Training on prevention of violence against women in the medical curriculum at the University of Ibadan, Nigeria

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Objectives. To determine the knowledge and skills of final-year medical students in managing victims of violence against women (VAW), and to describe the extent to which VAW is included in the undergraduate curriculum of the College of Medicine, University of Ibadan.

Method. A mixed-method study design was used that collected qualitative data through a review of curriculum documents and interviews of departmental heads (or their representatives) of 6 departments in the college. A semi-structured, self-administered questionnaire was used to collect quantitative data from 109 final-year students.

Results. The response rate was 85.1% and respondents' mean age was 25.2±3.1 years. Physical, sexual, psychological and economic abuse was found by 73.8%, 72.6%, 54.8% and 44.0% respectively, of the students. Most students (77.4%) felt it was part of their duty to ask patients about abuse. Students with previous training about violence were more likely to be knowledgeable (odds ratio (OR) 1.64; 95% confidence interval (CI) 0.61 - 4.42) and skilled (OR 1.27; 95% CI 0.53 - 3.05). Men had better knowledge and skills than women. VAW was not included as a topic in the curriculum.

Conclusion. Most students were willing to ask patients about abuse but lacked the fundamental knowledge and skills to do so. Faculty at the college agreed to review the curriculum to improve students' knowledge and management skills regarding VAW.

AJHPE 2013;5(2):75-79. DOI:10.7196/AJHPE.222

Violence against women (VAW) has become a major public health and human rights issue. This social evil occurs in all countries, irrespective of social, economic, religious and cultural traditions. Notably, the increasing incidence of battering, rape, domestic violence, honour killings, human trafficking, prostitution, forced and early marriages, female genital mutilation and sexual slavery was noted by the Secretary-General of the United Nations, at the 4th World Conference on Women.[1]

Deeply rooted African tradition and culture have been blamed for most of the physical and psychological customs that perpetuate VAW.[2] To illustrate, wife-beating is perceived as normal in African marital relationships,[3,4] and the custom of inheriting a woman as part of her deceased husband's estate has left many women poor, homeless and vulnerable to abuse. While most African countries have amended or passed gender-sensitive laws to stem the tide of violence and prejudice against women, concern remains over the lack of enforcement of such legislation[5] in a region characterised by widespread armed conflict, poverty and social inequality, which result in continued exploitation and abuse of vulnerable groups.[2,6]

Results of the Demographic and Health Survey in Nigeria of 2008 indicated that 28% of women aged 15 - 49 years had experienced physical violence since the age of 15, and that 15% had experienced physical violence in the 12 months prior to the survey.[7] Epidemiological evidence suggests that VAW affects the health and wellbeing of women in many ways, resulting in fatal (homicide, suicide and AIDS-related deaths) and non-fatal (physical injury, chronic pain syndromes and gastro-intestinal disorders) outcomes.[8] Physical and sexual violence further affects the mental health of victims, and has resulted in behavioral outcomes such as alcohol and/or drug abuse and high sexual risk-taking behavior.[8]

Evidence suggests that women are likely to disclose intimate partner violence to healthcare practitioners,[7] but the latter's inadequate training may leave them unable to recognise or, where disclosed, unable to respond to victims of abuse. Concern has also been raised about reports[9] of women suffering abuse or neglect at the hands of healthcare practitioners and the perceived reluctance of health personnel to discuss physical and sexual violence with patients who disclose being in violent relationships.[8]

Medical schools with gender-based violence curricula have played an important part in the promotion of good maternal and child health outcomes. Research indicates that physicians trained in VAW are significantly more likely to screen for signs of abuse.[10] There is also increasing debate about the efficacy of curricular approaches and the most effective educational techniques to be used for training.[11]

Realising the central role of medical schools in preparing a future generation of practitioners and citizens, there is consequently a need to educate medical students about the treatment, referral system and impact of VAW when managing victims. However, little research is done in the African context about the prior experiences of medical students of VAW and their attitudes to treating victims of abuse. The present study was therefore conducted to determine perceptions and the level of competence (knowledge, skills) to manage victims of VAW among the final-year student cohort and the extent to which the topic is taught in the College of Medicine at the University of Ibadan, Nigeria.

Method

The College of Medicine trains medical and dental students. It includes a 950-bed tertiary health facility – the University College Hospital. Medical students rotate through the Faculty of Public Health in their 3rd, 4th and 5th years of study. Students similarly rotate for periods of approximately 6 - 8 weeks through each of the 6 clinical blocks in their final year.

A mixed methods approach was used in this descriptive, analytical cross-sectional study. Quantitative data was collected through a self-administered questionnaire that collected data on students' knowledge of

VAW, factors influencing their acquisition of knowledge and skills, and the extent to which they had prior training on the topic. The final part of the questionnaire explored students' perceptions and attitudes towards abusers and victims, their levels of empathy for those in abusive relationships, and their skills in managing abused patients.

Final-year medical students (*N*=128) in their 5th year of study constituted the primary respondents, while faculty members were the secondary respondents. Faculty members included staff responsible for bedside teaching and lecturing from Family Medicine, Paediatrics, Obstetrics and Gynaecology, Accidents and Trauma, Dentistry and Public Health.

A qualitative data analysis of curriculum documents including module and course information on the Bachelor of Medicine and Bachelor of Surgery (MB BS) course were undertaken. In-depth interviews were also conducted with key faculty informants from each of the 6 departments to verify the extent of coverage of VAW in the curriculum. The questions explored included the availability of a programme on VAW, content covered, teaching methods, competencies of trainers, and suggestions to improve students' competence concerning VAW.

The questionnaire was adapted from previous studies.[12,13] A pilot study was conducted with 20 students enrolled in their 4th year of study at the school. Each questionnaire took about 20 minutes to complete. The questionnaire was amended to improve clarity and reduce ambiguity. A copy can be obtained from the corresponding author.

The qualitative data were transcribed, cleaned and coded, and themes identified. Descriptive analysis, frequencies, means and standard deviations were performed on the data, using statistical software STATA 11.0. Bivariate analysis using the chi-squared (χ^2) test was used to determine the associations between variables. Significant variables in the bivariate analysis were entered into a logistic regression model to determine the strength of the associations. *P*-values <0.05 were considered significant.

Ethical clearance for the study was obtained from the Joint University of Ibadan/University College Hospital Institutional Review Board (UI/EC/11/0103).

Results

Demographic data

A hundred-and-nine students (*N*=128; 85.1%) participated in the study. The mean age of the primary respondents ranged from 16 to 39 years with a median age of 24 years. Most students were male (59.6%), and 73.4% were from the Yoruba ethnic group.

Awareness of VAW

Seventy-seven per cent of the respondents indicated an awareness of VAW. Their descriptions of the term varied, e.g. the maltreatment of either sex, violence to women, physical assault, beating and/or battery, and forms of physical, sexual and psychological (mental) violence.

Knowledge of VAW

Physical violence. Most respondents (73.8%) could give at least one correct example of a physically violent act. Physical violence was described as beating (46.4%) and slaps (15.5%).

Sexual violence. About three-quarters (72.6%) of the respondents gave at least one correct example of a sexually violent act, while 11.9% gave 2 or more examples. Sexual violence was mostly (67.8%) described as rape.

Psychological violence. Slightly more than half (54.8%) gave an example of a psychologically violent act, while 6% mentioned 2 correct examples. Psychological violence was described as verbal abuse and insults (32.1% and 7.1% respectively).

Economic violence. Economic violence was described as financial deprivation (17.9%), not allowing a woman to work (14.3%), and lack of care (5.9%). Respondents' knowledge of what an act of economic violence comprised was stated by 44%; 5% could mention 2 such acts.

Signs and symptoms suggestive of VAW. Complaints of aches and pains were made by 90.4%. Students also mentioned other symptoms including abortions (86.9%), fractures (78.6%), sexually transmitted infections (66.7%) and headache (66.7%).

Perceptions of VAW

Magnitude of VAW. Regarding the attitudes of students as indicated in Table 1, most of the student respondents perceived VAW to be a common problem in their environment. Fifty-two respondents (61.9%) thought it was *common* (experienced by 10% of the population) while 26.2% thought it was *very common* (experienced by 15% of the population). Only 11.9% believed it was *rare* (experienced by <5% of the population).

Asking patients about VAW. Most (77.4%) students regarded it as part of their duty as physicians to enquire about violence, and many (67.9%) were willing to do so. Those who were not willing to engage with patients thought that it would intrude on the private life of their patients (57.1%), and some students (42.9%) believed it would be demeaning to enquire about VAW.

Students' confidence about discussing the topic with patients. Student responses varied on the extent to which they were confident about asking patients about VAW. Eighty-one per cent were *very confident* to ask about depression, 73.8% were *very confident* to ask about beatings, and 54.8% were *very confident* to ask about rape. Thirty-six per cent reported *little confidence* to ask about rape, while 9% were *not confident at all* to enquire about any aspect of the topic.

Table 1. Student respondents' attitude to screening and care of victims

Statement	Agree *n* (%)	Not sure *n* (%)	Disagree *n* (%)
It is an intrusion into the patient's private life	17 (20.2)	19 (22.7)	48 (57.1)
It will be part of my role as a physician	65 (77.4)	16 (19.1)	3 (3.6)
I do not think it will offend the patient	47 (56.0)	27 (32.1)	10 (11.9)
I think it will offend the patient	21 (25.0)	27 (32.2)	36 (42.9)
I am willing to do so	57 (67.9)	21 (25.0)	6 (7.1)

Table 2. Knowledge, attitude, confidence and skills scores of student respondents

Scores	Mean±SD	Maximum	Median
Knowledge	2.44±0.92	5	3.0
Attitude	4.0±1.6	7	4.0
Confidence	4.9±1.5	6	5.0
Skills	12.2±3.2	21	12.0

Table 3. Student respondents' perceived skills to manage VAW victims

Activity	Very skilled *n* (%)	Some skill *n* (%)	Not skilled/ Don't know *n* (%)
Recognising/detecting VAW (e.g. picking up warning signs and symptoms and/or screening techniques for patients suspected to be at risk)	12 (14.3)	45 (53.6)	27 (32.1)
Taking history on VAW episodes (e.g. frequency and severity of episodes, involvement of other family members, access to dangerous weapons, contributing factors such as alcohol and drugs)	11 (13.1)	54 (64.3)	19 (22.7)
Examining VAW victim (laboratory or side-room investigations, microbiology swabs etc.)	7 (8.4)	37 (44.0)	44 (47.6)
Treatment of and medical care for victims	8 (9.5)	46 (54.9)	30 (28.6)
Counselling and facilitating the development of a safety plan with the victim (e.g. establishing with the patient if it is safe to go home and, if not, discussion of options, referral for help, admission to hospital as temporary place of safety)	14 (16.7)	48 (57.1)	22 (26.2)
Managing/counselling the perpetrator if he/she is in the setting together with the victim	9 (10.7)	40 (47.6)	35 (41.7)
Discussing coping skills for victims of family violence or those in abusive relationships	6 (7.1)	46 (54.8)	32 (38.1)

Table 4. Logistic regression analysis of factors associated with good knowledge, attitude and competence scores

Profile	Adequate (*n*=84) OR (95% CI) *p*-value	Positive (*n*=84) OR (95% CI) *p*-value	Skills (*n*=84) OR (95% CI) *p*-value
Age			
<25 years	1	1	1
>25 years	4.89 (1.69 - 14.12) 0.003	4.55 (1.48 - 13.99) 0.008	1.00 (0.42 - 2.39) 1.00
Sex			
Female	1	1	1
Male	2.44 (0.89 - 6.65) 0.82	0.64 (0.23 - 1.74) 0.38	1.27 (0.53 - 3.05) 0.59
Training			
No	1	1	1
Yes	1.64 (0.61 - 4.42) 0.33	1.38 (0.51 - 3.70) 0.53	1.26 (0.54 - 3.04) 0.59

Table 5. Student respondents' suggestions for improving their knowledge

Suggestion (*N*=39)	*n* (%)
Include in curriculum	13 (33.3)
Clinical teaching and case studies	3 (7.7)
Publicise in media	3 (7.7)
Short courses and workshop	3 (7.7)
Group discussion	1 (2.6)
No response	9 (23.1)

Attitude towards victims. Less than half (44.0%) of respondents indicated that they would be sympathetic towards a woman who chose to remain in a violent relationship, while 48.8% felt that the abused victim did not deserve the experience and that violence was wrong.

Skills and competencies

Most respondents indicated not being *very skilled* to treat victims of violence. For instance, only 14.3% stated that they were *very skilled* and could detect the warning signs and symptoms of VAW. Less than 10% (9.5%) of the respondents reported being *very skilled* at treating and providing medical care to victims, and 57% admitted to having *some skill* to do so.

Knowledge, attitude, confidence and competence scores

Knowledge, attitude, confidence and competence scores were awarded by giving one mark for every correct statement. Tables 2 - 4 indicate the questions posed to students to ascertain their knowledge, skills and attitude towards victims of violence. A mean knowledge score of 2.44±0.92 was obtained from 5 knowledge statements. A mean attitude score of 4.0±1.6 was obtained from a maximum of 7 statements, while a mean confidence score of 4.9±1.5 was recorded from 6. The maximum obtainable competence (skills) score was 21, and a mean attitude score of 12.2±3.2 was obtained.

Using the 75th percentile as the cut-off for respondent scores, 60.7% (51) were knowledgeable on VAW, 47.6% (40) were very confident, 25% (21) had a positive attitude to managing victims of VAW, and 40.5% (34) were skilled in the management of victims.

Older students were 5 times more likely to be knowledgeable (aOR 4.89; p=0.003) and to have better attitudes (aOR 4.55; p=0.008) towards victims of violence. Male students had more knowledge of VAW, and female students had better attitudes to victims. Students who reported prior training on violence were more likely to have adequate knowledge (aOR1.64; p=0.33), and better attitudes (aOR 1.38; p=0.53) and skills to manage victims (aOR 1.26; p=0.59).

Suggestion to improve knowledge and skills

Student opinions were sought on how to improve their knowledge and skills on case management relating to VAW. Their responses included that the

Table 6. Summary of faculty respondents on teaching about VAW

Final-year departments	Is there a curriculum to teach students about VAW?	Reasons for not teaching VAW	How prepared are faculty from your department to teach about VAW?	How can VAW be included in the curriculum?
1	'Presently there is no programme in place, but when we see such cases and if there are medical students around, we use that avenue to talk to them'. 'When we see cases of VAW, we call the student around, even in our normal clinical sessions; topics that have to do with physical assault can be assigned to any doctor to present to them to discuss.'	'It can be attributed to two reasons: Our institution and National University Commission do not have it in the curriculum'.	'Most of our consultants and residents have never had formal training on VAW but they appreciate its importance'.	'The programme should cut across primary school, secondary schools and tertiary education; everybody should be involved. Public enlightenment is needed so that people can be adequately informed'.
2	'It is when we see a patient that we tend to teach, either in the clinic or on the bedside. If we see such cases, some of our residents will work on it but we have no structured lectures'.	'I don't think we should let them push teaching it to us. VAW should be tailored not only towards the health sector, others should do the teaching too'.	'Consultants and residents should get more training.'	'VAW is a topic that is getting a lot of importance. There should be more training on how to help women, in particular, who need help, and also how to get them to where they can get this help'.
3	'I don't think there is anything in … [name of department] on that except in forensic medicine where signs of battering are mentioned'.			'If the gynaecologist could be convinced, it is good to have at least a topic on it. Also, in departments that deal with social aspects of life such as preventive medicine and health promotion, a topic of a seminar can be dedicated to VAW'.
4	'We have no direct lectures on gender and violence, none whatsoever. But we have seminars on social … [name of department] which we conduct weekly, so if they see a child, they follow the child home, and talk about the surrounding circumstances, home and family issues, e.g. if the mother or child has battering issues or any issues relating to gender. For the clinical aspect of the practice, we see children who have been assaulted and most of them are females, and if the students happen to be in the clinic at the time, they also get to learn about it'.			'If the gynaecologist could be convinced, it is good to have at least a topic on it. Also in departments that deal with social aspects of life such as preventive medicine and health promotion, a topic of a seminar can be dedicated to VAW'.
5	'We do not have VAW in our undergraduate curriculum; most of the teaching on VAW is in the postgraduate module'.	'The curriculum that we have has been there for a long time, and if you look at the trendy things about reproductive rights, VAW and other issues only became topical in the last one or two decades'.	'I have no formal training. I am just interested in the topic because I worked on sexual violence as part of my postgraduate work'.	'It should be incorporated into the curriculum; that will stimulate doctors to know that VAW exists and to look out for it'.
6	'We don't go into the in-depth aspect of it, we just talk to them about domestic violence under rehabilitative medicine or family health'.		'As part of a workshop and when I was doing my MPH, part of some courses and occasionally in seminars, I have learnt about VAW'.	

topic should be taught or included in the curriculum (25.7%); dealt with in teaching practice (17.9%) and addressed through case demonstrations (11%). A summary of the student suggestions is provided in Table 5.

Training/teaching received on VAW

Thirty-nine student respondents (46.4%) received some formal training in VAW. Nearly 31% (12) received their teaching at medical school. Other sources were the church, parents and electronic media. Most (58.3%) teaching was in the final year of medical school, and was primarily offered by teachers from the Departments of Public Health; Obstetrics and Gynaecology; and Psychiatry. Teaching was mostly delivered as didactic lectures (83.3%) by doctors (66.7%) and social workers (16.7%). Interviews with faculty members (see Table 6) revealed an absence of teaching about VAW in their formal programme.

Of the 39 respondents who received formal training on VAW, 20.5% had training on how to detect warning signs and symptoms, 25.6% could take history on VAW incidents, 25.6% could examine victims, 33.3% could provide treatment or medical care to victims, and 28.2% could provide counselling to perpetrators. Most (51.2 - 64.1%) respondents stated that they would like these issues addressed in their teaching curriculum. Reasons for the non-inclusion of VAW in the curriculum and faculty's view on their expertise in training on the topic were captured in interviews with the departmental representatives and indicated in Table 6. Most of the interviewees admitted to not having had previous formal training on VAW.

Discussion

Although students demonstrated satisfactory knowledge of signs and symptoms, they lacked knowledge of the types of VAW. Their knowledge was best on physical and sexual violence, with psychological and economic aspects less known. Knowledge levels of the cohort might have been lower, as non-participation by some might have been due to a perceived lack of knowledge. Previous studies that assessed knowledge and perceptions of medical students were conducted predominantly in developed contexts[10] and highlighted the value of exposing and training students on a VAW programme. Studies have also expressed concern over inadequate training on intimate partner violence.[14]

In the present study, men surprisingly demonstrated better knowledge of VAW which might have been due to their increased exposure or that some might have been perpetrators of VAW. Older respondents, probably owing to their more extensive life experiences, and those who had been trained, also demonstrated better knowledge. This improved knowledge should ultimately translate into improved attitudes, screening procedures and case management during clinical practice.

Many students had an accurate estimation of the magnitude of VAW in society and correctly perceived it their duty to ask patients about violence. Some were, however, not sympathetic towards women who chose to remain in violent relationships, and even expressed the view that such an abused victim then deserved the experience. This perception is similar to that of nurses in a study in rural South Africa.[15] Research has indicated that some of these incorrect perceptions could still be challenged and changed during training.[10] Females empathised better with victims, possibly owing to knowledge of friends, family, neighbours or themselves being in similar situations. This aspect was, however, not explored in this study.

Most students admitted to having limited skills in managing victims of violence, which we suggest probably reflects the lack of training in this issue. The results suggest the need for an integrated institutional curriculum on VAW. This need was confirmed in the interviews with faculty who reiterated a commitment to include education about VAW; some reported sporadic teaching even in the absence of a formal curriculum. Some departments were aware of the need to review their curricula. Most faculty members interviewed further acknowledged a need for personal training on VAW, and agreed to institute training for students. It was felt that an effective training programme would promote student learning and expedite professional and personal development.

Two limitations to the study need noting. Firstly, students might have gained prior knowedge on VAW from sources outside the school; and secondly, the expertise of tutors and students on women's issues in public health might have confounded some of the observed associations. Similarly, the academic abilities of the students might have influenced the results. However, these are likely to affect knowledge and not skills. Nevertheless, the results still show the need to improve current teaching on the topic.

Conclusion

While most students were willing and considered it their duty to ask patients about abuse, they lacked the fundamental knowledge and skills to do so effectively. This study affirmed the need for both faculty and students to be trained on issues relating to VAW, and to receive skills and awareness training on how to screen patients, which may include an institutional plan or protocols for routine screening and dealing with emergencies. There is also a need for a faculty policy to integrate these efforts. The results from this study serve as a basis for reviewing the curriculum and enlisting currently committed members of faculty to enhance and improve students' knowledge, skills and attitudes on this important topic.

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