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Knowledge and Practice Regarding Management of Women Victims of Domestic of Violence among Health Workers at Bwindi Communnity Hospital

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Research Article

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ABSTRACT

Generally achieved through proper nutrition, moderate-vigorous physical exercise, and sufficient rest; Physical fitness is a general state of health and well-being and, more specifically, the ability to perform aspects of sports, occupations and daily activities. The goal of this study was to examine the relationship between diet, physical activity and anthropometric indicators [Weight (Wt.), Height (Ht.), Body Mass Index (BMI), Waist, Hip, circumferences (WC, HC) and Waist-Hip ratio (WHR)]. Three hundred and seventy five young adults with a mean age of 21.61 ± 2.168 years were conveniently selected. International physical activity questionnaire and food frequency questionnaire were used to collect information on their physical activity level and dietary intake respectively, following which selected anthropometric indices (Wt, Ht, BMI, WC, HC and WHR) were measured. Statistical measure of association (correlation) and differences in mean were obtained for variables using the spearman rank and one-way analysis of variance (ANOVA) respectively. Results revealed a higher dietary intake in males than females with a statistically insignificant association between BMI, HC, WC and dietary intake. However, there was a positive significant association between dietary intake and WHR, BMI and dietary intake. Result also saw a negative association between HC, WC and physical activity. This was statistically insignificant. Maneuverability of Dietary intake and physical activity may elicit positive physiological effect.

INTRODUCTION

Domestic violence (DV) is a global public health problem that draws attention of a wide spectrum of clinicians [1,2]. DV against women is currently seen as a transgression of fundamental human right. DV occurs in all settings and among all women irrespective of their age, race, socio-economic background, religion, culture, educational background and occupation. DV against women has been known to be more common than any other form of violence. It includes all forms of physical, sexual, emotional and controlling behavior against women by an intimate partner or society member in close relationship [3].

Proper management of DV women victims is very important in curbing down the worldwide alarming situation of DV. Proper DV management refers to the act of screening, identifying, treating and counseling, documenting and referring of victims. Management of DV also considers screening patients that come in with warning signs of DV like multiple injuries, unexplained pain, depression, anxiety disorders and substance abuse. Knowledge of Health Workers (HW) regarding DV management means the ability of the HW to screen, identify, treat, counsel, and document and refer victims of domestic

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violence. Practice of HW regarding DV management has been defined as the act of screening, identifying, treating, counselling, documenting and referring of victims of domestic violence.

Developed countries have inculcated management of DV in health system as they have embraced universal screening for domestic violence to every clients attending health care as the initial phase of management. This has reduced the prevalence of DV [4]. However this is not the case with developing countries like Uganda whose prevalence stands at 68%. In Africa, considering Rwanda, routine inquiry for DV suspects was low at 22% in and the general knowledge and practice on management of DV is still low.

In Uganda, the health sector has not been doing much on DV and its management. This is evident in that the first appearance of DV in health policy documents was in the second Health Sector Strategic Plan (HSSP II) of 2006/07 [5]. DV management is lacking and not captured in the health management information system (HMIS) according to Ministry of Health (MOH) Uganda [6]. This sill makes the whole process of management of DV against women to be poor thus its prevalence continuing to be unacceptably high. This forms the foundation of this study.

Good knowledge and practices of health workers regarding DV management would reduce its prevalence and complications as it would result into proper management and prevention of DV occurrence. However knowledge and practices of HW regarding management of DV in Uganda is still not well known as there is little information regarding it. This continues to forms the foundation of this study.

The overwhelming global burden of domestic violence has been found to be against women even though children are also affected. Domestic violence affects one in four women worldwide and has significant health consequences posing short and long term complications to women. These include; death, injuries, depression, substance abuse, acquiring sexually transmitted infections, post-traumatic stress disorder, unwanted pregnancy and low birth weight and high treatment costs among many others. Health workers (HW) require the knowledge and skills to ensure that they can recognize victims of violence and respond to their needs effectively since they provide the primary window of opportunity to meet the victims. Women experiencing abuse identify nurses and other health workers as potential sources of support [7]. However despite this unique opportunity that the health workers have, identification, reporting and referring (management) of DV victims does not occur systematically. This has made many victims to go unidentified or mismanaged hence promoting the cycle of occurrence of DV against women. This formed the foundation of this study and the researcher was inspired to explore the knowledge, and practice of HW towards management of women victims of DV.

RELEVANT LITERATURE

Health-care provider often unknowingly, comes into contact with women affected by DV, since abused women make extensive use of health-care resources [8-13]. Health-care providers are in a unique position to create a safe and confidential environment for facilitating disclosure of violence the initial phase of DV management, while offering appropriate support and referral to other resources and services.

Although health workers present the primary window of opportunity to access victims of DV as they come to seek health care, in many occasion they go unidentified. This is because they are not screened for yet this forms the first part of DV management. From statistics, the prevalence of domestic violence remains unacceptably high worldwide and more badly in developing countries like Uganda particularly in rural areas [14]. Therefore Bwindi area is not an exception. With such kind of statistics regarding DV, the sufferers do not easily disclose their problems of DV when they come to health facilities to treat related complications. This makes them to be discharged without identifying the actual cause of the problems. Thus making the existence of DV against women to be cyclic.

The purpose of this study was to assess knowledge and practice regarding management of women victims of health care workers (HW) at Bwindi Community Hospital (BCH) regarding management of victims of DV. It was envisioned that the study would add to the available knowledge and information regarding DV management by health workers thus reduce its continuous occurrence.

Health care systems can be an important part of a coordinated, community-wide effort to combat domestic violence since. This is because it forms the primary entry for victims with complications of domestic violence. Many battered women do not contact advocacy organizations, police or prosecutors, or do not do so until the abuse has become quite serious and life-threatening but instead seek healthcare first for management of complications sustained. With this unique opportunity, Health workers (HW) would be the best people to appropriately manage and refer victims to relevant authorities if they had good knowledge and better practice. Women often continue, to seek emergency and routine medical care for complications however victims cannot easily disclose to HW until they are logically asked in a private environment. In the health system of Uganda, it was revealed that the range of services provided to the victims of domestic violence and the level of access to those services that the survivors of DV receive was not very well known, as there was no literature to that effect. Even then, the few available studies have reported problems in the management of

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violence against women. Some of the problems reported include lack of health workers trained on gender issues and DV management. This has thus led to failure to screen for and recognize DV due to lack of knowledge and poor practice.

There is thus need to explore more on the knowledge and practice of HW towards DV management.

In 2006, in a study among HW at Mulago national referral hospital, it was found that HW had inadequate knowledge on domestic violence and its consequences, management or prevention. In the same study, it was revealed that many HW neither knew how to, nor routinely screened for domestic violence. However, very few believed that victims might hesitate to seek care. The study also revealed that HW had a basic knowledge of some of the risk factors and clinical issues associated with domestic violence even though most of them lacked confidence in identifying and managing women experiencing abuse. There was poor knowledge of domestic violence resources available for HW and more widely in the community [15].

In a study done, it was revealed that 58.7% HW had an adequate general knowledge about DV, though, in Regard to barriers to identify violence, HW mentioned the lack of an institutional policy and the silence of women who do not reveal violence. It was revealed in a study done by Ramsay in 2012 in their study that HW had only basic knowledge about domestic violence but many of them felt poorly prepared to ask relevant questions about it or to make appropriate referrals if abuse was disclosed. The study also showed that 40% of HW never or seldom asked about abuse when a woman presented with injuries however, the majority of HW 80% said that they did not have an adequate knowledge of domestic violence resources. Furthermore the study found out clinicians to be better prepared and more knowledgeable than nurses. In another study conducted by in Brazil, it was discovered that knowledge on definition of DV management was not associated with the sex, color, religion or profession of the interviewees, but it was found to be associated with age as older HW had better knowledge than young HW. Never the less, majority of the HW (55.7%) had good or high general knowledge about violence and only (12.7%) were identified as presenting low knowledge about management of DV. There is therefore need to enrich knowledge of HW regarding management of women victims of DV in order to reduce its occurrence. This can easily be done by producing evidence through research and thus need for carrying out such a study in Bwindi since there is no available information regarding knowledge of HW regarding DV management.

In another study it was, revealed that less than two-thirds (62.5%) of the primary health care workers were aware about the DV and its management while only about one-third (34.7%) regularly screened for violence among women. However, out of those regularly screened for violence, about two-thirds (66.1%) screened. Indicating poor practice regarding management of DV among HW.

In another study done it was revealed that majority of the clinicians (68.9%) reported asking their patients regarding domestic violence at times but 26.2% had never asked at all 13.2% of the respondents were un sure of how to ask patients about DV, less than a third of the participants reported knowing of any written protocol for domestic violence management [16]. And only 15% of the respondents had ever attended any educational program related to DV management [17].

According to the study done by the majority of participants (31%) had inquired about DV exposure among clients between 4-6 times over a period of three months, with 18% having not inquired at all [18]. The extent of DV inquiry in Uganda, a low income country, appeared higher than what is observed in middle and high income settings where 75% respectively 50% of care-providers had not inquired about the possibility of IPV on any occasion among clients over a three month period.

In a study that involved 94% of HW who had not received training in management of domestic violence, revealed that more than half of the respondents were not knowledgeable. Additionally, 60 of the respondents were not skilled in management of victims of domestic violence [19].

DEFINITIONS

Domestic violence management: Is the process of identifying, treating, counselling documenting and referring of the people who are suffering due to intimate fights and disputes

Domestic violence: Means any physical, emotional, sexual or any other form of torture to a woman by an intimate partner.

Health care workers: These are persons studied and qualified to deal directly or indirectly with clients who are suffering physically, emotionally, and socially.

Knowledge of domestic violence management: Is the awareness to screen, identify, treat, document, counsel and refer DV victims to the relevant agencies. It involved knowledge on the warning signs that victims present with to the health facilities

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Legal agencies: These are organizations such as police, human right activists, village leadership bodies that help battered women with extra support.

Poor knowledge on domestic violence management: Failing to raise 50% correct responses from definition of DV, mentioning warning signs, ability to ask victims etc.

Poor practice: Failure to identify, treat, document and refer clients contacted with obvious warning signs of domestic violence and observed absence of guidelines and resources like referral forms, domestic violence register at the work place summing up an average score < 50%.

Practice of domestic violence management: Is the act of identifying, treating counselling and referring of victims of domestic violence.

Universal DV screening: Refers the act of asking all women that come for health assistance about the incidences of domestic violence.

Warning signs of DV: Are those complaints that depicts that the woman could have been abused and included multiple injuries, substance abuse, anxiety, chronic unexplained pain, and depression.

METHODS

A descriptive, cross-sectional study design. The study focused only on the current knowledge and practice of HW towards management of women victims of DV at that point in time at Bwindi Community Hospital (BCH) in Mukono parish, involved all qualified HW including doctors, nurses, clinical officers and mental health team who worked at the at the hospital at that time. This is because this is the team the encounter the victims of DV as they come seeking medical consultation after sustaining complications from DV incidences **(Tables 1-3)**.

Table 1. Socio-demographic characteristics of participants.

Variables	Frequency (N)	Percentage (%)
Sex		
Males	30	60
Females	20	40
Total	N = 50	N = 100
Age		
20-30	28	56
31-40	12	24
41-50	10	20
Total	N = 50	N = 100
Profession		
Nurses	24	48
Midwives	13	26
Mental health workers	2	4
Clinical officers	4	8
Medical officers	5	10
Total	N = 50	N = 100
Level of qualification		
Certificate	24	48
Diploma	15	30

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Degree	6	12
Master's degree	3	6
Total	N = 50	N = 100
Time of experience		
1-2 years	18	36
3-4 years	16	32
5-6 years	9	18
Above 7 years	7	14
Total	N = 50	N = 100
Department		
Adult in patient	13	26
Sexual reproductive health	10	20
Community	10	20
Paediatric	9	18
Out patient	8	16
Total	N = 50	N = 100

Table 2. Knowledge of participants on warning signs that a woman victim of DV may present with at the health facility; as adopted from WHO 2013. N=50.

Warring signs	Frequency	Percentages
Chronic unexplained pain	7	14%
Substance abuse	15	30%
Anxiety	24	48%
Multiple injuries	27	54%
Depression	24	48%
None of the above	1	2%

Table 3. Participants' responses on how often they inquired about DV among patients with warning signs N=50.

Options	Frequency	Percentage (%)
Always asked patients with signs	26	52
Sometimes asked patients with signs of DV	20	40
Never asked patients with warning signs of DV	6	8

The sample size of legible HW was determined by the statistical formula However since there were only 60 Health workers (HW) at BCH all of them were considered for the interview. But only 50 consented to participate in the study. The researcher used a consecutive purposive sampling method.

Data was collected using a structured self -administered questionnaire. A Standard questionnaire designed according to WHO and other published studies of the same topic were designed protocol of and consisted of statements about DV management was used. It required a participant to tick 'T' for true, 'F' for false and to checking correct response, some data pertaining practice was directly observed using a check list that was designed according to the available literature.

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The researcher crosschecked each questionnaire for completeness. The researcher used a structured questionnaire with closed ended questions to be more specific and to facilitate collection of relevant data. Data was analyzed using Microsoft excel. Data was tallied with assistants and entered into the excel spread sheet

To transform knowledge and practice into a quantifiable form, each statement was awarded a score of one if correct and zero for an incorrect response or where the respondent was not sure. The total score was then expressed into percentages by dividing the standing score by the maximum score and then multiplying it by 100. For interpretation, the researcher divided the transformed scores into five levels as stipulated by curriculum for Uganda Nurses and Midwives curriculum as Scores (100%).

> 75%: Excellent, 65-74: Very good, 54-64: Good, 50-53: Fair, <50%: Poor

Written research proposal was presented to UNSB research review board after who provide the researcher with an introduction letter that allowed the researcher to BCH ethical committee for protection of human subjects. Informed consent was obtained by presenting a consent form written in English to participants and given a choice. There was limited time for further data analysis and for the researcher to critically observe how patients with warning signs of DV are handled which would add value to the study findings. But the researcher overcame this by using many research assistants (**Figure 1**).

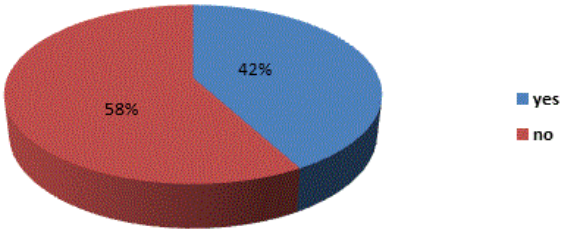

Figure 1. Participant's responses on whether they documented the identified cases of DV.

DISCUSSION

Knowledge of health workers regarding management of domestic violence

The According to the findings of this study, the participants had generally good knowledge regarding DV management. With majority 83% indicating correctly that proper DV management involves screening, identification, treating, counselling and referring the victims. This good knowledge among the participants may be attributed to the training which the participants had in management of DV victims. Where by more than half (56%) of participants had had training in management of DV through workshops, formal training institution and in refresher courses hence indicated good knowledge in DV victim management. Good knowledge in DV management can be achieved through training or education.

Suggested that use of domestic violence short training sessions can increase knowledge of HW in DV management. The findings of this study are contrary to the findings of the study of in Mulago who discovered that many health workers did not have good knowledge regarding management of DV. This could have been because they did not have sufficient training regarding DV management. Furthermore results of this study are contrary to results of another study done by Tumwebaze M et al. [19] among health workers who discovered that only 6.8% of the health workers had ever had training regarding DV management and thus had insufficient knowledge. Similarly, according to the study in Ethiopia, over 94% of all respondents had not received training in domestic violence management and 60% were not skillful and had inadequate knowledge on providing care to women experiencing DV [20]. Therefore, HW training on DV Management is an important first step towards successful management of DV victims and needs to be reemphasized.

According to this study more than half (54%) of the participants considered multiple injuries as the warning signs of DV followed by 48% for anxiety and depression 30% substance abuse, 14% chronic unexplained pain, 2% for none. This shows that knowledge on warning signs was generally poor as participants were unable to identify all warning signs of DV by more than 50%. Knowledge on warning signs like multiple injuries, depression, anxiety, substance abuse and unexplained chronic pain were few of the warning signs adopted, regarding identification of DV, as one of the primary component DV management.

According to the study findings, maximum score was 54% for multiple injuries with (2%) of participants failing to identify any of the warning signs. This reflected that HW at BCH had low knowledge on warning signs of DV hence would not identify cardinal patients to screen out for DV even when they come with obvious signs. This meant that they would treat without identifying them hence constructing the cycle of DV occurrence.

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The findings of this study are contrary to the findings of Ramsay in 2012 who presented the same warning signs in his study in UK and found that that the participants had excellent knowledge regarding management of DV. On a different note, finding of this study are in agreement with health care and social services workers generally do not recognize symptoms of domestic violence and do not provide adequate treatment, protection and support to the DV victims. There is need for more focused training on the warning signs of DV. These signs should always be charted and availed to the working stations for HW to use, or universal screening for all patients can solve this problem of continuous cycle of DV among women.

Practices of participants towards management of women victims of DV

The practice of management of DV was generally poor with a big number (58%) of the participants who reported that they were unable to document the identified cases of domestic violence, 52% were unable to refer DV victims and only (20%) documented the identified cases. With an alarming 80% of participants who did not have access to domestic violence register. These results could be because of the absence of policy regarding domestic violence management like screening criteria, and further management policy. The DV register was only observed to be in OPD accessed by only 20% of HW and was dominated by cases of rape, defilement, and sexual abuse this register may not be easily accessible hence the practice of documentation was poor.

The researcher observed several policies like universal alcohol audit, universal HIV screening, family planning screening, sexual assault policy and many to mention but there was none for DV management yet findings show that, majority did not know the right action to take after identifying DV victim which attributes to poor practice.

Also according to the study findings more than half (52%) of participants reported that, they were reported unable to refer DV victims. This could be because, DV referral forms were not available, there was no DV women victim management guidelines, to guide HW whether to refer to the police or counselor, or head of clinical services or gender based violence committee. This is in line with findings of many researchers including [21-23] who stated that DV has been under reported because of poor documentation and disclosure. Women victims of DV present to health workers with cases of DV but on many occasions health workers miss them out and instead treat for other diseases without making the right diagnosis of the cause of injuries. This leaves DV women victims frustrated as they do not get the desired help. In medical practice skills, knowledge and practice are all important elements of clinical expertise in the management of patients.

According to the study findings the practice of asking about incidence of DV was good with (60%), participants who were found to have asked patients for incidences of DV. Only 40% of the participants never asked patients who presented with warning signs of DV about incidences. In related point of view, according to the study done by Ramsay 2012, it was found that 40% of HW never or seldom asked about abuse when a woman presented with injuries. Similarly the same study by Ramsay. J, et al. Also found out that (49%) of respondents never routinely screened all patient who presented with signs of abuse [24-26].

Despite the findings showing slight better practice regarding DV victims management, than the referenced literature, recommend universal screening for all female patients and mandatory reporting of the cases. Therefore more needs to be done to improve practice of DV management in Bwindi area.

CONCLUSION

Generally, HW at BCH had good knowledge on DV and its management except on warning signs. Clinicians seemed more knowledgeable than nurses. Practice was generally poor with participants showing inability to identify, document, and refer of victims of DV. It was also observed that many participants had no access to the register or DV management guidelines.

Screening for women victims of DV has totally not been done even when clients come with obvious signs of DV. Resources for DV management like guiding protocols, DV register and unified DV referral forms were not observed and hence the practice towards DV management is lacking.

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