The Egyptian Journal of Hospital Medicine (October 2017) Vol. 69 (8), Page 3058-3065

Barriers that Impede Primary Health Care Physicians from Screening Women for Domestic Violence at Makkah ALmukarramah City

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ABSTRACT

Background: Nowadays, violence against women represents a major public health concern despite the efforts to raise awareness about it at the local and the global level. Doctors have a crucial role to play in detecting violence against women but they are confronted to many barriers.

Objective: To identify the barriers that impede physicians from screening women for domestic violence.

Subjects and methods: A cross-sectional study was conducted using a questionnaire to collect data from 62 primary health care physicians at Makah Almukarramah city.

Results: More than a half of the physicians, working at primary health centers at Makkah and who participated in our survey, dealt with a case of a women abused by her partner. Many participants agreed that there were barriers that impeded them from screening violence like insufficient training, feeling of embarrassment, shame of asking question about abuse and fear of revenge by the husband or relatives.

Conclusion: Implementing training program with intervention could help in managing and preventing violence against women.

Keywords: Violence, Women, Screening: physicians, barriers.

INTRODUCTION

Violence against women is a worldwide problem; The Declaration on the Elimination of Violence against Women, adopted by the United Nations General Assembly in 1993, defines violence against women as "any act of gender-based violence that results in, or is likely to result in, physical, sexual, or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life" [1]. On 2006, a multicounty study showed that the prevalence of violence against women ranges from 15 to 71% [2, 3]. On 2013, an international analysis conduct by WHO over 80 countries, found that worldwide, almost one third (30%) of all women who have been in a relationship have experienced physical and/or sexual violence by their intimate partner. In the Arab world, according to literature, the prevalence of women who reported being subject to violence ranges from 20 to 87% [4-9].

Violence against women can have a multitude of devastating consequences for their health and well-being in the short and long term [10]. The immediate physical and psychological consequences that affect the abused woman may be accompanied by deterioration in her overall quality of life throughout her life. This is in addition to the broader social costs associated with the delivery and maintenance of health care. Abused women often experience somatic and stress-related illnesses, chronic pain syndromes, depression, posttraumatic stress disorder, and substance abuse disorders. Furthermore, compared with women with no history of abuse, abused women have higher levels of health care use [11,12].

Physicians have a crucial role to play in detecting violence against women who, often through shame or denial, prefer to hide it. The proportion of physician who declares cases of intimate partner violence remains insufficient in comparison to the prevalence of those cases. Many explanation was advanced as barriers to screening women abuse, like the absence of guidelines on how to manage the victim of violence, the workload of health professional and other barriers related to the examiner [13,14]. Thus, the purpose of this study was to identify barriers of screening for domestic violence against women in the primary health care (PHC) centers in Makkah city.

SUBJECTS AND METHODS

A Cross-Sectional Study was conducted among general practitioners and family medicine physicians in the primary health care centers of Makkah City. An adapted questionnaire was used for data collection. The questionnaire consisted of two sections. The first section is the socio-demographic characteristics, including age, sex, nationality, marital status, educational qualification and current job and number of years at work.

Received: 07/09/2017
Accepted: 17/09/2017
DOI: 10.12816/0042856

The second section is the types of barriers divided to two domains and consisted of 11 items. The first domain is related to barriers related to the examiner, consisted of six statements. Five statements were assigned for barriers related to the health administration system.

The study was done after approval of ethical board of Umm AlQura University.

Statistical analysis

Frequencies were used to describe qualitative variables, means with standard deviation and median with interquartile range was used to describe quantitative data. To analyze the association between qualitative variables chi square test and fisher test were used, and to analyze the association between qualitative variables and ANOVA was performed. The threshold for statistical significance was fixed at 0.05.

RESULTS

Sixty two physicians working at the primary health care centers of Makkah City participated in the present survey. Males represented 55% of the respondents. Forty percent of the participants aged between 20 and 30 years old. Forty-four percent of the individuals were of a nationality other than the Saudi nationality and about 80 % were married (Table1).

Thirty eight physicians (61%) dealt with a case of woman abuse. The association between socio-demographic characteristics and the diagnosis of women abuse was only significant for gender and the marital status; male physicians diagnosed more cases of women abuse than female physicians and this diagnosis was done mainly by married physicians. General practitioners dealt more frequently with cases of women abuse than other specialists, but there was no significant difference (Table2).

Fifty eight percent of physicians who dealt with cases of women abuse agreed with the fact that fear of revenge by the husband or relatives represented a barrier to screening those women (p =0.016). Among physicians who dealt with the diagnosis of women abuse, 50 % agreed that insufficient training represented a barrier to screening intimate partner violence, 58% agreed that feeling of embarrassment was also a barrier to screening and around 40% of the participants agreed that personal experience and shame of asking question about abuse impedes interference. As regard to barriers related to health administration; around 70 % who dealt with cases of women abuse agreed with the lack of training and knowledge on legality of violence. More than 80% of the participants, who diagnosed cases of women abuse, agreed that heavy work and lack of staff were barriers to screening such cases (Table 3).

The analysis of the association between socio-demographic characteristics and examiner related barriers to violence screening revealed the following; among respondents who indicated that insufficient training is a barrier to screening, 42% were aged between 20 and 30 years old, 53% were males and 58% were general practitioners. Among participants who mentioned fear of revenge as a barrier to screening, 67% were females, 83% were married, 50% were Saudi and 58% were general practitioners (Table 4).

Table1: Socio-demographic characteristics of the physicians that participated in the study

		%
Gender		
Male	**34**	**55%**
Female	**28**	**45%**
Age		
20 to 30	**25**	**40%**
31 to 40	**20**	**32%**
41 to 50	**9**	**15%**
51 to 60	**8**	**13%**
Nationality		
Saudi	**35**	**56%**
Arab	**22**	**36%**
Non Arab	**5**	**8%**
Job		
GP	**41**	**66%**
Specialist	**17**	**27%**
Consultant	**4**	**7%**
Qualification		
Bachelor degree	**38**	**61%**
Board	**10**	**16%**
Master	**6**	**10%**
PhD	**8**	**13%**
Marital status		
Single	**13**	**21%**
Married	**49**	**79%**
Years at work		
Mean (Sd)	**Median (IQR)**	
6.9(7.1)	4(11)	

Table 2: Association between socio-demographic characteristics and the diagnosis of women abuse

	Did you deal with a case of woman abuse			
	Yes (%)	**Suspected (%)**	**No (%)**	**p- value**
Gender				
Male	71%	35%	14%	**0.003**
Female	29%	65%	86%	
Age				
20 to 30	32%	53%	57%	**>0.05**
31 to 40	32%	35%	29%	
41 to 50	21%	6%	0%	
51 to 60	16%	6%	14%	
Nationality				
Saudi	53%	59%	71%	**>0.05**
Arab	34%	41%	29%	
Non Arab	13%	0%	0%	
Job				
GP	71%	59%	57%	**>0.05**
Specialist	21%	35%	43%	
Consultant	8%	6%	0%	
Qualification				
Bachelor degree	63%	59%	57%	**>0.05**
Board	21%	12%	0%	
Master	8%	12%	14%	
PhD	8%	18%	29%	
Marital status				
Single	13%	30%	43%	**0.04**
Married	87%	71%	57%	
Total	**61%**	**27%**	**11%**	
Years at work	**Mean(Sd)** 7.7(7.5)	**Mean(Sd)** 6.9(7.1)	**Mean(Sd)** 2.7(3.6)	**>0.05**

Table3: Barriers that impede primary health care physicians from screening women for domestic violence at Makkah ALmukarramah city between 2017 and 2018

	Did you deal with a case of woman abuse			p-value
	Yes (%)	Suspected (%)	No (%)	
Barriers related to the examiner				
Insufficient training				
agree	**50%**	**47%**	**72%**	**>0.05**
uncertain	**17%**	**6%**	**14%**	
disagree	**33%**	**47%**	**14%**	
Feeling of embarrassment				
agree	**58%**	**30%**	**29%**	**>0.05**
uncertain	**17%**	**24%**	**57%**	
disagree	**25%**	**47%**	**14%**	
Fear of revenge by the husband or relatives				
agree				
uncertain	**58%**	**24%**	**14%**	**0.016**
disagree	**25%**	**30%**	**29%**	
	17%	**47%**	**57%**	
Not convinced with screening importance				
agree	**17%**	**6%**	**29%**	
uncertain	**50%**	**35%**	**43%**	**>0.05**
disagree	**33%**	**59%**	**29%**	
Personal experience impedes interference				
agree	**42%**	**24%**	**43%**	**>0.05**
uncertain	**25%**	**35%**	**43%**	
disagree	**33%**	**41%**	**14%**	
Shame of asking question about abuse				
agree				
uncertain	**41%**	**24%**	**14%**	**>0.05**
disagree	**25%**	**18%**	**14%**	
	33%	**59%**	**72%**	
Barriers related to health administration				
lack of training				
agree	**67%**	**35%**	**71%**	**>0.05**
uncertain	**25%**	**30%**	**29%**	
disagree	**8%**	**35%**	**0%**	
Lack of knowledge on legality of viol				
agree	**75%**	**53%**	**71%**	**>0.05**
uncertain	**25%**	**18%**	**14%**	
disagree	**0%**	**29%**	**14%**	
Time constraints				
agree	**25%**	**29%**	**71%**	**>0.05**
uncertain	**58%**	**41%**	**29%**	
disagree	**17%**	**29%**	**0%**	
Heavy workload of health care				
agree	**83%**	**65%**	**57%**	
uncertain	**17%**	**12%**	**29%**	**>0.05**
disagree	**0%**	**24%**	**14%**	
Lack staff				
agree	**83%**	**65%**	**71%**	**>0.05**
uncertain	**17%**	**6%**	**29%**	
disagree	**0%**	**29%**	**0%**	

Table4: Association between socio-demographic characteristics and examiner related barriers to violence screening

	insufficient training (agree /disagree)	feeling of embarrassment (agree/ disagree)	fear of revenge by the husband or relatives (agree/ disagree)	not convinced with screening importance (agree/ disagree)	personal experience impedes interference (agree/ disagree)	shame of asking question about abuse (agree/ disagree)
Age						
20 to 30	42%/46%	43%/58%	25%/64%	0%/50%	42%/42%	40%/53%
31to 40	32%/39%	36%/25%	42%/29%	40%/31%	33%/50%	40%/37%
41 to 50	5%/15%	7%/17%	17%/7%	40%/6%	17%/0%	10%/5%
51 to 60	21%/0%	14%/0%	16%/0%	20%13%	8%/8%	10%/5%
p-value	>0.05	>0.05	>0.05	>0.05	>0.05	>0.05
Gender						
Male	53%/39%	57%/42%	33%/36%	40%/50%	42%/67%	50%/37%
Female	47%/61%	43%/58%	67%/64%	60%/50%	58%/33%	50%/63%
p-value	>0.05	>0.05	>0.05	>0.05	>0.05	>0.05
Marital status						
Single						
Married	37%/23%	43%/25%	17%/36%	20%/25%	50%/8%	40%/21%
p-value	63%/77%	57%/75%	83%/64%	80%/75%	50%/92%	60%/79%
	>0.05	>0.05	>0.05	>0.05	>0.05	>0.05
Nationality						
Saudi	63%/54%	79%/58%	50%/64%	40%/50%	67%/58%	67%/58%
Arab	26%/46%	14%/42%	42%/36%	60%/38%	33%/33%	33%/33%
Non Arab	11%/0%	7%/0%	8%/0%	0%/12%	0%/9%	0%/9%
p-value	>0.05	>0.05	>0.05	>0.05	>0.05	>0.05
Qualification						
Bachelor	58%/62%	57%/58%	66%/50%	20%/56%	50%/58%	60%/68%
Master	11%/15%	7%/8%	17%7%	40%/6%	17%/17%	10%/0%
PhD	16%/8%	14%/17%	0%/14%	20%/13%	8%/17%	10%/16%
Board	16%/15%	22%/17%	17%/29%	20%/25%	25%/8%	20%/16%
p-value	>0.05	>0.05	>0.05	>0.05	>0.05	>0.05
Job						
GP	58%/61%	50%/58%	58%/50%	20%/56%	50%/67%	60%/68%
Specialist	32%/31%	29%/42%	33%/50%	60%/44%	33%/25%	20%/26%
Consultant	10%/8%	21%/0%	9%/0%	20%/0%	17%/8%	20%/5%
p-value	>0.05	>0.05	>0.05	0.04	>0.05	>0.05
Years at work						
Mean						
p-value	7/6.1	6.6/9.6	8.6/6.8	11.8/5.8	6.4/6.8	7.4/4.5
	0.05	>0.05	>0.05	>0.05	>0.05	>0.05

DISCUSSION

The current study revealed that more than a half of the physicians, working at primary health centers at Makah and participated in the survey dealt with a case of a women abused by her partner. Among those respondents, the majority were male general practitioners and were married. Around thirty percent agreed with the importance of screening intimate partner violence among women. Many participants agreed that there were barriers that impeded them from screening violence like insufficient training, feeling of embarrassment, shame of asking question about abuse and fear of revenge by the husband or relatives. For the latter barrier, physicians who agreed were in general, Saudi female physicians and married and worked as general practitioners.

Violence against women was studied by many authors and many of them point out the role of the physician in managing such cases, in the present survey there were a consensus around the importance of screening abused women, but the surveyed physicians complained that, because of an insufficient training, they couldn't properly diagnose violence among females, this barrier was also mentioned in other studies [15]. In general women who have been a victim of violence confides in the first place to their physician before than to the police [16]. Listening is a part of the role of the health professional, indeed women who may have suffered from violence can overcome her fear of talking about it if the physician knows how to engage in dialogue and give confidence to the patient [17]. Our study revealed that male physicians had a significantly higher screening rate of abused women than female physicians, this was inconsistent with the results of a study of **Elliot *et al.*[18].** But in a study conducted by **Usta*et al.*** some women screened for violence say that they prefer to talk to a male doctor than a female one, feeling better understood by the former [19].

Other than insufficient training, other barriers could impede the physician from fulfilling his role. In our study the majority of the surveyed physicians agreed that feeling of embarrassment and shame of asking questions about abuse was barriers to screening abused women, which is consistent with the results of a similar survey conducted in Kuwait [20]. This could be explained by the cultural background; in fact in our study, unlike Saudi and Arab doctors, Non-Arab doctors disagreed with these two barriers. Fear of revenge by the husband or relatives was a major concern for the respondents, fear for safety was also cited by the participants in a Lebanese study that included primary care practitioners [21].

Among the surveyed physicians, there was an agreement that there are some factors related to the health administration that could represent an obstacle to screening violence among women. First, lack of training program about screening and preventing domestic violence which was an issue discussed by many authors [22, 23]. The diagnosis of a case of domestic violence is not an easy task and it needs knowledge about its symptoms. In a survey performed among nurses, the most frequent cited barrier to screening domestic violence was lack of evidence of the act of violence [24]. Training physicians about the appropriate intervention could address the managing and the consequence of intimate partner violence [25, 26].

In **Hoke*et al.*[15]** and **Zaher*et al.*[27]**studies, the majority of the participants showed an interest in receiving training about screening abuse among patients. Furthermore, among physicians who dealt with a case of an abused woman in our study, many of them emphasized that the heavy workload and the lack of staff discourage the health worker from insisting on looking for signs of violence during consultation. The lack of knowledge about the legality of domestic violence was another concern of the surveyed physicians, in fact some practices are considered legal in some Arab regions without being supported by a text of law [28]. In a Kuwaiti study, although the majority of the primary care physicians accept to manage domestic violence, many of them think that, in some cases, an act of violence against women could be justified [29]. This behavior was related to beliefs toward women rights [30]. Increasing the awareness about legal frameworks that protect women's rights helps to foster labeling violence against women as a pathological phenomenon [31].

Study limitations

Our study had some limitations; first the sample size of sixty two physicians might impede us from observing statistically significant results. Second, our survey included only one region of the country, then, our sample is not representative of all the physicians working at other primary health care centers, so

we couldn't generalize those results at a larger scale.

Conclusion

In our study, more than the half of the physician has diagnosed a case of woman victim of domestic violence and the majority suffered from many barriers to screening abuse among their patients. As examiner related barrier, most of physicians agreed about fear for safety and embarrassment, and as an administration barrier the majority complained about heavy workload and lack of training. It is established that the physicians plays an important role in helping women who had suffered from violence, but their contribution is still insufficient to manage and prevent domestic violence. Stakeholders should be engaged in this mission by helping in reinforcing interventions to raise the awareness among the community about this scourge and by contributing in implementing training programs on how to manage a case of abused women.

Acknowledgments

We would like to thank Wajd Ramzi Falemban, Asya Rezayq Alsulami, Shahad Hani Almuntaser, ShroqAbdulkareemAlghraibi, Sumayah Ahmad, Fallatah, Asalah Fahad Alhazmi, Rehab Suhail Almajnooni and Ohood Ayed Allogman for their contribution in collecting the data that survey to complete this work.

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