



ORIGINAL ARTICLE

How to screen for domestic violence against women in primary health care centers

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Abstract *Background:* Violence against women is a major public health problem. Primary health care workers are involved in both detection and management of violence. Screening of women for violence is an important tool for early detection and prevention of violence through a valid and accepted screening tool.

Objectives: The purpose of this study was to identify the main elements and characteristics of a violence screening tool that can be used in primary health care centers.

Methods: An observational cross-sectional study was carried out in primary health care centers located in two randomly selected health regions in Kuwait. The study involved all available physicians (210) and nurses (464) in the selected centers. The overall response rate was 54.3%. A self-administrative questionnaire was used for data collection.

Results: Physicians favored an indirect question about violence (79.7%), while a question about feeling safe (83.6%) was suggested by nurses. The most frequently suggested method was searching for signs of violence. The majority of both nurses (82.4%) and physicians (82.0%) suggested physicians to carry out the screening process for domestic violence against women. The primary health care level was suggested to be in charge of screening for violence by 88.7% of nurses and 82.0% of

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physicians. Both nurses and physicians agreed that the examination should be carried out in complete privacy (95.0% and 91.4%), by an examiner of the same sex (89.1% and 89.8%), and not allowing a relative of the victim to attend the screening (85.3% and 78.9%). Opportunistic screening was preferred by both physicians (69.5%) and nurses (87.8%) when manifestations of violence are noticed.

Conclusion: A short tool containing a question about safety and looking for signs of violence administered by a physician on opportunistic basis in the primary health care centers in complete privacy was suggested for screening of women.

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1. Introduction

Violence against women is considered as one of the major public health and human rights problems worldwide. It is a health problem that depletes women's energy, compromises their physical and mental health, and destroys their self-esteem. It is associated with a lot of health problems that can affect both women and their children.^{1,2} In addition to causing injury, it can lead to gynecological disorders, mental health disruptions, abortive pregnancy outcomes, and sexually transmitted diseases.³⁻⁶ Violence also, increases women's risk of a number of other long term health problems as chronic pain, physical disability, alcohol and drug abuse, and depression.⁷ The 2005 "WHO Multi-country Study on Women's Health and Domestic Violence Against Women" found that abused women were twice as likely as non-abused women to have poor health and physical and mental problems, even years after the violent attacks have ceased.⁸

The serious consequences of domestic violence (DV) against women on the health and quality of life of women and their children push us to act toward its immediate prevention and elimination. Health professionals have been identified as being in a unique position to create safe and confidential environments for facilitating disclosure of violence and offering appropriate support and referrals to community and other resources.⁹

Although physical violence may be more readily apparent, battered women who have been subjected to physical violence often stated that the psychological and emotional violence were far more damaging.¹⁰ To avoid the shame of abuse, a woman in violent situations does not want to be seen by health care providers. Usually they use several different emergency clinics, neglect office visits and move among health care givers. Unclear, chronic and somatic complaints, depression and anxiety may be the symptoms that are usually discussed with her health care provider, rather violence in her home.^{11,12}

Most primary health care physicians do not screen for violence against women. Developing methods for screening all women for violence is of utmost importance to address the needs of battered women.¹¹ The purpose of this study was to identify the main elements and characteristics of a violence screening tool suggested by both physicians and nurses working in the primary health care units to detect affected women.

2. Methods

An observational cross-sectional study design was adopted for this study. The study was carried out in the primary health care centers located in two randomly selected health areas (Capital and Jahra) out of five in Kuwait. The total number

of physicians and nurses working in the selected centers was 239 and 510, respectively. All available physicians (210) and nurses (464) during the field work of the study in the selected centers were the target population of this study. Out of these, only 366 (128 physicians and 238 nurses) agreed to share in the study with an overall response rate of 54.3% (61.0% and 51.3%, respectively). The study covered the period August 2011 to February 2012. Data were collected over three months starting from September to December, 2011.

Data of this study were collected through a specially designed questionnaire. This questionnaire consisted of several sections. The first section dealt with socio-demographic characteristics, including age, sex, nationality, marital status and educational qualification. The suggested screening tool consisted of 25 questions covering seven aspects. The first aspect dealt with the type of question used and this part involved 7 questions. The second aspect consisted of four questions about screening methods and way of questioning. Three questions were assigned for each of the following aspects namely the examiner, the level of care and the characteristics of the place where screening will be carried out. Two health care programs were suggested for integration of the screening and three patterns of periodicity were suggested for examining the women.

A pilot study was carried out on 30 physicians and nurses (not included in the final study). This study was formulated with the following objectives: test the clarity, applicability of the study tools, accommodate the aim of the work to actual feasibility, and identify the difficulties that may be faced during the application. Also, the time needed for filling the questionnaire by the staff was estimated during this pilot study. The necessary modifications according to the results obtained were done, so some statements were reworded. Also, the structure of the questionnaire sheet was reformatted to facilitate data collection.

A pre-coded sheet was used. All questions were coded before data collection. This facilitates both data entry and verification as well as reduces the probability of errors during data entry. Data were fed to the computer directly from the questionnaire without an intermediate data transfer sheets. The Excel program was used for data entry. A file for data entry was prepared and structured according to the variables in the questionnaire. After data were fed to the Excel program; several methods were used to verify data entry. These methods included simple frequency, cross-tabulation, as well as manual revision of entered data. Percent score was calculated for the total attitude score as well as for each domain of attitude.

All the necessary approvals for carrying out the research were obtained. The Ethics Committee of the Kuwaiti Ministry of Health approved the research. A written format explaining

the purpose of the research was prepared and signed by the physician before filling the questionnaire. In addition, the purpose and importance of the research were discussed with the director of the health center.

3. Statistical analysis

Before analysis; data were imported to the Statistical Package for Social Sciences (SPSS) which were used for both data analysis and tabular presentation. Descriptive measures were utilized (count, percentage, arithmetic mean and standard deviation) as well as analytic measures (Chi square for qualitative variables and Student's *t* test for normally distributed quantitative variables). The level of significance selected for this study was $P \leq 0.05$.

4. Results

Table 1 shows characteristics of studied primary health care physicians and nurses. The majority of nurses were females (90.3%), married (84.9%), Non Kuwaiti (95%), holding a bachelor degree or lower (88.7%) with an average age of 34.0 + 7.03 years, while the majority of primary health care physicians were males (53.1%), married (89.1%), Non Kuwaiti (64.1%), holding an educational certificate higher than a bachelor one (71.9%) with an average age of 40.7 + 9.03 years. Statistically significant differences were found between physicians and nurses for personal characteristics except for marital status.

Table 2 portrays suggested pattern, characteristics and administrative procedures of a screening tool for detecting violence against women by primary health care physicians and nurses. Indirect questions about violence (79.7%) followed by questions about feeling safe came on the top of the list of questions by physicians, while a question about feeling safe (83.6%) followed by a question dealing with the relationship of the husband with family members (82.0%) topped the list by nurses. The least type of question suggested by physicians was a direct question about violence (60.9%) while in contradiction nurses suggested an indirection question about violence (53.8%) as the least suggested. Generally, nurses and physicians agreed on the ways of questioning and screening methods. The most frequently suggested method was searching for signs of violence (81.1% compared with 80.5%), while the least frequently suggested one was asking only oral questions (62.2%

compared with 50.8%). The majority of both nurses (82.4%) and physicians (82.0%) suggested physicians to carry out the screening process for DV against women. The primary health care level was suggested to be in charge of screening for violence by 88.7% of nurses and 82.0% of physicians. The least suggested one by both physicians and nurses was the casualty departments. Both nurses and physicians agreed that the examination should be carried out in complete privacy (95.0% and 91.4%), by an examiner of the same sex (89.1% and 89.8%), and not allowing a relative of the victim to attend the screening (85.3% and 78.9%). The majority of studied physicians (86.7%) and nurses (79.4%) agreed that violence screening should be integrated with mental health care program rather than family or personal history (70.3% and 74.4%). Opportunistic screening was preferred by both physicians (69.5%) and nurses (87.8%) when manifestations of violence are noticed, while regular annual screening was suggested by 58.6% of physicians and 67.2% of nurses.

5. Discussion

Intimate partner violence (IPV) is a major public health problem associated with adverse health problems for victims.¹³⁻¹⁵ Healthcare settings represent important sites for IPV screening and intervention. In 2004, however, the "U.S. Preventive Services Task Force" (USPSTF) concluded that there was "insufficient evidence to recommend for or against routine screening of women for IPV."¹⁶

Although literatures on family and IPV are numerous, few studies provide data on detection and management to help physicians. As a result, clinicians face many difficulties in prevention and treatment of the consequences of violence.¹⁷

Nelson and his colleagues¹⁷ reviewed studies dealing with violence screening among women. They did not find any studies that directly discussed the effectiveness of screening for reducing harm within families due to DV or the drawbacks of screening and intervention. Several tools have been developed for screening of IPV. They showed various degrees of consistency and validity. However, none have been tested against measurable violence or health outcomes. The standard methods of administration have not been introduced.

Some researchers recommended that physicians should routinely screen for patients whose partners are aggressive or nervous.¹⁸⁻²⁰ Many suggested using a single question to detect

Table 1 Characteristics of studied primary health care physicians and nurses.

Characteristics	Physicians no. (%) <i>N</i> = 128	Nurses no. (%) <i>N</i> = 238	Total no. (%) <i>N</i> = 366	<i>P</i> value
<i>Sex</i>				
Male	68 (53.1)	23 (9.7)	91 (24.9)	< 0.001*
Female	60 (46.9)	215 (90.3)	275 (75.1)	
<i>Marital status</i>				
Single	14 (10.9)	36 (15.1)	50 (13.7)	0.266
Married	114 (89.1)	202 (84.9)	316 (86.3)	
<i>Nationality</i>				
Kuwaiti	46 (35.9)	12 (5.0)	58 (15.8)	< 0.001*
Non Kuwaiti	82 (64.1)	236 (95.0)	308 (84.2)	
<i>Educational certificate</i>				
Bachelor or lower	36 (28.1)	211 (88.7)	247 (67.5)	< 0.001*
Higher than bachelor	92 (71.9)	27 (11.3)	119 (32.5)	
<i>Age (years)</i>				
Arithmetic mean (SD)	40.7 (9.03)	34.0 (7.03)	36.3 (8.40)	< 0.001

* Significant $P \leq 0.05$.

Table 2 Suggested pattern, characteristics and administrative procedures of a screening tool for detecting violence against women by primary health care physicians and nurses.

Character of violence screening tool	Physicians no. (%) <i>N</i> = 128	Nurses no. (%) <i>N</i> = 238	Total no. (%) <i>N</i> = 366	<i>P</i> value
<i>Type of questions</i>				
Indirect about violence	102 (79.7)	128 (53.8)	230 (62.8)	< 0.001*
Direct about feeling safe	99 (77.3)	207 (87.0)	306 (83.6)	0.018*
Direct about controlling by others	80 (62.5)	182 (76.5)	262 (71.6)	0.005*
Direct about limiting mobility out of house	79 (61.7)	163 (68.5)	242 (66.1)	0.192
Direct about receiving threats	89 (69.5)	160 (67.2)	249 (68.0)	0.652
Relation of husband with family members	80 (62.5)	220 (92.4)	300 (82.0)	< 0.001*
Direct about violence	78 (60.9)	171 (71.8)	249 (68.0)	0.033*
<i>Questioning and screening methods</i>				
Written in a questionnaire	85 (66.4)	158 (66.4)	243 (66.4)	0.997
Only oral questions	65 (50.8)	148 (62.2)	213 (58.2)	0.035*
Using short easy questions	98 (76.6)	179 (75.2)	277 (75.7)	0.774
Searching for signs of violence	103 (80.5)	193 (81.1)	296 (80.9)	0.885
<i>Who perform screening</i>				
Physician	105 (82.0)	196 (82.4)	301 (82.2)	0.939
Nurse	53 (41.4)	152 (63.9)	205 (56.0)	< 0.001
Socialist	74 (57.8)	191 (80.3)	265 (72.4)	< 0.001
<i>Level of care (setting for screening)</i>				
Primary health care centers	105 (82.0)	211 (88.7)	316 (86.3)	0.078
Casualty Departments	92 (71.9)	157 (66.0)	249 (68.0)	0.248
Obstetric and Gynecological Hospitals	96 (75.5)	190 (79.8)	286 (78.1)	0.286
<i>Place and circumstance of screening</i>				
Providing a place with privacy	117 (91.4)	226 (95.0)	343 (93.7)	0.182
The examiner is better to be of the same sex	115 (89.8)	21 (89.1)	327 (89.3)	0.820
No relatives are allowed to attend	101 (78.9)	203 (85.3)	304 (83.1)	0.120
<i>Health Program</i>				
Family or personal history	90 (70.3)	177 (74.4)	267 (73.0)	0.405
Mental health care	111 (86.7)	189 (79.4)	300 (82.0)	0.083
<i>Periodicity of screening</i>				
During first visit	50 (39.1)	118 (49.6)	168 (45.9)	0.054
Annual regular screening	75 (58.6)	160 (67.2)	235 (64.2)	0.100
Opportunistic when physical manifestations are noticed	89 (69.5)	209 (87.8)	298 (81.4)	< 0.001*

* Significant $P \leq 0.05$.

DV to be within a general health behavior surveys.^{21–23} Safety questions are suggested to be used for screening for DV in waiting rooms.²⁴ The results of the current study revealed that the indirect question about violence (79.7%) followed by a question about feeling safe came on the top of the list of questions by physicians, while a question about feeling safe (83.6%) followed by a question dealing with the relationship of the husband with family members (82.0%) topped the list by nurses. Inquiring about being afraid of a partner or ex-partner is getting increased interest and attention as a single screening item.^{25,26} Battered women attending primary care are much more likely to fear of a partner or ex-partner at some period in their lives than non-battered women.²⁵ Good sensitivity and specificity have been proved for the fear question for identifying physically, emotionally or sexually abused women in a large sample of women attending primary care. However, fear question does not perform as well for emotional abuse alone.²⁷ In contrast, other studies revealed that a single simple physical abuse question was more sensitive and specific than the questions regarding fear, with a high sensitivity and specificity. Moreover, the physical abuse question could detect as many of the abused patients as the other method.^{28,29} This contradiction can be explained by the non specific definition of feeling safe at home.²⁸

Not only the nature and characteristics of the used questions for screening women for violence can affect disclosure of the required information, but also the method these questions are administered to women. MacMillan and his colleagues examined the best screening methods (via computer, written on paper form, face-to-face interview) for DV in emergency departments, family practice and maternal health clinics. They reported that although women preferred the self-administered method however, they did not find significant differences among screening methods.³⁰ Also, Chen et al. in their randomized control trial did not find significant differences between interviews and self-administered questionnaires.³¹ Many other controlled trials have been conducted with conflicting results.^{32,33} The current study revealed that both physicians and nurses suggested searching for signs of violence as the first method (80.5% and 81.1%). This method is considered as a diagnostic method as it detects already battered women (physically hurt) and not a screening method that is supposed to detect risk of violence. However 66.4% of both physicians and nurses recommended the oral method for violence screening.

The personnel directly involved in documentation in the patient record of any suspected abuse are physicians, nurses, social workers, and psychologists.³⁴ In previous two studies,

the majority of female patients favored physician inquiry and reported that they would reveal abuse histories if asked directly.^{35,36} The findings of the current study supports these findings as the majority of both nurses (82.4%) and physicians (82.0%) suggested physicians to carry out the screening process for DV against women. This might be attributed to less preparedness of nurses than physicians to deal with screening for violence against women.³⁷

Screening for violence can be carried out in several settings including maternity hospitals, emergency departments and primary health care units. Primary care settings frequently are the first to be reached, and is unique in that it has the potential to provide diagnosis, early intervention and support for women at risk.³⁸ Results of the current study revealed that the primary health care level was suggested to be in charge of screening for violence against women by 88.7% of nurses and 82.0% of physicians. Battered women are over-represented in outpatient and primary care settings.^{39,40} About a third of battered women disclose abuse to their general practitioner.⁴¹ All these factors add further support to the recommendation of the studied primary health care givers to implement screening at the primary health care level than at the secondary or tertiary level of health care.

In the context of IPV, health care givers are required to provide conditions that help disclosure, discussion, and documentation. This includes interviewing the woman apart from partners and children, explaining that the questions are part of routine inquiry, and by getting an appreciation of the vulnerability due to the fear and shame feeling of victims.^{34,42,43} The suggestions of studied nurses and physicians are in line with circumstances as both nurses and physicians agreed that the examination should be carried out in complete privacy (95.0% and 91.4%), by an examiner of the same sex (89.1% and 89.8%), and not allowing a relative of the victim to attend the screening (85.3% and 78.9%). Examination by a health care giver of the same sex might reflect the habits and culture in the eastern countries to deal with such a sensitive social and health problem.

In order to help and start effective interventions for battered women in Kuwait, the suitable timing of IPV screening in healthcare settings needs to be better understood. Opportunistic screening was preferred by both physicians (69.5%) and nurses (87.8%) when manifestations of violence are noticed, while regular annual screening was suggested by 58.6% of physicians and 67.2% of nurses. There is no evidence concerning standard screening method. Routine inquiry when signs or symptoms of abuse are present is one of the approaches suggested for the identification of woman abuse in health care settings. This approach has been supported by several national organizations.^{16,44} This "diagnostic" or "case finding" method needs awareness by the clinician for factors associated with violence, including physical, mental, sexual issues that could be related to recent or current abuse.^{45,46}

Hence, screening tools for DV have been widely adopted as part of a growing effort by the medical organizations to disclose the health aspects of DV.⁴⁷ Identifying abused women helps the IPV trained healthcare provider to properly manage and provide the woman with a safer environment. Self-reports from women indicating that they are comfortable responding to IPV-related inquiries in healthcare settings⁴⁸ together with recent evidence suggesting that such inquiries may reflect positively on women's satisfaction with healthcare in general⁴⁹

underscore the importance of universal screening. In support of this argument, healthcare professionals acknowledge that routine screening is likely to improve identification and management of IPV.⁵⁰

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