



Building workforce capacity to detect and respond to child abuse and neglect cases: A training intervention for staff working in emergency settings in Vietnam



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ABSTRACT

Background: Too many children are brought to hospital emergency departments on numerous occasions before they are recognised as victims of child abuse and neglect. For this reason, improving knowledge and response behaviors of emergency staff at all levels is likely to have a significant impact on better outcomes.

Aim: An Australian based training programme was the first of its kind to address this issue in a Vietnamese Emergency Department. Titled 'Safe Children Vietnam', the programme aimed to improve knowledge, attitudes and reporting behaviors concerning child abuse in the emergency setting.

Method: A pre-post test design was used to evaluate the impact of 'Safe Children Vietnam' on emergency staff knowledge, attitudes and intentions to report child abuse and neglect.

Results: Emergency staff including doctors, nurses and healthcare staff (n = 116) participated in the clinical training programme. Linear Mixed Model analyses showed that on programme completion, they were more likely to recognise serious cases of all types of abuse.

Conclusion: The 'Safe Children Vietnam' programme was effective at improving emergency staff knowledge of child abuse and neglect. A systems wide approach may be necessary to impact on emergency staff attitudes towards reporting cases of abuse.

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1. Introduction

1.1. Background

The timely detection and appropriate response to cases of child abuse and neglect (CAN) presents a global challenge. Up to seven percent of paediatric injury presentations to emergency care settings are a result of CAN, making the emergency care setting an ideal environment for child abuse detection and management [1,2,3,4,5,6,7]. A widespread situation of under-recognition and under-reporting of abuse in emergency care settings poses a significant challenge to the accurate measurement and interpretation of this phenomenon.

The true extent of child abuse in Vietnam is still underreported, but available data suggest the problem is widespread and worse than in many other Asian and non-Asian countries. Current

estimates are that between 48 and 70% of Vietnamese children will experience physical abuse in their lifetime [8,9,10,11,12], and up to one in three will witness intimate partner violence in their home [9,11,13,14]. Many new initiatives have been implemented throughout Vietnam to improve early intervention for and prevention of family violence.

Emergency department doctors, nurses and healthcare staff in Vietnam are not trained in the recognition and management of child abuse presentations, the field of social work is in its infancy, and hospitals lack infrastructure to appropriately support vulnerable families. Capacity building for emergency staff has the potential to be life saving, with repeat injury and multiple presentations of abused children to emergency settings commonplace [15,16,17,18,19,20].

1.2. Goals of this study

This paper reports on the evaluation of a clinical training programme aimed at improving emergency staff knowledge, attitudes and reporting behaviors concerning child abuse presentations in the emergency care setting. Primary outcome measures were the

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ability to correctly identify abuse from case vignettes and the likelihood to report this abuse. Secondary outcome measures were attitudes towards reporting.

2. Methods

2.1. Study design and setting

A prospective cohort study using a pre- and post intervention design with longer-term follow-up was used. The pre-test was conducted with all participants in March 2014 (0 weeks). The post-test was conducted in May 2014 (6 weeks), 6 weeks after the training intervention. Longer-term follow-up was conducted in November 2014 (6 months), 6 months after the training intervention.

The study was conducted in three emergency care settings of a tertiary paediatric hospital in Vietnam. Together they treat between 4500 and 5000 new cases each day. Ethics approval was gained from the Human Research Ethics Committee of the participating hospital in Vietnam as well as the HREC for the University of Sydney.

2.2. Selection of the sample

Emergency department doctors, nurses and healthcare staff were eligible for the study. Staff were invited to participate by the chief investigator with support from the medical and nursing directors of the participating departments. Through an interpreter, the English speaking chief investigator detailed the voluntary nature of participation, and the protection of the healthcare professional from any adverse outcomes as a result of the decision to not participate in, or to withdraw from, the study. Participants were free to withdraw at any time throughout the study without penalty.

2.3. The intervention

The programme targeted knowledge, attitudes and CAN reporting behavior. Staff were expected to exhibit a change in professional self-efficacy, child abuse knowledge and child abuse reporting behavior [21]. The programme's overarching aim was to embed child abuse recognition and response firmly within emergency care culture and practice, thereby improving outcomes for at-risk children. As a capacity building programme, senior healthcare professionals in the emergency department who completed the programme were qualified to conduct ongoing training for junior staff.

The programme used findings from a needs analysis conducted in late 2013. Training content included the definition and description of multiple types of abuse and neglect, common characteristics of child abuse presentations, and the consequences of abuse. Participating staff were trained to recognise child abuse presentations, how to interact with patients and their families, and how to communicate their concerns to their superior. A subset of the intervention focused specifically on abusive head trauma and incorporated a translated version of the successful Shaken Baby Prevention Project from the Children's Hospital Westmead [22].

The programme included a take-home workbook, in-service presentations, a DVD screening, and a two-day interactive workshop. The extent of participation in the programme was recorded in post-test surveys six weeks and six months after the programme. Cultural and clinical validity was maintained using the input of key stakeholders. Independent translators back-translated all content (English-Vietnamese-English), and all training was presented in Vietnamese.

The programme was delivered by a variety of specialists in the field including the chief investigator of the study (JF), the director of the emergency department, academics from Ho Chi Minh City University of Medicine and Pharmacy and representatives of child welfare organisations. Fidelity of programme implementation was assured through the comprehensive supervision of the chief investigator and research programme staff.

2.4. Methods and measurements

Paper surveys were distributed to participating staff in each of three emergency care settings by research assistants assisted by hospital administration staff. The surveys were completed before and after the training programme was delivered at 0 weeks, 6 weeks, and repeated at 6 months. Participants were allocated 30 min during the course of their normal workday for participation in each survey. Our research assistants then collected the surveys and delivered them securely to the research office located offsite in Ho Chi Minh City. Data were translated into English and entered into SPSS (Version 23.0) by bilingual (Vietnamese/English) research staff. Data were entered twice and crosschecked for missing values, outliers and invalid codes. Discrepancies were resolved by crosschecking with the hard copy surveys.

2.5. Outcome measures

The Questionnaire: The Safe Children Vietnam Child Abuse and Neglect Questionnaire (CANQ) is a modified version of a questionnaire developed for use in Australia [23]. The questionnaire collected baseline demographic information, as well as data about healthcare professional training in child protection, their knowledge of CAN presentations, intentions to report, and attitudes towards reporting.

Attitudes Towards Reporting: Attitudes towards reporting were explored through a series of statements replicated from the CANQ implementation in Australia. Participants were asked the extent to which they agreed or disagreed with a series of statements based on their own personal experience and attitudes towards reporting. Scores for each statement ranged from 1 (strongly disagree) to 5 (strongly agree) in response to five statements concerning fear of reprisal, faith in department, organisational barriers to reporting, and roles and responsibilities of healthcare professionals in reporting.

Knowledge and Intention to Report According to Vignettes: Recognition and reporting behavior of child abuse cases were explored through four vignettes, each focusing on a different type of abuse (child physical abuse, child emotional abuse, witnessing intimate partner violence, and child sexual abuse). Development of the vignettes was informed by similar research in Australia and Vietnam [9,23], parent training in Vietnam [24], a hospital needs analysis, and discussion with local colleagues and friends. Content validity was further strengthened by undergoing review by clinical experts to ensure they accurately depicted the situations under assessment [25]. The vignettes were developed to represent a case of child abuse with serious consequences for a child, and aligned with the definition of domestic violence in Vietnam at the time of the intervention [26] (see Table 1).

A series of Likert items on a measure of 1–10 were used to record perception of seriousness of the vignette (1 = not at all serious, 10 = extremely serious); a professional judgment decision on whether or not the case constituted abuse or neglect (1 = definitely no, 10 = definitely yes); and likelihood to report (1 = almost certainly would not report, 10 = almost certainly would report). The numbers 1–10 were arranged at equal spacing along a horizontal line and for the purposes of analysis were considered as interval level data. The vignettes were developed such that staff would

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