Knowledge, attitudes, and practices of health care providers in intimate partner violence screening in a private tertiary hospital*

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ABSTRACT

Background: Intimate partner violence (IPV) is a public health problem and human rights concern that has an enormous impact on physical, mental, reproductive and socioeconomic aspects of health. Several health professional organizations recommend screening for violence though current screening rates tend to be low because healthcare providers are generally hesitant to be involved in dealing with women who are victims of violence.

Objective: This study therefore attempted to assess the knowledge, attitudes, and practices of obstetricians and gynecologists on screening for intimate partner violence in a private tertiary hospital.

Materials and Methods: The Physician Readiness to Manage Intimate Partner Violence Survey (PREMIS) tool was utilized among 123 obstetricians and gynecologists in a private tertiary hospital in Pasig, Metro Manila, with a response rate of 65.8% (81/123).

Results: Results showed that the sample participants did not have adequate knowledge on IPV; majority of the sample participants were not fully prepared and equipped to handle patients who are victims of IPV; and the sample participants did not routinely screen for IPV.

Conclusion: In the Philippines, the obstetricians and gynecologists generally act as the primary care physicians to the general female population. This provides them a good opportunity to be involved in the secondary prevention of IPV. Recognition of barriers to screening for IPV, development of strategies for increasing awareness to IPV, and education and training of physicians and allied health care professionals may improve the screening practices for IPV. These in turn will help them to provide appropriate, effective, and holistic care to their patients who are victims of violence.

Keywords: Intimate partner violence, domestic violence, physicians, tertiary care centers, Philippines

INTRODUCTION

Violence against women (VAW) is a global public health problem and human rights concern that has an enormous physical, mental and reproductive impact on health.[1] It is also a threat to social and economic development.[2] It takes many forms such as women trafficking, female genital mutilation, murders in the name of honor and dowry, early and forced marriage, and sexual harassment and abuse by authority figures; and includes physical violence, sexual violence, and emotional violence.[1-3] It also includes its consequences that compromise the well-being of individuals, families, and communities.[4]

One of the many forms of violence against women is intimate partner violence (IPV). IPV, also called domestic violence, is a type of violence in which a woman has encountered any types of violence from an intimate partner or ex-partner such as physical and sexual violence, and/or threats or emotional abuse in the context of physical and sexual violence.[2,5] Intimate partners include current spouses, current non-marital partners, dating partners, boyfriends or girlfriends, former marital partners, divorced spouses, former common-law spouses, separated spouses, former non-marital partners, former dates, and former boyfriends/girlfriends.[6] Established risk factors associated with higher rates of IPV include young age (less than 24 years old) or being a teenager, single relationship status, minority race/ethnicity, and poverty.[5] Mental health problems and substance use can be both be risk factors or consequences of abuse.[7]

IPV is one of the most common forms of violence experienced by women.[2] Around one third of women or 35% of women worldwide have experienced violence, and most of this violence is IPV. Globally, 30% of all ever-partnered women worldwide experienced physical and/or IPV at some point in their lives, and 38% of all murders are committed by intimate partners. By World Health Organization (WHO) region, the highest prevalence was reported in African (36.6%), Eastern Mediterranean (37.0%), and South-East Asia (37.7%) regions (Figure 1). By age group, the highest prevalence was reported in 40 – 44

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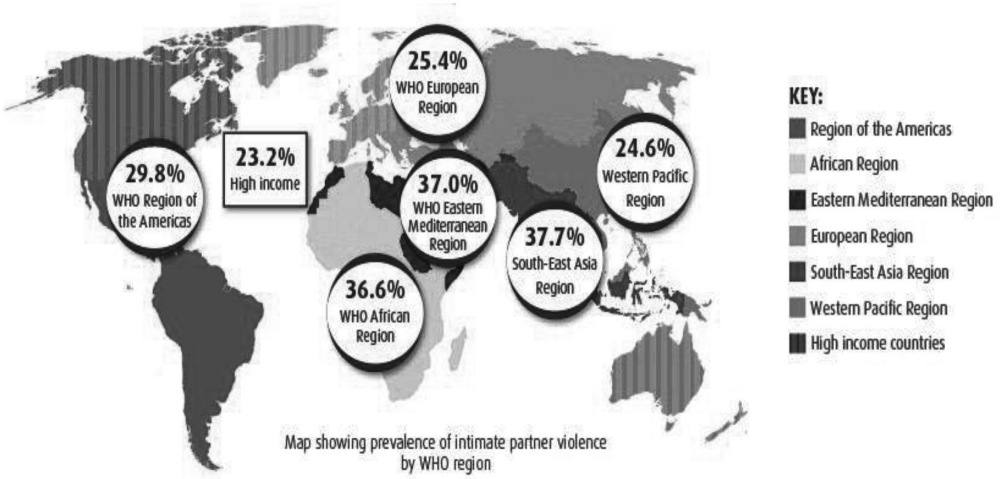

Figure 1. Global map showing regional prevalence rates of intimate partner violence by WHO region (2010)[3]

years old (37.8%), 35 – 39 years old (36.6%), and 25 – 29 years old (32.3%).[3] In the Philippines, the 2008 National Demographic and Health Survey (NDHS) revealed that the prevalence of physical and sexual violence among women aged 15 – 49 ranges from 4 to 20%.[8]

A woman who has experienced violence in her lifetime has poorer self-perception of health status, and her health-related quality of life is likely lower than that of woman who has not experienced violence. The physical and mental health consequences are proportional to the severity of violence suffered, and the impact over time is cumulative.[1,7,9]

There are three key pathways through which IPV can lead to adverse health outcomes (Figure 2).[3]

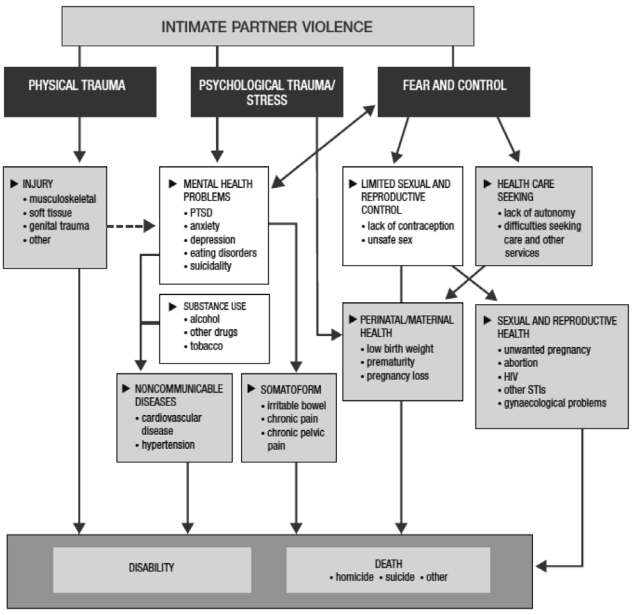

Figure 2. Pathways and health effects on intimate partner violence[3]

Aside from the adverse consequences on physical and mental well-being, IPV can also lead to adverse sexual and reproductive outcomes, which can be non-fatal or fatal.[1,3,5] The 2008 NDHS of the Philippines showed that one in three women who experienced IPV reported having physical injuries and three in five women who experienced IPV reported having experienced psychological consequences.[8] IPV during pregnancy has been shown to have bad effects on maternal health and neonatal outcomes. It increases the risk of insufficient or inconsistent prenatal care, perinatal death, preterm birth, intrauterine growth retardation and/or low birth weight, antepartum hemorrhage and/or abruption placenta, uterine rupture, and fetal distress.[5,7,9]

Despite the prevalence of violence against women and its tremendous impacts on health, it remains hidden because many women do not report it nor seek help. However, it is important to keep in mind that a healthcare provider, especially an obstetrician and gynecologist, is likely to be the first professional contact for women suffering violence. They are the professionals whom the women would most trust with disclosure of violence. Aside from supporting disclosure, providing treatment, care and support, referral and follow-up, and creating documentation can be done by healthcare providers. Provision of acute care during clinical encounter includes recognition of the abuse, proper clinical documentation of abuse, ascertainment of patient safety and review of options for patient referral. It is also important to consider ethical issues when providing services to victims of violence.[1,10] These include providing information on how to recognize the physical, social, and psychological manifestations of violence; assuring confidentiality in documentation of cases of violence; treating the physical and psychological

manifestations of the violence; upholding the right of the women to information and self-determination; providing affirmation to the women that violence towards them are not acceptable; and advocating or supporting advocacies for social infrastructures that provide security refuge and counselling for women.[10] These ethical obligations can be met if the healthcare providers have an adequate knowledge, attitudes, and skills.[11]

Women at risk of or experiencing violence can be identified through routine screening in the healthcare setting. This could also lead to interventions that reduce violence and improve health outcomes. Several professional organizations, such as the American Congress of Obstetricians and Gynecologists (ACOG), the American Medical Association, and the American Academy of Pediatrics, recommend screening for IPV violence by physicians.[11-14] ACOG recommends that screening should occur at routine checkup visits, family planning visits, and preconception visits for non-pregnant women. For pregnant women, screening should occur at the first prenatal visit, at least once per trimester, and at the postpartum checkup. [12-14]

Although multiple organizations recommend screening for IPV, current evidence suggests that actual screening rates in the health care settings remain low.[7,15] Healthcare providers are generally hesitant to be involved in dealing with women who are victims of violence.[8] Less than 2% of women were asked about IPV by a healthcare provider in family practice settings, and only about 0.1% of abuse victims were identified in emergency settings.[14] This is attributed to time constraints, attitudes and perceptions (e.g. provider perception that patients won't be compliant, fear of offending patients, provider's personal experience with abuse, fears of being involved with the judicial system), gaps in provider knowledge and lack of education regarding domestic violence, lack of training, lack of protocol and policies and procedures for screening, and departmental or unit philosophies of care that may contradict screening recommendations.[7,8,14,15]

In the Philippines, the Department of Health (DOH) is one of the 12 agencies tasked to address VAW through formulation of programs and projects that will eliminate VAW, development of training programs for the providers to address the needs of victims of VAW, and monitoring of all VAW initiatives.[16] The Women and Child Protection units (WCPUs) were established in DOH-retained and local government unit supported hospitals since the issuance of Administrative Order 1-B or the "Establishment of a Women and Children Protection Unit in All Department of Health (DOH) Hospitals" in 1997, in response to the increase in number of women and children who are victims of violence.[17] As of 2011, there are 38 working WCPUs in 25 provinces of the Philippines. According to DOH, doctors and social workers are hesitant to be involved in WCPU due to heavy workload, lack of training and feeling of inadequacy, and the nature of work e.g., responding to subpoenas and appearing in court.[8]

A survey study in Flanders, Belgium on knowledge, attitudes, and practice among obstetricians and gynecologists on IPV done in 2006 attempted to identify barriers on IPV screening. In their setting, there were no screening guidelines yet on IPV. The study concluded that training of these physicians on IPV is essential for a successful implementation of screening guidelines on intimate partner violence.[7] On the other hand, a systematic review from Cochrane Library on screening for IPV in healthcare settings shows that although screening increases the identification of women suffering from IPV, evidence is lacking for justification of screening in healthcare settings. The systematic review also concluded that there is a need for studies comparing universal screening to case-finding for long term well-being of women who are victims of violence. These studies in turn will help in policy-making and policy identification for IPV in healthcare settings.[18]

There are several survey tools for the assessment of dimensions of IPV. The gathered information on healthcare providers' knowledge, attitudes, and practices can help a healthcare institution understand what issues need to be addressed. This information can also be used to document a baseline data that can measure changes in healthcare providers' knowledge, attitudes, and practices over time. Such information that can be gathered from the healthcare providers includes whether, how often, and when they have discussed violence with patients; what they think are the barriers to screening; what they do when they discover that a patient has experienced violence; their discriminatory or stigmatizing attitudes; attitudes toward women who experience violence; knowledge about the consequences of gender-based violence; and what types of training they have received in the past.[11,19]

One of the validated instruments and questions for the assessment of providers' level of knowledge, attitudes, and practices is the Physician Readiness to Manage Intimate Partner Violence Survey (PREMIS) tool. The PREMIS is a 15 to 25-minute survey that is valid, comprehensive, reliable, and publicly available measure of physicians' knowledge, attitudes, and practices on IPV. This tool is more current and more comprehensive than previous standardized IPV assessment tools, and has been psychometrically tested among physicians. It can be also used as a pretest to measure physician knowledge, attitudes, beliefs, behaviors, and skills, as a training adjunct to orient physicians to the IPV issues, as a posttest to measure changes in physician knowledge,

attitudes, beliefs, behaviors, and skills over time, or as a comparative instrument to assess differences in knowledge, attitudes, beliefs, behaviors, and skills between physicians who have trained and those who have not. However, this tool has also limitations. This include a lack of psychometric data from non-physician healthcare providers and lack of correlation with individual practices on IPV.[20]

Screening for violence against women in the healthcare setting identifies survivors and increases safety, reduces abuse, and improves clinical and social outcomes.[21] Although, screening, diagnosis, and management of female patients who are victims of violence are part of Obstetrics and Gynecology residency training, there is no adequate knowledge, implementation and infrastructure in most private institutions to support IPV screening and to provide holistic care to patients who are victims of IPV. Addressing these issues will have direct and indirect contributions in achieving the sustainable development goals (SDG), especially the SDGs 5 – achieve gender equality and empower all women and girls; and 16 – promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels.[22] The data from this study can be used to contribute in creation of policy, training, and support for the department of obstetrics and gynecology on violence against women, as well as for other health care institutions.

OBJECTIVES

This study aims to assess the level of knowledge, attitudes, and practices of obstetricians and gynecologists on screening for IPV in a private tertiary hospital using the PREMIS tool.

Specifically, the study aims to:

1. describe the background of obstetricians and gynecologists,
2. measure the level of knowledge of obstetricians and gynecologists on IPV,
3. describe the attitudes of obstetricians and gynecologists on IPV,
4. describe the practices of obstetricians and gynecologists on screening for IPV, and
5. determine the proportion of obstetricians and gynecologists who routinely screen for IPV in their private practice.

MATERIALS AND METHODS

Ethical consideration

This study received technical and ethical approval from Institutional Review Board. Informed consent was given to and secured from the participants. Participants' responses were confidential.

Study setting and design

This is a descriptive study using the PREMIS tool to conduct a survey among 123 OBGYN consultants in a private tertiary hospital located at Pasig, Metro Manila.

Data Collection:

The study adapted and utilized the PREMIS tool to obtain data from the participants. The PREMIS tool has five sections: Respondent Profile, Background, IPV Knowledge, Opinions, and Practice Issues. Within each of the latter four sections, several items have been combined to create scales. Perceived Preparation and Perceived Knowledge are two composite items contained in the Background section. Correct items are scored and a composite created in the Knowledge section. Eight scales are derived from the Opinion section. Items in the Practice Issues section may be considered separately or as a composite item.[20] The first and last two sections contained few revisions to tailor fit to local setting.

A survey kit was given to each attendee of the three staff meetings held in March and April 2017. The survey was also given to all the consultants with a private clinic in the hospital. Those who were present in at least two assemblies were noted in order to ensure that a participant was only given a survey tool once. Each survey kit contained an informed consent and PREMIS tool questionnaire. Each survey kit was retrieved after the assembly and/or after the participant finished answering the questionnaires.

Data Analysis:

The PREMIS tool kit includes the codebook, SPSS syntax and scoring information instrument. Coding of the data was patterned to the codebook provided. Using SPSS, mean scores with standard deviation were obtained for each section. Each answer to question per section was also measured using proportion, mean, and standard deviation. Only participants who had responded to all items of the PREMIS tool were included in the data analysis to reduce the erroneous estimates resulting from missing data. Results of the study were compared to the results of other IPV screening studies that used the PREMIS tool.

Study Consultation

This study was reviewed and finalized with contributions from a VAW expert.

RESULTS

Out of the 123 consultants, 81 returned the completely filled survey with a response rate of 65.8%.

Table 1. Respondent Profile (n = 81)

Age (in years)	
Average ± SD	50.63 ± 10.13
31 - 40	17 (21.3%)
41 - 50	29 (36.3%)
51 - 60	16 (20%)
61 - 70	16 (20%)
71 - 80	1 (1.3%)
81 - 90	1 (1.3%)
Gender	
Male	8 (9.9%)
Female	73 (90.1%)
Other Hospital Affiliation	
Yes	64 (79%)
Private Hospital	62 (76.5%)
Government Hospital	20 (24.7%)
No	17 (21%)
Subspecialty	
Ultrasound	33 (40.7%)
Maternal and Fetal Medicine	8 (9.9%)
Urogynecology and Pelvic Reconstructive Surgery	2 (2.5%)
Pediatric Gynecology	0 (0%)
Infectious Disease	1 (1.2%)
Reproductive Endocrinology and Infertility	8 (9.9%)
Minimally Invasive Surgery	8 (9.9%)
Gynecologic Oncology	5 (6.2%)
Gestational Trophoblastic Disease	4 (4.9%)
Others	0 (0%)
General Ob-Gyn	23 (28.4%)
Year Grad from Med School	
1900 – 1970	1 (1.2%)
1971 – 1980	17 (21%)
1981 – 1990	17 (21%)
1991 – 2000	27 (33.3%)
2001 – 2010	19 (23.5%)
Years Practicing	
1 – 10	11 (13.6%)
11 – 20	21 (25.9%)
21 – 30	30 (37%)
31 – 40	15 (18.5%)
41 – 50	4 (4.9%)
Average Number of Patients per week	
not seeing patients	1 (1.2%)
less than 20	15 (18.5%)
20 – 39	30 (37%)
40 – 59	12 (14.8%)
60 or more	23 (28.4%)

The remaining 32.5 % did not return the survey kit, and 1.6 % did not completely filled up the survey. The profile of the participants and their practice are presented in Table 1. The age of the participants ranged from 33 to 83 years (average = 50.63 ± 10.13). Of the participating consultants, 9.9% were males, 17% did not have other hospital affiliations, 40.7% were ultrasound subspecialists, 37% were on 21 to 30 years of practice, and 37% had an average of 20 to 39 patients per week.

Table 2 shows the mean scores for each section comparing it to other studies that used the PREMIS tool. The participants' scores were generally lower than that of the participants of the original study and other studies that utilized the PREMIS tool. Table 3 shows the perceived background of participants on IPV. The mean scores showed that they were "minimally to slightly" prepared and had "very little to a little" knowledge on IPV. Also, less than half of the participants did not receive previous training on IPV at 49.4%.

Table 4 shows the proportion of agreement and disagreement among participants about attitudes and beliefs (opinions) on IPV. Table 5 presents the screening practices of the participants. Of the participating consultants, 45.7% of the participants screened certain patient categories only – 38.3% for depressed/suicidal women, 28.4% for women with alcohol or other substance abuse, 18.5% for mothers of children with confirmed or suspected child abuse or neglect. On the other hand, 39.5% of the participants did not screen. Presence of injuries and depression/anxiety in patients were the top two conditions that always prompt the participants to ask about the possibility of IPV.

DISCUSSION

The key findings of the study showed that the sample participants did not have adequate knowledge on IPV; Majority of the sample participants were not fully prepared and equipped to handle patients who are victims of IPV, and the sample participants did not routinely screen for IPV.

The low scores of the participants showed that a majority of them lack adequate knowledge and skills, and appropriate attitude for screening of IPV. Determination of what care and support needed by the women who are victims of violence can be delivered well if screening for IPV is done appropriately.[11] Screening for IPV not only contributes to documentation of the VAW issues for the survivor but also leads to formulation of interventions that reduce IPV exposure and improve health outcomes.[11,13] At present, no consensus has been made on the most acceptable screening setting or modality for IPV.[13] The ACOG supports the universal screening for IPV. In developing countries, such as Philippines, universal screening may

Table 2. Comparison of mean scale scores

	SCORES	Short et al[20]	McAndrew et al[24]		Martin-Engel and Allen[25]
	n = 81	n = 67	Control Group n = 8	Treatment Group n = 17	n = 73
Background					
Perceived Preparation	2.97 ± 1.31	3.67 ± 1.05	3.81 ± 1.12	3.25 ± 0.98	3.48 ± 1.34
Perceived Knowledge	2.95 ± 1.19	3.55 ± 0.97	3.23 ± 1.44	3.21 ± 1.11	3.76 ± 1.36
IPV Knowledge					
Actual Knowledge	23.22 ± 5.47	26 ± 5.18	21.25 ± 6.27	17.53 ± 5.00	18.03 ± 3.44
Opinions					
Preparations	3.74 ± 1.02	4.20 ± 1.11	4.25 ± 1.61	3.91 ± 1.07	-
Legal Requirements	4.03 ± 1.15	3.92 ± 1.15	3.96 ± 1.76	3.78 ± 1.55	-
Workplace Issues	3.86 ± 0.85	4.18 ± 1.05	3.56 ± 1.94	3.82 ± 1.13	-
Self-Efficacy	3.89 ± 2.85	3.68 ± 1.26	2.71 ± 1.20	3.14 ± 0.94	-
Alcohol/Drugs	4.41 ± 0.78	4.46 ± 0.61	4.08 ± 0.46	4.12 ± 0.46	-
Victim Understanding	4.25 ± 0.82	5.06 ± 0.78	4.50 ± 0.68	4.29 ± 0.65	-
Victim Autonomy	4.34 ± 0.82	4.33 ± 0.83	4.29 ± 1.34	4.33 ± 0.83	-
Constraints	5.02 ± 1.21	4.65 ± 1.26	6.50 ± 0.53	6.00 ± 0.94	-
Practice Issues					
Practice Issues	16.33 ± 8.29	12.35 ± 7.44	-	-	16.97 ± 6.46

Table 3. Perceived Background of Respondents on Intimate Partner Violence (n=81)

Preparedness to perform the following:	1 = Not prepared	2 = Minimally prepared	3 = Slightly prepared	4 = Moderately prepared	5 = Fairly well prepared	6 = Well prepared	7 = Quite well prepared
Ask appropriate questions about IPV	9 (11.1%)	18 (22.2%)	19 (23.5%)	18 (22.2%)	13 (16%)	1 (1.2%)	3 (3.7%)
Appropriately respond to disclosures of abuse	8 (9.9%)	12 (14.8%)	20 (24.7%)	18 (22.2%)	14 (17.3%)	5 (6.2%)	3 (3.7%)
Identify IPV indicators based on patient history, and physical examination	9 (11.1%)	11 (13.6%)	18 (22.2%)	20 (24.7%)	17 (21%)	4 (4.9%)	2 (2.5%)
Assess an IPV victim's readiness to change	16 (19.8%)	14 (17.3%)	21 (25.9%)	18 (22.2%)	10 (12.3%)	1 (1.2%)	1 (1.2%)
Help an IPV victim assess his/her danger of lethality	17 (21%)	13 (16%)	24 (29.6%)	15 (18.5%)	10 (12.3%)	1 (1.2%)	1 (1.2%)
Conduct a safety assessment for the victim's children	20 (24.7%)	23 (28.4%)	19 (23.5%)	9 (11.1%)	8 (9.9%)	1 (1.2%)	1 (1.2%)
Help an IPV victim create a safety plan	21 (25.9%)	22 (27.2%)	18 (22.2%)	8 (9.9%)	9 (11.1%)	2 (2.5%)	1 (1.2%)
Document IPV history and physical examination findings in patient's chart	15 (18.5%)	16 (19.8%)	19 (23.5%)	11 (13.6%)	13 (16%)	5 (6.2%)	2 (2.5%)
Make appropriate referrals for IPV	15 (18.5%)	13 (16%)	16 (19.8%)	11 (13.6%)	18 (22.2%)	3 (3.7%)	5 (6.2%)
Fulfill state reporting requirements for:							
IPV	26 (32.1%)	20 (24.7%)	16 (19.8%)	9 (11.1%)	7 (8.6%)	2 (2.5%)	1 (1.2%)
Elder abuse	26 (32.1%)	20 (24.7%)	16 (19.8%)	10 (12.3%)	6 (7.4%)	2 (2.5%)	1 (1.2%)
Child abuse	26 (32.1%)	20 (24.7%)	15 (18.5%)	9 (11.1%)	8 (9.9%)	2 (2.5%)	1 (1.2%)

not be feasible because of the scarcity of resources. Thus, selected integration of screening into reproductive health, mental health, and emergency services and selective screening of women and girls exhibiting signs of abuse in other health services are recommended.[11] In the study, very few of the participants tend to do universal screening. This poses a public health concern in our setting as screening is a form of secondary prevention. Although universal screening may not be applicable in our setting as a developing country, it must be reiterated that the healthcare providers have ethical obligations to women who are victims of violence, that there is low risk of harm in screening, and screening is a key step in the identification, intervention, and provision of appropriate care to these women.[7,10,11]

The study reflects that inadequate attitudes and skills of the participants on IPV screening are consequences of inadequate knowledge. Most of them have not fully fulfilled their role with regard to victims of violence, as mandated by the Republic Act 9262. This law, also known as The Anti-Violence Against Women and Their Children Act Of 2004, states in Section 31 the role of healthcare providers to victims of violence. Healthcare providers in our country are not legally mandated to report IPV cases but assistance shall be provided as mandated.[23]

In the Philippines, the obstetricians and gynecologists generally act as the primary care physicians to the general female population. This provides them a good opportunity to be involved in the secondary prevention of IPV. The

Table 4. Opinions of Respondents on Intimate Partner Violence (n=81)

	Strongly disagree - 1		Disagree		Agree		Strongly agree - 7	*Mean ± SD*
If an IPV victim does not acknowledge the abuse, there is very little that I can do to help	13 (16%)	10 (12.3%)	28 (34.6%)	8 (9.9%)	12 (14.8%)	6 (7.4%)	4 (4.9%)	*3.37 ± 1.68*
I ask all new patients about abuse in their relationships	16 (19.8%)	12 (14.8%)	32 (39.5%)	12 (14.8%)	9 (11.1%)	0 (0%)	0 (0%)	*2.83 ± 1.23*
My workplace encourages me to respond to IPV	5 (6.2%)	9 (11.1%)	17 (21%)	21 (25.9%)	25 (30.9%)	3 (3.7%)	1 (1.2%)	*3.8 ± 1.33*
I can make appropriate referrals to services within the community for IPV victims	1 (1.2%)	1 (1.2%)	17 (21%)	19 (23.5%)	27 (33.3%)	9 (11.1%)	7 (8.6%)	*4.54 ± 1.29*
I am capable of identifying IPV without asking my patient about it	3 (3.7%)	7 (8.6%)	31 (38.3%)	24 (29.6%)	16 (19.8%)	0 (0%)	0 (0%)	*3.53 ± 1.03*
I do not have sufficient training to assist individuals in addressing situations of IPV	1 (1.2%)	2 (2.5%)	12 (14.8%)	23 (28.4%)	23 (28.4%)	9 (11.1%)	11 (13.6%)	*4.68 ± 1.37*
Patients who abuse alcohol or other drugs are likely to have a history of IPV	2 (2.5%)	1 (1.2%)	7 (8.6%)	25 (30.9%)	21 (25.9%)	19 (23.5%)	6 (7.4%)	*4.77 ± 1.29*
Victims of abuse have the right to make their own decisions about whether hospital staff should intervene	0 (0%)	2 (2.5%)	14 (17.3%)	25 (30.9%)	25 (30.9%)	10 (12.3%)	5 (6.2%)	*4.52 ± 1.17*
I feel comfortable discussing IPV with my patients	2 (2.5%)	7 (8.8%)	18 (22.5%)	21 (26.3%)	23 (28.8%)	7 (8.8%)	2 (2.5%)	*4.96 ± 8.21*
I don't have the necessary skills to discuss abuse with an IPV (female) victim	1 (1.2%)	5 (6.2%)	16 (19.8%)	22 (27.2%)	23 (28.4%)	12 (14.8%)	2 (2.5%)	*4.3 ± 1.26*
If victims of abuse remain in the relationship after repeated episodes of violence, they must accept responsibility for that violence	6 (7.4%)	20 (24.7%)	23 (28.4%)	16 (19.8%)	9 (11.1%)	6 (7.4%)	1 (1.2%)	*3.3 ± 1.41*
I am aware of legal requirements in this state regarding reporting of suspected cases of IPV	8 (9.9%)	8 (9.9%)	18 (22.2%)	22 (27.2%)	13 (16%)	6 (7.4%)	6 (7.4%)	*3.81 ± 1.62*
Health care providers do not have the time to assist patients in addressing IPV	19 (23.5%)	13 (16%)	25 (30.9%)	12 (14.8%)	9 (11.1%)	1 (1.2%)	2 (2.5%)	*2.88 ± 1.49*
I am able to gather the necessary information to identify IPV as the underlying cause of patient illnesses (eg, depression, migraines)	2 (2.5%)	4 (4.9%)	27 (33.3%)	25 (30.9%)	15 (18.5%)	8 (9.9%)	0 (0%)	*3.88 ± 1.16*
If a patient refuses to discuss the abuse, staff can only treat the patient's injuries	2 (2.5%)	7 (8.6%)	13 (16%)	31 (38.3%)	18 (22.2%)	7 (8.6%)	3 (3.7%)	*4.1 ± 1.28*
Victims of abuse could leave the relationship if they wanted to	3 (3.7%)	2 (2.5%)	8 (9.9%)	15 (18.5%)	13 (16%)	18 (22.2%)	22 (27.2%)	*5.16 ± 1.65*
I comply with the Joint Commission standards that require assessment for IPV	0 (0%)	6 (7.4%)	21 (25.9%)	25 (30.9%)	12 (14.8%)	10 (12.3%)	7 (8.6%)	*4.25 ± 1.39*
Health care providers have a responsibility to ask all patients about IPV	1 (1.2%)	1 (1.2%)	11 (13.6%)	23 (28.4%)	22 (27.2%)	13 (16%)	10 (12.3%)	*4.77 ± 1.33*
My practice setting allows me adequate time to respond to victims of IPV	3 (3.7%)	9 (11.1%)	21 (25.9%)	24 (29.6%)	18 (22.2%)	5 (6.2%)	1 (1.2%)	*3.79 ± 1.26*
I have contacted services within the community to establish referrals for IPV victims	8 (9.9%)	14 (17.3%)	27 (33.3%)	20 (24.7%)	8 (9.9%)	3 (3.7%)	1 (1.2%)	*3.23 ± 1.31*
Alcohol abuse is a leading cause of IPV	2 (2.5%)	5 (6.2%)	11 (13.6%)	21 (25.9%)	18 (22.2%)	14 (17.3%)	10 (12.3%)	*4.6 ± 1.51*
Victims of abuse often have valid reasons for remaining in the abusive relationship	4 (4.9%)	8 (9.9%)	13 (16%)	20 (24.7%)	23 (28.4%)	13 (16%)	0 (0%)	*4.1 ± 1.39*
I am too busy to participate on a multidisciplinary team that manages IPV cases	14 (17.3%)	11 (13.6%)	28 (34.6%)	17 (21%)	8 (9.9%)	0 (0%)	3 (3.7%)	*3.07 ± 1.43*
Screening for IPV is likely to offend those who are screened	8 (9.9%)	14 (17.3%)	20 (24.7%)	26 (32.1%)	10 (12.3%)	1 (1.2%)	2 (2.5%)	*3.33 ± 1.34*
There is adequate private space for me to provide care for victims of IPV	3 (3.7%)	7 (8.6%)	29 (35.8%)	18 (22.2%)	15 (18.5%)	8 (9.9%)	1 (1.2%)	*3.78 ± 1.3*
I am able to gather the necessary information to identify IPV as the underlying cause of patient injuries (eg, bruises, fractures, etc)	2 (2.5%)	4 (4.9%)	20 (24.7%)	26 (32.1%)	22 (27.2%)	7 (8.6%)	0 (0%)	*4.02 ± 1.14*
Women who choose to step out of traditional roles are a major cause of IPV	12 (14.8%)	16 (19.8%)	25 (30.9%)	14 (17.3%)	12 (14.8%)	2 (2.5%)	0 (0%)	*3.05 ± 1.34*
Health care providers do not have the knowledge to assist patients in addressing IPV	7 (8.6%)	9 (11.1%)	17 (21%)	16 (19.8%)	24 (29.6%)	7 (8.6%)	1 (1.2%)	*3.81 ± 1.48*
I can match therapeutic interventions to an IPV patient's readiness to change	2 (2.5%)	11 (13.6%)	25 (30.9%)	23 (28.4%)	13 (16%)	6 (7.4%)	1 (1.2%)	*3.69 ± 1.25*
I understand why IPV victims do not always comply with staff recommendations	0 (0%)	3 (3.7%)	12 (14.8%)	32 (39.5%)	20 (24.7%)	12 (14.8%)	2 (2.5%)	*4.4 ± 1.1*
Use of alcohol or other drugs is related to IPV victimization	0 (0%)	2 (2.5%)	1 (1.2%)	28 (34.6%)	23 (28.4%)	14 (17.3%)	12 (14.8%)	*5.07 ± 1.26*
I can recognize victims of IPV by the way they behave	3 (3.7%)	11 (13.6%)	17 (21%)	25 (30.9%)	19 (23.5%)	5 (6.2%)	1 (1.2%)	*3.8 ± 1.29*

Table 5. Screening Practices of Respondents on Intimate Partner Violence (n=81)

Not applicable – I am not in clinical practice	0 (0%)
I do not currently screen	32 (39.5%)
I screen all new patients	1 (1.2%)
I screen all new female patients	2 (2.5%)
I screen all patients with abuse indicators on history or exam	30 (37%)
I screen all female patients at the time of their annual exam	4 (4.9%)
I screen all pregnant patients at specific times of their pregnancy	2 (2.5%)
I screen all patients periodically	1 (1.2%)
I screen all female patients periodically	3 (3.7%)
I screen certain patient categories only (check below)	37 (45.7%)
Teenagers	6 (7.4%)
Young adult women (under 30 years old)	5 (6.2%)
Elderly women (over 65 years old)	3 (3.7%)
Single or divorced women	5 (6.2%)
Married women	5 (6.2%)
Women with alcohol or other substance abuse	23 (28.4%)
Single mothers	3 (3.7%)
Women of other races*	2 (2.5%)
Lesbian women	4 (4.9%)
Homosexual men	2 (2.5%)
Depressed/suicidal women	31 (38.3%)
Pregnant women	3 (3.7%)
Mothers of all my pediatric patients (if applicable)	0 (0%)
Mothers of pediatric patients who show signs of witnessing IPV	12 (14.8%)
Mothers of children with confirmed or suspected child abuse, neglect	15 (18.5%)
Others	3 (3.7%)
Women who are manifesting some form of STD obtained from a partner	
I would probably ask leading questions to patients who would give me a hint or imply (on series of consultations) that they are victims of IPV	
Screen only if with signs of possible IPV	

institution in the study does not have a clear-cut and readily available protocol for screening of IPV. Also, in our healthcare setting, neither the government, DOH, nor the Philippine Obstetrical and Gynecological Society has current recommendations or practice guidelines regarding screening for IPV.

CONCLUSION

Majority of the obstetricians and gynecologists in this study do not have an adequate knowledge, appropriate attitudes, and competent skills for screening of IPV. Screening for IPV is not routinely done by the obstetricians and gynecologists in this study. Recognition of barriers to screening for IPV, development of strategies for increasing awareness to IPV, and education and training in IPV during continuing medical education activities and residency training may improve the IPV screening practices of current and future obstetricians and gynecologists. These in turn will help them to provide appropriate, effective, and holistic care to their patients who are victims of violence. ■

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