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Original Research Article

Healthcare professionals' attitudes and experiences of domestic violence

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ABSTRACT

Background: Domestic violence (DV) or intimate partner violence has been declared as public health epidemic by the WHO. Healthcare professionals (HCPs) have an important role in addressing the victims of DV or abuse and are the first to offer them care. Aim of study was to assess the attitude and professional experiences of HCPs concerning DV and their female patients.
Methods: The study is conducted using pre-structured questionnaire and via google form sent to the study subjects through a WhatsApp link on their mobiles. The study population were comprises consultants, resident doctors and nurses. The study subjects' response about receiving adequate training and their attitude whether enquiry about DV was considered an essential part of their job were the main outcomes.
Results: A total of 392 responses were received. Overall, 50.3% of HCPs agreed that the incidence of DV has increased in the covid era and only 49.2% believe that enquiry about DV is an essential part of their job; 49.0% of HCPs agreed that they are comfortable while asking questions pertaining to DV. Only 17.4% of HCPs received adequate support during training period in regards to evaluating patients with DV.
Conclusions: Training of all HCPs to identify and manage patients with DV is needed in order to deal efficiently with this public health problem. The attitude of HCPs towards DV needs to be addressed.

Keywords: Attitude, Covid-19, Domestic violence, Experiences, Healthcare professionals, Intimate partner violence

INTRODUCTION

The term "domestic violence" (DV) or intimate partner violence includes violence against women and girls by an intimate partner, including a cohabiting partner, and by other family members, whether this violence occurs within or beyond the confines of the home.[1] Globally, one in three women experience physical or sexual violence by their partners.[2] DV has been recognized as a public health problem and the World Health Organization (WHO) has recommended effective prevention and intervention strategies to address and bring the issue under check.[3]

The published literature, shows that there are significant differences in the prevalence of DV based on geographical regions. As a result of the COVID-19 pandemic, instances of domestic abuse have increased significantly across the UK mainly because women are trapped in their household with their abuser, with very few or no opportunities to seek help.[4] Obstetricians, who spend time with women in a range of settings, are particularly well placed to identify and respond to abuse. The Royal College of Midwives and the Royal College of Obstetricians and Gynaecologists urge maternity staff to commit to work collaboratively to identify women experiencing abuse and provide support.[5]

DV has been recognized as a criminal offence under Indian Penal Code 498-A since 1983. It was only in 2006 when the Protection of Women from Domestic Violence Act 2005 (PWDVA) came into effect in India and the victims of DV received civil protection. This Act establishes a comprehensive definition of DV including various forms of physical, emotional, verbal, sexual, and economic abuse. Marital rape is recognized as an offence and unlawful dowry demands as a form of abuse under the act.

The latest survey of National Family Health 2019-2020 estimates 31.1% of Indian women experience violence from their husband and 4% violence during pregnancy.[6] The National Crime Records Bureau (NCRB) report says that the prevalence of violence against women in India is high compared to other crimes and the causes are cruelty at the hands of their husband or relatives.[7] In India, DV is directly related with unemployment, poor education, alcoholism by the spouse, socio-economic status, religion, dowry and husbands extra marital affairs.[8,9]

Healthcare systems should be receptive and responsive in providing support to women and HCPs at all levels need to be trained to detect signs of DV.

Objectives was to assess the attitude and professional experiences of HCPs concerning DV and their female patients.

METHODS

This was an observational, cross-sectional, prospective study conducted at a tertiary care center in North India among physicians, obstetrician and gynecologists, resident doctors, medical students and nursing faculty from September 2021 to March 2022. The institute ethical committee clearance was obtained for the study. Consent was implied from all the participants and a pre-structured questionnaire was given to them through a WhatsApp link. The questionnaire covered the demographic details, overall views on DV, training and support acquired during post-graduation, approach of government for dealing patients of DV or abuse and the role of hospital and care givers in the proper management of women facing violence from their partners and family members. A pilot study was conducted initially and the questions were refined by a focus group meeting. Results were tabulated using Microsoft Excel.

RESULTS

Of the 392 responses 141 (36%) were from female participants and 115 (29.3%) of the participants were married. The mean age of the participants was 27.9 (+/- 11.6) years and their mean experience in medical field was 5.8 years. Table 1 illustrates the demography and overall views on DV from 392 HCPs; 56.4% of the participants had some time during their practice had to dealt with patients with DV. In addition, 50.3 % of the participants were of the opinion that the DV has slightly become more prevalent in the Covid era and 49.2% of the HCPs felt that addressing DV is an essential part of their job.

Table 1: The demography and overall views on domestic violence from 392 health care professionals.

	Number	Percentage
Doctor (consultant)	93	23.7
Doctor (resident/intern)	53	13.5
Medical student	205	52.3
Nurse	26	6.6
Nursing student	15	3.8
Total	392	100
Mean (SD) age (y)	27.9 (11.6)	
Mean (SD) experience (y)	5.8 (9.9)	
Female	141	36.0
Married	115	29.3
Ever cared for victim of domestic violence	221	56.4
Domestic violence is worse/slightly worse in covid era[a]	197	50.3
Domestic violence is less/ slightly less in covid era[a]	88	22.4
Do not know where to find information[b]	161	41.1
Asking about domestic violence is a significant/ essential part of your job[a]	193	49.2

[a]5 answers covering positive, negative and neutral answers
[b]4 answers covering positive and negative answers

The majority of the HCPs (82.6%) did not think they received adequate training for dealing with patients with DV during their undergraduate or post graduate training (Table 2). The HCPs (83.42%) who are in the post training phase (ongoing practice) seemed to lack adequate support and information regarding DV.

Table 2: Support and training on the issue of domestic violence from 392 health care workers.

	Yes	Percentage
Have you been given adequate support in training[a]	68	17.4
Have you been given adequate support in post graduate training[a]	65	16.6
Has the governments approach to domestic violence been adequate or good[b]	247	63.0

[a]4 options for each answer adequate support/information, some support/information, poor support/information, no support/information
[b]4 answers on governments approach - good, adequate, could be better or not adequate

The approach of government for the victims of DV was considered adequate by 63.0% of healthcare professionals.

The Table 3 illustrates the opinion of HCPs to questions pertaining to DV and the role of care givers and hospital in dealing with such patients.

Table 3: Answers to questions about domestic violence and the care givers and hospital role.

	Number	Percentage
Comfortable/mostly comfortable asking about domestic violence[a]	192	49.0
Worried about your relationship with the patient[a]	273	69.6
Worried about the health of existing children[a]	361	92.1
Worried about mothers health in pregnancy[a]	379	96.7
Hospital role in helping women with domestic violence		
No role	16	4.1
Provide information only	28	7.1
Provide a dedicated service	122	31.1
Provide help/support/referrals	190	48.5
Provide a referral service	36	9.2

[a]5 answers covering positive, negative and neutral answer

It is evident from the Table 3 that most of the HCPs (69.6%) are worried about their relationship with patients while enquiring about DV in their family and 51.0% are not comfortable in asking questions regarding the same.

DISCUSSION

Subjects in the present study included professionals who had graduated from government medical college and had a reasonable level of experience of attending to patients, taking into account the mean of 5.8 years of experience in their profession. The findings of this study demonstrated that in general HCPs had insufficient knowledge, dismissive attitudes, and preparedness to provide competent DV care and services. The lack of training and experience regarding identifying the women suffering from DV among the HCPs in this study was consistent with previous studies in various settings.[10]

Although some participants had the opportunity to receive training on DV, they were those younger HCPs who had a shorter work experience and may have recently received training so were more likely to report having training on DV. HCPs with longer work experience reported being more likely to have had opportunities for training on DV once they started their practice.

The findings of this study support the role of DV training, as corroborated by previous studies.[11,12] The recently developed WHO DV curriculum for training healthcare providers needs to be integrated into existing medical and nursing education curriculum during their under and post-graduate training.[13] The content should include basic/background knowledge, screening and assessment as per the WHO recommendations.[14]

The main limitation of the study is the relatively small sample size and involving HCPs working at one healthcare center. This may lead to differences in assessment if the same study were conducted nationwide. The study may benefit from questions regarding the experience of HCPs pertaining to various forms of DV (physical, emotional, sexual, verbal and economic) affecting women which they deal more frequently in their day to day practice.

Interpretation: DV care provision is one of the essential factors to improve medical care capacity; therefore, it is important to integrate DV care provision into under and post-graduate training curriculum across the medical and nursing education and to ensure continuous training of those HCPs who lack such training during their under graduate and post-graduation training. Moreover, this study emphasizes that the attitude of HCPs to DV need to be addressed for the provision of timely and safe care and services as recommended by the WHO.[15]

Healthcare systems in the South Asian countries should be more receptive, responsive and proactive in providing support to women suffering DV. Most of the time, it is the HCP whose help is sought for physical injuries. HCPs should, among other things, help to link the victims with support services and provide further help in the future.

There should be a national public health campaign on violence against women and girls, getting them to act on that awareness and enabling women and girls to access services effectively.

CONCLUSION

This study reported actual conditions of knowledge, attitude, and preparedness in relation to DV care provision among HCPs. The attitudes toward DV care present a challenge for improvement, although guidelines and training could improve HCPs knowledge and preparedness to provide required management of the DV affected women. Many HCPs see their role quite narrowly and they don’t see responding to violence against women as part of what they do. Raising awareness of the different sorts of violence among HCPs is a crucial element in the early

detection of signs of DV, because heightened awareness may be an initiative in changing attitudes and behavior that perpetuate or condone the varied sorts of violence. Efforts to help women who have experienced DV must go beyond caring for individual patients, and aim to change the cultural, political, and social contexts that produce and maintain DV at the minimum possible level. HCPs at different levels from community health workers to specialists at tertiary care center need to be trained to detect signs of DV and be comfortable with addressing the problem. Finally, it is important to make them aware of the relevant laws and of their legal duty to report the matter to the concerned authorities in their country.

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