findings can be replicated in developing countries. Data from African countries, including Nigeria, suggest that over 60% of women regard domestic violence as a justified domestic matter (Hindin, 2003; Oyediran & Isiugo-Abanihe, 2005; Lawoko, 2006), raising concerns about how they would view screening for IPV in healthcare. Such an attitude among women might work to impede screening for IPV in this societal setting. The current study will investigate whether this hypothesis is reasonable, given the Nigerian context.

3.4. Rationale for the study

The health and social consequences of gender-based violence, alongside the international and local calls/declarations/conventions aimed at eliminating violence against women, should not be ignored. It therefore becomes incumbent on us to scrutinise the alarming pervasiveness of IPV. By ascertaining the condition in healthcare, health professionals become key players in identification of the phenomenon. Also, women play an even greater role in assisting healthcare to identify and manage an apparently 'hidden disease'. Challenges to these endeavours rest on the identification of provider-related/client-related barriers to screening for IPV in healthcare, in particular in a Nigerian context, and on suggesting appropriate measures to manage such barriers. Identification and management of such barriers may prove significant milestones in improving provider-client relations, and thereby client satisfaction with care. From a research point of view, management of barriers to screening for IPV may improve disclosure and enhance better understanding of the extent, nature, and health and social implications of IPV in Nigeria and in similar societal contexts.

4.0 Study objectives and hypotheses

4.1. General aim

The overall aim of this dissertation is to scrutinise provider-related and client-related barriers to screening for intimate partner violence in healthcare, using data from a healthcare facility in Kano, northern Nigeria.

4.2. Specific objectives

More specifically, the current project will:

- initially test the structural validity of the Domestic Violence Healthcare Providers' Survey questionnaire, the main instrument used in studies II and III;
- investigate healthcare providers readiness to screen for intimate partner violence in northern Nigeria (Study II);
- study the extent and determinants of actual inquiries into intimate partner violence in healthcare in Kano, Nigeria (Study III);
- investigate acceptance of screening among female clients, and also actual screening, and whether this impacts on satisfaction with care among female clients visiting a health facility in Kano, Nigeria (Study IV).

5.0 METHODS

5.1. Study area

Kano is the capital of the Nigerian northern state of Kano. Kano is the second largest city in Nigeria, with an estimated population of 3,848,885 in 2007 (Kano, 2009). It was founded in the 6th century, and conquered by Fulani Jihadists in the early 19th century. The population of the city represents to a large extent more than half of the 250 peoples of the different ethnicities in Nigeria, Arab and European expatriates. Hausa is the main language, but English remains the official language of government. Medical education at the hospitals and universities in Nigeria, including Kano, is conducted in English, based on the universal Western medical curriculum. About 99% of Kano indigenes are Muslims, while Christians and followers of other religions are minorities in Kano.

Kano is the commercial and international gateway of Nigeria to the north. Nigeria has a population of one hundred and forty-nine million, two hundred and twenty-nine thousand according to an estimate for 2009, with a growth rate of 2%. Population of females and males were 73 million and 76 million respectively. (Nigeria, 2009). Life expectancy at birth is 46 years for males, and 48 years for females. Infant mortality is 94/1,000 live births. Nigeria is rich in crude petroleum, agriculture, and minerals. Oil contributes to 95% of foreign earnings and constitutes 80% of the country's annual budget. GDP per capita was \$2,300 in 2008, and the country had a human development index (HDI) score of 0.51. HDI broadly measures well-being on three dimensions (life expectancy; education by gross enrolment in schools and adult literacy; and, decent standard of living, as measured by purchasing power parity or income of individuals). However, the fact that the HDI does not consider gender disparity prompted the introduction of the gender-related development index (GDI). The GDI measures inequalities between men and women within the HDI. Nigerians' GDI was put at 97.7% (UNDP, 2009). The same report indicated that the adult illiteracy level of Nigerian was 28%, with women constituting 62.7% of the illiterate population (UNICEF, 2010). National poverty incidence was 54.4% in 2004, and 61.29% in Kano State in the same year (Nigeria Statistics, 2005). The prevalence of intimate partner violence (IPV) was estimated at 31%-87% (Ilika et al., 2002; Ameh & Abdul, 2004; Fawole et al., 2005; Owoaje & OLaOlorun, 2006). IPV has been studied descriptively, but systematic assessments of the attitudes, knowledge and competence of all healthcare workers in screening for IPV have yet to receive explicit attention. Health care in Nigeria varies from one state to another. While consultations, maternal and child

health services are free of charge in most of the Northern states including Kano, other states in the South have subsidized fees for these services.

Our research site, Aminu Kano Teaching Hospital, is a 230-bed modern federal hospital that provides all levels of healthcare to Kano inhabitants. It also serves as a specialist and referral centre for surrounding states and neighbouring countries or parts of neighbouring countries, such as Niger, Chad and north-eastern Cameroon. In 2004, 101,036 outpatients visited the facility, and 8,937 patients were admitted for various ailments. In December 2008, there were 438 nurses (of whom 90% were female). There were 387 doctors (of whom more than 70% were male). Social workers and other clinical staff had an over-representation of females, while men dominated administrative positions.



Map of Nigeria (left, <https://www.cia.gov/library/publications/the-world-factbook/geos/ni.html>) with Kano State in red (right, www.speakersoffice.gov.ng/images/map.kano2.gif)

5.2. Studies I-III

These studies were based on data from the Aminu Kano Teaching Hospital in Kano, Nigeria, which is the largest multi-departmental federal health institution in Kano State. Staff and patients have a multi-ethnic background and speak English, the official language in the country. In general, staff members at the hospital have not undergone any specific training in screening for IPV. All healthcare providers having regular contact with patients (n=430) were informed of the study by department heads and invited to participate. Self-administered questionnaires were sent to the eligible participants, of which 274 (response rate of 64%)

returned a completed questionnaire. Voluntary participation was emphasised, and informed consent given. The participants included psychiatrists, obstetricians and gynaecologists, paediatricians, physicians, laboratory scientists, opticians, nurses, and midwives.

5.2.1. Design

The design for studies I-III was cross-sectional.

5.2.2. Instrument measures for studies I-III

The *Domestic Violence Healthcare Provider Survey scales* measure healthcare providers' readiness to screen for IPV as well as their actual screening activity (Maiuro et al., 2000). The instrument has been previously validated, and shown promising results, in developed countries. Study I attempted to assess the structural validity of the *Domestic Violence Healthcare Provider Survey scales* in the Nigerian context. The questionnaire consists of the following 5 subscales:

The *perceived self-efficacy subscale (4 items)*, which assesses providers' own perceived efficacy in inquiring about IPV.

The *system support subscale (4 items)*, which assesses healthcare providers' access to support networks for referral/management of IPV victims.

The *professional's role resistance/fear of offending clients subscale (6 items)*, which assesses providers' opinions on whether inquiries about IPV may conflict with ethical issues governing their communication with clients.

The *blame victim subscale (7 items)*, which assesses providers' attitudes towards victims.

The *victim/provider safety subscale (10 items)*, which assesses whether providers perceive inquiries about IPV from batterers further to jeopardise the safety of victims/care providers.

All items require the respondent to take a position on specific statements. The response options for each statement range from 1 (strongly disagree) to 5 (strongly agree).

Frequency of violence was assessed using an open-ended question inquiring how often during the past three months the respondent had inquired about the possibility of domestic violence in his/her contact with a patient. Due to the skewed distribution of responses to this question (i.e. many had not screened), the responses were dichotomised, where respondents who had inquired about violence at least once (i.e. screened for violence) formed one group and those who had not inquired during the same period (i.e. had not screened for violence at all) formed the other group.

The questionnaire also collected demographic and occupational information on each respondent (i.e. age, gender, marital status, religion, ethnicity, profession, departmental affiliation, and years of work experience). To enhance statistical power, some responses were merged to increase numbers within categories; for example, departments with very few participants were merged to form the group “other” department.

Study I scrutinised the structural validity of the Domestic Violence Healthcare Provider Survey scales. In Study II, determinants of readiness to screen for IPV (using the scales above) were investigated. Thus, in this study, readiness to screen was the dependent variable. Study III scrutinised whether readiness to screen was associated with actual screening behaviour. In this study, actual inquiry into IPV was the dependent variable, with readiness to screen as the independent variable.

5.2.3. Statistical analyses

Study I

Exploratory factor analysis, using the principal component method, was performed to test underlying factors and their stability as expressed in factor loadings. Varimax rotation was applied to limit the number of high loadings on the same factor. This was designed for clearer identification of items emerging under each subscale. The criteria for the number of resulting significant factors were based on the Kaiser Criterion and confirmed by scree plots (Carroll, 1957; Maiuro et al., 2000; Field et al., 2007) Items with a factor loading of at least 0.30 were considered significant; this is based on criteria for significant correlation (Cohen, 1988). The contribution of each factor to explaining the total variation in the item pool was reported. Significant factors (i.e. those with loading of at least 0.30) were tested for internal consistency using Cronbach’s alpha. Each item was then scrutinised further to assess whether the removal of that item would improve the alpha coefficient. If removal of an item entailed an improved alpha, that item would be removed, and the reliability test re-run without that item. The process would continue until a point of saturation was reached (i.e. removal of additional items would not improve alpha). Alpha coefficients of at least 0.70 were considered significant, a threshold adequate for research purposes (Nunnally, 1978; Streiner & Norman, 1989). The resulting items/scales following the reliability test were then re-examined in a new factor analysis. If any of the highest item loadings was less than 0.30, the process described above (i.e. performing a series of factor analyses and a reliability test) continued until all remaining items loaded at least 0.30, the threshold set a priori. Where double loadings were evident, the item was assigned to the factor under which it loaded highest.

Bivariate correlations were measured to investigate the factor distinctiveness of the final factor solution (Nunnally, 1978; Streiner & Norman, 1989)

Prior to the analyses above, certain procedures were carried out to clean the data. First, only participants who had responded to all items were included in the analyses, since failure to do so might introduce erroneous estimates. Second, items were checked for normality using the skewness statistic and its confidence interval. A skewness value with a magnitude of zero is an indication of perfect symmetry.

Study II

Univariate associations between demographic/occupational factors and the subscales were assessed by t-testing and one way analysis of variance (ANOVA). Linear regression analyses were employed to assess the independent predictors of the outcome variables (i.e. readiness measures).

Study III

T-tests were utilised to assess associations between inquiry after violence and years in service, age, perceived self-efficacy, victim/provider safety, system support, professional roles resistance/fear of offending clients, and blaming the victim.

Associations between categorical variables were assessed using Chi-square tests. Simple logistic regression was used to adjust for possible confounding; that is, all the variables that were significantly associated with screening in the univariate analysis were adjusted for possible confounders (adjusted odds ratios presented). All data were analysed using SPSS version 16.0 for Windows®.

5.3. Study IV

5.3.1. Procedure, study design and participants

The study was based on structured interviews with women attending the general out-patient department, and maternal and child-health clinics at the Aminu Kano Teaching Hospital, Kano, Nigeria. The study attempted to assess women's preferences with regard to screening, and whether actual inquiry into IPV in healthcare resulted in increased satisfaction with care among the women. Screening was not routinely practised at this centre at the time of our study; therefore, if screening was practised at all, it had to have been initiated by the healthcare providers themselves. Five females and one male assistant were recruited to assist in the interviews. All the female assistants were nurses/midwives of different grades. The male

assistant was a medical student in his final year of studies. Two training sessions on the study, its aims, questionnaire administration and ethical considerations were conducted for the assistants.

The study design was cross-sectional. After one interview was completed, the next woman visiting the clinic was approached until responses from 507 women were obtained. This sample size was based on a power analysis assuming a binomial distribution, a prevalence of IPV in developing countries of 0.12, as estimated in previous studies (Illika & Adogu, 2002; Koenig et al., 2003), a statistical significance level $\alpha=0.05$, and a power of 80%. Forty women refused to participate in the study.

5.3.2. Questionnaire measures

Each interview was performed by a pair of interviewers using structured questionnaires. Participants' *preferences for screening for IPV* were assessed by asking participants to describe how they would feel if asked about abuse in their intimate relationship in healthcare. This was an open-ended question. Two assistants previously trained in IPV listened carefully to every respondent and recorded their responses. When each interview was completed, the pair of assistants discussed the participant's response to the open-ended question, reached a consensus and placed the result under one of four predetermined options: 'Acceptable'; 'Neither acceptable nor unacceptable'; 'Both acceptable and unacceptable'; or 'Unacceptable'. The *Acceptable* response implied that the participant expressed a clear and positive attitude to being questioned about IPV. The *Neither acceptable nor unacceptable* response implied that the client expressed no sign of being offended by the question, nor any overt expression of acceptance. The *Both acceptable and unacceptable* response implied that the client expressed a positive attitude to being asked about IPV, but also expressed some concern over being asked such a question (a mixed response). The *Unacceptable* response implied offence or discomfort on being questioned about IPV. These categories have been determined previously in qualitative studies, and the responses validated (Stenson et al., 2001).

Actual screening was assessed by asking the interviewed women whether they had, during the present contact, been asked about the possibility of IPV by their healthcare provider. Response options were "Yes" or "No".

Clients' satisfaction with care was probed using the *pyramid patient questionnaire*, a previously validated instrument with three subscales (Arnetz & Arnetz, 1996). Nurses' competence and skills were assessed on the subscale '*Nursing Staff*' (a subscale with 3 items; Cronbach's alpha for the current sample was 0.87). Contact with staff was assessed on the

subscale 'Contact' (a subscale with 3 items; Cronbach's alpha for the current sample was 0.83). Support of client/victim was assessed on the subscale 'Social Support' (a subscale with 4 items; Cronbach's alpha for the current sample was 0.83). For each item on these subscales, response option was scored on a Likert scale of 1 to 4. (1 was 'Not at all'; 2 was 'No'; 3 was 'Yes'; and 4 was 'Strong Yes'). Accordingly, high scores reflect higher satisfaction on both specific items and subscales.

Socio-demographic indicators, including age, marital status, number of children, profession, religion, ethnicity, literacy level, educational level and employment status were also recorded.

5.3.3. Statistical analyses

Chi-square tests were used to assess associations between participants' preferences for screening and socio-demographic variables. Because there were only few participants in two categories of the variable measuring acceptability of screening (i.e. "Neither acceptable nor unacceptable" and "Both acceptable and unacceptable") a dichotomous variable was formed with the other two options i.e. "Acceptable" and "Unacceptable". Associations between actual screening for IPV and different satisfaction with care subscales/total satisfaction were assessed using the student t-test. Statistical significance was set at $p < 0.05$. SPSS version 16.0 for Windows was used for all the analyses.

5.3.4. Ethical considerations

- National ethical approval was received from the Nigerian Institute of Medical Research, Yaba-Lagos, Nigeria.
- Local ethical approval was received from the authorities of Aminu Kano Teaching Hospital, Kano.
- The aims and relevance of the study were further emphasised in a separate document accompanying the questionnaires.
- Questionnaires were delivered to all the clinical and laboratory departments within the hospital; for both clients and providers' voluntary participation was emphasised, privacy guaranteed and informed consent obtained.

6.0 RESULTS/MAIN FINDINGS

6.1. Structural validity of the Domestic Violence Healthcare Provider Survey scales (DVHPSS)

Following a priori set criteria of eigen values >1 , a factor loading of at least 0.30, and number of items that would yield the highest possible reliability as expressed by Cronbach's alpha, items were successively removed from the model in a series of factor analyses and reliability test. The final factor structure is reported in Table 4. A six factor model emerged, with 2 factors similar to the original scale, another two differing slightly and a further two factors resulting from a splitting up of the original combination of victim/provider safety to having distinct victim and provider safety scales.

As indicated by the bivariate correlations in Table 5, significant correlations, ranging in magnitude from 0.17 to 0.53, were found between most factors

We concluded that with slight modifications, the DVHPSS can be used to study IPV screening among Nigerian healthcare professionals. Introducing screening protocols could promote better understanding of crucial questions that were lost in the analysis

Table 4. Factor loadings for the Domestic Violence Healthcare Provider Survey scales.

Components	1	2	3	4	5	6
Professional role resistance/fear of offending patients						
I am afraid of offending patients if I ask about #their abusive behaviour.	0.63					
I am afraid of offending the patient if I ask about #domestic violence (DV).	0.70					
Asking patients about DV is an invasion of their privacy.	0.79					
It is demeaning to patients to question them about abuse.	0.73					
If I ask non-abused patients about DV, they will get very angry.	0.41					
It is not my place to interfere with how a couple chooses to resolve conflicts.	0.61					
When challenged, batterers frequently direct their anger toward healthcare providers.	0.45					
Blame victim						
A victim must be getting something out of the abusive relationship, or else he/she would leave.		0.70				
People are only victims if they choose to be.		0.64				
When it comes to domestic violence victimisation, it usually "takes two to tango".		0.74				
I have patients whose personalities cause them to be abused.		0.62				
Women who choose to step out of traditional roles are a major cause of DV.		0.53				
The victim's passive-dependent personality often leads to abuse.		0.50				
The victim has often done something to bring about violence in the relationship		0.41				
System support						
I have ready access to medical social workers or community advocates to assist in the management of DV.			0.75			
I feel that medical social work personnel can help manage DV patients.			0.56			
I have ready access to mental health services should our patients need referrals.			0.64			
I feel that the mental health services at my clinic or agency can meet the needs #of DV victims in cases where they are needed.			0.67			
Perceived self-efficacy						
There are strategies I can use to encourage batterers to seek help.				0.69		
There are strategies I can use to help victims of DV change their situation.				0.76		
I feel confident that I can make appropriate referrals for batterers.				0.67		
I feel confident that I can make the appropriate referrals for abused patients.				0.59		
There're ways I can ask batterers about their behaviour that will minimise risk to the potential victim.				0.43		
Victim safety						
I feel it is best to avoid dealing with the batterer out of fear and concern for the victim's safety.					0.72	
There is no way to ask batterers about their behaviours without putting the victims in more danger.					0.82	
I am afraid if I talk to the batterer, I will increase risk for the victim					0.76	
Provider safety						
I feel there are ways of asking about battering behaviour without placing myself at risk						0.68
I feel I can effectively discuss issues of battering and abuse with a battering patient						0.77
I feel I can discuss issues of battering and abuse with a battering patient without further endangering the victim						0.77
Eigen value	5.47	4.61	2.20	1.58	1.52	1.29
% of variance	18.24	15.37	7.32	5.29	5.06	4.31

Table 5. Bivariate Pearson correlations of Domestic Violence Healthcare Providers Survey scales.

	Professional role	Blame victim	System support	Victim safety	Self - efficacy	Provider safety
Professional role	1.000					
Blame victim	0.257**					
System support	0.006	0.198*				
Victim safety	0.406**	0.382**	0.060			
Self-efficacy	-0.081	0.320**	0.528**	0.075		
Provider safety	0.049	0.171*	0.424**	0.021	0.431**	1.000

**Correlation is significant at 0.01 level (2-tailed test).

* Correlation is significant at 0.05 level (2-tailed test).

6.2. Readiness to screen for IPV and actual screening – extent and determinants

Healthcare providers' readiness to screen and actual screening behaviour.

On average, the healthcare providers scored moderately on the readiness indicators,¹ i.e. self-efficacy (24.81), system support (14.30), blaming the victim (22.25), professional role (14.73) and the victim/provider safety subscales (30.92), indicating that these factors may to some extent constitute barriers to screening for IPV (Study II). The majority of care providers (74%) had not inquired about the possibility of IPV among their patients in the past three months. (Study III).

Demographic and occupational predictors of healthcare providers' readiness to screen as expressed in self-efficacy, system support, attitudes towards screening and professional roles

After controlling for other demographic and occupational factors, profession remained significantly associated with perceived self-efficacy, where social workers had a higher perceived self-efficacy than doctors, midwives/nurses and other professions, as indicated by the beta coefficients and p-values (Table 6). Likewise, social workers perceived a better support network to refer victims of violence than other professions (Table 6). Gender and profession were significantly associated with blaming the victim even after other factors were controlled for. Female care providers were less likely to blame the victim than males, and doctors less likely to do so than social workers. Age, ethnicity and profession impacted significantly on professional roles related to screening for IPV. Younger care providers, providers of Yoruba ethnicity and social workers were less likely to perceive a conflicting professional role related to screening than older providers, providers of Hausa ethnicity and doctors, respectively

¹ Note that the scores for readiness indicators are as follows: Self efficacy (7-35); system Support (4-20); Blame victim (7-35); Professional role (7-35); Victim/provider safety (10-50).

Table 6. Linear regression exhibiting demographic/occupational predictors of self-efficacy, system support, attitudes towards screening and professional role.

	Self-efficacy		System support		Blame victim		Professional role	
	Standardised beta	P-value	Standardised beta	P-value	Standardised beta	P-value	Standardised beta	P-value
Age								
Gender								
Male	0.21	NS	0.13	NS	-0.09	NS	0.18	<0.05
Female	-0.77	NS	-0.009	NS	0.18	<0.05	0.006	NS
Marital Status								
Married	0.32	NS	0.19	NS	0.28	NS	0.06	NS
Single	0.30	NS	0.30	NS	0.16	NS	0.06	NS
Divorced/Separated								
Religion								
Muslim	-0.16	NS	0.22	NS	-0.11	NS	-0.18	NS
Protestant	-0.001	NS	0.16	NS	-0.04	NS	-0.05	NS
Other	-0.03	NS	0.04	NS	0.01	NS	-0.03	NS
Catholic								
Ethnicity								
Hausa	0.01	NS	-0.01	NS	-0.05	NS	0.25	<0.05
Ibo	-0.12	NS	-0.05	NS	-0.06	NS	0.02	NS
Other	-0.09	NS	-0.01	NS	0.02	NS	0.50	NS
Yoruba								
Profession								
Doctor	-0.36	<0.01	-0.003	NS	-0.26	<0.05	-0.29	<0.05
Nurse/Midwife	-0.35	<0.01	-0.02	NS	0.04	NS	0.14	NS
Others	-0.19	<0.05	-0.15	<0.05	-0.10	NS	-0.03	NS
Social worker								
Department								
Surgery	0.03	NS	0.11	NS	-0.001	NS	0.09	NS
Paediatrics	0.06	NS	0.13	NS	0.09	NS	0.11	NS
Obstetrics/gynaecology	0.05	NS	0.03	NS	0.09	NS	0.12	NS
General practice	-0.09	NS	0.12	NS	0.08	NS	0.07	NS
Other department	-0.05	NS	0.08	NS	-0.06	NS	0.10	NS
Medicine								

Screening for IPV and associations with readiness to screen and demographic/occupational characteristics of the participants

The self-efficacy and blame-victim scales were significantly associated with screening for IPV even after adjusting for age, gender and ethnicity. With increasing perceived self-efficacy, the likelihood of screening for IPV increased. Blaming the victim, however, was also associated with an increased likelihood of screening for IPV (Table 7).

Table 7. Adjusted odds ratios for the relationship between screening for IPV and Self efficacy & blaming the victim

	Adjusted for Age		Adjusted for Gender		Adjusted for Ethnicity	
	OR (95% CI)	P-Value	OR (95% CI)	P-Value	OR (95% CI)	P-Value
Self Efficacy	0.94 (0.88-0.99)	0.04*	0.92 (0.87-0.98)	0.01*	0.92 (0.87-0.98)	0.009*
BlameVictim	0.94 (0.89-0.99)	0.03*	0.94 (0.89-0.99)	0.04*	0.93 (0.88-0.98)	0.01*

*CI = Confidence Interval. OR = Odd Ratio Significance * P < 0.05*

Participants of Yoruba ethnicity (50%) more frequently inquired about the possibility of IPV among their clients than peers of Hausa (20%), Ibo (21%) and “other” (28%) ethnic belonging ($\chi^2(1)=8,828$, $p<0.005$). Ethnicity, however, did not impact significantly on screening after adjusting for the readiness-to-screen indicators. Gender was significantly associated with screening, since male care providers were more likely to screen for IPV among clients than their female peers ($\chi^2(1) = 8,300$, $p<0.005$). This association remained even after control for the readiness indicators. Social workers, when contrasted with doctors, nurses and midwives, were found more often to screen for IPV among their clients ($\chi^2(1) = 4,391$, $p<0.05$). There were no statistically significant differences in screening in relation to marital status, religion and department of care.

6.3. Preference for screening among clients – extent and associated factors

A majority of the participants (76%) found being probed about IPV in healthcare acceptable (n=355), while almost 20% regarded such inquiry as unacceptable. Seven percent of the interviewed women had been probed on the possibility of IPV by a healthcare provider during their latest visit.

Associations between acceptance of IPV, actual IPV inquiry and socio-demographic factors

As indicated in Table 8, marital status ($\chi^2(2) =9, 49$, $p<0.01$) and employment status ($\chi^2(1) =4, 4$, $p<0.05$) were associated with acceptance of screening for IPV among women where married and employed women were more likely to accept being probe for abuse. There was no significant association between acceptance of screening and the other socio-demographic variables.

As indicated in Table 8, ethnicity ($\chi^2(1)=5.6, p<0.05$) was associated with being probed about IPV in healthcare; participants belonging to the Hausa/Fulani ethnic group were more often probed about the possibility of IPV in healthcare than the other ethnic groups taken together (i.e. migrant ethnic groups in the region). A trend was observed regarding the association between probing about IPV in healthcare and religion ($\chi^2(1)=2.8, p<0.09$), where Muslim participants were more likely to have been probed about IPV than the other religions taken together. There was no statistical association between being probed about IPV in healthcare and the other demographic factors.

Table 8. Associations between acceptance of IPV inquiry, actual IPV inquiry and socio-demographic characteristics of participants.

	Acceptance			Actual screening		
	N	n ₁	%	N	n ₂	%
PROFESSION						
Housewife	167	132	79.0	175	16	9.1
Others§	158	130	82.3	173	16	9.2
MARITAL STATUS						
Married	332	270	81.3	348	33	9.5
Single	100	77	77.0	110	0	-
Divorced/ Separated	16	8	50.0	21	0	-
RELIGION						
Islam	304	247	81.2	330	27	8.2
Others‡	144	108	75.0	149	6	4.0
ETHNICITY						
Hausa/Fulani	279	227	81.4	299	27	9.0
Others*	168	127	75.6	179	6	3.4
MARITAL SITUATION						
Monogamous	186	147	79.0	190	14	7.3
Polygamous	114	94	82.5	122	16	13.1
EMPLOYMENT						
Employed	115	99	86.1	123	10	8.1
Unemployed	324	249	76.9	347	22	6.3
LITERACY LEVEL						
Cannot read at all	78	62	79.5	80	6	7.5
Able to read	359	283	78.8	389	26	6.7
EDUCATIONAL LEVEL						
No education	71	58	81.7	74	4	5.4
Primary	31	24	77.4	36	4	11.1
Secondary	173	135	78.0	181	5	2.7
Post-secondary	166	132	79.5	181	18	9.9
Islamic/Quranic	4	3	75.0	4	2	50.0

N=Total numbers in the category. n₁=number accepting. n₂=number of participants actually screened. %=percentage of total within the group. Others§=gainfully employed professionals including students. Others‡=Christianity or other minority religion. Others*=Yoruba, Ibo and other ethnic groups

6.4. Screening for IPV and satisfaction with care

As shown in Table 9, there were associations between being probed about IPV in healthcare and satisfaction with nursing staff ($t(469) = 4.74$; $p < 0.001$), contact ($t(466) = 3.51$; $p < 0.001$) and social support ($t(462) = 4.19$; $p < 0.001$). On average, participants who had been probed about IPV in their latest contact expressed higher satisfaction in these regards than peers who had not been probed about IPV.

Table 9. Associations between actual IPV inquiry and satisfaction with care (nursing staff, contact, social support).

Screened	Nursing staff				Contact				Social support			
	N	Mean	SD	P	N	Mean	SD	P	N	Mean	SD	P
Yes	33	11.3	1.3	0.001	32	10.8	2.1	0.001	31	14.9	2.7	0.001
No	438	9.5	2.2	0.001	436	9.4	2.2	0.001	433	12.7	2.7	0.001
Total	471	9.6	2.2	-	468	9.5	2.2	-	464	12.9	2.8	-

7.0 DISCUSSION

7.1 Measures and structural validity of the instruments employed

Hindrances to successful screening for IPV may emanate from both factors associated with the healthcare provider and those associated with the client. Several instruments for the assessment of patients' characteristic and measurement of violence have been developed, validated and utilised in our study context (Adeyemi et al., 2008; Rani et al., 2004; Hindin et al., 2008). However, to the best of our knowledge, tools for assessing healthcare providers' readiness to screen for IPV have yet to be piloted in this setting. Evidence from this study suggests that the instrument can be used in its current form or with slight modifications (Study I). The concurrent validity of the Domestic Violence Healthcare Providers Survey scales was further substantiated in Study II, since the confirmed discrepancies were those that we expected.

All the instruments utilised showed stable and consistent reliability (studies I, II, III and IV).

7.2. Readiness to screen for IPV and actual inquiry about IPV in healthcare

On average, the care providers scored moderately on perceived self-efficacy, access to system support, professional role resistance/fear of offending clients, and blaming the client for being victimised, indicating possible shortfalls in their readiness to screen for IPV (Study I).

Moreover, only few of the providers had actually inquired of their clients about the possibility of IPV in the past three months (26% in Study III) and in their latest contact (7% in Study IV). These findings are comparable with previous findings in a developed-country context (Erikson et al., 2001; Roelens et al., 2006), which suggest that, despite the initiation of screening protocols in those settings, routine screening remains low (about 10%). Thus, if

barriers to screening are effectively to be managed, it is important to understand the determinants of screening behaviour from both the client and the provider perspective.

7.3. Determinants of readiness to screen and actual inquiry about IPV

Demographic and occupational features of the care providers impacted on their readiness to screen for IPV, and also on screening per se. The ethnicity and religious affiliation of HCP was demonstrated to be an important determinant of readiness to screen and actual screening activity (studies II and III). Contrary to the assumed idea of neutrality in medical practice, ethnic affiliation was found to be associated with screening; HCP from the Yoruba ethnic group were more likely to screen their clients for IPV (Study III), and were less likely to perceive a conflicting professional role in screening for IPV than peers from other ethnic groups (Study II). The reasons for this are not clear from our data. However, previous research suggests a high prevalence of IPV among ethnic Yoruba (Rotimi, 2007). They may therefore identify more closely with the problem than members of other ethnic groups. From the client perspective, on the other hand, women from the Hausa ethnic group were more likely to be probed on the possibility of violence than women with another ethnic belonging (Study IV), an aspect for which there is no explicit explanation. The fact that the Hausa form the majority ethnic group in the region might explain why women from this group were more likely to be screened. But, as indicated in our findings, the role of ethnicity in screening for IPV is complex, and cannot be entirely explained in the current work. In general, however, ethnicity has been found to influence health behaviours indirectly in socio-economic and health behavioural models. Some of these theoretical models have been proposed to explain disparities in health between people of different races and ethnicities (Dressler et al., 2005). Also, ethnicity has been conceptualised as an inherent trait among Africans (Ake, 1993), suggesting that we need to reckon with it as we deal with IPV.

The religious affiliation of HCP was demonstrated to be an important factor that impacts on readiness to screen and screening activity per se (Study II). Care providers of an Islamic or protestant religious affiliation were found to be more likely to have better access to support networks to which to refer victims of IPV than their colleagues with Catholic or other religions. The reasons for this are not clear. However, it should be noted that Muslims constitute the majority in Kano, and Protestants the majority among evangelicals (Ehrhardt, 2009; Deegan, 2009). Preponderance and strength in the population may therefore be the key to access to networks that can assist victims of IPV. Similar explanations may account for the screening of more women of the Islam religion than those of other religions (Study IV). The

fact that Islam is the majority religion in Kano might possibly explain why women of this group were more likely to be screened.

Male care providers were found in our study to be more likely to inquire about IPV than their female colleagues. This finding contradicts previous work in the field (Reid & Glasser, 1997; Sugg & Inui, 1992; LoFoWong et al., 2006). A plausible explanation for this discrepancy is a contextual one. Most of the earlier studies were from Western countries. Studies in sub-Saharan African contexts have consistently demonstrated the acceptance of wife abuse as a societal norm (Fawole et al., 2005; Obi & Ozumba, 2007). Ironically, representative national samples from over 19 sub-Saharan African countries indicate that endorsement of wife beating is more prevalent among women than men (Lawoko, 2008; Uthman et al., 2009). Thus, a higher tendency to screen among male healthcare providers may simply be reflecting differences between males and females in perceptions related to IPV in the general population. That male were more likely to screen did not however imply that they were more sympathetic towards abused women. Our findings indicated that male healthcare providers were more likely than their female peers to blame the victim of IPV, an indication that patriarchal attitudes remain a societal norm in our study setting, as they are in other sub-Saharan African countries (Lawoko, 2008; Hindin et al., 2008). Together, these findings indicate that the association between gender and screening in general may be more complex than initially hypothesised. Deeper insight on this issue could be achieved via qualitative studies.

Social workers were found to be more likely to inquire about violence than doctors, nurses and midwives, which is consistent with some previous findings (Eisenstat & Bancroft, 1999) but contrary to others (Davis & Harsh, 2001; Furniss et al., 2007). That social workers in Nigeria make up the most likely professional group to effect screening (Study III) might be explained by reference to their training and duties, which primarily are to provide support, social as well as psychological, for their clients. Corroborating the role of occupational status further with regard to screening, social workers perceived greater self-efficacy in inquiring about IPV (Study II) than peers in other occupational categories, while doctors were less likely to blame the victims of IPV for being abused (Study II). This finding has implications for the further education of specific occupational groups in screening.

7.4. Women's acceptance of screening for IPV

Seventy-six percent of the women in our sample accepted being asked about violence during their contact with the HCP (Study IV). Our findings are comparable with those in high-income settings (Stenson et al., 2001; Kozoil-McLain et al., 2008). Yet, contrary to previous studies elsewhere, women generally justified the abuse, and therefore were expected to be reluctant to accept being asked about it (Gerbert et al., 1999; Dowd et al., 2002; Kershner & Anderson, 2002; Nash, 2005). Moreover, data on disclosure of IPV indicates that very few women are willing to disclose abuse to the establishment i.e. police, healthcare providers etc (Okenwa et al., 2009). Societal norms and laws that are gender restrictive may account for failure to disclose. Thus, while women may be willing to be probed about abuse in healthcare, the establishment in its current form may hinder them from such disclosure.

Married women were more willing to accept screening for IPV than peers of other civil status. A plausible explanation for this pattern of acceptance preference is that married women are more likely to be confronted by IPV and therefore find such inquiry warranted. Also, unemployment was found to be significantly associated with viewing screening for IPV as unacceptable, a finding that concurs with previous studies (Hindin, 2003; Naved et al., 2006). Being unemployed and having lower socio-economic autonomy may hinder women from accepting screening, since they are more likely to be economically dependent on their abusive partners (Fawole et al., 2005).

7.5. Outcomes of screening – satisfaction with care

We had hypothesised that, since the evidence in high income societies suggests that women generally feel comfortable about responding to IPV questions in clinical settings, they will express satisfaction with care according to whether or not IPV is addressed in their contact with staff (Stenson et al., 2001; Stenson et al., 2005; Swahnberg & Wijma 2007).

We found (Study IV) that clients who had been probed about IPV exhibited higher satisfaction with care than peers who had not been probed, which corroborates recent work in the field (Manchester 2007). This suggests that screening in healthcare can be regarded as a part of a holistic approach to care for women irrespective of their primary complaints; such an approach would offer prompt referral and appropriate management of the consequences of IPV against women.

7.6 Study limitations

The weaknesses of this dissertation deserve some attention. Kano and Nigeria are vast entities, and research into an important subject of this nature, although highly sensitive, needs broad coverage and has to be population-based. The cross-sectional approach, though systematically well performed, limits conclusions that can be drawn with regard to causality. The demography of Kano entails over-representation of its majority ethnic group, the Hausa/Fulani, and its major religion, Islam, in our sample of patients. Replication of these studies in other regions of Nigeria is suggested, with the hope of offering comparable findings.

Quantitative methods were used for our analysis primarily to investigate associations. However for an inductive and in-depth explanation of some of our findings qualitative studies may be complimentary to understand some of the challenges faced by HCP and clients that might hinder better healthcare delivery to affected women through screening for IPV.

8.0 CONCLUSION

8.1 Implications for intervention

This dissertation provides new knowledge on factors that hinder effective screening for IPV against women, using a typical clinical facility in a typical African setting, which is imbued with a culture and religion that might give rise to conflict concerning the professional role of the healthcare provider.

The possibility of the lack of a cross-cultural perspective on the part of practitioners on the subject of IPV was probed with an instrument previously used in another context. Both expected and unexpected results were reported with regard to both provider and client aspects of attitudes towards screening for IPV, which make up a challenge to re-conceptualise the indigenous factors that should be considered when embarking on screening for IPV in healthcare in Nigeria and in a sub-Saharan context in general.

On the individual level, knowledge of different aspects of violence against women must be advocated from childhood, in school, and among health providers. In the short term, HCP should be offered in-service training on IPV, in order to enhance the capacity to identify and manage its consequences. Health providers should also be trained to acknowledge their individual shortcomings, which – as identified in studies II, III and IV – may be based on

ethnic bias and personal attitudes towards IPV against women. The community has an important role to play in education, and in the empowerment of girls and women to prevent abuse. The culture and religion of the community should be proactive towards the health of women and children; hence, community leaders must be sensitised through training and re-orientation to support traditions and religions that abhor violence against women. At the policy level, enactment and enforcement of legal instruments and the commitments of government at all levels are pivotal in achieving the lofty goals of the Millennium Development Goals. In this regard, the Nigerian government should speed up the implementation of its proposed National Gender Policy, introduced during the regime of President Obasanjo, and work in partnership with groups advocating the enhanced status of women in Nigeria (Pereira, 2002). In the immediate and long term, the curriculum of medical schools, where health workers are trained, needs to be updated on the subject of violence, and especially violence against women. Social science students and policy-makers would also benefit from a curriculum that addresses women's empowerment and universal rights for women and girls. Instituting universal screening, irrespective of ethnic or religious affiliation, as a routine practice among HCP should be emphasised, since this will lead to identification and appropriate management of IPV against women. Delivery of screening as a vital component of the management of health and other consequences of intimate partner violence may not be attainable if hindrances to screening for IPV are not recognised and addressed.

8.2 Future studies

The current work makes a contribution to the ongoing debate on a global issue that has tremendous negative health impacts on women and children, and invariably on nations. Our specific findings expose the need for more research on the need to adapt screening tools (for HCP) to characteristics of Nigerian healthcare providers with regard to religion and ethnicity, which have proven to be core attributes of Nigerian society.

Screening was overwhelmingly accepted by clients at the hospital, suggesting that hospital-based studies may provide better understanding of the extent, nature and management of IPV against women. The associations between ethnic and religious aspects and IPV against women should be further researched in order to understand the phenomenon in a multiethnic and religious country like Nigeria.

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