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Abstract

Background: Lack of diagnosis and reporting of child maltreatment are important problems worldwide.

Aims: This study aimed to assess the knowledge, attitude and practice of physicians in Alexandria University teaching hospitals about the diagnosis and reporting of child maltreatment cases.

Methods: A descriptive cross-sectional study was conducted at three hospitals. All physicians working regularly in emergency units were invited to complete a self-administered questionnaire. Data collected included sociodemographic characteristics, knowledge of and formal training on child maltreatment, attitude to dealing with child maltreatment, and experience of child maltreatment cases and reporting behaviour.

Results: A total of 90 physicians were included in the study. Only 11% correctly identified all the signs of child maltreatment and 29% correctly answered all questions on the social indicators of maltreatment. Only 41% of the participants had a good knowledge score (≥ 75%) on child maltreatment. Longer work experience (P = 0.019) and older age (P = 0.039) were associated with better knowledge. Of 249 suspected cases of child maltreatment that the physicians reported they had experienced, only 36% were reported. Formal training on child maltreatment (P

Conclusion: Physicians' knowledge of the signs and social indicators of child maltreatment was unsatisfactory. Clinical training and education are needed to improve their ability to diagnosis and report cases of child maltreatment.

Keywords: child abuse, physicians, knowledge, university hospitals, Egypt

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Introduction

Child maltreatment is a problems in all countries, possibly because of failure in committing to child rights (1). The World Health Organization (WHO) estimated in 2016, that 1 in 2 children aged 2–17 years had suffered violence in the past year. Boys and girls are at equal risk of physical and emotional abuse and neglect, and girls are at greater risk of sexual abuse (2).

Lack of diagnosis and reporting of child maltreatment were considered the main problems in stopping the maltreatment in up to 75% of cases (3). Reporting all cases of child maltreatment is vital in order to prevent further exposure, protect children and enhance coordination between legal, medical and social services. However, physicians need preparation for the ethical and legal challenges in cases of child maltreatment. This is considered necessary because evidence suggests that, on their own, physicians are not able to deal with these challenges when confronted with them (4–6).

Few studies about child maltreatment in Egypt are available. One study estimated that 91% of children in Egypt are exposed to child abuse with varying degrees of severity (7). In Egypt, law No. 126 ensures a child's right to be protected from all forms of violence (8). However, no law states the mandatory reporting of child maltreatment and penalties of non-reporting. In this study we, aimed to assess the knowledge, attitude and opinion of physicians in Alexandria University teaching hospitals about the diagnosis and reporting of child maltreatment as an important first step to developing interventions and setting laws and legislations to protect children from maltreatment.

Methods

Setting and sample

We conducted a descriptive cross-sectional study from July to December 2018 at three hospitals affiliated to Alexandria University: Main University Hospital, El-Shatby hospital and El-Hadara hospital. Our sample was all physicians (residents, teaching assistants and assistant lecturers) working in the emergency units of these hospitals on a regular basis who had frequent contact with child maltreatment cases and were willing to participate in the study.

Data collection

We used a structured self-administered questionnaire for data collection adapted from other questionnaires (9–11). The questionnaire was in English. We tested the validity and reliability of the questionnaire before use. First, we asked three Egyptian experts in the field of medical education and research at the Faculty of Medicine to assess the degree to which items in the questionnaires were relevant and could correctly measure the knowledge and attitudes of participants regarding child maltreatment. As a result of their feedback, we modified questions on the causes of underreporting and not taking action if child maltreatment was suspected to include the main possible causes relevant to the Egyptian culture.

We then pretested the questionnaire on 14 physicians who we excluded from the later study sample. They completed the questionnaire twice, 3 weeks apart. We assessed internal consistency and reliability using the Cronbach alpha and the test–retest reliability using intraclass correlation coefficient. The results showed adequate internal consistency and reliability: Cronbach alpha = 0.82 and the intraclass correlation coefficient = 0.94). The pilot study also indicated some modifications were needed to the structure of the questionnaire (e.g. using simple, familiar words and clarifying some sentences).

The questionnaire had five main sections:

Sociodemographic characteristics of the physicians (age, sex, years of experience and highest scientific degree) and formal child maltreatment training.

Knowledge of physicians about child maltreatment, e.g. knowledge of signs and symptoms of child maltreatment, different forms of child maltreatment and to which legal authority child maltreatment cases should be reported.

Attitudes of physicians to child maltreatment using a five-point Likert scale and their opinions on the main causes of underreporting of child maltreatment cases.

Experience of physicians of cases of child maltreatment, their reporting behaviour with suspected cases of child maltreatment and barriers to reporting suspected cases.

Physicians' satisfaction with their knowledge of child maltreatment and procedures of dealing with child maltreatment, and their desire to improve their knowledge and how they could do this.

The physicians completed the questionnaire with a researcher available for any questions. As the researcher dealt with the respondents personally, there was no risk of the same physician

completing the questionnaire more than once. The questionnaire took on average about 15–20 minutes to complete.

Data analysis

We used SPSS, version 20.0 for data entry and analysis (12,13). For testing associations between qualitative variables, we used the chi-squared, Fisher exact and Monte Carlo tests. For normally distributed quantitative variables, we used a two-sample t-test to compare between two groups and ANOVA to compare between more than two groups. We considered $P \leq 0.05$ statistically significant.

For each knowledge question, we assigned a score of 1 for a correct answer and 0 for an

incorrect answer. The maximum total score was 21. We summed the scores and calculated the total percentage score. We rated the total percentage scores as follows: