Barriers faced by healthcare professionals in screening for Intimate Partner Violence (IPV) in Sub-Saharan Africa: A scoping review of the literature

Accepted 29th June, 2020

ABSTRACT

Intimate Partner Violence (IPV), a subtype of interpersonal violence, occurs within an intimate relationship causing physical and psychological harm and it is an international priority. Although screening in health settings, especially for women, has been recommended by professionals associations, national and international policies and programs on violence, the African Sub-Saharan countries are still experiencing many barriers. Data and systematic synthesis on this matter are still scarce. The aim of the present study was to describe the barriers that health professionals face for IPV screening in Sub-Saharan African countries. As a result, a literature search – scoping review was conducted in PubMed, using the following terms - screening, diagnosis, barriers and Sub-Saharan Africa and considering specific inclusion and exclusion criteria. In the studies analyzed, it was found that in Africa the Intimate Partner screening process faces barriers related to health personnel training, organization of sectorial programs and health systems, including lack of consensus on good practice and the type of screening instruments.

Key words: Violence, intimate partner violence, IPV, screening barriers, IPV screening.

INTRODUCTION

World Health Organization defines violence as the use of physical force or power, threatening or in practice, against yourself, another person, or against a group or community that results in or may result in suffering, death, psychological harm, impaired development or deprivation, and is assumed to be a public health problem (WHO, 2002).

The typology of violence incorporates three categories, namely: Self-inflicted Violence, Interpersonal Violence, and Collective Violence. Interpersonal violence category includes, among others, the Intimate Partner Violence (IPV), which refers to any type of violence committed by the spouse, former spouse, boyfriend, ex-boyfriend (WHO, 2012), affecting more women than men, in countries where gender disparity is stark, particularly in sub-Saharan African countries (Zacarias, 2012).

Prevalence of IPV varies substantially depending on the methodological aspects, the type of sample and type of violence studied (Zacarias, 2012). Therefore, the phenomenon of violence is a potential risk factor for the obstruction of integral human development (Barros et al., 2009).

Data from the Mozambique Immunization, Malaria and HIV / AIDS Indicator Survey (IMASIDA) report that one in four women (24%) admitted to being victim of physical, sexual or emotional violence, with physical violence being the most prevalent (18%), followed by emotional violence (15%) and sexual violence (3%). The same survey states that about 13% of men surveyed also reported having suffered physical, sexual or emotional violence, with the most common type of IPV being emotional violence, which is about 10% (MISAU, INE and ICF, 2015).

These data show an increase in the prevalence of violence, given that the previous survey, reported three years earlier, pointed to a prevalence of physical violence corresponding to one in three women aged 15-49 (MISAU, INE and ICF, 2012).
However, the actual prevalence of violence in Mozambique, particularly against women, may be much higher, taking into account the stigma and underreporting, and widespread tolerance and acceptance of violence, given that the violence is viewed historically as a private family affair and only recently has it begun to gain recognition as a public health and human rights issue (Zacarias, 2012). Absolutely, in many situations, widespread beliefs about gender roles and violence perpetuate violence with partners (WHO/LSHTM, 2010; Swart et al., 2002; Heise et al., 1999).

Yet in Mozambique, the legal instruments considered to deal with violence are both the Penal Code because domestic violence has the category of public crime, and the Family Law, which aims to protect the physical, moral, psychological, patrimonial and sexual integrity of women against any form of violence by spouse, former spouse, partner, former partner, boyfriend, ex-boyfriend and family members (BR nº34, 1ªSérie de 25/08/2004). In the light of gender equality issues, the provisions of the Law apply to men on equal terms and with the necessary adaptations.

Currently, there is a Multisectoral Mechanism for Assistance to Women Victims of Violence, integrating the Health, Gender, Child and Social Action, Police and Justice sectors, which led to the creation of the Integrated Violence Care Centers (CAIV) materializing the Norms of Integrated Care to Victims of Gender Violence approved by the Ministry of Health of Mozambique (BR nº2, 1ªSérie de 12/01/2011).

However, the process of Violence screening in general and IPV screening specifically, remains deficient, not routine in the Mozambican National Health Service and when cases are identified and/or referred, the clinical treatment of physical trauma and the criminalization of perpetrators are often the priority, ignoring the problematic of re-victimization, psychological trauma and other holistically important socio-cultural factors to consider.

Due to the magnitude of the IPV problem, many organizations and associations of health professionals, including national and international policies, have recommended and advocate for IPV screening at the primary health care level, a process that has been having difficulties for implementation, particularly in Africa.

**Aim**

The purpose of this study is to describe the barriers that health professionals face for IPV screening in Sub Saharan African countries.

**METHODS**

A scoping review with scientific production indexed in PubMed was made, focusing on Intimate Partner Violence (IPV) and Violence, with the following main descriptors in English: *screening, diagnosis, barriers and Sub-Saharan Africa*.

Prioritizing was given to the most recent articles, which were grouped by thematic area taking into account the title, the abstract and the full text reading, which served for final analysis using the approach in IPV screening barriers in African Sub Saharan countries as a main criteria inclusion. Based on the descriptors, a total of 143 studies were found, of which selected through the title (143/143) - 100%, based on the reading of abstract (79/143) - 55.2% and reading the full article (9/143) - 6.3%.

Subsequently the studies were divided into groups, namely: IPV Screening Barriers (5/143) - 3.5%, IPV Screening Africa (79/143) - 55.2%, IPV Diagnosis Africa (59/143) - 41.2% and IPV Screening Africa Sub-Saharan (0/143) - 0% and IPV Screening Barriers (5/143) - 3.5%, these were considered for this review (Figure 1).
RESULTS

From the review of the studies, it was found that although awareness of IPV screening in health facilities is increasing, implementation of this practice varies across the countries, with barriers from personal, programmatic and organizational levels for the African case.

At a personal level, barriers include aspects such as subject sensitivity, training and daily activity. Programmatic barriers include the fact that IPV is not yet a priority for health services, particularly in the mental health field, and organizational barriers include the configuration of public health systems at whole.

DISCUSSION

Intimate Partner Violence (IPV) usually involves a combination of abuse behaviors, including threats and physical, sexual violence, emotionally abusive behaviors, economic restrictions and other controlling behaviors, with short and long term negative consequences for survivors even after termination of abuse (Campbell, 2002), being its, screening in health facilities are recommended and advocated by various specialized medical institutions and organizations.

Studies on violence in Africa remain scarce, and WHO data point to a 36.6% prevalence of physical and/or sexual IPV among women, with South Africa and Zimbabwe being the countries with the highest prevalence of IPV against women, estimated in physics (55.5%) and (42.8%) respectively (Chaquisse, 2018). Although awareness of IPV screening in health facilities is increasing, implementation of this practice varies across the countries, and remains not a routine in Africa Sub Saharan country health systems. Absolutely, a recent systematic review reported only 9 to 40% of clinicians routinely screen for IPV (Todahl and Walters, 2011).

The personal barriers in IPV screening process reported in African Sub Saharan countries is regarding the way the health professionals understand the IPV. Many of them feel personal discomfort with subject matter, has lack of knowledge, refer to time constraints (Williams et al., 2016), and consider that IPV screening tools are difficult and time consuming to apply (Husso et al., 2012; Higgins et al., 2015).

The fact of IPV is not yet a priority for health services, particularly in the mental health field in Africa is a barrier on programmatic and organizational level, because the focus in mental health do not include the Intimate Partner Violence but currently has been on suicide and other forms of violence such as physical and sexual violence (Higgins et al., 2015).

The configuration of health systems appears to be one of the most barriers to IPV screening process. A systematic review reported only 9 to 40% of clinicians routinely screen for IPV (Todahl and Walters, 2011).

The major barriers to IPV screening process are regarding the infrastructures, limitations on trained human resources, lack of consensus on best practices for IPV screening, including the type of instruments, as well as difficulties in protecting the confidentiality of victims and socio-cultural norms that may make victims reluctant to seek institutional support for IPV without receiving the subsequent basic support and appropriate referral (Paul, 2016).

Conclusion

Studies on violence in Africa remain scarce, and although awareness of IPV screening in health facilities is increasing, implementation of this practice varies across the countries, and remains not a routine in Africa Sub Saharan country health systems.

Although the process of screening for IPV is currently recommended, it still faces multiple barriers in Africa, such as personal, programmatic and organizational barriers, which point to the need of determining the applicability and feasibility of the screening for intimate partner violence process in the African clinical context, characterized by limited resources and several limitations at the personal, programmatic and organizational levels.

Acknowledgments

The author would like to express deep gratitude to Prof. Doutor James G. Linn, MD, PhD and Doutora Khátia Munguambe, Bsc, Msc, PhD, the research supervisors, for their patient guidance, enthusiastic encouragement and useful critiques of this scope review article and for their advice and assistance in keeping his progress on schedule.

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