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# Domestic Violence in Mid-Level Health Care Providers: Survey among midwives

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***Abstract:***
***Background****: Violence against women is a global phenomenon. WHO reported a 35% global prevalence of domestic violence. Most of it is perpetrated by an intimate partner.InPatriarchalsocieties,domestic configuration issuchthat males are unquestionable leaders and violence withinthe home isprivate and acceptable. The predisposingfactors to violence are illiteracy, poverty, childabuse,earlymarriages,gender discrimination, and alcohol/ substance abuse. Most of the women in Pakistan are poor, pregnant and powerless.However,womenwho are educated and empowered as financialcontributors to the family as midwives are alsosubjected to violence. Gender-based violence isprevalent in all strata as being XX makeuppredisposes to it. Sincethere are very few studies on educated and empoweredwomenas victims of domestic violence (DV),thisstudy looks at prevalence in midwives. The objectives of the study are to estimate the frequency, to explore the predictors of violence and to assess the response/reactions towards domestic violence in the Midwives.*
***Material and Method:****A cross-sectional study was conducted with the participants (midwives) of the refresher courses in the Koohi Goth hospital,Karachi.These midwives come in the group of 70-80 for the period of 3 months from the rural areas of Sindh, Punjab and KPK and Balochistan.A structured self-administered questionnaire with few open-ended questions was designed after the thorough literature search, which was later content validated by an expert. It contains information on Demographic characteristics, Experiences of Domestic Violence and the Reaction towards Domestic violence. The data were analyzed by SPSS version 20. The percentage and frequency of DV were depicted.Chi-square was used to establish a relationship of DV with different factors like age,maritalstatus,education, province,income,number of children and family members. P-value of 0.05 was considered significant.*
***Results:*** *The study includes 221 community midwives.The frequency of Domestic Violence was found to be 34.8% (Fig.1); the commonest perpetrator was the husband (44.2%).Going out for education was the most common reason for domestic violence 58.4%, followed by being a woman 36.4% and going out of house 27.3 % respectively.Different types of violence they faced were Verbal (33%), Psychological, physical and verbal (30%), Psychological (20%), Physical 15 % and Sexual 2.5%.Our study also shows that those midwives who were married were more likely to face domestic violence as compared to unmarried and this difference was statistically significant (p=0.005). Furthermore, the decline is seen in violence with the increase in income, as well as with more children and having no children; however, this difference is not statistically significant. Further it was seen that more than half of respondents, almost 57% suffered in silence.*
***Conclusion:*** *Midlevel health care providers especially midwives are first line contact with patients and they need sensitization towards the health effects of DV. This study is showing that midwives were not aware of DV as a risk factor for adverse health outcomes. They themselves were victims of DV and were suffering in silence.*
***Key Words: Domestic Violence, midwives, verbal abuse, intimate partner***

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## I. Introduction

Violence against women can be defined as a gender misbalance equation wherein the women being the weaker sex suffer more [1]. Women globally suffer by default because of being of XX chromosomal makeup this leads to inequity which becomes a barrier in their development[2]. WHO reported that worldwide 35% of women experience either physical and/or sexual violence by their intimate partners or non-partner sexual violence in their life time[3, 4].

Unlike men who become the victim of violence by war, street crime or gang-related activities, women face violence usually by someone they know like an intimate partner, stepfather or other relatives[5], which makes the otherwise safest places like homes most risky for them. Unyielding cultures and masculine attitudes, which diminish the status of women result in the frequent occurrence of violence against them. Due to the

domestic configuration, in which muscularity equates with an unquestionable leader, violence women undergo is considered within the family as private, and acceptable[6].

The important contributors to female violence include, illiteracy, child abuse, alcohol/substance use and attitudes of accepting gender discrimination and violence[3]. Moreover, during childhood, less importance is given to the education of female children and early marriage as occurs in 45% of women[6], may also heighten susceptibility to domestic violence (DV) [7-9]. In reproductive years, mothers pregnant with and/or those who give birth to only female children may be more susceptible to abuse [10]and financial, medical, and nutritional neglect. Later in life, culturally bred views of dishonor associated with widowhood may also influence susceptibility to DV by other family members [10].

When it comes to domestic violence, intimate partner violence is the most prevalent. It is an enormous public health problem that is considered a routine due to gender-related cultural values, norms, beliefs and social institutions. Especially those associated with male entitlement and privilege which shape the inferior social position of women[11]. The element of shame prevents women from reporting or from taking help in case of intimate partner violence [11].

Women in Pakistani context are less educated and less empowered therefore suffer violence in silence[12]. Status of women in Pakistani scenario can be defined in two percepts first by the access to education, employment, and health services and second by the power or authority of decision making she possesses[12]. Women who are least educated make the highest working group in Pakistan[12]. Data regarding education shows that 54% of ever-married women have never gone to school, 21% have acquired informal or Quranic education and only 25% have gone to school[12]. Women's decision making is affected by age and also the province. Women aged above 30 can take part in decision making; women from Sindh and Punjab enjoys a better situation than that of KPK and Balochistan who are less likely to be involved in decision making[12].

Violence against women is now identified as a health, human rights, and an economic development concern, nevertheless, in many countries, it is still considered as a family or a private matter[11]. Our context is no different rather worse when it comes to violence against women. Midwives from rural areas of Sindh, KPK and Punjab come for refresher competency-based training at Koohi Goth Hospital. One topic that is important is domestic violence. During this session, the midwives shared their personal experiences of domestic violence. This led to the realization that in spite of the financial contribution in the family, the life of these midlevel health care providers is miserable due to the gender-related power imbalances. Therefore, the aim of the study is to identify the burden of violence in this class and also to explore the reasons which made these women soft target for domestic violence. Very less work has been done so far to explore the problems faced by working women from the health sector. Therefore, the objectives of the study are to estimate the frequency, to explore the predictors of violence and to assess the response/reactions towards domestic violence in the Midwives.

## II.Material And Methods

A cross-sectional study was conducted with the participants (midwives) of the refresher courses in the Koohi Goth hospital, located in Bin Qasim Town, DehLandhi, Karachi, Pakistan. The hospital provides free of cost obstetrical and gynecological services to underprivileged women and is also the regional center for vesicovaginal fistula repair.[13] It has a nursing midwifery school recognized by Pakistan Nursing Council which conducts regular as well as refresher courses for nurses and midwives. These midwives come in the group of 70-80 for the period of 3 months from the rural areas of Sindh, Punjab and KPK and Balochistan. All of the participants were invited to participate and the questionnaire was filled after getting the informed consent. Those unwilling to participate, refuse to give informed consent or were mentally and physically not capable of being interviewed were not taken in the study. The participants in no way were subjected to undue discomfort during the interview. After getting the questionnaire filled, they were counseled and educated on sexual and reproductive health, safe childbirth and also on providing information to the clients regarding the availability and accessibility to the facilities. The ethical approval of the study was obtained from IRB (Institutional Review Board) of Jinnah Sindh Medical University.

A structured self-administered questionnaire with few open-ended questions was designed after the thorough literature search, which was later content validated by an expert. It contains information on Demographic characteristics, Experiences of Domestic Violence and the Reaction towards Domestic violence.

**Statistical Analysis:**

Data were analyzed using SPSS software version 20. Descriptive statistics were reported for the socio-demographic characteristics (province, level of education, age, marital status, monthly household income, number of family members and children), Reasons of domestic violence (going out for education, being a woman, going out of house, going to mother's house, dowry, asking for money and not having son) and the behaviors of Domestic Violence (shouting, no education access, beating, not allowed to go out, threatening,

criticizing, extramarital affairs, no TV access, beating children, no contraception, remarrying of husband and no health access).

Percentages for both domestic violence and the type of domestic violence were reported by a pie chart, whereas the frequency of different perpetrators by a bar graph. Chi-square test was employed, to detect the relationship of domestic violence with different factors like age, marital status, province, level of education, monthly household income, number of children and family members. P values < 0.05 were considered significant.

## III. Result

The study included 221 community midwives mostly from Sindh (68.3%), followed by KPK (23.1%) and Punjab (8.6%). Out of the total participants, 29.4% were matriculated, 46.6% were intermediate, and 17.2 % were bachelors and only 6.8% were Masters. Out of them, 62.4% were in the age range of 18- 25 years and 37.6% were greater than 25 years of age, whereas almost half of them were married. Regarding monthly household income, 43% were on less than 10,000, 41.6% were in the range of 10-30000, and 15.4% of the participants were on greater than 30000. Participants with no children, 1-2 children and 3-4 children were almost 27% each. In addition, 44.3% had 2-7, 43% had 8-13, 7.7% had 14-19 and 5% had 20-25 members living in their homes. (Table 1)

The frequency of Domestic Violence was found to be 34.8% (Fig.1); the biggest perpetrator was the husband (44.2%), followed by relatives and neighbors 20.8%, father 16.9%, brother 13% and in-laws 5.2% respectively (Fig.2).

Going out for education was the most common reason for domestic violence 58.4%, followed by being a woman 36.4% and going out of house 27.3 % respectively (Table 2).

Different types of violence they faced were Verbal (33%), Psychological, physical and verbal (30%), Psychological (20%), Physical 15 % and Sexual 2.5% (Fig.3). The most frequent ways of violence were – shouting, no education access, beating, not allowing going out and threatening with 69.6%, 57.7%, 46.8%, 39.7% and 29.1% respectively (Table 3).

Table 4 shows that those who were married were more likely to face domestic violence as compared to unmarried and this difference was statistically significant (p=0.005). Furthermore, the decline is seen in violence with the increase in income, as well as with more children and have no children; however, this difference is not statistically significant. Table 5 shows the reaction of respondents towards domestic violence, according to which more than half (57%) of them stayed quiet.

**Table 1: Socio-demographic characteristics of the study participants (n=221)**

| Variables | No. (%) |
|---|---|
| **Province** | |
| Sindh | 151(68.3) |
| KPK | 51(23.1) |
| Punjab | 19(8.6) |
| **Level of Education** | |
| Matric | 65(29.4) |
| Inter | 103(46.6) |
| Bachelors | 38(17.2) |
| Masters | 15(6.8) |
| **Age** | |
| 18-25 | 138 (62.4) |
| Greater than 25 | 83 (37.6) |
| **Marital Status** | |
| Married | 112(50.7) |
| Unmarried | 109(49.3) |
| **Monthly household income** | |
| <10,000 | 95 (43) |
| 10-30,000 | 92 (41.6) |
| > 30,000 | 34 (15.4) |
| **Number of children** | |
| No children | 31(26.1) |
| 1-2 children | 33(27.7) |
| 3-4 children | 32(26.9) |
| ≥ 5 | 23 (19.3) |
| **Family members** | |
| 2-7 | 98(44.3) |
| 8-13 | 95(43.0) |
| 14-19 | 17(7.7) |
| 20-25 | 11(5.0) |

**Figure 1: Frequency of Domestic Violence amongst midwives (n=221)**

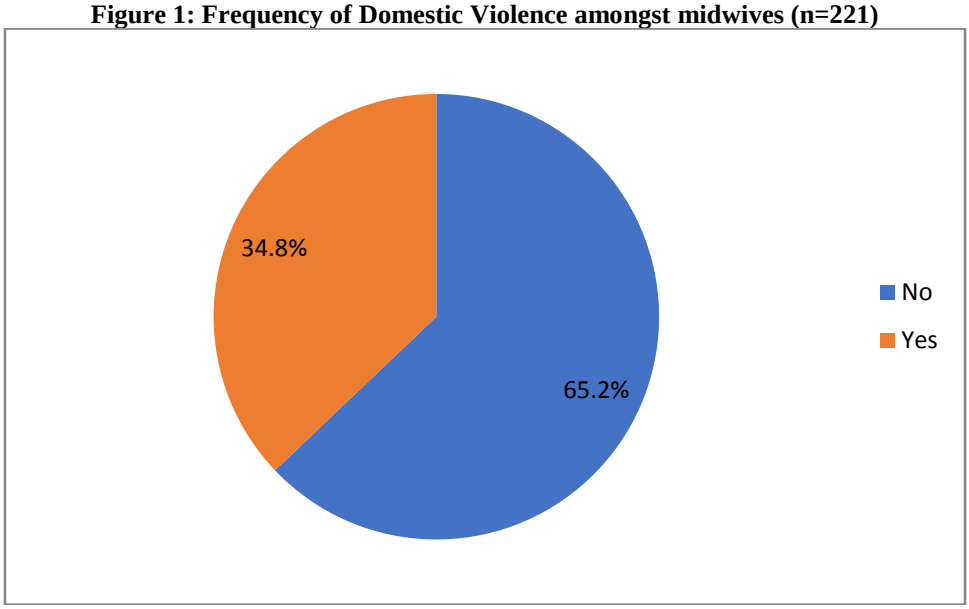


**Figure 2: Frequency of different perpetrators of domestic violence amongst the community midwives (n=77)**

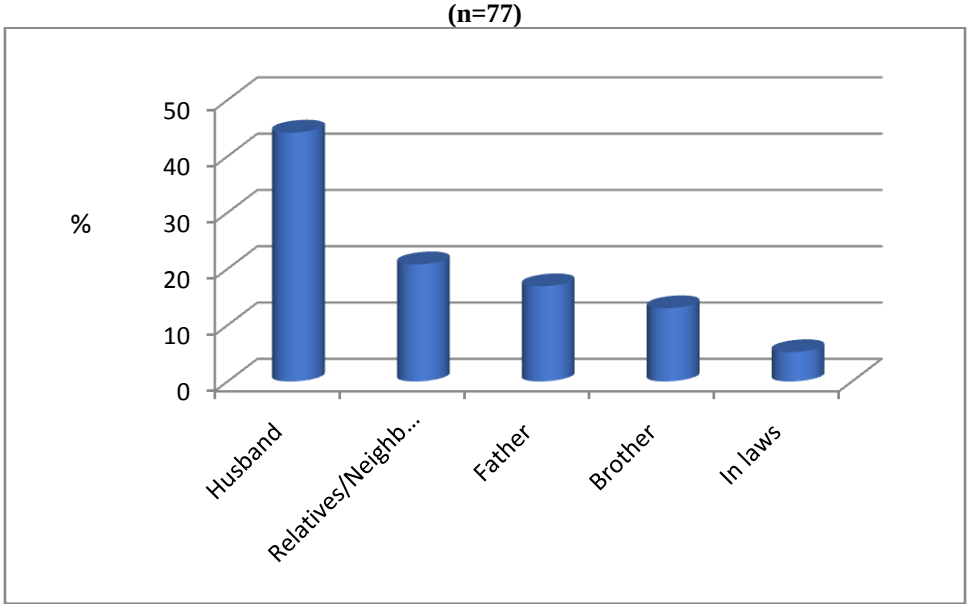


**Table 2: Reasons of Domestic Violence amongst the community midwives (n=77)**

| **Reasons** | **n(%)** |
|---|---|
| Going out for education | 45(58.4%) |
| Being a woman | 28(36.4%) |
| Going out of house | 21(27.3%) |
| Going to mother's house | 10(13.2%) |
| Dowry | 10(13.0%) |
| Asking for money | 11(14.5%) |
| Not having son | 11(14.5%) |

**Figure 3: Frequency of abuse type amongst the community midwives (n=77)**

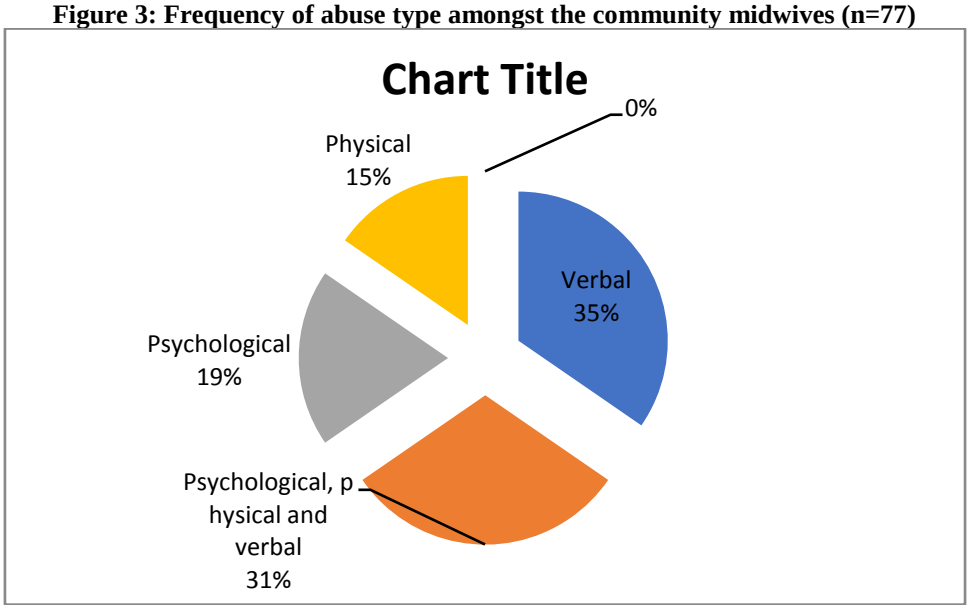


**Table 3: Frequency of different ways of violence faced by the community midwives (n=77)**

| Ways of Violence | N (%) |
|---|---|
| • Shouting | 55(69.6) |
| • No education access | 45 (57.7) |
| • Beating | 37(46.8) |
| • Not allowed to go out | 31 (39.7) |
| • Threatening | 23(29.1) |
| • Criticizing | 14 (17.7) |
| • Extra marital affairs | 9 (12) |
| • No TV access | 8 (10.3) |
| • Beating children | 5(6.4) |
| • No contraception | 5(6.4) |
| • Husband remarries | 4 (5.2) |
| • No Health access | 4 (5.2) |

**Table 4: Comparison of frequencies of Domestic Violence among different groups of Community Midwives (n=77)**

| Variable | Domestic Violence | | P value |
|---|---|---|---|
| | Yes | No | |
| **Marital Status** | | | |
| Married | 49(63.6) | 63(43.8) | 0.005 |
| Unmarried | 28(36.4) | 81(56.2) | |
| **Family members** | | | |
| 1 – 5 | 16 (20.8) | 36 (25.0) | |
| 6-12 | 53 (68.8) | 86 (59.7) | 0.283 |
| Greater than 12 | 8(10.4) | 22(15.3) | |
| **Age** | | | |
| 18-25 | 43(55.8) | 95(66.0) | 0.139 |
| Greater than 25 | 34 (44.2) | 49 (34.0) | |
| **Number of children** | | | |
| No children | 14 (26.9) | 17 (25.4) | |
| 1-2 children | 18 (34.6) | 15 (22.4) | 0.305 |
| 3-4 children | 10 (19.2) | 22 (32.8) | |
| ≥ 5 | 10 (19.2) | 13 (19.4) | |
| **Monthly household income** | | | |
| <10,000 | | | |
| 10-30,000 | 34 (44.2) | 61 (42.4) | 0.954 |
| > 30,000 | 31 (40.3) | 61 (42.4) | |
| | 12 (15.6) | 22 (15.3) | |
| **Province** | | | |
| Sindh | 48 (62.3) | 103 (71.5) | 0.33 |
| Punjab | 7 (9.1) | 12 (8.3) | |

| | | | |
|---|---|---|---|
| KPK | 22 (28.6) | 29 (20.1) | |
| **Qualification** | | | |
| Matric | 24(31.2) | 41 (28.5) | 0.720 |
| Intermediate | 38 (49.4) | 65 (45.1) | |
| Graduate | 11 (14.3) | 27 (18.8) | |
| Masters | 4 (5.2) | 11 (7.6) | |

**Table 5: Reaction to Violence among community Midwives faced Domestic Violence (n=77)**

| Reaction to Violence | N (%) |
|---|---|
| Stayed quiet | 44 (57.1) |
| Left the abusive person | 17 (22.1) |
| Replied back in anger | 16 (20.8) |

## IV.Discussion

Our study is different as it looks at Domestic violence (DV) in the first line mid-level health care providers the community midwives. They narrated their experiences of domestic violence during the "management of Domestic violence" session. This was an endeavor in sensitization and reflection. Midwives who had themselves experienced physical or sexual violence were particularly apprehensive about the prospect of introducing routine screening for domestic violence. In our study and other studies as well, midwives who had failed to resolve such experiences often felt overwhelmed by the prospect of trying to help others deal with it[14]. In a study from Leeds teaching hospital, midwives were confident in dealing with DV cases [15], whereas in our study midwives were intimidated and slowly through the workshop realized that domestic violence was a health issue.

The frequency of domestic violence in this group was 34.8% in both married and unmarried women. This finding is in compliance with the WHO report which suggests that globally 35% of women experience either physical and/or sexual violence by their intimate partners or non-partner sexual violence in their lifetime.[4]Thiscomparison, however, cannot be fully made as our research is done with a broader focus in which other family members in addition to the husband are also considered. Most of the studies on domestic violence are done with reference to intimate partner and none of the research in our knowledge has been done with a broader domain of considering all family members [16].According to the current study, the most common perpetrator of domestic violence is husband around 44%. This is sufficiently demonstrated and documented globally in research studies as well. Reports from IRIN (2007) show that 25% of women in Dakar &Kaolack in Senegal are subjected to physical violence from their partners but very few admitted that they are being beaten.[17]Stock H et al. in their systemic review on the global prevalence of violence show 30% of women who have ever been in a relationship have experienced physical violence, sexual violence, or both, from intimate partners.[18]

Strangely in our study, the second common perpetrator were relatives like uncle, aunts and neighbors, this reflects power dynamics whosoever in the family is considered elder and powerful can exercise their right of dominance, this is not so in other studies where the intimate partner is the only perpetrator[8].

According to our research, 43.8% of married women have faced violence which is in compliance with findings of UNFPA Pakistan, which stated that 40% of the ever-married women faced domestic abuse at some point in their married life.[19] Also, according to the WHO 2017 fact sheet on violence against women, 30% of women worldwide who are in a relationship, experience any kind of physical or sexual violence by their partners [20]. The main reason for violence in our group was that these girls wished to pursue education and go out for this purpose. This contributed to almost 70% of violence. This is in contrast to many studies where the main cause is low socio-economic class, poverty and illiteracy [21].

Often, men's inability to perform their role of breadwinners results in wife-beating. "In a survey by International Centre for Research on Women (ICRW) and United Nations Population Fund (UNFPA), 40% of men who reported facing economic stress admitted to perpetuating domestic violence, in comparison to the 27% of men who were not in such stress"[22]. Participants of this study, in spite of being income generators borne domestic violence as they consider it part of marriage. In fact, studies show that culturally the dignity and self-esteem of women are synonymous with being obedient to males of the family [23].

None of the health care providers reported this to legal authorities whereas in a study from Ethiopia 19% of women reported violence to authorities[24].This shows non responsiveness of our system towards dealing/acknowledging violence as an issue.

International studies have shown that marital rape and sexual violence are significant, disciplining activities occurring within the institution of marriage. Patriarchal and controlling philosophy maintains a firm grip on women's means of redressal. Generally, encounters of violence in the private sphere are hushed as shown in our study as well that more than 40 % of women were quiet and did not seek help. The honor-shame ideology is hard to miss here as women are beholders of family honor[25].

These mid-level health care providers are the initial and at times only health providers in rural settings. When they succumb to violence in their routine how will they address it for their patients and society? Our study perhaps raises more questions than answers.

The workshops we did let them unburden their issues so that they can play a vital role in preventing violence against women, helping to identify abuse early, giving them the necessary treatment, and referring women to the relevant places.

It is imperative to build safer health care facilities where women feel respected, and they can easily open up about their problems without being judged. There is a need fora responsive health care system, particularly addressing the abused women who are reluctant to seek help. The study challenges the perception that educated and empowered women are safe and free from violence.

**Strengths of the study:**

This is one of the very few studies looking at violence in educated, empowered mid-level health workers. It was very important to do so, as these health care workers looked at violence as the norm and never thought of proactively dealing with it in themselves and in their patients. Further, this study represented community midwives of all provinces from rural areas. The study has looked at the problem with a public health perspective which has shown many dimensions of the problem for generating the multidisciplinary responses.

**Limitation of study:**

This was convenience sampling at one center, whosoever was present was asked to participate. The participants were very shy and some didn't want to discuss it. Hidden under all that could be more cases which may have missed.

## V. Conclusion

Midlevel health care providers especially midwives are first line contact with patients and they need sensitization towards the health effects of DV.This study is showing that midwives were not aware of DV as a risk factor for adverse health outcomes. They themselves were victims of DV and were suffering in Silence.The health sector has a crucial part to play in the prevention of violence against women. Sustainable actions are required to eliminate violence against women from its very roots but it is subjected to the translation of political commitments into meaningful actions. In addition, the implementation of well-coordinated evidence-informed strategies must be adopted by communities,social societies and government.

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