

## **Final Report**

**Protocol Title:** Screening for intimate Partner Violence against women in healthcare in Uganda: barriers and possibilities

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### **BRIEF OUTLINE OF THE RATIONALE FOR THE STUDY**

Self-reports from women indicate that they are comfortable responding to inquiries about Intimate Partner Violence (IPV) in healthcare settings and recent evidence suggest that such inquiries may augment women's satisfaction with health care in general. Reciprocating this view, healthcare professionals themselves acknowledge that routine screening for IPV is likely to improve identification and management of IPV. These views notwithstanding, only one in ten healthcare providers routinely screen for IPV in healthcare, suggesting the presence of barriers. However, the assessment of such barriers has so far remained an issue of peripheral debate, with little support by way of scientific research. Only recently, studies on the topic have begun to emerge particularly in Europe and North America. The screening behaviour of healthcare providers and related barriers in other parts of the world remains largely elusive. This project attempts to identify some of these barriers in Sub-Saharan Africa, using community studies in Uganda. To the best of our knowledge, only one systematic assessment of barriers to IPV screening has yet been undertaken in Sub-Saharan Africa (Nigeria), by the PI and colleagues. This study will attempt to fill this knowledge gap, adding data from Uganda. A triangulation of quantitative (i.e. questionnaire study) and qualitative methods (focus group discussions) is proposed. For the questionnaire study, stratified random sampling will be used to draw a representative sample of healthcare providers from 4 hospitals, two in Gulu district, one in Nwoya district and one in Iganga district. Statistical methods including factor analysis, reliability analysis, Chi-square test, T-test, ANOVA, Logistic and Linear regression will be used for analysis of the quantitative data. For the qualitative data, purposive sampling will be performed to sample 54 participants to take part in 8 focus group discussions. Data will be analyzed thematically using a Template Analysis approach.

### **RESEARCH OBJECTIVES:**

The main objective of this project is to study the readiness of healthcare providers to screen for IPV among clients in healthcare in Ugandan settings.

### **Specific objectives**

Specifically, the current project will:

- i) Assess the extent to which healthcare providers screen for IPV in Uganda
- ii) Assess healthcare providers knowledge/capabilities regarding screening for IPV
- iii) Assess healthcare providers awareness about and access to support networks for referral of IPV victims
- iv) Assess whether professional roles may conflict with inquiry about IPV (e.g. fear of offending victims or mutual respect)
- v) Assess healthcare professionals attitudes towards and perceptions about IPV screening
- vi) Assess how factors (i-iv) may vary depending on healthcare professionals occupational characteristics (e.g. nurses vs. doctors, working experience and working conditions) and demographic belonging (e.g. men vs. women, ethnicity and religion)
- vii) Assess how factors (ii-iv) together with occupational and demographic characteristics may influence the frequency of inquiring about IPV among healthcare professionals in Uganda
- viii) Compare readiness to screen and actual screening behaviour of healthcare providers in Gulu (recently a conflict region for over two decades) with that of peers in Iganga which has been peaceful for more than two decades.

### **METHODOLOGY**

#### **NUMBER OF SUBJECTS ENROLLED:**

The project employed both qualitative and quantitative methods to respond to the research questions. As indicated in the table below, the Institutional Review Board (IRB) approved 413 and 48 participants for the quantitative and qualitative studies respectively, based on a sampling of eligible participants drawn from the latest

human resource list at respective hospitals. However, 37 participants among the sampled had by the time of the study been transferred (n= 9), died (n= 2) were on annual/maternity/sick leave (n= 9) were on full-time studies (n= 11) or were not available for unknown reasons (n= 6). Thus, 376 of the sampled received the questionnaire of which 282 responded, giving a total response rate of 68% (i.e. 282/413) and an effective response rate of 75% (i.e. 282/376).

For the qualitative study, 48 participants were approved by the IRB. However, at each hospital, the contact persons coordinating participant recruitment with the researchers opted to participate in the discussions. Thus, an additional 6 participants than those approved by the IRB participated.

Category	Total Number this Reporting period	Cumulative Total
<b>Number of subjects approved to enroll: Quantitative: 413 Qualitative: 48</b>	Quantitative: 413 Qualitative: 48	Quantitative: 413 Qualitative: 48
<b>Number Enrolled: Quantitative: 413 Qualitative: 54</b>	Quantitative: 413 Qualitative: 54	Quantitative: 413 Qualitative: 54
<b>Number Lost (deaths, other) and reason for each: 37</b>	Quantitative: 37 Qualitative: 0	Quantitative: 376 Qualitative: 54
<b>Number withdrawn by Investigator and reason for withdrawal(s) of each:</b>	Quantitative: 0 Qualitative: 0	Quantitative: 376 Qualitative: 54
<b>Number withdrawn (drop outs – subject withdrew him/ herself) and reason for withdrawal(s) for each:</b>	Quantitative: 94 (simply did not return questionnaire and signed consent	Quantitative: 282 Qualitative: 54

	despite reminders. No reasons known for non-response) Qualitative: 0	
<b>Number of active subjects:</b>	Quantitative: 282 Qualitative: 54	Quantitative: 282 Qualitative: 54
<b>Number completed all study activities:</b>	Quantitative: 260 Qualitative: 54	Quantitative: 260 Qualitative: 54

## CURRENT LITERATURE

The literature on screening for Intimate Partner Violence (IPV) in healthcare is rather substantial though a vacuum on such discussion exist with reference to Sub-Saharan Africa. In medicine, screening refers to a strategy used in a population to detect a disease in individuals without signs or symptoms of that disease. In essence therefore, screening for IPV in healthcare is a systematic involvement of healthcare workers in the detection of IPV among clients who may or may not present with direct signs of victimization/abuse. There has been a discussion as to whether screening should be universal. Self-reports from women indicating that they are comfortable responding to IPV-related inquiries in healthcare settings (Stenson, Sidenvall & Heimer, 2005) and recent evidence suggesting that such inquiries may augment women's satisfaction with health care in general (John, Lawoko, Svanstrom, 2010) underscore the importance of universal screening. Reciprocating this view, healthcare professionals themselves acknowledge that routine screening is likely to improve identification and management of IPV (Furniss, McCaffrey, Parnell & Rovi 2007).

Despite a consensus among women and healthcare practitioners that screening for IPV among patients may be beneficial in its prevention, evidence suggest that only between 8-10% of healthcare personnel routinely screen for the phenomena (Erikson et al., 2001; Roelens, Verstraelen, Van Egmond, Temmerman 2006). The healthcare providers' insufficient knowledge and training in screening could explain this discrepancy (Waalén et al., 2000, Erikson, Hill, Siegal, 2001). Other factor related to professional roles governing the provider-client relations (e.g. mutual respect, fear of offending clients) (Maiuro, Vitaliano, Sugg et al 2000) and healthcare provider's individual attitudes towards IPV may influence screening for IPV in healthcare (John, Lawoko, Svanström 2011). The latter may pose significant challenges to screening for IPV in the Sub-Saharan African context where between 60-80% of both women and men in the general population acknowledge abuse of

women in the domestic arena (Uthman, Lawoko & Moradi, 2009). Whether or not healthcare professionals in Sub-Saharan African contexts subdue to search attitudes will determine the success of screening for IPV in healthcare in those contexts.

In summary therefore, an assessment of healthcare provider's skills and capabilities in screening, their attitudes towards IPV screening and their access to support systems to which victims can be referred thus warrants further research attention in the Sub-Saharan African region. Moreover, studies on possible demographic and occupational factors that may account for differences in IPV screening between individual healthcare providers are lacking in general. For example, it may be hypothesised that female care providers are more prone than male peers to inquire about IPV as they are more likely to identify with the problem, being potential victims; Nurses may be more prone to inquire about IPV as they are more often at the forefront of care provision; experienced personal may be more likely to probe for IPV etc. An assessment of how such factors are related to screening is useful among other things in identifying potential groups requiring further education in screening. The current work will assess healthcare providers' readiness to screen for IPV in Sub-Saharan Africa, using a Ugandan context.

### **Summary of Adverse Events/ Side Effects**

Adverse events occurred in the qualitative studies. Attempts to perform the mixed focus group discussions (e.g. doctors and nurses together) were futile in all the four hospitals. Administration, doctors and nurses strongly expressed that due to the culture of hierarchy in healthcare in Uganda (i.e. doctors being superior) nurses may not discuss freely in mixed FGDs including doctors. In addition, the focus group discussions planned for other staff cadres e.g. psychiatrist, dentist etc. were discouraged by the administration in all hospitals owing to time constraints, low number of such cadres in some hospitals and a purportedly weak role such groups can play in the detection of IPV in these hospitals (as viewed by the administration). The Focus group discussions were thus limited to doctors and nurses only. The consequences of these events thus are that we are unable to get a complete understanding of hindrances and possibilities to screening from a more general perspective rather than that of nurses and doctors. However, as these staff

cadres form the forefront of healthcare, their perspectives remain interesting for the field.

## **SUMMARY OF INDIVIDUAL STUDIES**

As indicated earlier, we employed both qualitative and quantitative methods to respond to our research questions. A summary of each of these studies are provided below with regard to methodology, results and conclusions. For detailed information, please consult the appended scientific articles.

### **Summary of the qualitative study**

**Aim:** The qualitative study explored the perceptions of healthcare providers on screening for Intimate Partner Violence (IPV) in healthcare Uganda, to develop a conceptual framework for factors likely to hinder/promote IPV screening in the country.

**Methods:** Using purposive sampling, the study enlisted 54 healthcare workers (doctors and nurses) from four hospitals (*i.e.* Gulu referral hospital, Iganga referral hospital, Lacor hospital, Anaka hospital) to participate in eight focus group discussions. Data was thematically analysed using Template Analysis.

**Results:** The study found support for an ecological framework suggesting a complex interaction of factors at the individual (e.g. poor skills in detection of IPV by health workers and unwillingness to disclose abuse by patients), organisational (e.g. understaffing and lack of protocols for IPV screening) and societal (e.g. societal acceptance of abuse of women and poor policy on IPV management) levels as potential barriers to the practice of IPV screening in healthcare Uganda.

**Conclusions:** These findings have important implications on further training of healthcare workers to adequately screen for IPV, re-organisation of the healthcare system so that it is fully-fledged to accommodate IPV screening and improved collaboration between the health sector and other community advocates in IPV management. These initiatives should run concurrently with a concerted community sensitization effort aimed at modifying attitudes towards IPV among care providers and recipients alike, as well as preparing the general population to will-fully

disclose IPV to healthworkers. Study limitations and implications for further research are discussed in detail in the appended article, Appendix 1.

Article for reference (in Appendix 1): Lawoko S, Seruwagi GK, Marunga I, Mutto M, Ochola E, Oloya G, Piloya J, Lubega M. Healthcare provider's perceptions on screening for Intimate Partner Violence in healthcare: a qualitative study of four health centres in Uganda. *Open Journal of Preventive Medicine*, 2013; **3**, 1-11. doi: 10.4236/ojpm.2013.31001.

## **Summary of the quantitative study**

### ***Pilot study***

Prior to the main quantitative study (which employed a questionnaire “the Domestic Violence Healthcare Provider Survey Scale (DVHPSS)” to study readiness to screen among health workers) a pilot study to test some aspects of the validity of the DVHPSS was carried out at Arua hospital. The study is summarized below and full results appended in the article (Appendix 2).

**Aim:** we assessed the factorial structure and reliability of the Domestic Violence Healthcare Provider Survey Scale (DVHPSS) for future use in Uganda.

**Method:** A convenient sample of healthcare workers at a referral hospital in Arua district, Uganda (n = 90) responded to the DVHPSS. Exploratory factor analysis using principle components and Cronbach’s alphas testing for internal reliability were applied on 86 complete individual responses to items of the DVHPSS. Bivariate correlations were run to assess scale distinctiveness.

**Results:** All but one item of the DVHPSS exhibited significant factor loadings. Most subscales emerging from the factor analysis (i.e. Blame victim, professional role resistance and system support sub-scales) were congruent with the original scales. A split of the original victim/provider safety scale was however evident in the current data, forming two distinct scales i.e. victim and provider safety respectively. Items of the original perceived self-efficacy scale exhibited significant factor loadings but under separate factors, indicating that they may not be measuring a uni-dimensional concept in the Ugandan healthcare context.

**Conclusions:** This data confirms the validity and reliability of the DVHSS for use in Uganda in its current or slightly modified form.

Article for reference (in Appendix 2): Lawoko S, Mutto M, Guwatudde D. Piloting the Domestic Violence Healthcare Providers' Survey for Use in Uganda: Testing Factorial Structure and Reliability. *Psychology*, 2012; 3, 947-952. doi: 10.4236/psych.2012.311142.

### ***Main quantitative study***

The main quantitative study has been concluded and the resulting manuscript has been sent for consideration for publication. Below is a summary of the study

**Aim:** to scrutinize the factors associated with the readiness to screen for Intimate partner violence and actual screening behavior among healthcare providers in Uganda.

**Methods:** Systematic sampling was used to enroll 280 health workers from 4 hospitals (Gulu referral, Lacor, Anaka and Iganga referral) in Uganda. Participants responded to a series of previously validated instruments including the "the Domestic Violence Healthcare Provider Survey Scale (DVHPSS)", which assessed attitudes towards IPV screening, safety issues related with IPV screening, support systems for IPV screening, care providers efficacy with regard to IPV screening and professional role conflicts related with IPV screening. Bivariate and multivariable statistical methods were used to analyze data.

**Results:** Healthcare workers of male gender, from Iganga hospital, with a high workload and little support at work were more likely to blame the victim for being abused. Safety concerns with regard to IPV screening were mainly expressed by health workers of male gender. Doctors, participants from Lacor hospital and those with high workload were more prone to report low efficacy in relation to IPV screening than other participants. Respondents from Lacor hospital, of young age and little working experience were more prone to experience poor system support with regard to IPV screening. The frequency of screening increased with increasing age, experience, efficacy, system support but reduced with increasing safety concerns with regard to screening.



**Conclusions:** Demographic, professional and work-related factors account for differences in readiness to screen as well as actual screening between healthcare professionals. Need-adapted interventions targeting individuals (e.g. further training of specific groups) and directed at environmental change (e.g. improved working conditions) are warranted for a more effective IPV screening in healthcare Uganda.

Manuscript for reference: Lawoko S, Ochola E, Oloya G, Piloya J, Lubega M, Kiyembe C, Loum B, Oketayot K, Akot M, Guwattude D. Factors associated with the readiness to screen for Intimate Partner Violence and actual screening: a study of 4 health centers in Uganda (Submitted for publication)

**Future Plans/ Activities:**

Having completed this baseline study on the barriers and possibilities for screening for IPV in healthcare Uganda, a natural next step is the introduction of screening. The results of this project suggest however that prior to introduction of routine screening in Uganda, staff training and structural changes at institutional level is warranted. The P.I has now obtained funding for a staff training initiative, and evaluation of such training, to begin in 2014. Applications for ethical approval for this planned study will in due course be submitted to the HDREC and UNCST

**Declaration & Signature:**

By signing this form, the PI certifies that he has disclosed to the HDREC and UNCST all relevant information concerning the execution and results of this project.



2013-04-04

**Signature of PI:** .....

**Date:** .....

## References

1. Stenson K, Sidenvall B, Heimer G. Midwives' experiences of routine antenatal questioning relating to men's violence against women. *Midwifery*.2005; 21(4):311-21
2. John I, **Lawoko S**, Svanstrom L. Screening for Intimate Partner Violence in Healthcare in Kano, Nigeria: Extent and Determinants. *J Fam Viol*, 2011; 26: 109-116 **DOI:** <http://dx.doi.org/10.1007/s10896-010-9348-y>
3. Furniss K, McCaffrey M, Parnell V, Rovi S. Nurses and Barriers to Screening for Intimate Partner Violence. *MCN Am J Matern Child Nurs*. 2007; 32 (4):238-243.
4. Erikson MJ, Hill TD, Siegal RM. Barriers to domestic Violence screening in the Padiatric Setting. *Pediatrics*,2001: 108, 98-102
5. Roelens K, Verstraelen H, Van Egmond K & Temmerman M. A knowledge, attitudes and practice survey among obstetrician-gynaecologists on intimate partner violence in Flanders, Belgium. *BMC Public Health*, 2006; **6**: 238
6. Waalen J, Goodwin M, Alison M, Spitz MS, Petersen R, Saltzman LE. Screening for Intimate Partner Violence by Health Care Providers: barriers and interventions. *American Journal of Preventive Medicine*, 2000;19:230-237
7. Maiuro RD, Vitaliano PP, Sugg NK, Thompson DC, Rivara FP & Thompson RS. Development of a health care provider survey for domestic violence: psychometric properties. *Am J Prev Med*, 2000; **19**: 245–52
8. Uthman OA, **Lawoko S**, Moradi T. Factors associated with attitudes towards intimate partner violence against women: a comparative analysis of 17 sub-Saharan countries. *BMC Int Health Hum Rights* 2009;9:14. PMID: 19619299 [PubMed]