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Healthcare Provider Responses and Preparedness towards Caring for Females who have Experienced Intimate Partner Violence in Sri Lanka

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Abstract

Females who experience intimate partner violence have frequent and repeated contact with healthcare providers whose ability to provide care and support is contextual and often problematized by gendered attitudes and beliefs. This cross-sectional study examined healthcare providers' responses and preparedness to care for females who reported intimate partner violence in hospital and community care settings in Sri Lanka. In total, 405 healthcare providers from four provinces completed a questionnaire. Data were analyzed using descriptive and analytical statistics. Of the 177 nurses, 145 doctors, and 83 midwives who participated in the study, most (76%) had met females living with intimate partner violence, but the types of violence

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reported to them, and their responses varied among the three professions. A range of factors operating at the individual, institutional, and community levels shaped healthcare provider responses and preparedness to support females reporting intimate partner violence (IPV). These results have implications for the training of healthcare providers and for putting in place adequate institutional resources in order to improve the health sector response to IPV.

Keywords: Healthcare provider preparedness, healthcare provider responses, health sector response, intimate partner violence

Introduction

The World Health Organization (WHO) defines intimate partner violence (IPV) as "any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship" (WHO, 2012). A large and growing body of evidence shows that IPV can have short- and long-term consequences, including physical, mental, sexual, and reproductive health issues (García-Moreno et al., 2015; WHO, 2013). Research from different countries also shows that females who experience IPV have frequent and repeated contact with healthcare providers (HCP) (WHO, 2012; Bair-Merritt et al., 2014; Ellsberg et al., 2008; Fulu et al., 2013; Campbell, 2002). It is also evident that HCPs can help females living with IPV in various ways: providing them with opportunities to talk about the abuse, offer counselling, get information about other services and resources, become less tolerant of abusive behaviours, and, eventually, encourage a survivor to leave abusive relationships (Kothari & Rhodes, 2006; Nguyen et al., 2016; Thomas, n.d.; Boeckel et al., 2017; Change et al., 2010; Hegarty et al., 2012). However, there are many barriers to providing IPV-related care in healthcare settings. Some of these barriers relate to HCPs' lack of knowledge and skills about how to respond to females experiencing IPV and/or negative attitudes and beliefs about IPV, and others relate to the availability of institutional supports and resources (Crowe & Murray, 2015; Nguyen et al., 2016; Boeckel et al., 2017; Morse et al., 2012).

Much of the research on HCPs' role in IPV-related care provision is from high-income countries. The knowledge base from low and middle-income countries (LMIC) is growing, and research conducted in different settings in Asia reports that while 40–90% of females have

experienced IPV (Colombini et al., 2017), only a small proportion sought help from HCPs (Nguyen et al., 2016; Norris et al., 2017; Sheehan et al., 2011). The literature is limited on HCP preparedness and responses to provide IPV-related care in Sri Lanka, the setting for this study. Twenty-two percent (22%) of 653 females who participated in a recent survey in Sri Lanka had experienced IPV from a male partner during their lifetime (de Mel et al., 2013). In the same study, nearly 40% of participant men (n=1658) reported perpetrating IPV in their lifetime. A scoping review of studies published from 1980 to 2015 (Guruge et al., 2015) found that IPV rates vary across Sri Lanka. More females in the Northern and Eastern Provinces who were affected by the 25-year long civil war reported IPV than in the other provinces.

Since 2002, specialized one-stop crisis centres (called Mithuru Piyasa) have been designated in Sri Lanka to provide IPV-related services to females have been institutionalized into the health sector (Guruge et al., 2015). Supported by the Ministry of Health, these centres aimed to integrate hospital-based services such as treatment of injuries, reproductive care, counselling, and psychological and other care, treatments, and supports with out-of-hospital resources, such as the Police, women's shelters, legal aid, and social services. The Ministry of Health also delivers IPV-related training to HCPs who work in hospitals or community-based primary healthcare units across the country (Family Health Bureau, n.d.). However, there is limited knowledge about whether and how HCPs respond and feel prepared to provide IPV-related care to females who seek their services.

As noted earlier, barriers to providing IPV-related care in healthcare settings have been documented in different countries and include HCPs' limited preparedness, lack of access to relevant knowledge and skills, inadequate support from colleagues, and heavy workloads (Kamimura et al., 2014; Paul, 2016; Parvin et al., 2016). In Sri Lanka, a few studies have focused on different HCP groups and students (e.g., nurses, midwives, and medical students) (Guruge, 2012; Jayatilleke et al., 2015; Seneviratne, 2020; Wijewardene, 2016). A 2012 study of nurses from across the country reported that they were inadequately prepared to care for females subjected to IPV (Guruge, 2012). A more recent study found that nursing diploma and degree

programs do not adequately prepare nurses to identify or provide care to females experiencing IPV (Seneviratne, 2020). Surveys of university students and male medical students also revealed victim-blaming attitudes towards female survivors of IPV and, in general, gender inequitable attitudes towards females (Haj-Yahia & de Zoysa, 2007; Wijewardene, 2016). However, there is relatively little comparative information about HCP preparedness as part of the health sector response to IPV. This study aimed to examine nurses, doctors, and midwives' responses and preparedness to care for females experiencing IPV in the Sri Lankan context.

Materials and Methods

The Study Settings and Data Collection Methods

The study focused on government hospitals and community health centres in the Western, Southern, Central, and Northern Provinces of Sri Lanka. The research team developed a questionnaire based on literature as well as the findings of a series of key informant interviews with HCPs, researchers, and educators in Sri Lanka. This self-administered questionnaire had 34 questions organized into seven sections to gather basic demographic information, information about experiences with females who reported IPV, perceptions and attitudes towards IPV, and the preparedness to provide services including specific training and knowledge about related laws. The survey instrument was checked for face validity by a panel of five academics and educators in Sri Lanka and pre-tested among a small sample of HCPs not included in the study. Six (06) research assistants (RAs) trained in health sciences, social work, psychology, health promotion, and fluent in local languages (Tamil and Sinhalese) were recruited and trained to conduct participant recruitment and data collection. After obtaining approval from relevant research ethics boards and the hospitals involved, nurses, doctors, and midwives who have worked in a government hospital or a community-based primary healthcare centre for at least six months were invited to participate in the study. The expected sample size (388) was calculated assuming that 30% of the HCPs will have contact with a female reporting abuse (based on community prevalence of IPV), a 95% confidence level, 5% margin of error, and a 20% non-response rate (Dhand & Khatkar, 2014).

Data Collection and Analysis

Potential participants received information about the study through posters or word of mouth. Those interested in learning more about the study were invited to meet with one of the RAs at a hospital or community-based primary healthcare centre to receive information. Individuals interested in participating in the study signed the study consent form and received a survey questionnaire in their language of choice (Tamil, Sinhala or English). They returned the completed questionnaires to the RA on the same day or within the week. They received an honorarium to cover the time spent and travel costs related to participating in the study. The completed surveys were identified by a numeric code and were not linked to any personal information.

The data were entered into an SPSS program (version 32) and analyzed using descriptive and analytical statistics; Cross-tabulations and chi-square tests were used to assess the relationships' magnitude and reliability when comparing responses among different HCP groups.

Results

Study Participants

In total, 405 HCPs (177 nurses, 145 doctors, and 83 midwives), participated in the study. All the midwives, most nurses (89%), and almost half of doctors (48%) were female. Participants' ages ranged from 24–60 years; and most (83%) were married. Sixty-one percent (61%) had worked as HCPs for five years or less.

HCPs' Encounters with Females who have Experienced IPV

In total, 398 HCPs (98%) reported having had at least one female reporting IPV to them in their lifetime, while 302 (76%) of the participants (81% of nurses, 77% of doctors, and 64% of midwives) said that at least one female reported IPV to them in the last six months. On average, HCPs said five females (range= 1-150; SD=15.7) reported IPV to them during the six months prior to their participation in this study. Doctors encountered more reporting on average (mean=9.8, SD=25.2), compared to nurses (mean=2.3,

SD=4.4) and midwives (mean=2, SD=2.2). Healthcare providers who said they had met a female experiencing IPV (142 nurses, 111 doctors, and 50 midwives) were asked about the location of the most recent encounter. Most respondents physically met the females who reported IPV in the wards (56%), outpatient departments (23%), and clinics (28%). Only eight percent (8%) reported meeting a survivor at a One-stop Crisis Center.

Types of Abuse Reported to HCPs

The most frequent type of abuse reported to the HCPs was physical abuse. Overall, (82%) of the HCPs surveyed said that females reported physical violence (see Table 1 below). This was highest among doctors (93%) and lowest among nurses (73%). The second most frequent form of abuse reported to HCPs was emotional abuse (60%). A higher proportion of midwives (82%) reported meeting females experiencing emotional abuse compared to doctors (60%) and nurses (51%) ($p<0.05$). Only 29% of the HCPs said that females reported experiences of sexual violence (29%). However, this proportion was significantly higher for midwives (51%) than for nurses (30%) and doctors (20%). When reporting was examined by gender of the doctors (the group with the most gender diversity, as noted earlier), a significantly higher proportion of female doctors (30%) than male doctors (12%) ($p<0.05$) reported meeting a female who experienced sexual violence. Overall, midwives encountered more reporting of all types of abuse except physical abuse and controlling behaviours.

Table 1. *Types of abuse reported to the HCPs*

HCP group / Type of abuse	Nurses	Doctors	Midwives	Total#	
Physical abuse	102/139 (73.4%)	103/111 (92.8%)	25/31 (80.6%)	230/281 (81.9%)	p= 0.17
Emotional abuse	77/139 (55.4%)	66/111 (59.5%)	27/33 (81.8%)	170/283 (60.1%)	p= 0.41
Sexual abuse	42/139 (30.2%)	22/111 (19.8%)	18/35 (51.4%)	82/285 (28.8%)	P= 0.03*
Financial abuse	34/139 (24.5%)	26/111 (23.4%)	20/35 (57.1%)	80/285 (28.1%)	p= 0.01*

Controlling behaviour	14/139 (10.1%)	21/111 (18.9%)	5/29 (17.2%)	40/279 (14.3%)	p= 0.21

#Multiple responses, percentages based on different numbers that responded to the question. *Chi-square test for reliability testing, significance level $p<0.05$

HCPs' Responses to the Females

Most nurses and midwives reported that they offered befriending services (82%) – a term used mostly by nurses and midwives in Sri Lanka to differentiate supportive listening from the formal counselling offered by doctors. Of the 302 HCPs who had met at least one female experiencing IPV in the last 6 months, 50% said they provided treatment and care for injuries, including wound care and medication to control pain or infections. The proportions varied by HCP category: highest among doctors (68%), followed by nurses (50%) and midwives (6%). Only 30% of the HCPs said they documented IPV in the clinical records, and only 34% of the nurses, 38% of the doctors, and 46% of the midwives said they worked with survivors to develop a safety plan. Furthermore, only 20% of nurses and doctors and 25% of midwives said they provided IPV-related information to them. About half (47%) of the HCPs said that they considered whether the female's life was threatened by IPV and inquired if they wanted to report the abuse or take any other action.

Referral to Other Services

Among the 302 HCPs who said they met a female who had experienced IPV during the last six months, only 33% reported making referrals within the hospital to the psychiatric ward or clinic, the Judicial Medical Officer (JMO), or the Police station located within the hospital. Only 22% reported referring females to the Police station outside the hospital. The rest (45%) did not refer them to any services.

HCPs' Perceptions about IPV

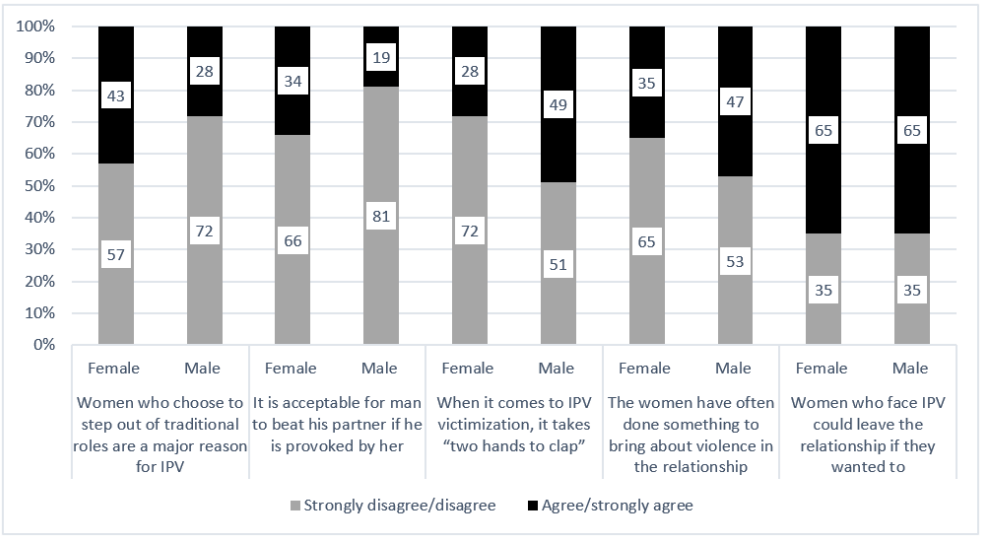

Figure 1. HCPs' Perceptions about IPV

As shown in Figure 1, HCPs' responses varied with the type of statement asked. For example, about 43% of the female HCPs agreed that females stepping out of traditional roles is a major reason for IPV,

and 34% of the female HCPs believed that that it is acceptable for a male to abuse a female if he is "provoked" by her, while 35% believed that the female has "done something" to bring about the abuse. About 50% of the male HCPs agreed with the statement about males and females being responsible for IPV victimization equally, and almost 50% of the male HCPs agreed with the statement that females have often done something to bring about violence. Sixty-five percent of both male and female HCPs agreed/strongly agreed with the statement that female victims of IPV could leave an abusive relationship if they wanted to.

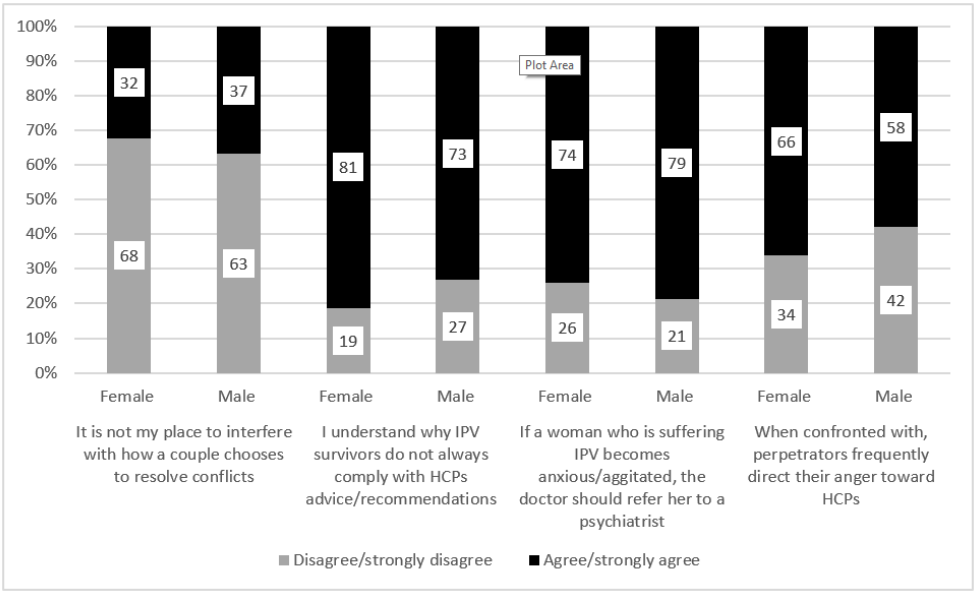

Figure 2. HCPs' Perceptions about Providing IPV-related Care

HCPs Perceptions about Providing IPV-related Care

As shown in Figure 2, most HCPs, both female and male, disagreed with the statement that it was not their place to intervene in IPV situations. Most of them also understand why IPV survivors may not always take their advice. They also believed that the abusers may direct their anger towards them if confronted. Most male and female HCPs also agreed with the statement that doctors should refer females who experience IPV-related anxiety or agitation to a psychiatrist.

HCPs' Perceptions of Laws Related to IPV

As shown in Figure 3 below, out of the 363 HCPs who responded to the questions about the laws related to IPV in Sri Lanka, 77% of females and 67% males agreed/strongly agreed that existing laws fail to adequately protect females who experience IPV, however less males than females (50% compared to 74%) agreed that laws were not harsh enough to deter males from committing such acts of violence. More than 70% of female and male HCPs disagreed that the laws make it "too easy" for a female to bring charges against males.

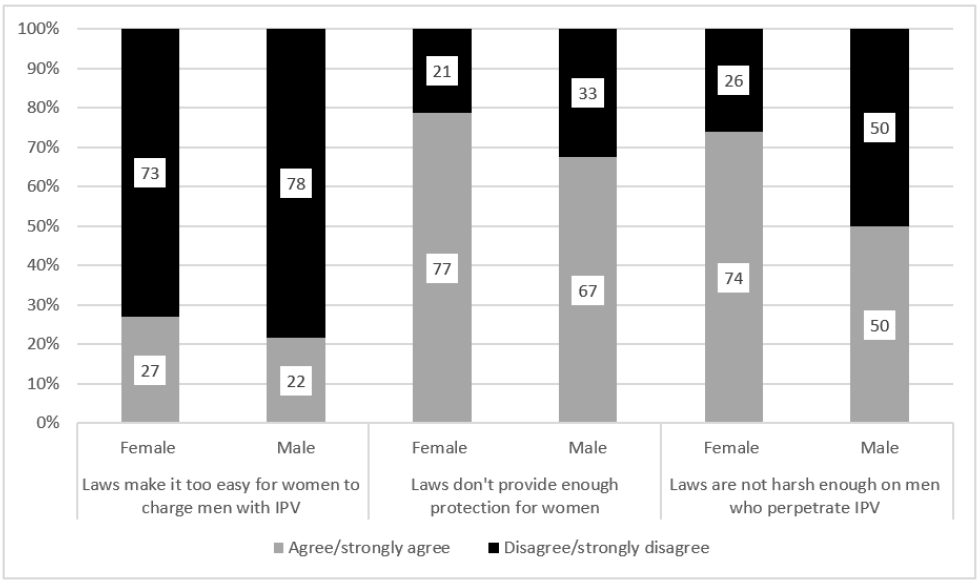

Figure 3. HCPs' Opinions about Laws Related to IPV

HCPs' IPV-related Training and Preparedness

Of the 363 HCPs who responded to the question about IPV-related training, only 30% of the doctors, 42% of the midwives, and 17% of the nurses reported having received such training. Most participants who had received training reported attending workshops or seminars (66%), followed by specific training programs (26%), as part of their undergraduate (10%) or graduate training (6%), but only 60% of them felt prepared to respond to females who report IPV to them. More doctors (65%) than nurses and midwives (56% and 57%, respectively) reported feeling that they were prepared after the training ($p>0.05$). Most HCPs (81%) reported that they need more training to work with females experiencing IPV: the proportion of HCPs who reported this was highest among the midwives (90%), followed by nurses (80%) and doctors (77%) ($p >0.05$).

Discussion

Intimate partner violence is a serious and prevalent issue in Sri Lanka. However, despite various stakeholders' efforts to raise awareness and change attitudes, it remains challenging for most affected females to seek care, supports, and services for IPV and leave abusive relationships. Previous studies have shown that females are more likely to seek help from informal networks than formal ones

(Guruge et al., 2015). In Sri Lanka, some hospital-based IPV-related services such as befriending and referral to counselling, Police, and outside shelters have been offered since 2002, and more recently, investments were made to set up hospital-based one-stop crises services type centres and to train HCPs to provide services in those centers (Seneviratne, 2020).

The present study is one of the largest conducted in Sri Lanka to gather insights from HCPs to understand the opportunities and barriers to providing care and services to females experiencing IPV. It included nurses, midwives, and doctors working in hospital settings and a sample of midwives working in community settings in four provinces.

With more than 75% of the HCPs across the country reporting that females had disclosed IPV to them at the healthcare setting where they worked, all HCPs must receive the necessary training to be prepared to better respond to females disclosing IPV. More doctors and nurses working in hospital settings said that they met females reporting IPV than midwives who work in a hospital or community setting. Although investments have been made to create specialized centres for IPV-related care, the results of this study show that doctors and nurses mostly met females during routine care in wards, outpatient departments, and clinics. Most midwives also received reports of IPV at clinics (and not in the home or other community settings).

Community settings represent some of the earliest IPV-related services in Sri Lanka that have provided essential support to females for decades before the institutionalization of services (Guruge et al., 2015). These results may indicate why surviving females may be reluctant to access care at centers specifically set up for IPV because of stigma or fears about safety if they are seen visiting those centres. These results also highlight the need for HCPs to be prepared to provide IPV-related care in all settings as the ideal scenario. A review of health sector responses in various settings and countries has also shown that the choice of service entry point is less critical than a well-coordinated and connected systems-level response for IPV (Colombini et al., 2017).

More nurses and midwives than doctors said that females reported sexual violence to them indicating a higher level of comfort in reporting sexual abuse to female HCPs. Also, more midwives who work in the community said that females reported emotional and financial abuse to them than did nurses and doctors. This may be because females are likely to report these forms of abuse to HCPs with whom they have built long-standing relationships rather than those they meet in a hospital during a short visit. Overall, HCPs' encounters with females and the type of abuse reported to them may be determined by their gender, the setting they work in, and the nature of their contact with affected females.

The Ministry of Health guidelines for responding to IPV within hospital settings recommends befriending or supportive listening as one of the first-line services offered by all HCPs (Wijewardena, 2016). Most HCPs, but more nurses and midwives than doctors, reported providing supportive listening to females. On the one hand, this may indicate adherence to the guidelines. However, on the other hand, it could also indicate a reluctance by HCPs to characterize the services they offered as counselling and their lack of preparedness to provide such counselling. As what is considered 'formal counselling' in Sri Lanka is limited to the services provided by trained psychiatrists or psychologists, the former being the more common category of staff in government hospital settings, nurses and midwives were less likely to report the services being offered as counselling. This may explain why most HCPs refer females who are 'unable to cope' to the psychiatry unit in Sri Lanka. Although the primary goal of referral to a psychiatry unit would be to access the support of mental health specialists, this practice may prevent females from reporting IPV for fear of being 'committed to' a psychiatry unit and facing the stigma associated with mental illness in countries like Sri Lanka.

Only about one-third of HCPs, primarily doctors, reported that they documented the injuries or the IPV, and the number of HCPs who said they made a safety plan for the victims was even lower. These responses also indicate a lack of specific protocols for dealing with IPV in healthcare settings (Jayatilleke et al., 2015; Guruge et al., 2015). In other locations, such responses have correlated with HCPs' workload and lack of clear practice guidelines and protocols (Colombini et al., 2017). Conversely, clear guidelines and protocols

have supported well-coordinated health systems responses (Colombini et al., 2017). In addition, HCPs may be reluctant to take on additional responsibilities with IPV-related care as it creates more paperwork and involvement in legal proceedings.

Unlike in the past when gender inequitable attitudes toward females were strongly evident among medical students (for example, Haj-Yahia & de Zoysa, 2007), most HCPs in our study, regardless of gender, could recognize stereotypical ideas about IPV. They rejected survivor/female-blaming statements as well as ideas that justified or rationalized male perpetration of IPV against females. However, male and female HCP responses tended to differ for the statements that revealed slightly less overt ideas and attitudes about gender inequality (e.g., the deficiencies in the laws to punish men who abuse females or laws making it too easy for females to charge males with IPV). Given that people, in general, hold more negative, stereotypical, or stigmatizing attitudes than they are willing to disclose to others, especially to a team of health researchers, these stereotypical negative beliefs and attitudes may likely be higher in reality than reported here.

Previous research has revealed that HCPs have cited personal discomfort and lack of training as reasons for reluctance to ask about and document IPV (Aksan & Aksu, 2007; Nguyen et al., 2016; O' Doherty et al., 2014; Waalen et al., 2000; Sprague et al., 2012). Most of the HCPs surveyed in this study, and more nurses and midwives than doctors among them, reported that they need more training to help females experiencing IPV. Although most in-service training programs focus on IPV-specific training for HCPs, Colombini et al. (2017) found that nurses trained in medico-legal responses and counselling had more confidence in their ability to be part of a comprehensive health systems response.

In addition to lack of training, HCPs reported fears about facing abusers when providing IPV-related services and may have reflected the setting in which the HCPs provided services, i.e. routine care settings such as wards and clinics rather than in specialized care centres. The lack of space and privacy is consistent with the healthcare infrastructure in Sri Lanka, where patient care settings tend to be busy and overcrowded. Most HCPs also reported that

although they possess some knowledge, they have limited access to information detailing appropriate management of IPV disclosure in healthcare settings. This is not surprising as most training so far on this subject has been ad hoc. Thus, despite the demands on HCPs and other stakeholders to improve IPV-related care and services, the knowledge and clinical skills needed for HCPs to provide such care and services have not yet become an integral part of undergraduate and graduate HCP education in Sri Lanka.

Limitations

Because of resource limitations, the sampling method used in this study was non-random. After purposefully selecting hospitals in four provinces, details about the study were shared widely within hospitals. However, most participants were recruited through word of mouth. This may have attracted participants who are more likely to have had similar experiences or hold the same attitudes towards IPV and gender-based violence. However, the results of this study still provide insights into HCPs' perceptions about and preparedness to provide IPV-related care and services in a setting where such information is largely missing.

Conclusions and Implications

Healthcare providers' encounters and experiences with females who reported IPV in healthcare settings in Sri Lanka depended on a range of factors. Some of the factors are related to individual characteristics, such as the HCPs' gender and nature of contact and connections with the females affected by IPV; others are related to institutional supports and training. Preparing all HCPs to provide IPV-related services is an important step in the Sri Lankan health sector response; it will improve HCPs' confidence and provide clarity about their roles. Nurses and midwives who already play an important role in supporting females reporting IPV in hospital and community settings need to feel well-equipped, trained, and given clear guidelines for counselling IPV survivors.

As only a small proportion of HCPs sampled reported having met IPV survivors at the one-stop crisis centres, this raises important questions about the availability and accessibility of these specialized services. The Ministry of Health policy of further IPV training the

HCPs attached to these specialized centres may not be effective since most females seem to report IPV in routine clinical settings. Because of the stigma attached to IPV and how it shapes surviving females' willingness to access services in hospital or primary healthcare settings, building their trust and confidence in HCPs is key to creating an effective health sector response to IPV. While HCPs who can build long-term trusting relationships with females may be most effective in improving females' access to care, they may not be able to do so without a strong community support system. To effectively support HCPs, the underlying stigma attached to IPV should be addressed in both clinical and primary healthcare settings.

Healthcare providers need institutional leadership and specific investments into IPV-related programs. Creating the infrastructure and support needed to provide IPV care in a safe setting will improve the HCPs readiness and raise both service provider and survivor confidence to more readily communicate with each other and openly discuss IPV. Institutional investments into specialized IPV-care centres must be accompanied by allocation of resources to other support units in hospitals and the community, specifically to improve counselling services and place them outside general psychiatric units or wards. Improving HCPs' responses and preparedness to provide IPV-related care must happen as part of a coordinated inter-sectoral response that involves educators, hospital administrators, policymakers, as well as HCPs and service users. Gathering HCPs' perspectives in providing care to females who report IPV, as we have done in this study, must be part of that response as such information is critical to identifying gaps in training and resources in different parts of the country.

Abbreviations

GBV – Gender Based Violence
HCP – Healthcare Provider
IPV – Intimate Partner Violence
JMO – Judicial Medical Officer
RA – Research Assistant
SPSS – Statistical Package for Social Sciences
WHO – World Health Organization

Declarations

Ethics approval and consent to participate
The study protocol, instruments, and consent forms were reviewed and approved by the Sri Lanka Medical Association Ethics Review Committee (ERC/15-001) and the Ryerson University Research Ethics Board (REB 2014-379). Informed consent was obtained from all participants in the study.

Consent for publication
Not applicable.

Availability of Data and Material
The datasets generated and/or analyzed during the current study are not publicly available as they are being analysed for manuscripts in preparation. When ready, they could be made available from the corresponding author on request.

Competing Interests

The authors declare that they have no competing interests.

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