A Health Educational Program to Improve Women's Perception Regarding Domestic Violence

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Abstract

Domestic violence is a serious public health problem that is internationally recognized due to its magnitude and the consequences on women's health and widely recognized as a serious violation of human right. Aim: The study aimed to evaluate the effect of a health educational program to improve women's perception regarding domestic violence. Design: A quasi-experimental design was applied in this study. Sample: convenient sample was equal 139 women. Setting: Association affiliated to social affairs (local society development association "women protection project" at Minia City. Tools: Three tools were used, 1st interviewing questionnaire covering two parts. Part1 demographic characteristic of women and their husbands, part 2 women's knowledge about domestic violence, 2nd tool women's attitude regarding domestic violence and 3rd tool women's reported practice. Results: The study results revealed that 57.6% of the studied women had poor knowledge preprogram which improved to 68.3% had good knowledge at post program, 75.5% had negative attitude preprogram which improved to 64.7% of women had positive attitude regarding domestic violence post program and 48% of women had moderate level of exposure to domestic violence preprogram which improved to 15.1% had moderate level of exposure at post program. Conclusion: There was a highly statistically significant positive correlation between total knowledge and total attitude. While there was highly significant negative correlation between total knowledge and total reported practice. Also there was highly significant negative correlation between total practice and total attitude at pre and post program. Recommendations: Periodic teaching courses for women about hazards and health effects of domestic violence.

Keywords: Domestic violence, health educational program and Women's perception

1. Introduction

Violence has become a global phenomenon which has weakens deep into the marrow of the family and society as a whole, to the extent that it is sometimes not seen as a societal ill, but rather accepted as a normal occurrence. Domestic violence is 'misuse of power by a husband or intimate partner against a woman, resulting in a loss of dignity, control and safety as well as a feeling of powerlessness and entrapment experienced by the woman (1).

Violence against women occurs in all countries of the world and remains one of the most serious unresolved problems of our time. Despite progress in the development of international legal norms, standards and principles, the creation of international legal and political structures that monitor the various forms and types of violence committed both in public places and in the family, progress in reducing the level of violence against them is small (2).

Domestic violence is one of the most common types of violence against women that exists in all societies and among rich as well as poor women. The term domestic violence refers to the abuse taking place usually between husband and wife, or between other present or former cohabiting partners. Other terms that are often used to describe domestic violence include: intimate partner violence, battering, wife/ spouse/partner abuse (3).

Domestic violence is the preferred term as it is more descriptive in defining the type of relationship the subjects are involved in—however, it says nothing about the direction of this violence. Even though this is one of the most common forms of violence directed at women, the term domestic violence needs to be made specific by adding ''against women'' to exactly describe the phenomenon (4).

Domestic violence is a serious and widespread problem worldwide. Apart from being violations of human rights, they profoundly damage the physical, sexual, emotional, mental and social well-being of women and families. The immediate and long-term health outcomes that have been linked to these types of violence encompasses physical injury, unwanted pregnancy, abortion, gynecological complications and sexually transmitted infections (including HIV/AIDS). There are also a number of pregnancy-related complications such as miscarriage, premature labour and low birth weight associated with violence during pregnancy. In addition, high-risk behaviors such as smoking, harmful use of alcohol and drugs are significantly more frequent among victims of intimate partner violence (5).

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Intimate partner violence against women can be exercised either as physical, sexual, psychological violence, or any combination of these. Studies from United States of America (USA) and Mexico, estimated that 40%–52% of women experiencing physical violence by an intimate partner have also been sexually coerced by that partner. Battering as a separate category of partner abuse distinguished from physical assault by its longstanding, continuous nature and battering has been defined as "a process whereby one member of an intimate relationship experiences psychological vulnerability, loss of power and control and entrapment as a consequence of the other member's exercise of power through the patterned use of physical, sexual, psychological and/or moral force (6).

Women's health education promotes living in good life. In general, healthy women learn better. Numerous studies have shown that healthier women tend to do better in their life. They have higher self-confidence, have better life and perform better on different life situation. Health literacy and education initiatives to raise awareness promote healthy behaviors and provide women with the knowledge and skills to make informed decisions, to support good health and wellbeing must be encouraged (7).

Community health nurses could play a central part in raising awareness among the women and community to prevent domestic violence. To openly debate this subject is a way to reduce society's tolerance towards violence against women. There is still limited knowledge about what interventions are most effective for the prevention of domestic violence, however health education and evaluation are keys elements in building knowledge among women to prevent violence against women and its consequences on the family health as awhole. (7).

1.1 Significance of the Study

Violence against women in Egypt, particularly spousal violence, is rooted in the subordinate position of women in the family and society. The stigma against divorced women, for example, puts Egyptian women who had a previous marriage at highest risk of abuse; they are twice as likely as women who are in their first marriage to be physically abused by their husband recently. Poor and less-educated women who generally tend to marry at a younger age are more likely to experience spousal violence than those who marry later and have more education. Gender-based violence is more common among less privileged women (8).

In Egypt, the result of Egypt demographic health survey conducted at 2014 found that more than 1 in 3 women experiencing spousal physical or sexual violence are injuries as a result of the violence and 7 % have serious injuries. Three in 10 ever married women age 15 – 49 years have experienced some form of spousal violence as 25 % of them physical violence, 19% emotional violence and 45% sexual violence (9).

While domestic violence remains a serious and frequent aspect of women's intimate relationships and women and children suffer health consequences as a result, community health nurses have a significant role to play in working toward the prevention and early intervention of domestic violence (10). Therefore, this study was conducted to improve women's perception regarding domestic violence.

1.2 Aim of the study

The aim of this study to evaluate the effect of A health educational program to improve women's perception regarding domestic violence through:

Assessing women's knowledge, attitude and reported practice regarding domestic violence.

Designing and implementing a health educational program for women about domestic violence.

Evaluating the effect of a health educational program to improve women's perception regarding domestic violence.

2. Research Hypothesis

Women's knowledge, attitude and practices will be improved after implementing a health educational program about domestic violence.

Subject and Methods

2.1 Technical item

The technical item includes **(**study design, setting, subject and tools for data collection).

Study Design

A Quasi-experimental study design was applied to achieve the aim of this study.

Study Settings

The study has been carried at associations affiliated to social affairs (local society development association **"**women protection project**"** at El Minia City).Which chosen due to introducing many services for women. have consulting and supporting office for women which provide guidance, counseling and hosting for battered women.

Subjects

A convenient sample was equal 139 women attended at the association. The calculation of sample size done based on power analysis.

Tool for data collection

Data was collected using the following tools:

1st A structure interviewing sheet was designed based on literature review and approved by supervisors. It was written in simple Arabic language and consists of two parts:

Part I

Demographic characteristics of the women and their husbands include age, educational level, marital status, place of residence, occupation and monthly income it composed of 10 closed/ended questions (Q1:Q10).

Part II:

Concerned with women's knowledge about domestic violence. It covering 10 questions items from (Q11:Q20).

Scoring system: The Women's knowledge was checked with a model key answer and accordingly. Women's knowledge was categorized into "complete answer 2

grade, incomplete answer 1 grade and don't know zero". Total scores were 20 grades for 10 items. These scores were be stumped and converted into a percent score. It was classified into 3 categories:

- Good knowledge score ≥ 75% (15-20 grades).
- Average knowledge score from 50%-<75% (10-<15 grades).
- Poor knowledge score <50% (0-<10 grades).

2nd tool: Concerned with women's attitude about domestic violence developed by (Fox and Gadd, 2012). Covering 14 questions, from (Q21:Q34) Pre/post.

Scoring system: Each item was evaluated as Likert scale "Agree, Neutral and disagree" 3, 2, 1 respectively, total scores was 42 point. The scores of each item summed up and then converted into a percentage score. It classified into 2 categories:

- Positive attitude: if score ≥ 60% (26-42 grades).
- Negative attitude: if score < 60% (14<26 grades).

3rd tool: Concerned with women's reported practice about domestic violence (WHO, 2014). Which consist of 19 items for controlling behaviors by husband covering 6 items, psychological violence covering 4 items, physical violence covering 6 item, and sexual violence covering 3 item (Pre/post). Contain four sections from (Q35:Q53).

Scoring system women's reported practice designed to be answered by always, sometimes and never. Scores of each item ranged from three to one (always=3, sometimes=2 and never=1) respectively. Total scores were 57 grades for 19 items. The scores of each item summed up and then converted into a percentage score. It classified into 3 categories:

- High level of exposure: ≥ 75% (43-57 grades).
- Moderate level of exposure: 50% - <75% (29-<43 grades).
- Low level of exposure: < 50% (19-<29 grades).

Validity:

The validity of the tools were tested through a panel of three experts from Community Health Nursing Faculty Staff to review relevance of the tools for, comprehensiveness, accuracy, understanding and applicability.

Reliability

Testing the reliability of the tools through Alpha Cronbach Reliability analysis.

Items	No. of items	Alpha Cronbach	F	p-value
Women's knowledge regarding domestic violence	10	0.857	3.251	.007**
Women's attitude regarding domestic violence	14	0.870	3.500	.000**
Women's Reported practice regarding domestic violence	19	0.896	3.722	.000**

Ethical consideration

Ethical consideration was be gained from scientific ethical committee of Helwan University; in addition to verbal and written informed consent was be attained from each participant prior to data collection they were be assured that anonymity and confidentiality were be guaranteed and the right to withdraw from the study at any time. Ethics, values, culture and beliefs were be respected.

2.2 Operational item

The operational item includes preparatory phase, pilot study and field work.

Preparatory phase

A review of the past and current literature related to domestic violence and prevention ways. Covering all aspects helpful in designing and processing of data collection tools were available books, Journals, Internet and article.

Pilot study

Pilot study has been conducted to test the applicability, clarity and the efficiency of the tools. It has been conducted on a sample of 14 women. The results of the pilot helped in refining the interview questionnaire and to schedule the time framework. The participants of the pilot were included in the main study sample.

Field work

Before conducting the study, an official permission was obtained from the Dean of Faculty of Nursing, Helwan University to the director of local society development association "women protection project" at El Minia City. The researcher met the women and explained the aim of the study and components of the tools to them. Formal consent was secured before collecting data.

The researcher distributed questionnaire to studied women for assess their knowledge, attitude and reported practice at pre intervention phase. The researcher educate the women about domestic violence after divided them into six groups and each group was educated about six session each one 20-30 minutes. The Educational program was developed based on the result of pretest questionnaire sheet. The plan of health educational program was prepared, implemented and evaluate the degree of improvement in study group condition in relation to objective.

Heath educational program was conducted through four phases: preparatory, assessment, planning, implementation and evaluation.

1. Preparatory phase: tools of data collection development review of the past and current related literature covering various aspects of domestic violence.
2. Assessment phase: Before start the designed health educational program, the study tool was applied to assess women's knowledge, attitude and reported practices regarding domestic violence.
3. Planning and implement phase: by developing the health educational program content, the objective was to improve women's knowledge, attitude and reported practices regarding domestic violence; it was explained to all women participants. The studied women were divided into 6 groups (five groups contained 23 women and 1 group contained 24 women). The guideline was applied through six sessions,

each group received six sessions, and each session took about 20-30 minutes every group at the setting.

4. Guideline program include 6 sessions (four theoretical sessions, one session practical and last session to evaluated and make post-test).

5. Evaluation phase: post-test was done to evaluate the effect of the program; the post test was done immediately by end of the sessions using the same tools of pretest evaluation.

2.3 Administrative item

An official permission approval was obtained from the Dean of Faculty of Nursing at Helwan University and official permission from the director of local society development association "women protection project" to conduct the study. This letter included a permission to collect the necessary data and explain the purpose and nature of the study.

2.4 Statistical analysis item

Data collected from the studied sample was revised, coded and entered using Personal Computer. Computerized data entry and Statistical analysis were fulfilled using the Statistical Package for Social Sciences (SPSS) version 24. Data were presented using descriptive statistics in the form of frequencies, percentages. Chi-square test (X2) was used for comparisons between qualitative variables. Spearman correlation measures the strength and direction of association between two ranked variables.

3. Results

Table (1) shows that, 37.4% of the studied women their age ranged between 30<40 years, the mean of age was 36.29 ± 5.7 year. In relation to the educational level of the women 33.1% of them had secondary education. As regard to marital status, 76.3% of the studied women were married. Concerning places of residence, 52.5% of them residing in rural areas. Regarding occupation, 71.2% of the women were housewife. In addition, 71.9% of the women their monthly income were not adequate.

Figure (1) shows that, 57.6%, 18% and 24.4% of the studied women had poor, average and good knowledge regarding domestic violence preprogram, respectively, which improved to 68.3%, 21.6% and 10.1% of studied women had good, average and poor knowledge respectively post implement the program.

Figure (2) clarifies 75.5% and 35.3% of studied women had negative and positive attitude respectively preprogram, which improved to 64.7% and 24.5% of studied women had positive and negative attitude respectively post implement the program.

Figure (3) shows that, 28.1%, 48.9% and 23% of the studied women had low level, moderate level and high level of exposure to domestic violence respectively pre the program, which improved to 5.8%, 15.1% and 79.1% of women had high level, moderate level and low level of exposure to domestic violence post implement the program.

Table (2) shows that, there were highly statistically positive correlation between total knowledge scores among the studied women's regarding domestic violence and their attitude scores at post a health educational program (P= < 0.01).

Table (3) shows that, there were highly statistically negative correlation between total knowledge scores of the studied women's regarding domestic violence and their reported practice scores at post a health educational program (P= < 0.01).

Table (4) shows that, there were highly statistically negative correlation between total reported practice scores of the studied women's regarding domestic violence and their total attitude scores at post a health educational program (P= < 0.01).

Table (1): Frequency distribution of studied women related to their demographic characteristics (n= 139).

Demographic characteristics for women	no.	%
Age / year		
20-<30	42	30.2
30-<40	52	37.4
40-<50	30	21.6
≥ 50	15	10.8
Mean ± SD 36.29 ± 5.7 year		
Educational level		
Not read and write	34	24.5
Read and write	20	14.4
Basic education	18	12.9
Secondary education	46	33.1
University and more	21	15.1
Marital status		
Married	106	76.3
Divorced	33	23.7
Residence		
Urban	66	47.5
Rural	73	52.5
Occupation		
Work	40	28.8
Housewife	99	71.2
Monthly income		
Adequate	30	21.6
Not Adequate	100	71.9
Adequate and save	9	6.5

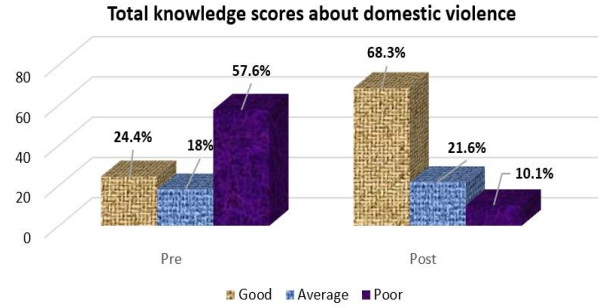

Figure (1): Percentage distribution of the studied women according to their total knowledge scores about Domestic Violence at Pre and Post health educational program (n=139)

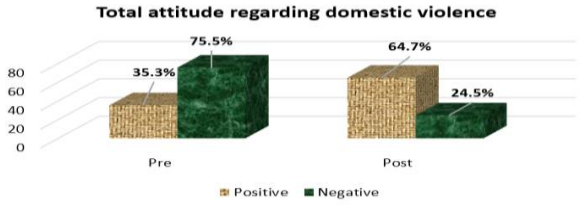

Figure (2): Percentage distribution of the studied women according to their total attitude regarding Domestic Violence at Pre and Post a health educational program (n=139)

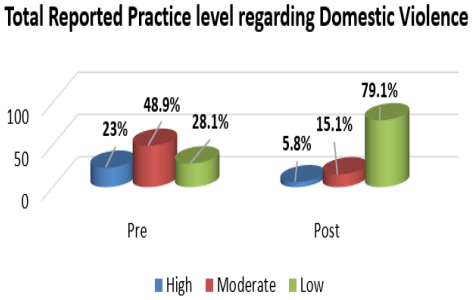

Figure (3): Percentage distribution of the studied women according to their total reported practice regarding Domestic Violence at Pre and Post a health educational program (n=139).

Table (2): Correlation between women's' knowledge and their attitude towards domestic violence at post a health educational program.									
Variables		Levels of total knowledge at post implementation of health educational program						X2	P- Value
		Good (n=95)		Average (n=30)		Poor (n=14)			
		N	%	N	%	N	%		
Total attitude	Positive	95	100	10	33.3	0	0.0	15.60	.000**
	Negative	0	0.0	20	66.7	14	100		
Pearson correlation coefficient		r=.437 p= .000**							
**highly significant at p ‹ 0.01. r=Correlation Coefficient									

Table (3): Correlation between women's' knowledge and their reported practice towards domestic violence at post a health educational program.									
Variables		Levels of total knowledge at post implementation of health educational program						X2	P- Value
		Good (n=95)		Average (n=30)		Poor (n=14)			
		N	%	N	%	N	%		
Total reported practice	High	0		0		8		14.99	.000**
	Moderate	0	0.0	15		6			
	Low	95		15		0			
Pearson correlation coefficient		r= -.488 p= .000**							
**highly significant at p ‹ 0.01. r=Correlation Coefficient									

Table (4): Correlation between women's' attitude and their reported practice towards domestic violence at post a health educational program.									
Variables		Levels of total reported practice at post implementation of health educational program						X2	P- Value
		High (n=8)		Moderate (n=21)		Low (n=110)			
		N	%	N	%	N	%		
Total attitude	Positive	0	0.0	0	0.0	105		14.70	.000**
	Negative	8	100	21	100	5			
Pearson correlation coefficient		r= -.413 p= .000**							
**highly significant at p ‹ 0.01. r=Correlation Coefficient									

4. Discussion

Violence against women is widely recognized as an important public health problem, owing to its substantial consequences for women's physical, mental and reproductive health. Domestic violence against women is universal phenomenon that persists in all countries of the world and a major contributor of ill health of women. The social, sexual, reproductive health and wellbeing of millions of individuals and families is adversely affected by violence (14). Therefore, the aim of this study to evaluate the effect of a health educational program to improve women's perception regarding domestic violence.

The present study finding showed that, more than one third of the studied women their age ranged between 30-<40 years with the mean age was 36.29

± 5.7 year. This result was approved with the study performed by (15). in Egypt on entitled as "Prevalence and predictors of intimate partner violence among married women in Egypt" and showed that 37.8% of the studied women their age ranged between 30-<40 years. In the same field, this result was similar with the result of study performed by (16). in Riyadh, Saudi Arabia on 720 women entitled as "Prevalence and risk factors of domestic violence against women attending a primary care center" who stated that, more than one third of women under study their age ranged between 30-<40 years. From the researcher point of view, this result might be due to this age group considered high risk for exposure to domestic violence.

Regarding to women's educational level the present study showed that, about one-third of the studied sample had secondary education. This result was congruent with (17). in Tanzania on 403 women and entitled as " Knowledge, experience and perception of gender-based violence health services: a mixed methods study on adolescent girls and young women" whose mentioned that 33.8% of the studied women had secondary education. These results may be due to the different culture of the community and the different concept of women's education in society.

Regarding to marital status, the present study illustrated that more than three quarters of the studied women were married. This result was consistent with result of (18). in Tanzania carried out on 1049 women entitled as "Prevalence of intimate partner violence and abuse and associated factors among women enrolled into a cluster randomized trial in northwestern Tanzania" whose proved that 78% of participants were married. From the researcher point of view, these results might be due to that women whose getting married at young ages are more exposed to domestic violence more than women whose getting married in adulthood.

Regarding to residence and occupation, the present study findings reported that, more than half of the studied women residing in rural areas and less than three quarters of them were housewife. This finding was similar with the study done by (19). in Ghana on 1024 married women entitled as "Determinants of domestic violence against women" whose revealed that 53% of the studied sample were living in rural areas and 71.8%of them were housewife. On the other hand, this finding incongruent with study done in Turkey on 762 women by (20). whose conducted study about "Determination of the factors affecting sexual violence against women in Turkey" and reported that less than three quarters of the studied women living at urban areas. From researcher point view, these results might be due to different social beliefs which play an important role such as prevent women's work outside home or considering women's work inappropriate or unnecessary.

Concerning to monthly income, the present study illustrated that less than three quarters of the studied women their monthly income was not adequate. This result was approved with the study done in Brazil on 1046 women by (21). entitled as "Effects of socioeconomic status and social support on violence against women" whose stated that 71.4% of women were housewife. Also, 71,4% of them their monthly income were not adequate. These results might be due to high standard of living and high prices of products which makes family income not adequate.

Regarding to total knowledge about domestic violence, the current study showed that more than half of the studied women had poor knowledge about domestic violence before the program, while improved to more than two thirds of them had good knowledge after program implementation. This finding was consistent with (22). in their study which conducted in Sahneh city, Iran on 274 pregnant women about "The effect of family-based counseling intervention on domestic violence in pregnant women referring to health centers" and revealed that, there was a marked improvement in women's knowledge regarding domestic violence at post implementation of the intervention as evidence, the most of studied women had good knowledge regarding domestic violence post implementation of family-based counseling intervention. This result might due to effectiveness of health program to improve knowledge.

On other hand, this result was disagreement with the finding from study in Nepal on 127 women by (23). about "Knowledge and experience of domestic violence among women in Jaimini municipality of Baglung" and stated that more than ninety percent respondents had a high level of knowledge about domestic violence without any intervention. This discrepancy could be due to a difference in the tools used to assess knowledge level and educational level among studied sample.

Regarding total attitude regarding domestic violence, the present study illustrated that there was a marked improvement in total women's attitude regarding domestic violence at post implementation of health educational program with highly statistically significant difference at (P= < 0.01) between pre and post implementation of health educational program. As evidence, more than three quarters of studied women had negative attitude before the program, while improved to less than two thirds of them had positive attitude after the program. These results were consistent with study done by (24). in England on 181 women entitled as "Community-based intervention for women exposed to intimate partner violence" and reported improvement of attitude regarding domestic violence after intervention with highly statistically significant difference at (P= < 0.01) between pre and post implementation of intervention. These results might be due to the role of educational program in improving women's attitude regarding domestic violence.

Concerning to total reported practice regarding domestic violence at pre and post health educational program, psychological was the common while

sexual was the lowest type of domestic violence. Moreover, there was a marked difference in women's total reported practice regarding domestic violence post program with highly statistically significant difference at (P= < 0.01) between pre and post implementation of health educational program. As evidence, less than half of them had moderate level of exposure to domestic violence preprogram, where changed to more than three-quarters had low level of exposure to domestic violence post program. These results were approved with the study performed by (25). in Bihar on 197 women entitled as "Interventions for preventing violence against women and girls" and found that there was a marked improvement in women's reported practice regarding domestic violence at post interventions. This result could be due to that the intervention program was planned based on true met needs identified during the assessment phase of the study.

Related to the correlation between women's' knowledge and their attitude towards domestic violence at pre- and post-educational program, the current study showed that, there were highly statistically positive correlation between total knowledge scores among the studied women's regarding domestic violence and their attitude scores at pre and post health educational program (P= < 0.01). This could be explained as; correct knowledge was higher among women with positive attitude. These results were harmony with study Libyan Migrants in the UK on 175 women by (26). about "Attitudes to and perceptions of domestic violence against women in an Arab community" who found that there was statistically positive correlation between total knowledge scores among the studied women's regarding domestic violence and their attitude scores. This result might be due to person knowledgeable had ability to deal with their stress and problems in addition increase knowledge lead to improve attitude.

Regarding to the correlation between women's' knowledge and their reported practice towards domestic violence at pre and post a health educational program, the current study presented that, there were highly statistically negative correlation between total knowledge among the studied women's regarding domestic violence and their reported practice scores at pre and post program (P= < 0.01). These results were supported with study done by (25). Whose found that good knowledge was higher among women with positive reported practice. This could be explained as; correct knowledge was higher among women with correct practices

Regarding to the correlation between women's' attitude and their reported practice towards domestic violence at pre and post program, the current study presented that, there were highly statistically negative correlation between total attitude scores among the studied women's regarding domestic violence and their reported practice scores at pre and post (P= < 0.01). These results were supported with study conducted by (27). in Canada on 180 women entitled as "Promoting wellness and perception of young women experiencing gender-based violence and homelessness: the role of trauma-informed health promotion interventions" and revealed that there was highly statistically negative correlation between total attitude scores among the studied women's regarding domestic violence and their reported practice scores at pre and post interventions. This could be explained as; positive attitude was higher among women with correct practices.

5. Conclusion

On the light of results of the current study and answers of the research questions, it could be concluded that; there was 57.6% of women had poor knowledge regarding domestic violence preprogram which improved post program. As regard to women's attitude findings represented that, 75.5% of women had negative attitude before the program, which improved to positive attitude post program. Concerning women's reported practice results indicated that, 28.1%, 48% and 23% of women had low, moderate and high level of exposure to domestic violence. While, improved to 5.8%, 15.1% and 79.1% of them had high, moderate and low level of exposure to domestic violence post program. Moreover, there were statistically significant relation between total knowledge of the studied women and their demographic characteristics at pre and post a health educational program (p=<0.05%). Also, there was highly significant positive correlation between total knowledge scores among the studied women regarding domestic violence and their attitude scores. While there was highly significant negative correlation between total knowledge scores among studied women and their reported practice scores. Also, there was highly significant negative correlation between total practice scores among the studied women and their total attitude scores regarding domestic violence at pre and post the program (p=<0.01%).

6. Recommendation

On the light of the current study findings the following recommendations are suggested;

1. Periodic teaching courses for women about hazards and health effects of domestic violence.
2. Continuous implementing educational program for women about prevention and control of domestic violence.
3. Further health educational programs on a large sample and other settings are needed using multi-disciplinary approach.

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