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Screening, Identification, and Medical-Psychological Services for Domestic Violence Survivors in Inpatient Primary Health Centers in Kendari City

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ABSTRACT:
Background: Domestic violence is a public health problem with physical, psychological, and social consequences.
Objective: This study aimed to analyze the role of healthcare workers in screening, identifying, and providing medical and psychological services for domestic violence survivors at inpatient primary health centers in Kendari City.
Methods: This qualitative descriptive study used in-depth interviews, observation, and documentation involving 16 informants. Data were analyzed thematically using NVivo.
Results: Screening was mainly conducted through clinical observation and trust-based communication rather than consistent use of standardized tools. Identification relied on visible injuries, recurrent psychosomatic complaints, and private anamnesis. Medical care was prioritized, while psychological support was limited by the absence of psychologists, restricted counseling rooms, and uneven training.
Conclusion: Domestic violence screening and identification at primary health centers remain reactive and insufficiently standardized. Strengthening SOPs, healthcare worker training, referral pathways, and psychological support services is needed.

KEYWORDS: Domestic violence, screening, primary health care, healthcare workers, psychological support

INTRODUCTION

Domestic violence (DV) is one of the most common forms of human rights violations worldwide. United Nations data estimate that approximately 736 million women, or one in three women globally, have experienced physical and/or sexual violence at least once in their lifetime [1]. In Indonesia, the Ministry of Women Empowerment and Child Protection recorded at least 21,649 cases of violence against women and children in 2024, with multidimensional impacts including physical injuries, severe psychological disorders such as depression, anxiety, and post-traumatic stress disorder (PTSD), social isolation, and economic losses [2,3].

In Southeast Sulawesi, SIMFONI PPA data up to mid-2025 recorded 116 cases of violence against women and 184 cases of violence against children. Meanwhile, in Kendari City, the Office of Women Empowerment and Child Protection reported 25 cases during January-May 2025, 20 of which involved children, with most cases involving sexual violence. Although these figures do not fully reflect the reality in the field because many cases remain unreported due to stigma and a strong patriarchal culture, the data emphasize the urgency of strengthening DV detection and response systems at the local level [4,5].

Healthcare workers in primary healthcare facilities, particularly primary health centers, are strategically positioned as the first parties to interact with victims of DV. Their role includes screening, symptom identification, initial medical and psychological care, and referral to further services. However, various studies have shown that this role remains far from optimal. Only about 40% of healthcare workers have ever received specific training related to DV [6]. The absence of standardized SOPs, limited training, and sociocultural barriers are key obstacles that cause many cases to remain unidentified at an early stage [7,8].

Previous studies in Brazil [9], Ethiopia [10], and Indonesia [11] consistently demonstrate that health service system readiness to respond to DV remains low, especially in primary care facilities. Iskandar et al. [11], in a study conducted in primary health centers in Jakarta, found that the prevalence of intimate partner violence reached 36.3% among examined women, a figure much higher than official reports. This finding indicates the substantial potential of active screening that has not yet been fully utilized.

This study aimed to analyze in depth the role of healthcare workers in screening and identifying victims of DV and in providing medical and psychological services at inpatient primary health centers in Kendari City in 2025. The study is expected to contribute to strengthening evidence-based early detection and DV management systems at the local level.

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MATERIALS AND METHODS

This study used a qualitative approach with a descriptive design to explore in depth the role of healthcare workers in screening, identification, and the provision of medical and psychological services for victims of DV. A qualitative approach was selected because it enables the researcher to understand the phenomenon from the perspectives of direct field actors (informants) in a holistic and contextual manner.

The study was conducted in five inpatient primary health centers in Kendari City, namely Lepo-Lepo Primary Health Center, Abeli Primary Health Center, Poasia Primary Health Center, Kandai Primary Health Center, and Puuwatu Primary Health Center, as well as at the UPTD PPA of Kendari City and Bhayangkara Hospital as cross-sector partner institutions. The study was conducted from November to December 2025.

Study Design and Informants

Informants were selected using purposive sampling with the following criteria: healthcare workers directly involved in services for victims of violence against women and children, UPTD PPA and Bhayangkara Hospital officers who coordinated with primary health centers, and DV survivors who were willing to become informants. A total of 16 informants participated in this study, consisting of five primary health center physicians (IU.DK), five primary health center midwives (IU.BD), one head of a primary health center (IP.01), one Bhayangkara Hospital officer (IP.02), one UPTD PPA officer (IP.03), one police officer (IP.04), and two DV survivors (IP.05 and IP.06).

Data Collection Techniques

Data were collected using three methods: in-depth interviews using a semi-structured interview guide, direct observation of facilities and service practices at primary health centers, and documentation of medical records, case registers, SOPs, and available screening forms. Source and method triangulation were used to ensure data validity.

Additional Data Collection Procedure

The interviews were conducted using a semi-structured guide, but informants were still given space to describe their experiences freely. Interviews were carried out in a private and comfortable setting, particularly when speaking with domestic violence survivors. Before data collection, the researcher explained the study objectives, voluntary participation, confidentiality, and the right to withdraw from the interview. Written informed consent was obtained from all informants. With the informants' permission, interviews were recorded, and field notes were also written during and after the interview. Most interviews lasted approximately 30–60 minutes. Data collection was continued until the information obtained from informants became repetitive and no major new themes appeared.

Data Analysis

Data were analyzed thematically using NVivo software. The analysis process included verbatim transcription of interview results, open coding to identify initial categories, focused coding to group categories into themes, and preparation of thematic narratives. Data credibility was examined through member checking, triangulation, and peer debriefing.

RESULTS

Screening and Identification of DV Victims

All primary health centers included in this study had DV case registration books and the Women Abuse Screening Tool (WAST) as an official screening instrument. However, the findings showed that the use of this instrument was not yet consistent in daily practice. Screening was generally conducted when healthcare workers suspected a possible case of domestic violence, rather than as a routine procedure for all female patients.

Healthcare workers usually began the identification process through clinical observation. They paid attention to visible injuries, emotional expressions, repeated complaints, and the way patients explained their condition. Some patients came with direct physical injuries, while others presented with complaints such as recurrent headaches, sleep disturbances, abdominal pain, body aches, or anxiety. These symptoms often encouraged healthcare workers to ask further questions, especially when the complaints appeared repeatedly or did not match the patient's explanation.

A physician at Lepo-Lepo Primary Health Center explained:

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"*However, most of them do not come saying that they are victims of domestic violence. Instead, they come with medical complaints, such as pain, or psychosomatic complaints, such as recurrent headaches, sleep disturbances, abdominal pain, body aches, or anxiety*."

Privacy was also important in the identification process. Several healthcare workers stated that victims were more willing to speak when they were separated from the person accompanying them, especially when the companion was the husband or another family member. A midwife at Kandai Primary Health Center noted that some victims only started to explain their real condition after the companion was asked to wait outside.

The physical signs most often used as the basis for suspicion included bruises in unusual locations, swollen eyes, repeated injuries, and explanations that were inconsistent with the injury pattern. However, healthcare workers also recognized that not all victims showed clear physical signs. Because of this, communication style, trust-building, and private anamnesis became important parts of the identification process.

Table 1. Characteristics of Study Informants

Code	Informant Category	Location	Number
IU.DK	Primary health center physicians	Five inpatient primary health centers	5 persons
IU.BD	Primary health center midwives	Five inpatient primary health centers	5 persons
IP.01	Head of primary health center	Five inpatient primary health centers	1 person
IP.02	Bhayangkara Hospital officer	Bhayangkara Hospital Kendari	1 person
IP.03	Head of UPTD PPA	UPTD PPA Kendari City	1 person
IP.04	Police officer	Kendari City Police	1 person
IP.05-06	DV survivors	Kendari City	2 persons

Source: Primary Data, 2025

Medical Services for DV Victims

All primary health centers prioritized medical services when victims arrived. The procedures followed the standard flow of triage, physical examination, wound treatment, and patient stabilization. Documentation was conducted through electronic medical records integrated across all service units.

However, there was significant variation in the completeness of documentation. Cases accompanied by police referral letters received more complete documentation, including injury photographs for visum et repertum purposes. In contrast, cases identified clinically without legal procedures were often recorded only as clinical diagnoses without specific notes related to DV.

A physician at Poasia Primary Health Center stated: "The first step we take is to provide medical services according to the patient's needs. After the patient's condition has been treated, we use a communicative approach to identify the patient's further needs."

The main challenge in medical services was the difficulty of identifying victims who came without explicitly reporting DV. Healthcare workers reported that victims commonly presented with psychosomatic complaints, such as recurrent headaches, sleep disturbances, abdominal pain, and anxiety. These complaints often required healthcare workers to explore the patient's condition more carefully through gradual and private communication.

Psychological Services and Emotional Support

Psychological support was mostly provided through empathic communication by healthcare workers. This included listening to the victim, giving emotional support, validating the victim's feelings, and encouraging the victim not to normalize violence. The support was usually given by doctors or midwives because psychologists were not available in the primary health centers included in this study.

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A midwife described this limitation:

"*There happens to be no psychologist here, but I am the one who often provides counseling together with Dr. Zahra*."

Some primary health centers conducted mental health screening, especially for pregnant women accessing maternal and child health services. However, this screening was not specifically designed for all domestic violence survivors. Victims who showed severe signs of depression, anxiety, or emotional distress were usually referred to psychiatric clinics or mental hospitals.

The availability of private counseling rooms was also limited. Most primary health centers used available rooms depending on the situation. Only Poasia Primary Health Center and Kandai Primary Health Center had rooms that were considered more suitable for private counseling. Healthcare workers stated that the lack of a dedicated room made it difficult to provide emotional support in a safe and comfortable setting.

Table 2. Summary of Findings on DV Screening, Identification, and Medical-Psychological Services

Aspect	Findings	Barriers
Screening	Conducted situationally using clinical observation; WAST was available but not used consistently	No universal SOP, limited training, social stigma
Identification	Based on physical signs, psychosomatic complaints, and in-depth anamnesis in private settings	Victims often hide their condition, fear stigma, and experience economic dependence on the perpetrator
Medical Services	Prioritized wound treatment and stabilization; documentation through electronic medical records	Variation in documentation completeness; visum only when accompanied by a police referral letter
Psychological Services	Empathic communication by healthcare workers; mental health screening among pregnant women	No psychologists in primary health centers, limited counseling rooms, uneven training

Source: Primary Data, 2025

DISCUSSION

The results of this study show that screening and identification of domestic violence in inpatient primary health centers in Kendari City are still not fully routine. Although WAST was available as a screening tool, it was not always used in daily services. In many situations, healthcare workers identified possible cases through clinical observation, visible injuries, repeated psychosomatic complaints, and gradual communication with the patient. This means that the screening process still depends much on the awareness and experience of each healthcare worker.

This situation is quite similar with previous studies. Abebe et al. [7] reported that limited training and the absence of clear protocols can make health workers less prepared to screen intimate partner violence. Usanov et al. [8] also explained that screening for domestic violence is often influenced by structural, cultural, and practical barriers. In this study, these barriers were seen from the inconsistent use of screening forms, limited training, and the absence of the same SOP in all primary health centers.

Private communication was also found as an important part of identification. Some victims were not comfortable to talk when they came with their husband or family member. They were more open when the accompanying person was asked to wait outside. This shows that privacy is not only a technical matter, but also part of safety for the victim. Iskandar et al. [11] also found that direct questioning in a private situation can help identify intimate partner violence better than waiting for passive reports. Colombini et al. [9] also emphasized that health services need to integrate screening and response mechanisms into routine care, not only provide the screening tool.

In terms of medical care, the response from healthcare workers was generally appropriate. They gave priority to physical examination, wound treatment, pain management, and stabilization before asking more about the domestic violence situation. This approach is reasonable because victims may come with pain, fear, or emotional distress, and they may not be ready to explain everything at the first contact. WHO [1] recommends that services for violence survivors should prioritize safety, privacy, respect, and non-judgmental care. Roberts et al. [12] also showed that trauma-informed care can improve patient engagement and reduce the possibility of retraumatization.

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However, documentation and referral still need more attention. Cases that came with police involvement were usually documented more completely, including injury photos for visum et repertum. Meanwhile, cases that were suspected clinically but not reported legally were often written only as general medical cases. This condition may make many domestic violence cases not well recorded in primary care. A clearer documentation system is needed so health workers can record important clinical findings, but still protect the victim and not force them into legal steps before they are ready.

Psychological support was already given, but still limited. In daily practice, doctors and midwives tried to provide emotional support through listening, calming the victim, and giving reassurance that violence should not be accepted as normal. However, this support was not always enough because there were no psychologists in the primary health centers, counseling rooms were limited, and not all staff had received special training. Anguzu et al. [13] also reported that health workers often meet violence survivors, but they do not always have enough resources to provide survivor-centered care. This gap was also found in the present study.

The absence of a private counseling room also became a problem. For domestic violence survivors, a private room is not only about comfort, but also about safety and trust. When the room is not private, victims may feel afraid that other people can hear their story. This can make them less willing to speak openly. Therefore, providing a safe counseling space should be considered as part of basic service readiness in primary health centers.

These findings show that domestic violence management in primary care cannot depend only on the personal concern of individual healthcare workers. A more organized system is needed, including standard SOPs, regular training, private counseling rooms, clear referral pathways, and better coordination with UPTD PPA, hospitals, police services, and mental health services. The Ministry of Health of the Republic of Indonesia [15] and WHO [14] have also emphasized the importance of integrated services for violence against women and children.

In the context of Kendari City, primary health centers can become an important first contact point for domestic violence victims. However, this role needs to be supported by better procedures and resources. If screening, documentation, psychological support, and referral systems are strengthened, victims may be identified earlier and receive safer and more appropriate assistance.

LIMITATIONS

This study has some limitations. The number of domestic violence survivors who participated in the interviews was limited, so their experiences may not represent all survivors in Kendari City. The study was also conducted only in five inpatient primary health centers, which means the findings cannot be generalized to all primary healthcare settings. Since the data were obtained from informants' experiences, the results may also be influenced by memory, openness, and the sensitivity of the topic. Domestic violence is a private and sensitive issue, so some informants may not have shared all information in detail. Even so, the use of interviews, observation, documentation, and triangulation helped improve the credibility of the study.

PRACTICAL IMPLICATIONS

Based on the findings, primary health centers need a more organized system for handling domestic violence cases. A clear SOP is needed so screening and identification are not only done when healthcare workers suspect a case. Regular training is also important because health workers need to recognize physical and psychological signs, ask sensitive questions, give basic emotional support, and document cases properly. Referral pathways with UPTD PPA, hospitals, police services, and mental health services should also be clearer, so victims can receive further help when needed. In addition, each primary health center should have a private counseling room, because privacy is important for the safety and comfort of domestic violence survivors. A standard documentation system is also needed to make sure cases are recorded well while still protecting the identity and confidentiality of victims.

CONCLUSION

DV screening and identification at inpatient primary health centers in Kendari City remain reactive and situational, relying on clinical observation and a gradual trust-based approach rather than the universal use of standardized screening instruments. Medical services have been provided with appropriate prioritization; however, the completeness of documentation and the integration of DV management pathways into routine services still need to be strengthened.

Psychological services face substantial structural limitations, particularly the absence of psychologists in all primary health centers included in this study, limited availability of dedicated counseling rooms, and uneven training in violence management. As

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practical implications, standardized SOPs for DV screening and identification are needed across all primary health centers, together with strengthened healthcare worker capacity through continuous specific training, the provision of psychologists or DV counselors in primary healthcare facilities, and the availability of safe and private counseling rooms in every primary health center.

ETHICAL APPROVAL AND INFORMED CONSENT

This study was conducted in accordance with ethical principles for research involving human participants. Although formal ethical clearance was not obtained, all procedures were carried out with careful attention to participant safety, confidentiality, and anonymity. All respondents were informed about the study objectives, voluntary participation, their right to withdraw, and the confidentiality of their responses. Written informed consent was obtained from all respondents before data collection. Interviews were conducted in a private setting, and no personally identifiable information was collected or reported in this study.

CONFLICT OF INTEREST

The author declares that there is no conflict of interest related to the conduct, authorship, or publication of this study.

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AUTHOR CONTRIBUTION

Sartiah Yusran contributed to the study supervision, conceptual review, and final manuscript approval. Rima Anggraini Asbar was responsible for the study conception and design, data collection, data analysis, interpretation of findings, and manuscript drafting. Nani Yuniar contributed to methodological review, data interpretation, and manuscript revision. Chindy Permata Sari contributed to literature review, manuscript editing, and final review. All authors read and approved the final manuscript.

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