# "ASSESSMENT OF NURSES' PREPAREDNESS (KNOWLEDGE, ATTITUDES AND SKILL) AND IDENTIFY BARRIERS TO CARE WOMEN EXPOSE TO IPV ATTENDING AT GOVERNMENTAL HEALTH CARE INSTITUTION, IN EAST GOJJAM ZONE, AMHARA REGIONAL STATE, ETHIOPIA, 2014."

**BY: HAYMANOT ZELEKE MITIKU (BSC, MSC CANDIDATE).**

**A RESEARCH THESIS SUBMITTED TO THE SCHOOL OF GRADUATE STUDIES OF ADDIS ABABA UNIVERSITY IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTERS OF SCIENCE IN ADULT HEALTH NURSING**

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# "ASSESSMENT OF NURSES' PREPAREDNESS (KNOWLEDGE, ATTITUDES AND SKILL) AND IDENTIFY BARRIERS TO CARE WOMEN EXPOSE TO IPV ATTENDING AT GOVERNMENTAL HEALTH CARE INSTITUTION, IN EAST GOJJAM ZONE, AMHARA REGIONAL STATE, ETHIOPIA, 2014."

**By: HAYMANOT ZELEKE MITIKU (Bsc, Msc Candidate)**

**Advisor: DANIAL MENGISTU (RN, BscN, MscN)**

**June, 2014**

**ADDIS ABABA, ETHIOPIA**

**Approval by the board of examiners**

This thesis by Haymanot Zeleke is accepted in its form by the board of examiners as satisfying requirement for the degree of master of science in adult health nursing.

**Research Advisor:**

| **Full Name** | **Rank** | **Signature** | **Date** |
|---|---|---|---|
| ATO DANIEL MENGISTU | ( BScN, MScN ) | _____ | _____ |

**Examiner:**

| **Full Name** | **Rank** | **Signature** | **Date** |
|---|---|---|---|
| ATO JOSEPH TSIGE | (BScN, MScN ) | _____ | _____ |

**Chair of Department:**

| **Full Name** | **Rank** | **Signature** | **Date** |
|---|---|---|---|
| ATO DANIEL MENGISTU | (RN, BScN, MscN ) | _____ | _____ |

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## Acronyms

AOR---------- Adjust Odd Ratio

CBOs ----------Community-Based Organizations

COR----------Curude Odd Ratio

HITS---------- Hurt, Insult, Threaten, And Scream

HIV----------Human Immuno Virus

IPV----------.Intimate Partner Violence

PTSD---------- Depressive Symptoms And Posttraumatic Stress Disorder

RADAR----------Routinely screen, Ask, Document, Assess and Refer/Resources

SPSS----------Statistic Program For Social Science

OPD---------- Out Patient Department

UK----------United Kingdom

WHO---------- World Health Organization

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## Abstract

**Introduction:** Intimate partner violence (IPV) is a pattern of purposeful coercive behaviors that may include inflicted physical injury, psychological abuse, sexual assault, progressive social isolation. This violence can be considered a leading public health problem with serious health consequences for *Women exposed to IPV*. Due to, the nurse is often an early point of contact, no information of nurses‟ preparedness (knowledge, attitude and skill, and barriers) regarding to IPV care in Ethiopia, high prevalence and impact on women health, these make it problem.

**Objectives:** To assess nurses‟ knowledge, practice and attitude, and identify barriers to care women exposed to intimate partner violence in East Gojjam, Amhara region, Ethiopia.

**Method: Q**uantitative study design was conducted to assess nurses‟ preparedness (knowledge, practice and attitude) to care women exposed to IPV and qualitative design for barriers to care Women exposed to IPV. East Gojjam has 18 woredas. Required sample size was 448 nurses**.** From 18 woredas, nine woredas were randomly selected through proportionate sampling method then the study sample was selected randomly. The collected data was cleaned, coded and entered in EpiData version 3.1 then transferred to SPSS version 16.0 for analysis. Descriptive statistics like frequency and percentage was used to summarize the socio-demographic characteristics‟, knowledge, attitude and skill. To know whether there is association or not between factors and nurses‟ care of, multivariate regression was used. Then odds ratio was used to find which variable was the most significant to affect of care women exposed to IPV. The strength of statistical association measured by adjusted odds ratios with 95% confidence intervals and 0.5% marginal error. Three groups of nurses from emergency, OPD and Obygynacology wards nurses purposely were selected. Total nurses who were participating in focus group discussions were 24. nurses‟ conversation auto taped, transcribed, translated and analyzed through open code soft ware 6.3 version. Finally, integrated according to emerging themes and then narriated.

**Result:** Just over 94% of all respondents had not received training. More than the half of nurses was not knowledgeable. Around 60% of nurses had negative attitude to IPV cases. In addition, almost 60% of nurses were not skillful. A logistic regression analysis indicated that there was a significant association between being male to care to Women exposed to IPV. Males were 7.899 times more likely to give care to Women exposed to IPV. Nurses who had experience on the care of women exposed to IPV were more give care than who never had experience. Barriers described by nurses were; related to social, institutional, nurses and victim/ women exposed to intimate partner violence/ that affect nurse care to women exposed to IPV were addressed.

**Conclusion:**. Training was significantly affecting the care of women exposed to IPV. Many of nurses had no skill/experience to care women exposed to IPV and majority of nurses could not ask sign of women exposed to IPV like eating disorders, hypertension, headaches and irritable bowel syndrome. Majority of nurses were not knowledgeable and not skillfull thus affect nursing care of women exposed to IPV. Generally, the majority of the nurses did not provide nursing care to women exposed to IPV.

**Recommendation**: East Gojjam zone health offices to open the opportunity of getting nursing care training regarding to women exposed to IPV. At higher institutions like university r training before and afte graduation, expanding education opportunity, expanding education opportunity and incorporating in nursing curriculum is recommended. Strengthening of health services in promoting early nurses‟ training and experience sharing and special emphasis to information on signs and what next action shall be done is recommended.

**Key words: Preparedness to care, readiness to care, barriers to care and IPV care**

# 1. Introduction

## 1.1 Background statement

Intimate partner violence (IPV) is a pattern of purposeful coercive behaviors that may include inflicted physical injury, psychological abuse, sexual assault, progressive social isolation, stalking, deprivation, intimidation and threats. Someone who is, was or wishes to be involved in an intimate or dating relationship with an adult or adolescent victim and are aimed at establishing control of one partner over the other perpetrates these behaviors. It is a purposeful designed to achieve domination and control in the relationship by their current or former intimate partner(1-3).

Mostly they exposed because of alcohol drinkers(4), low education and socioeconomic status, and being younger can increase women‟s risk of experiencing intimate partner violence(5-7). Lack of assets makes women vulnerable to violence and affects her decision making power in the family because of tradition and women‟s low social and economic status limits their ownership of assets, even though, Ethiopian laws give equal property rights to women. Also the perception of women who believe that a husband is justified in hitting his wife may believe themselves to be of low or inferior status, could act as a barrier to accessing health care for themselves and their children, affect their attitude towards contraceptive use, and damage their general well-being(8-9).

This violence can be considered a leading public health problem with serious health consequences for *Women exposed to IPV* and more likely develop headaches, back pain, sexually transmitted diseases, vaginal bleeding, vaginal infections, pelvic pain, painful intercourse, urinary tract infections, appetite loss, abdominal pain, digestive problems, gynecological, chronic stress-

related, central nervous system, and total health problems(10-12). And even rising of violence can have risk of death (13). There was a study that showed IPV had a negative effect on women‟s mental health, increasing the incidence of depressive, depressive symptoms and posttraumatic stress disorder (PTSD), and state anxiety symptomatology, as well as thoughts and attempts of suicide(14). Women exposed to physical spousal violence, sexual abuse and Psychological abuse in the past year are more likely to experience symptoms of depression, anxiety, psychogenic non-epileptic seizures, and psychotic disorders. Even the Violence of physical, sexual or Psychological has effect on each other(15).

Since violence of women can occur at any ages, races and cultures, socioeconomic and demographic barriers that are unacceptable and against the law (2, 16), the World Health Organization (WHO) cites eradicating violence against women as an urgent public health priority to achieving Millennium Development Goal, the promotion of gender equality and empowerment of women. Violence is a major obstacle to Millennium Development Goal(16).

Health professions can address IPV by asking all women about violence during privately and prevention-related visits (e.g. hospital admissions and prenatal visits), trauma-related visits, and follow-up visits but they may use multiple IPV screening tools like RADAR (Routinely screen, Ask. Document, Assess, Refer/Resources) (17) and HITS (hurt, insult, threaten, scream), Partner Violence Screen(18).

## 1.2 Statement of the problem

Intimate partner violence (IPV) against women is considered as a leading public health problem (19) affecting approximately 50% of women during the course of their lifetimes(20). Women with a history of IPV had significantly higher healthcare utilization, costs, efforts to prevent its occurrence and consequences even continuing long after IPV seceded (21-22).

IPV exists ever day in all parts of the world regardless of age, religion, societies, ethnicities, and geographic borders(23-24). Annual prevalence of IPV in Canada was found to range from 0.4% to 23%, with severe violence occurring from 2% to 10% annually(25). WHO surveys reported that percentage of women exposed to IPV who reported either physical or sexual violence 15% in Japanese and over 60% in Bangladesh and Peru(2). Interviews were conducted in Cape Town municipalities of South Africa, an average of 42.3% reported physical violence against a partner of the last 10 years(26). In Ethiopia, a study which was conducted in East Welega showed that the prevalence of IPV against women in their lifetime 76.5% and past 12 months 72.5%(27). But a study in the rural part of Ethiopia reported that the lifetime prevalence of any form of intimate partner violence was 72.0%(28). This shows that nurses should be alarm and ready to give care for Women exposed to IPV and also to investigate or screen them by solving the barriers which will have great impact on health of women(29).

IPV can be beneficial for maternal health and pregnancy outcomes (30-31) because of IPV occurs in all over the worlds‟ countries(2). Physical violence, mild emotional violence to severe emotional violence and high spousal control of women by their partners(32), high relationship between *IPV* and HIV as a risk factor(33).WHO multi-country study reflect, women who had ever experienced physical violence by a partner reported from more serious injuries to minor injuries like bruises, abrasions, cuts, punctures, and bites. Among the main injuries were abrasions or bruises (in 39% of women who had been injured), sprains and dislocations (22%),

injuries to eyes and ears (10%), fractures (18%), and broken teeth (6%). One third of injured women were hurt badly enough to need health care. Therefore, IPV should be managed by health professionals through giving care and identify barriers to care for women exposed to their partner is crucial to reduce the impact(34-35). Sufficient preparedness of nurses in the health institutions necessarily require in both knowledge and experience for identifying and caring women exposed to IPV properly(36).

In general, nurses must become competent in identifying victims of IPV and offer them appropriate interventions. Because of the nurse is often an early point of contact for women who have experienced violence(16, 37), no information regarding preparedness of nurses, barriers to give care for Women exposed to IPV in Ethiopia, prevalence of IPV and profound impact on women health (36). In women‟s lifetime, three out of four experienced at least one incident of IPV in western Ethiopia that need urgent attention at professionals to alleviate the situation (27). If Organizations like health professions are ready to prevent IPV then there will be reduction of trauma; increased family and community cohesion; a greater overall sense of safety; reduced costs to individuals, families, government and businesses (38).

## 1.3 Significant of the study

Much has been learned in recent years about the epidemiology of violence against women, but information about intervention approaches in the health care setting for preventing intimate partner violence is seriously lacking in the Ethiopian context. Assessing nurses‟ knowledge, skill and attitude, and identifying barriers to care victim of IPV will have a clue for further intervention such as preparing educational messages, training and incorporating in nursing curriculum based on existing beliefs.

The results from this study, crucial to design effective intervention strategies and identify barriers, in the care of violated. In addition, policy maker can use for further to address improper screening Women exposed to IPV who seek care. It is important for schools, community-based organizations (CBOs), and health clinics, among others, to address this problem through prevention education curricula or specific intervention programming. Therefore, the aim of the research was to assess barriers that affect nurses to care victim of IPV who seek treatment or health service and their preparedness regarding to knowledge, skill and attitude to care or mange community in the health institutions.

## 3. Literature Reviews

### 3.1 Nurses' preparedness (Knowledge, practice and attitude) to care women exposed to IPV

Feeling prepared was connected to obtaining knowledge by themselves and also to identifying women exposed to IPV(39). Nurses should have knowledge about IPV to care women in the way clients‟ right rather than as the result of IPV. A study showed that the majority of the nurses were found to be quiet unprepared in knowledge to provide nursing care for women exposed to IPV(36). In addition, study in Turkish showed only half of nurses always asked women about violence mostly when a woman was severely physically injured unless they never asked(40). Nurses felt difficulties to know how to ask; even if they identified violence, they mostly offered the women a doctor‟s appointment rather than giving nursing care for violated women. Similar ideas in other study revealed that, nurses were uncertain about how to ask, concerned about breaching the woman‟s integrity, or unsure about which intervention should be implemented once IPV is confirmed(41). Study showed that from 28 nurses (15%) had had previous discussions about how to intervene when meeting with women exposed to IPV, 10 (5%) had used existing guidelines and 47 (25%) had had information packages at their disposal to hand out to women exposed to IPV. Even after that they used symptom based treatment without identifying abuse, because of this, more and unnecessary suffering faced on women will occur(36).

Study which was conducted on nurses reported that the study participants believed the following: firstly females who experienced IPV frequently came from the lower socio-economic classes (52%) and had lower education levels (52.4%), secondly males who beat their wives were usually aggressive in all their social relationships (75.6%), and lastly pregnancy would prevent women from being subjected to violence (45.9%) (39). In other study, nurse responded that the

predominant views on the nature of the perpetrator among the participants were that „alcohol and drugs are common reasons that men abuse" and „the perpetrator simply loses control which enabled them violet their women(36).

A study, which conducted, reported care of women exposed to IPV increased as the level of experience (practice) increased. Inadequate preparation, for experience, emerged as a key factor to routine inquiry and management to women exposed to IPV (42). Similarly, providing experienced nurses with increased insight into the phenomenon of violence against women can reduce fear and increase commitment and willingness to intervene(43) . This idea supported by a study done on Midwives, which felt that IPV was an important issue to address after having experiences. Also this study reported that routine enquiry for IPV cannot be implemented effectively without ensuring that in-depth training, resources, staff support and policies to ensure that screening to be conducted and to give care for Women exposed to IPV safely and confidentially(41). The percentage of the participants who had at least one professional experience with Women exposed to IPV, as their patient was 66.1% from the total participants. When asked about current screening practices, 63.9% of the study group declared that they included questions about IPV when they worked with an injured patient, but when the frequency of screening examined the result was; only one-fourth of the study group stated that they screened each injury case from asking questions about IPV. In addition, there was 41.9% of the respondents had at least one of their relatives as an Women exposed to IPV(39).

To have more ethical, competent and compassionate clinical care in the health institutions; nurses attitude, belief and values should be changed through training which also improved healthcare providers" respecting for patient rights and knowledge and confidence in direct patient(44). It is possible to say, training program is necessary on this issue. Finding reveled that with training and experience had significantly higher initiator and higher preparedness to care than those with

training and no experience and those with no training but with experience(42). However, study showed, when participants were asked whether they had received any kind of training 48% stated that they had obtained information on their own initiative which account majority of participants because of actively searched the information in the mass media and literature due to personal commitment and interest in the area. 20% had had vocational training and 8% had received training on their employers‟ initiative(36). In other study showed that from the study group, 89.8% had no training regarding how to approach the Women exposed to IPV professionally. Among the group who had training, 70.9% believed that the training was not adequate to satisfactorily help for the victims. When the training program had given to nurses, it should also include a module on gender roles and also attention must be given to the legal aspects and clinical manifestations of IPV in order to improve the knowledge, practice and attitudes towards IPV care(39) .

Study also reported, there is a need for amending and enforcing the existing laws as well as formulating the new laws concerning IPV to diminish myths, misconceptions and traditional norms and beliefs that affect women health(45). In supporting this study, Quesi experiment reveled that measuring changes after IPV intervention training to nursing students in the form of a ten-week elective nursing course on IPV, had an increase in mean scores related to attitude, skills, and knowledge(46). Among those with no formal IPV, education in the present survey, professional differences were noted in preparedness to address IPV, with nurses feeling less prepared than physicians. These professional differences in preparedness disappear when training is present(42). Nurses were more likely to ask about violence if they had obtained information about violence(36).

### 3.2 Barriers to give care for women exposed to IPV

Different barriers influenced nurses‟ care given to women exposed to IPV. Self-efficacy, including feelings of powerlessness and loss of control, safety concerns and fear of offending, affective barriers (e.g., lack of comfort, interest, and sympathy), poor interviewing or communication skills and providers‟ personal experience with abuse affects IPV care(42). Study showed that from total 158 of nurses‟, 86% considered themselves to be insufficiently prepared to provide nursing care to women exposed to IPV(36).

Among those with no formal IPV, education in the present survey, professional differences were noted in preparedness to address IPV, with nurses feeling less prepared than physicians. These professional differences in preparedness disappear when training is present(42). Study showed even during selection activity of women exposed to IPV was significantly associated with different barriers. Demographic factors, for example, being female healthcare professionals were more likely to screen for IPV than male colleagues and also occupational factors being a Doctor appeared better placed than nurses and midwives to inquire and care of women exposed to IPV(47). In other study revealed that healthcare providers who perceived high efficacy in handling IPV issues, low fears of offending clients, professional preparedness, and availability of support networks from the institution were more likely to inquire and care women exposed to IPV properly(48). Study confirmed that there was a specially assigned person at their workplace responsible for quality improvement of nursing care but nurses were not aware of any collaboration with the authorities in dealing with IPV and if they aware they named those as volunteer organizations and psychiatric and social services to be their collaborators(36). But study indicated that health institutions did not have an appropriate hospital protocol or forms for documentation and which was reported a lack of privacy and time to develop trusting relationships as a barrier to screening and care women exposed to IPV(49)

Since, barriers to identify IPV are great challenges that affect health of women, study showed that, nurses reported that women were not raising the issue of violence during history taking. The woman is accompanied by partner or children or lacks privacy, appointment times are too short for a discussion of topic or cultural norms and customs interfere with the discussion of violence(50). And also in other study, the majority of the participants declared that dealing with victims of IPV requires interfering with the privacy of the family and patients who are ashamed to talk about it(39). In addition to this also health of women affected when health professions did not refer Women exposed to IPV because of thinking that women do not follow up on the referral. Even, the health profession may uncertain to refer women exposed to IPV unless patient indicates desire for referral(50). Other study showed that Patient-related factors like patient nondisclosure, fear of offending the patient were also frequently mentioned(51)

When participants were asked about the barriers in dealing with Women exposed to IPV in other study showed that, classified under four categories: 1) social, 2) institutional, 3) related to health staff, and 4) related to the victims. From social barriers that have effect on IPV care were; lack of legal arrangements, lack of social support institutions and low socioeconomic status of women had strong significant association with care of women exposed but the last with the list relation was Religion. However, from institutional barriers lack of proper place to interview the victim had strong relation with care of IPV. From that of related to health staff barriers, lack of training and lack of knowledge on legal aspect of the issue which had impact on care of women exposed to IPV. Related to the victim barriers; Hide and endure abuse despairingly, turning back to the same environment and Afraid of the repeat of abuse(39).

### 3.3 Conceptual Frame Work

Through reading different literatures, which have the same objectives to this study, the investigator developed the following conceptual framework.

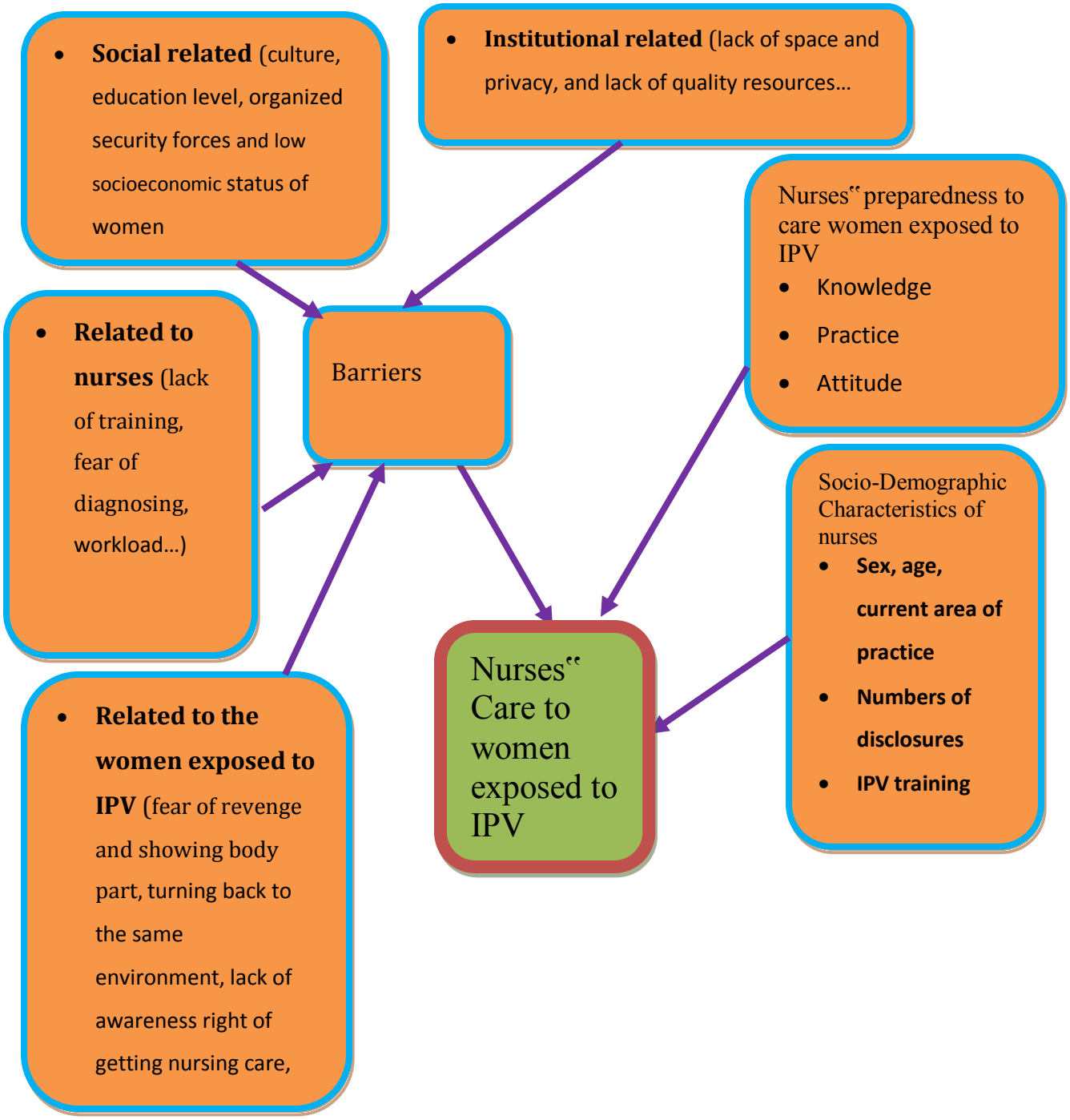


**Figure 1: conceptual framework of nurses' preparedness and barriers to care women exposed to IPV East Gojjam governmental health institutions, 2014.**

## 4. Objective

### 3.1 General objective

- To assess nurses‟ knowledge, practice and attitude, and identify barriers to care women exposed to intimate partner violence in East Gojjam, Amhara region, Ethiopia.

### 3.2 Specific objectives to

- Determine nurses‟ knowledge to care women exposed to IPV.
- Assess nurses‟ attitude to care women exposed to IPV.
- Assess nurses‟ skill to care women exposed to IPV.
- Identify barriers related to nursing care of women exposed to IPV.
- Identify association between nurses‟ care of women exposed to IPV with socio-demographic factors and nurses' preparedness (knowledge, attitude and skill).

# 4. Methods and Materials

## 4.1 Study design

Cross sectional quantitative design was conducted to assess nurses‟ knowledge, practice and attitude, and qualitative design to identify barriers to nurses‟ care of women exposed to IPV in selected Governmental health institutions, East Gojjam,.

## 4.2 Study area

East Gojjam is a zone, which is found in Amhara Region of Ethiopia. East Gojjam is bordered on the south by the Oromia Region, on the west by West Gojjam, on the north by south Gondar, and on the east by south Wollo; the bend of the Abay River defines the zone's northern, eastern and southern boundaries. Towns and cities in East Gojjam include Bichena, Debre Marqos, Debre Werq, and Mota. East Gojjam became the new home for 20,000 heads of households and 80,000 total family members. Based on the 2007 Census conducted by the Central Statistical Agency of Ethiopia, this Zone has a total population of 2,153,937, and increase of 26.68% over the 1994 census, of whom 1,066,716 are men and 1,087,221 women; with an area of 14,004.47 square kilometers, East Gojjam has a population density of 153.80. Amharic is spoken as a first language by 99.81%; the remaining 0.19% spoke all other primary languages reported. 97.42% of the population said, they practiced Ethiopian Orthodox Christianity, and 2.49% were Muslim.

East Gojjam has 18 woredas. Within the zone, there are 100 health centers 1 referral hospital and 1district hospitals with 917 nurses.

## 4.3 Source population

The source population was all nurses who were working in East Gojjam governmental health institutions.

## 4.4 Study population

All nurses who were working at randomly selected woredas in East Gojjam governmental health institutions.

## 4.5 Eligibility criteria

### 4.5.1 Inclusion criteria

- Nurses worked in East Gojjam, Amhara region governmental health institutions and available at the time of data collection.
- Who had 6 months or more than 6 months experience in East Gojjam governmental health institutions.

### 4.5.2 Exclusion criteria

- Nurses who decided to exercise their right not to participate in the study.

## 4.6 Sample Size and Sampling Procedure

### 4.6.1 Sample Size Determination

Sample size was calculated using single population proportion sample size calculation formula with a source population of size less than 10,000. Assuming that the maximum prevalence of nurses not prepared to care Women exposed to IPV is to be 50%, Z value of 1.96 and marginal error of 5% sample size calculated as follows;

$$no = \frac{(Z\,A/2)^2 * P\,(1-P)}{D^2}$$

no= (1.96)2x0.5 (1-0.5) =384

(0.05)2

Where:

no=the required sample size

Z= standard score corresponding to 95% CI

P= assumed proportion of nurses preparedness to care Women exposed to IPV

D= the margin of error 5%

N= total numbers of nurses or study source

Because of the study population less than 10,000, adjustment or correction formula was applied to this study**.**

N= no*N = 384*917 =**271nurses**

no+ (N-1) 384+ (917-1)

Design effect was 1.5 then, it was 271*1.5= 407

None response rate = 10%

None respondent rate 10% of 407 nurses = 41 nurses

Required sample size was 407+41=448 nurses = the last sample required

For qualitative part, Focus Group Discussion conducted until information saturated.

### 4.6.2 Sampling Procedure

In East Gojjam, there are 18 woredas (Motta, Hulet Ejjue Enesie, Enarge Enawga, Goncha Siso Enesie, Enebsie Sarmider, Enemay, Shebel, Dejen, Debay Tilatgin, Awabel, Basoliben, Aneded, Bibugn, Machakel, Debrelias, Gozamen, Debremarkos and Sinan).

Woredas were selected by using simple random sampling. From 18 woredas, nine woredas (Motta, Anded, Dejen, Awabel, Gozamen, Enemay, Debremarkos, Enebsie and Goncha) selected.

In these nine woredas, there are 58 health centers, and one district and one referral hospital with 514 nurses. By using proportionate sampling method, the required nurses randomly were selected.

For qualitative part, purposive sampling was used. Focus Group Discussion conducted from none selected woredas up to information saturation happened.

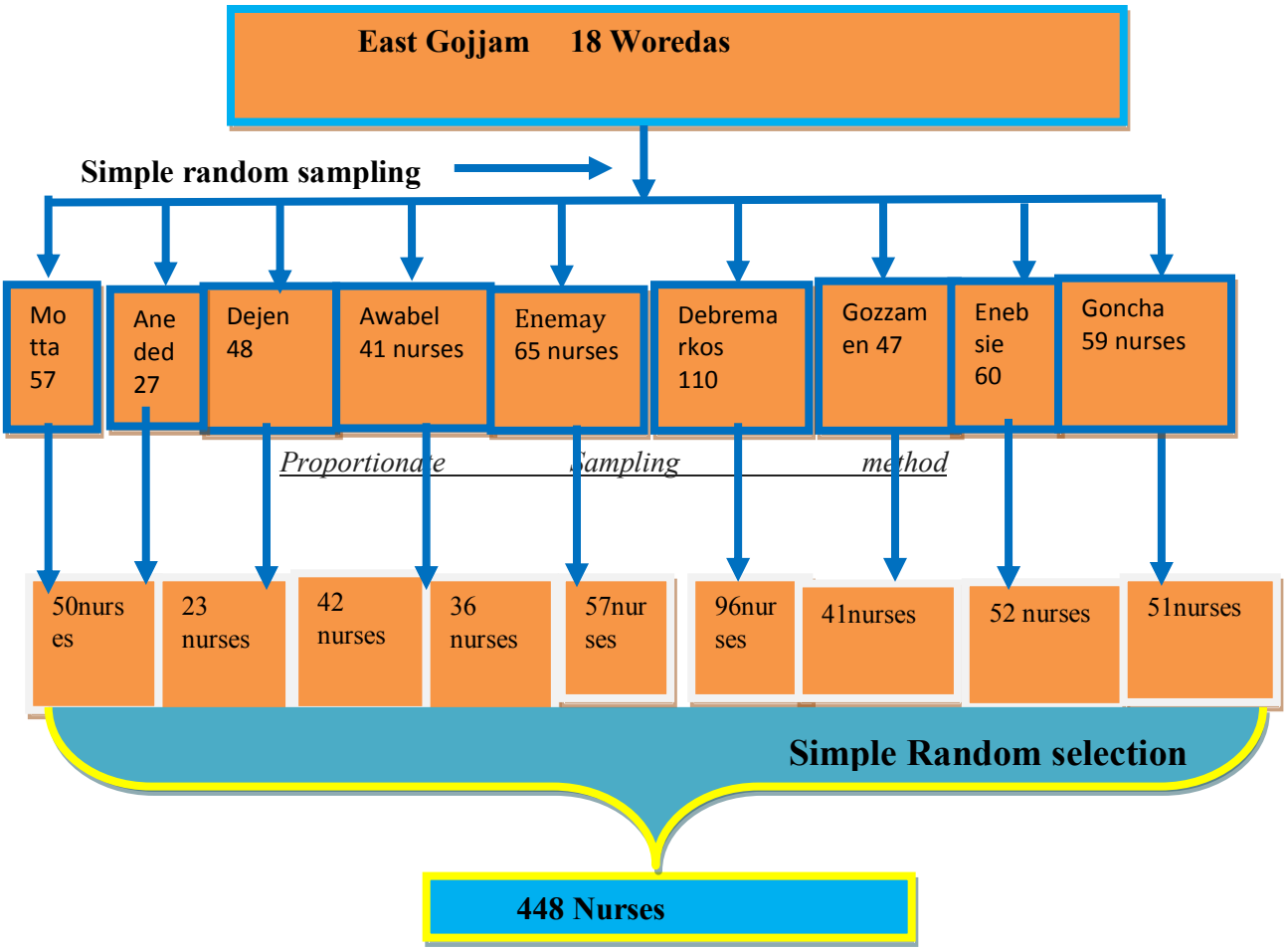


Figure2. Schematic presentation of sampling procedure

## 4.7 Study period

The actual study carried out from April 8- 2014 – April 29-2014 using pretested administered questionnaire.

## 4.8 Data Collection Procedure

### 4.8.1 Instrument

A structured self-administered questionnaire was used to collect data from nurses. It was constructed from already studied research adopting and modifying (36) and PREMIS (Physician Readiness to Manage Intimate Partner Violence Survey) tool(52). It consisted of five sections. Section I comprised the questions about demographic factors. Section II consisted of questions about the knowledge of IPV and section III consisted of questions about attitude. Section IV used to assess practice to care women exposed to IPV in the governmental health institutions. The questionnaire was distributed to the health care institutions of randomly selected woredas.

The qualitative data that was obtained from nurses'' conversation and then it was auto taped, transcribed, translated and coded with open code. Semi structure guideline was prepared to conduct Focus Group Discussion for the last section of questionnaire barriers to care Women exposed to IPV.

### 4.8.2 Personnel

Nine diploma graduate nurses who were not working in the selected study health care institutions (one nurse for each Woreda health institution) were recruited as data collectors, two degree. Graduate nurses were recruited as supervisors. All data collectors and supervisors had taken oriented for a day on data collection process based on the guide that was developed by principal investigator for data collectors and clarifying how to collect the questionnaire. They were to be

allowed to fill the questionnaire and later discussion was made in all contents of the format and areas of difficulties also revised.

Beside this, they had duty for describing the purpose of the study, giving orientation, telling nurses the importance of honest and sincere reply, on responding to questions. At the time of the actual data collection, the data collectors arrived early in the morning and gave questionnaire with time of arrival. Nurses were respondent to questionnaire for this study. The principal investigator and the coordinator strictly followed the overall activities for each activity on daily base to ensure the completeness of questionnaire, to give further clarification and support for data collectors.

### 4.8.3 Data quality assurance

Questionnaire prepared in English version and then translated to Amharic finally returned back to English. It had pre-test on 10% of the calculated sample size in health facility, which was not selected in the study. Additional adjustment made based on the results of the pre-test. Data collection carried out by trained nurses who are from other work area of the health facilities. 10% of the collected data checked by the supervisor daily for completeness and finally the principal investigator monitored the overall quality of data collection.

For qualitative part data transcript and analysis was done at the same day.

## 4.9 Data Processing and Analysis

The collected data was cleaned, coded and entered in EpiData version 3.1 then transferred to SPSS version 16.0 for analysis. Descriptive statistics like frequency and percentage was used to summarize the socio-demographic characteristics", knowledge, attitude and skill of the study nurses. To know whether there is association or not between factors and care of IPV, bivariet and multivariate regression used. Then odds ratio was used to find which variable was the most

significant to affect care of IPV. By using multiple regressions, the principal investigator assessed which independent variables had association with care of women exposed to IPV in governmental health care institutions. For all analyses, SPSS version 16.0 was used. The strength of statistical association measured by adjusted odds ratios and 95% confidence intervals to show association.

Three groups of nurses from Emergency, OPD and Obygynacology wards nurses purposely were selected. Total nurses who were participating in focus group discussions were 24. The qualitative data that obtained from nurses‟ conversation auto taped, transcribed, translated and analyzed. Finally, the narrative qualitative information and the observation organized and integrated according to emerging themes that answered the research questions.

## 4.10 Ethical considerations

Ethical clearance obtained from AAU, department of nursing and midwifery research committee and college of health science institutional review board. Each study participant, by their data collector adequately informed about the purpose, anticipated benefit and risk of the study. Informed consent obtained from study participants for protecting anonymity and ensuring confidentiality.

## 4.11 Variables

### 4.11.1 Independent

- Nurses‟ preparedness (knowledge, practice and attitude)
- Socio-demographic factors of nurses (sex, training, numbers of women exposed to IPV disclosed, current area of practice)
- Barriers (social related, institutional related, related to health staff, related to the victim)

### 4.11.2 Dependent

- Nurses‟ Care to women exposed to IPV

## 4.12 Operational definitions:

The following operational definitions were used for this study:

1. Knowledgeable: - Nurses who answered correctly to knowledge questions above the median were considered as knowledgeable.
2. Not knowledgeable: - nurses who answered correctly to knowledge questions below the median were considered as not knowledgeable.
3. Negative attitude: - Nurses who agreed to attitude questions below the median were considered as negative attitude.
4. Positive attitude: - Nurses who agreed to attitude questions above the median were considered as positive attitude.
5. Barriers: - Anything, which influenced negatively nurses‟ care to women exposed to IPV that would be listed by nurses from focused grouped discussion, was considered as barriers.
6. Skillful: -Nurses who worked to practice questions above the median were considered as skillful.
7. Not skillful: - Nurses who worked to practice questions below the median were considered as not skillful.
8. Nurses‟ care to women exposed to IPV: - nurses who did care like identifying victim, taking intervention actions after identifying (like counseling, referring, providing resources...) for women exposed to IPV in the last 6 months at governmental health care institution, East Gojjam, 2014.

## 4.13 Dissemination and Utilization of results

Result of the study will be disseminated to Addis Ababa University School of Nursing as fulfillment of master‟s degree in nursing. Through communicated to East Gojjam health Bureau and all government health services in Amhara region, it will be disseminated there. Hard and soft copies will be available in the library of Addis Ababa University for graduate students as well as for other concerned readers.

## 5. Results

### I. Sociodemographic variables of nurses

As shown in Table one, 46.1% nurses were male and 53.9% were female nurses. The majority of respondents were between 30 to 39 years of age. Most of them worked in OPD, Emergency and obstetrics/gynecology/. The majority of respondents were orthodox religion follower (79.7%).

**Table one. Nurses' socio-demographic characteristics about women exposed to IPV in East Gojjam governmental health care institution, 2014.**

| Variable | | Frequency | Percentage |
|---|---|---|---|
| Sex | Male | 188 | 46.1 |
| | Female | 220 | 53.9 |
| Age | "20-29 years" | 114 | 27.9 |
| | "30-39 years" | 193 | 47.3 |
| | "40-49 years" | 74 | 18.1 |
| | "50-59 years" | 27 | 6.6 |
| Religion | Orthodox | 325 | 79.7 |
| | Catholic | 12 | 2.9 |
| | Protestant | 35 | 8.6 |
| | Muslim | 36 | 8.8 |
| Practices Area | Opd | 129 | 31.6 |
| | Obygynacology | 83 | 20.3 |
| | Emergency | 133 | 32.6 |
| | Surgical | 31 | 7.6 |
| | Medical | 32 | 7.8 |

| | | | |
|---|---|---|---|
| How many | Never | 85 | 20.8 |
| Women | "none this year" | 97 | 23.8 |
| exposed to IPV | "less than twenty" | 193 | 47.3 |
| you did | "twenty or over" | 33 | 8.1 |
| How many | less than 20 | 41 | 10.0 |
| patients you saw | 20 to 39 | 56 | 13.7 |
| per week | 40 to 59 | 46 | 11.3 |
| | 60 or more | 265 | **65.0** |
| Training | Yes | 24 | 5.9 |
| | No | 384 | 94.1 |
| nurses work | 1-5 | 223 | 54.7 |
| with you | 6-10 | 138 | 33.8 |
| /including you/ | >11 | 47 | 11.5 |
| Physicians work | 0 | 329 | 80.6 |
| with you. | 1-5 | 76 | 18.6 |
| | >5 | 3 | 0.7 |

65% of nurses reported that they saw 60 or over patients per week. However, 20.8% of nurses indicated that they never had experience regarding to care of women exposed to IPV. Over 94% of them did not have any formal training regarding women exposed to IPV. Almost 55% nurses worked together (from 1 up to 5 nurses) in the same place/room and 81% them worked independently i.e without physician (see table one above).

## II. Knowledge

In this study, 33(8.1%) of nurses responded that being female sex as strongest single risk factors to have IPV. However, 248(60.8%) of nurses respond that, to become a victim of intimate partner violence the strongest *single* risk factor is their partner abuses of alcohol/drugs, which accounted largest response (see table four below).

242(59.3%) nurses replied that, women exposed to IPV got harm from ttheir intimate partner because of violence as means of controlling them. In this study, nurses replied that warning signs of woman exposed to IPV were, anxiety and frequent injuries accounted the largest response 254(62.3%) and 233(57.1%) respectively. Nurses also replied that women with IPV had their own reason not break up their relationship due to fear of revenge and financial dependence 217(53.2%) and 320(78.4) respectively. However, women exposed to IPV did not depart their relationship due to love for their partner had lowest responses, which were 27(6.6%) nurses (see table four below).

During nurses saw women exposed to IPV at health care institution, there are ways to ask them. The most appropriate ways to ask about women exposed to IPV „Have you ever been afraid of your partner?" as the most appropriate ways to ask 273(66.9%) nurses replied. From the indicators of women exposed to IPV 258 (63.2%) nurses replied that injuries in different stages of recovery may indicate abuse (see table four below).

**Table Two.** Assessment of nurses‟ knowledge towards women exposed to IPV in East Gojjam health care institution, 2014.

| Variables | | No | % |
|---|---|---|---|
| Which one is strongest single risk to have IPV | "Age" | 38 | 9.3 |
| | "partner abuse of alcohol" | 248 | 60.8 |
| | "family history" | 89 | 21.8 |
| | "being female sex" | **33** | **8.1** |
| Why partner harm their intimate partner | "trouble control anger" | 67 | 16.4 |
| | "violence as means of control" | 242 | 59.3 |
| | "drink or use drug" | 99 | 24.3 |
| | They pick fights with anyone | 00 | 00 |
| What are warning signs of women exposed to IPV | Chronic unexplained pain | 58 | 14.2 |
| | Anxiety | **233** | **57.1** |
| | Substance abuse | 118 | 28.9 |
| | Frequent injuries | **254** | **62.3** |
| | Depression | 105 | 25.7 |
| Women exposed to IPV reason not leave r/ship | Fear of revenge | 217 | 53.2 |
| | Financial dependence | 320 | 78.4 |
| | Religious beliefs | 92 | 22.5 |
| | Children‟s needs | 52 | 12.7 |
| | Love for one‟s partner | 27 | 6.6 |
| | Isolation | 45 | 11.0 |

| | | | |
|---|---|---|---|
| Most appropriate ways to ask women exposed to IPV | "Are you a victim of intimate partner violence?" | 67 | 16.4 |
| | "Has your partner ever hurt or threatened you?" | 94 | 23.0 |
| | "Have you ever been afraid of your partner?" | 273 | 66.9 |
| | "Has your partner ever hit or hurt you?" | 42 | 10.3 |
| How to identify women exposed to IPV | There are common, non-injury presentations of women exposed to IPV (True) | 258 | 63.2 |
| | There are behavioral patterns in couples that may indicate women exposed to IPV (True) | 203 | 49.8 |
| | Specific areas of the body are most often targeted in women exposed to IPV cases (True) | 222 | 54.4 |
| | There are common injury pattern associated with women exposed to IPV (True) | 209 | 51.2 |
| | Injuries in different stages of recovery may indicate women exposed to IPV (True) | 237 | 58.1 |

## III. Attitude

**Self-efficacy;** 57.8% of nurses agreed that it is their responsibility to ask women exposed to IPV. Most nurses agreed that it is not possible to identify abuse by the way women behave (79.2%) or without asking directly (83.3%). However, more than half (65.7%) reported that comfortable about discussing IPV and 36.8% nurses thought that they could gather information to identify abuse if the patient presented with a condition like depression or migraine.

However, 48.0% nurses were able to gather the necessary information to identify IPV as the underlying cause of patient injuries (e.g., bruises, fractures, etc.). Even though, victims of abuse have the right to make their own decisions about whether hospital staff should intervene (51.0 %), they did not get any therapeutic interventions (60.3%) (see table three).

**Workplace issues;** Approximately one-quarter of the nurses thought that their practices work place did not *encourage a response to IPV (27.7%).* From total participants only 39.7% nurses replied that their practice setting allowed them adequate time to respond to victims of IPV. And also, 42.6% believed that they were able to make appropriate referrals to community services, and only 32.1% thought that they had contacted services within the community to establish referrals (see table three).

**Awareness about IPV;** 35.5% nurses thought victims of abuse often have valid reasons for remaining in the abusive relationship. However, almost 59% nurses believed that Women exposed to IPV can leave the relationship if they want. More than half of nurses thought that those who abuse alcohol or other drugs are likely to have a history of IPV. Moreover, 57.4% of nurses did not agree that women who choose to step out of traditional roles are a major cause of IPV. Only 33.8% nurses were aware of legal requirements regarding to report suspected cases of women exposed to IPV to legal institutions (See table three above).

**Table Three.** Assessment of nurses" attitude towards care of women exposed to IPV in East Gojjam, governmental health care institution, 2014.

| Variable | | Nurses (**n = 408**) **%** | |
|---|---|---|---|
| ***Workplace issues*** | My practice setting allows me adequate time to respond to victims of IPV. | Disagree | 60.3 |
| | | agree | 39.7 |
| | I have contacted services within the community to establish referrals for IPV victims. | Disagree | 67.9 |
| | | agree | 32.1 |
| | My workplace encourages me to respond to IPV | Disagree | 72.3 |
| | | agree | 27.7 |
| | I can make appropriate referrals to services within the community for IPV victims | Disagree | 57.4 |
| | | agree | 42.6 |
| ***Self-efficacy*** | nurses care providers have a responsibility to ask all patients about IPV | Disagree | 42.2 |
| | | agree | 57.8 |
| | I am capable of identifying IPV without asking my patient about it | Disagree | 83.3 |
| | | agree | 16.7 |
| | I can match therapeutic interventions to an IPV patient's readiness to change. | Disagree | 60.3 |
| | | agree | 39.7 |
| | I can recognize victims of IPV by the way they behave. | Disagree | 79.2 |
| | | agree | 20.8 |
| | I am able to gather the necessary information to identify IPV as | Disagree | 52.0 |

| | | | |
|---|---|---|---|
| | the underlying cause of patient injuries (e.g., bruises, fractures, etc.) | agree | 48.0 |
| | I am able to gather the necessary information to identify IPV as the underlying cause of patient illnesses (e.g., depression, migraines). | Disagree | 63.2 |
| | | agree | 36.8 |
| | I feel comfortable discussing IPV with my patients | Disagree | 34.3 |
| | | agree | 65.7 |
| ***Awareness about IPV*** | Victims of abuse could leave the relationship if they wanted. | Disagree | 41.2 |
| | | agree | 58.8 |
| | Victims of abuse often have valid reasons for remaining in the abusive relationship. | Disagree | 64.5 |
| | | agree | 35.5 |
| | I am aware of legal requirements in this state regarding reporting of suspected cases of IPV women. | Disagree | 66.2 |
| | | agree | 33.8 |
| | Patients who abuse alcohol or other drugs are likely to have a history of IPV. | Disagree | 46.6 |
| | | agree | 53.4 |
| | Victims of abuse have the right to make their own decisions about whether hospital staff should intervene. | Disagree | 49.0 |
| | | agree | 51.0 |
| | Women who choose to step out of traditional roles are a major cause of IPV. | Disagree | 57.4 |
| | | agree | 42.6 |

## IV. Nurses skills to care women exposed to IPV

From the total nurses 59.3% did not give care for women exposed to IPV. From those nurses who did care to women exposed to IPV, only 23(5.6%) of nurses asked all new female patient about IPV. Nurses who had identified woman exposed to IPV in the last 6 months, 57 (14.0%) of nurses provided information, 116 (28.4%) nurses were counseling to woman exposed to IPV, while 61(15%) had made a referral to other agencies. And 57(34.3%) of nurses provided education or resource materials for women exposed to IPV.

Only 14(3.4%) of nurses conducted safety assessment and helped them to develop a personal safety plan for women exposed to IPV. This study showed that 62(27.1% nurses practiced in a state where it is legally mandate to report women exposed to IPV cases. (see table four below).

**Table Four. Assessment of nurses' skill towards care of women exposed to IPV in East Gojjam health care institution, 2014.**

| Variable | | No | % |
|---|---|---|---|
| How many woman exposed to IPV did you give nursing care | None | 242 | 59.3 |
| | 1-5 | 112 | 27.5 |
| | 6-10 | 43 | 10.5 |
| | 11-20 | 8 | 2.0 |
| | 21 or more | 3 | 0.7 |
| From the following lists, which you asked to screen women exposed to IPV? | I ask all new female patients | 23 | 5.6 |
| | I ask all patients with abuse indicators on history or physical examinations | 84 | 66.1 |
| | I ask certain female patients" categories only | 59 | 14.5 |
| *What actions have you taken | Provided information (phone numbers, | 57 | 14.0 |

| | | | | |
|---|---|---|---|---|
| when you identified women exposed to IPV | pamphlet, other information) | | | |
| | Counseled patient about options she may have | | 116 | 28.4 |
| | Conducted a safety assessment for the victim | | 14 | 3.4 |
| | Helped patient develop a personal safety plan | | 14 | 3.4 |
| | Refer patient | | 61 | 15 |
| Do you practice legally mandate to report women exposed to IPV cases | | Yes | 62 | 27.1 |
| | | No | 121 | 72.9 |
| Did you Provide education or resource materials for women exposed to IPV | | Yes | 57 | 34.3 |
| | | No | 109 | 65.7 |

**Note * questions who had multiple answer**

From out of total nurses, 59.3% of them did not give care to women exposed to IPV but the left 40.7% of nurses did care at least once to women exposed to IPV in the last six months.

When questioned in more detail about asking patients presenting with specific signs associated with IPV, nurses replied that as they asked women exposed to IPV when they saw specific signs related to IPV. From these signs, injuries accounted 88.0% and depressions 75.3%. However, from total nurses who did care the percentages of nurses that asked about women exposed to IPV presenting with other signs associated with IPV were low. For example, only 15.7% of nurses asked if patients presented with hypertension (see table five below).

**Table Five. Assessment of nurses' skill towards asking sign of victims and actions taken to care women exposed to IPV in East Gojjam health care institution, 2014.**

| Variables | Never & seldom % | Sometimes & always % |
|---|---|---|
| How often in the past 6 months, have you asked about the possibility of IPV (women) when seeing the following sign? | | |
| **a) Injuries** | **12.0** | **88.0** |
| b) Chronic pelvic pain | 72.3 | 27.7 |
| c) Irritable bowel syndrome | 84.3 | 15.7 |
| d) Headaches | 80.7 | 19.3 |
| **e) Depression** | **24.7** | **75.3** |
| f) Hypertension | 81.3 | 18.7 |
| g) Eating disorders | 72.3 | 27.7 |
| **For every Women exposed to IPV(women) you have identified in the past 6 months, how often have you** | | |
| a) Documented patient"s statements IPV in chart | **28.3** | **71.7** |
| b) Used a body-map to document patient injuries | **24.1** | **75.9** |
| c) Photographed victim"s injuries to include in chart | 82.5 | 17.5 |
| d) Notified appropriate authorities when mandate | 77.7 | 22.3 |
| e) Conducted a safety assessment for victim | 88.0 | 12.0 |

| | | |
|---|---|---|
| f) Helped an Women exposed to IPV develop a safety plan | 83.7 | 16.3 |
| g) Contacted an IPV service provider | 88.0 | 12.0 |
| h) Provided referral and/or resource information | 74.1 | 25.9 |

**Note * questions who had multiple answer**

When nurses were asked questions about specific actions after identifying of women exposed to IPV, the action most commonly they did were, using a body-map to document patient injuries (75.9%) and documentation of the abuse history on patient chart (71.7%). However, they never or seldom did actions like, use photograph to take picture of victims‟ injury, provided referral or resource materials, notify appropriate authorities when mandate, conduct a safety assessment for victim and contact IPV service provider (see table five above).

## V. Knowledge, attitude and skill score

In this study, median for each question was used for knowledge, attitude and skill classification. The median of nurses‟ knowledge, attitude and skill about women exposed to IPV were 31.00, 23.00 and 27.00 respectively. Below the median was considered as poor knowledge, not skillful and negative attitude. Above the median was considered as knowledgeable, skillful and positive attitude in their categories variables.

The participants who were knowledgeable (above the median) were 42.6% nurses. More than the half of them was not knowledgeable. Around 60% of nurses had negative attitude to IPV cases and almost 60% of nurses were not skillful (see table six below).

**Table Six.** Score of nurses‟ preparedness (knowledge, attitude and skill) about women exposed to IPV by using median who were working at East Gojjam zone health care institutions, 2014.

| Variable | | Frequency | Percent |
|---|---|---|---|
| | not knowledgeable | 234 | 57.4 |
| Knowledge score | Knowledgeable | 174 | 42.6 |
| Attitude score | negative attitude to IPV care | 228 | 55.9 |
| | positive attitude to IPV care | 180 | 44.1 |
| Skill score | not skillful | 242 | 59.3 |
| | Skillful | 166 | 40.7 |

## VI. Identifying association between nurses' care of women exposed to IPV with socio-demographic factors, knowledge attitude and practice.

In binary and multiple regressions analysis socio-demographic characteristics such as sex, training and nurses‟ experience were significant to nurses‟ care of women exposed to IPV. A logistic regression analysis indicated that there was a significant association between being male nurse to care to *women exposed to IPV* with COR 2.540(1.693, 3.810) and AOR 2.891(1.658, 5.041). Nurses who had experience on women exposed to IPV care more likely to care women exposed to IPV than nurses never had any experiences (see table seven below)

**Table seven.** Identifying association through biviriate and multivariate analysis between nurses‟ care of women exposed to IPV with socio-demographic factors of nurses who were working at East Gojjam governmental health institutions, 2014**.**

| Variable | | Care to women exposed to IPV | | p-values | COR(95% CI) | p-values | AOR (95% CI) |
|---|---|---|---|---|---|---|---|
| | | No | YES | | | | |
| Sex | Male | 89 | 99 | 0.002 | 2.540(1.693, 3.810) | **0.04** | **2.891(1.658, 5.041)** |
| | Female | 153 | 67 | 0.00 | 1.00 | 0.00 | 1.00 |
| Training | Yes | 6 | 18 | 0.007 | 4.784(1.857, 12.326) | **0.014** | **7.899(2.140, 29.899)** |
| | No | 236 | 148 | 0.001 | 1.00 | 0.00 | 1.00 |
| *How many Women exposed to IPV you did care* | Never | 78 | 7 | 0.000 | 1.00 | 0.000 | 1.00 |
| | "none this year" | 90 | 7 | 0.799 | 0.867 (0. .291, 2.579) | 0.498 | 1.342 (0.573, 3.141) |
| | "less than 20" | 63 | 130 | 0.000 | 22.993 (10.028, 52.720) | **0.000** | **13.214 (6.485, 26.928)** |
| | "20 or over" | 11 | 22 | 0.000 | 22.286 (7.727, 64.272) | **0.000** | **10.808 (4.08, 28.63)** |

Nurses‟ skill and attitude were significant with biviriate but knowledge of nurses was not significant. Through multiple regressions, skill and knowledge became significant. Nurses who were not skillful and not knowledgeable less likely gave care for women exposed to IPV (multiple regressions) with p-value of 0.00 and 0.008 correspondingly. However, attitude of nurses did not affect the care of women exposed to IPV (see table eight).

**Table Eight** Identifying association through biviriate and multivariate analysis between nurses" care of women exposed to IPV with nurses" preparedness (Knowledge, Attitude and Skill) factors of nurses who were working at East Gojjam governmental health institutions, 2014**.**

| Variable | | Nurses' care to women exposed to IPV | | p-value | COR(95% CI) | p-value | AOR (95% CI) |
|---|---|---|---|---|---|---|---|
| | | No | Yes | | | | |
| Skill | Not skillful | 220 | 22 | .000 | .008(0.004, .016) | **.000** | **.006(.003, .014)** |
| | Skillful | 12 | 154 | | 1.00 | | 1.00 |
| Knowledge | Not knowledgeable | 140 | 94 | 0.161 | 0.753(0.507, 1.119) | **0.008** | **.349(.161, .757)** |
| | Knowledgeable | 92 | 82 | | 1.00 | | 1.00 |
| Attitude | Negative attitude | 139 | 89 | 0.060 | 0.684(0461, 1.016) | 0.614 | 1.208(.579, 2.519) |
| | Positive attitude | 93 | 87 | 0.655 | 1.00 | | 1.00 |

## VII. Qualitative part about barriers to care Women exposed to IPV

Barriers to asking about *women exposed to IPV* Analysis of the data from the open-ended questions identified four categories of barriers. Overall, the barriers described most often by nurses were; from social barriers nurses listed as barriers to care *women exposed to IPV* were culture of community, low education level, lack of organized security forces and low socioeconomic status of women. In the institution lack of proper place to interview and manage, lack of privacy, lack of quality resources and did not employing who had skill full and trained personals. Health professional lack of training listed as barriers and they gave highly emphasis to it. Related to women exposed to IPV did not get full health services due to turning back to the same environment because of traditional mediation (*shimglina*), fear of the repeat of violation or revenge and show body part**,** lack of awareness on legal rights and they will have discrimination from the community once their issue disclosed. Because of such problem, they did not tell or not attained full services**.**

**Social related barriers**

From social barriers nurses listed as barriers to care *women exposed to IPV* were culture of community, low education level, lack of organized security forces and low socioeconomic status of women

Participants mentioned culture and economy of the women exposed to IPV influence their care, which is given by nurses at the health institution. Below their response;

> *"Husbands are dominant over their wives due to cultural influences including the economic issues, which are handled by husbands. She will not buy the drugs prescribed by the health professionals but rather the husband does it". (P2 male,* Shebel health center*)*

*"They couldn't clearly tell what they want or what happened to them. Even if they start telling, they do not give the full information because the culture in the community has an influence on them." (P6 male,* Shebel health center*)*

*"Such case mostly occurred on women who are dependant in economically on their husband. They may lack money for getting health service. The other is culture, even the family knows the case, through mediation / shimglina / through traditional they will stay there, and they do not get service." (P6 male,* Shebel health center*)*

Nurses were identified education as barrier to give care for *women exposed to IPV*. The following were their responding;

*"When you ask them what their problem is, at the beginning, they consider you as you are making fun of them. It is expected from you to teach them a lot." (P2 male,* Shebel health center*)*

*"Education is crucial. Education coverage in the rural population is law therefore; they have no awareness about the service where is it given. Even the educated women want to secrete the case being silent." (P5 male,* Shebel health center*)*

*"After coming at health center, they regret back b/c of traditional mediation that will be achieved by elder's / shimnigilna /." (P1 female,* Shebel health center*)*

Participants also showed that there is a problem at legal organization and security forces. *Women exposed to IPV* will feel hopeless to go court and tell the issue to nurses. Below what they replied;

*One of the discussant of the sheble health center said that, "They do not believe about court because of they think, „we have no evidence that will help us". They have low awareness to their legal right. They do not think, getting care regarding to violence." (P2 male,* Shebel health center*)*

*"Even the partner accused, with in the short time he will out from prison and again he will revenge her. I am telling to you because I saw such case." (P4* male, Shebel health center*)*

**Related to institutional**

Participants described lack of space/room and privacy as barriers to give care for them. This included the presence of other family members as well as other patients and work environments that were not conducive to confidential one-to-one interviews. Even they did care with other client in the same room that break women"s privacy. Considering other clients, presence and lack of space and privacy suggest that, these are substantial barriers for nurses to give care for *women exposed to IPV* when they came to health institutions. In addition, lack of responsible institution who should employee skill full and trained nurse regarding to care of these women when they come to health institution. Following disclosure:

*"She will get treatment at the same room, the same and equally or not give priority to them like other clients then they lack privacy. There are no prepared rooms for this case." (P5 male,* Shebel health center*)*

*"They will take health service at same place and by same health professional like that of other case/patients/ she also afraid and frustrated because of other patient may see her injured body part due to same place all patients got services." (P18 male, debrework health center)*

*"I have no training and cannot do care deeply for women exposed to IPV. Therefore, the institutions should employee trained personal to alleviate this issue." (P17 female, debrework health center)*

**Lack of quality resources**

Nurses described the lack of quality resources as a barrier as evident by the following responses:

> *"There are no specified advanced instruments for diagnosis of IPV." (P15 female, debrework health center)*
>
> *"For example, there are place, which takes more than 10 hours with walk to come and get health service at health center. After you see them, you may refer to D/markos hospital because of lack of advanced instrument. Because of the distance and resources, we are afraid of making referral to them." (P14 male, debrework health center)*

**Related to nurses** as barriers to give nursing care were also listed by nurses, which act as barriers. Participants identified lack of training, quality resource, workload and fear of diagnosing.

A significantly nurses described a lack of training as a barrier as evident by the following written responses, some nurses were very open about their lack of training often linking the need for additional training to care women exposed to IPV, wanting to know how and when to initiate the topic and what to do. Following disclosure:

> *"Such case needs special care through trained counselor. Still there are no trained personal for* women exposed to IPV.*" (P17 female, debrework health center)*

Participants also listed the other barriers in the perspective of nurses that act as barriers on the care of women exposed to IPV. These were workload and fear of diagnosis. Following were nurses" responses:

> *"We have fear on the diagnosis because of possibility of wrong diagnose which may have impact on us." (P18 male, debrework health center)*

*"There may be workload on nurses; we see severe case first then other will take treatment based on their condition and they may return to home without care because of workload." (P9 male,* Basoliben *health center)*

**Related to women exposed to IPV**

Nurses described lack of awareness to their right to get health services as a barrier as evident by the following written response.

*One of basoliben woreda health center nurses said that, "Especially rural females afraid to show their body. The other point, they do not know their legal right. They have no awareness about their own right to get health service. They also frustrate about revenge because of this they do not want to tell the cases for us. They are under control by their partner." (P8 female,* Basoliben *health center)*

Traditional beliefs and discrimination that make women to be silent as barriers not take nurses" care. Here it is the response of nurse

*"The community rejects her from social activity. The community has impact on her by saying; she is out of her husband /intimate/ without permission of her husband. They fear what will be happened to their at home. If she tells to health nurses here later, her husband will do something on her." (P4 male, Shebel health center)*

*Women exposed to IPV become hopeless because of she never gets witness she preferred to be at home even after coming at health institutions she will be calm and does not want to talk about issues that happened on her. One of Shebel health center nurse replied that,*

*"Nevertheless, she never gets witness. The witnesses are available for male b/c male can invite witness man like alcohol or other. Then they will reply to court by saying „we do not know anything" such case make her hopeless to take nursing care." (P2 male,* Shebel health center*).*

## 6. Discussion

### Nurses' preparedness (Knowledge, attitude and skill) to care women exposed to IPV.

Nurses" care for *women exposed to IPV* influenced with demographic factors. Male nurse was more likely to care women exposed toIPV than female nurse. The findings could not be echoing previous work indicating that women patients were more likely to discuss IPV issues with female professionals(53). In addition, study was indicating that female nurses were more prone for screening and giving care to *women exposed to IPV* (54). The discrepancy is that due to more males nurses had taken training than that of females nurses and in this study, training is significant variable that can increase the nurses" care to wards IPV victims. Training was highly significant to care *women exposed to IPV*. Thus, nurses who had training 7.899 times more likely to give care than not had training (multivariate regression). In this study, 94.1% of the participants did not have taken any training. Which is similar finding with other study in Sweden that accounted 92% did not have any training with in 3 years(36).

In this study, nurses who never did care for women exposed to IPV less likely to give care to them. Other study also supportes that when nurses had experience on women exposed to IPV their care also increased. Inadequate experience is as a key factor to routine inquiry and management of women exposed to IPV (42).

Nurse who were knowledgeable more likely to give care than not knowledgeable nurses. In this study over halves of nurses were not knowledgeable. A study showed that the majority of the nurses were unprepared in knowledge to provide nursing care for women exposed to IPV(36).

A study showed that 16.7% nurses from 89 had gave care to women exposed to IPV (55). However, in this study, 40.7% of the nurses had gave care at least once IPV case. It is due to IPV prevalence in Ethiopia(26) different from UK (56) and large participants in these studies.

Nurse‟s specific actions most commonly did after identification of women exposed to IPV were, documentation of the abuse on the patients‟ chart (71.7%) and used a body-map to document patients‟ injuries 75.9%. However, nurses had less used other action photograph, provided referral or resource materials, notified appropriate authorities when mandate, conducted a safety assessment and contacted IPV service provider. There is also similar finding in study in UK, nurses less commonly did other actions like photograph, provided referral or resource materials, notified appropriate authorities when mandate, conducted a safety assessment and contacted IPV service provider (55).

From social barriers nurses listed as barriers to care women exposed to IPV was, culture of community which also mentioned in other studies (57). The other barriers were, low education level, lack of organized security forces, low socioeconomic status of women, lack of social support institutions and lack of legal arrangement affect the care given to women exposed to IPV which is also supported by other study (58).

In the institution, lack of proper place to interview and manage the *women exposed to IPV* was listed dawn by nurses as barriers not give care to them. For example, a study of barriers to screening for IPV in nurses from 10 US sites reported that 91.7% of maternity nurses ($N = 385$) ranked lack of privacy as the number one barrier (59) . In other study identified other institutional barriers, such as lack of time, space, and privacy in healthcare settings, did not employing who had skill full and trained personals as impediments to providing appropriate care for abused women (60) .

Nurses‟ lack of training listed as barriers and they gave highly emphasis to it. A qualitative research on IPV competencies and training needs of nurses in health institution has focused. Nurses identified the training and experiences as a key barrier to providing suitable care for

women living with IPV (61). The other was heavy workload, and the limited time available to identify *women exposed to IPV* or create a safe space for the patients to disclose abuse, nurses raised as barriers, which were also mentioned in other study (62).

From a systematic review of qualitative studies that survivors of IPV want to be asked by health profession but not pressured to disclosure, but patient disclosure is a prerequisite for health professions engagement with IPV (63). Related to women exposed to IPV did not get full nursing care due to turning back to the same environment because of traditional mediation, which make women exposed to IPV to be silent during disclose of the violence at health care institutions then after they will have repeated violation. These also supported by other study (64). They had lack of knowledge on legal rights and also they faced discrimination from the community once their issue disclosed. Similar finding in other study, they did not tell or not attained full services because of such problems, lack of knowledge on legal rights and faced discrimination (65). The women exposed to IPV had lack privacy and the women exposed to IPV did not raise the issue of battering during history-taking (66).

## 7. Conclusion

In summary, the results implied shortcomings regarding to nurses‟ care for women exposed to IPV among the nurses included in the study. More than the halves of nurses were not knowledgeable, negative attitude and even not skillful to IPV. The knowledge and skill of nurses‟ affect the nursing care, which were given to women exposed to IPV. Specifically, lacks of nurses‟ training and exprience were indentified from this study. Training was significantly affecting the care of *women exposed to IPV*.

Many had no skill of the issues around IPV cases identifying and what was to do for them. They did not identify sign of IPV. Over the half of nurses who did care (166 nurses) to *women exposed to IPV*, majority of nurses did not ask women who had sign of IPV, like eating disorders, hypertension, headaches and irritable bowel syndrome, which are the sign of IPV that identified in other study (67).

Barriers described by nurses were; related to social, institutional, nurses and victim barriers. From social barriers nurses listed as barriers to care IPV were culture of community, low education level, lack of organized security forces and low socioeconomic status of women.

Participants also listed the other barriers in the perspective of institutional barriers to care *women exposed to IPV* were list down by participants, lack of space and privacy, and lack of quality resources. Participants also listed the other barriers in the perspective of nurses that act as barriers on the care of *women exposed to IPV*. These were lack of training, workload and fear of diagnosing. Nurses described a fear of revenge and showing body, lack of awareness to their right to get health services, traditional beliefs, and discrimination and did not get witness were barriers from perspective of victims.

## 8. Recommendations

- Strengthening of health services in promoting early nurses‟ training and experience sharing and special emphasis to information on signs and what next action shall be done is recommended.
- Empowerment of nurses by expanding education opportunity about IPV at higher institutions like university is recommended.
- Eventhough, further broad study is required to investigate whether all nurses who are working in Ethiopia governmental health care institutions have the same problems faced or not during the care of women exposed to IPV, it is recommended to higher institutions (nursing colleges) to incorporate in the curriculum with all issues of IPV cases.
- It is recommended East Gojjam zone health offices to open the opportunity of getting training to nurses regarding to women exposed to IPV.
- It is also recommended that free service training during and after graduation at health care institution is necessary.

## 9. Strengths and limitations

Strengths of this cross-sectional study include the use of a validated questionnaire to ascertain the views and practices of nurses in relation to IPV and a 91% response rate, which is high for above the convention for a „good" response to research (75%) (68). Which is mixed type of study incorporated both qualitative and quantitative study. Other strength is that it identified the barriers than other study (67).

The limitation it was not compared other profession like physician and midwifery because differences in the health profession affect the care. Other limitation of this study was the length of the PREMIS tool. The developers of PREMIS specify that it can be completed in about 15 minutes (69). In the present study, several nurses informed the researchers that it took about 25 minutes to complete because of this they found it difficult to fill. This may have affected their responses, particularly when answering the last questions, due to responder feel fatigue (70).

## 10. Implications for research and practice

- Health care institutions can use this study to start nursing training regarding to Women exposed to IPV in order to increase the practices and referral pathways.
- At higher education, nursing schools (college and university), can use it and then incorporate on existing curriculum. Therefore, it is crucial for nursing curriculum devolvement to alleviant such society problem.
- Important for chiefs who are responsible for making decision, like health centers and hospital head, in the recruitment of trained and experienced nurses at health institutions for IPV services.
- Further studies on nurses‟ care for women exposed to IPV at regional and country level is required.

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**Annex one: Participant information sheet in English and Amharic**

Addis Ababa University Faculty of Medicine, Allied health science school of Nursing & midwifery

Quantitative part

Participant Information Sheet

You are invited to participate in a research study to be conducted by MSc student at Addis Ababa University, College of health science, Department of nursing and midwifery. Please read the following statement and ask any unclear questions before you agree to participate.

1. **Topic:** Assessment of nurses‟ preparedness and barriers to care Women exposed to IPV attending at Governmental Health Care institutions.
2. **Objective of the study** To assesses Knowledge, practice and attitude, and barriers to care Intimate partner violated women. The information you provide will help us better understand of nursing care to Women exposed to IPV and barriers that influence nursing care to Women exposed to IPV when they coming to Health institution. We would greatly appreciate your help in responding to this question.
3. **Participation procedure and guide line**

**a.** The information you provide will be kept completely anonymous. That is, your name will not be on any of the forms.

**b.** It will take about 30 minutes to complete the survey.

**c.** The questions are written in Amharic and it is self-administered questionnaire by Nurses.

4. **Participation benefits and risks**

**a.** Your participation in this study does not involve risk that is greater than those are you are experienced in your daily life. You might feel some mild discomfort from reading and

responding to some items on the questionnaire but again, the risk of discomfort is not greater than you might have in your working area or in other normal activities.

**b.** You also may experience some benefits from participating on this project this benefit might be positive feelings from helping an important research study.

**c.** No incentive will be given for participating in this study.

5. **Right to refuse or withdraw;** your participation is volunteer and there is no penalty for you not wanting to participate. This means that you are free to stop at any point or to choose not to answer any particular question or all the questions.
6. **Right as a participant,** you have a right to have any questions about this research project answered. Please direct any question to **haymanot zeleke.** Cell phone 0910371389, e mail haymanot.zeleke@yahoo.com
7. Agree to participate **Yes** _____ **No**_____

   **Signature** _____ **Date** _____

**Section one: Demographic Characteristics of Study Sample**

1. Sex A. male B. female

2. Age A. 20-29 B. 30-39 C. 40-49 D. 50-59 E. >60

3. Religion A. Orthodox B. catholic C. prostates D. Muslim E. other

4. Current area of practice

A. OPD elective ward B. Obstetrics/Gynecology unit C. Emergency ward D. surgical Ward

E. Medical wards F. Other (specify)_____

5. ANY DISCLOSURES women exposed to IPV

A. Never B. None this year C. Less than 20 this year D. 20 or over this year

6. Average number of patients you care for per week *(check one)*:

A. Not seeing patients B. less than 20 C. 20-39 D. 40-59 E. 60 or more

7. FORMAL IPV TRAINING A. Yes B. No

8. Including you, how many nurses practice at your work site? _____

9. And how many physician or assistance practitioners? _____

Section Two**: IPV** KNOWLEDGE**.**

Check one answer per item, unless noted otherwise.

1. What is the strongest *single* risk factor for becoming a victim of intimate partner violence?

a. Age (<30yrs) b. Partner abuses alcohol/drugs c. Family history of abuse d. being female sex

2. Which *one* of the following is generally true about batterers?

I. They have trouble controlling their anger

II. They use violence as a means of controlling their partners

III. They are violent because they drink or use drugs

IV. They pick fights with anyone

3. Which of the following are warning signs that a patient may have been abused by his/her partner? *(check all that apply* [ ] Chronic unexplained pain [ ] Anxiety [ ] Substance abuse [ ] Frequent injuries [ ] Depression

4. Which of the following are reasons an Women exposed to IPV may not be able to leave a violent relationship? *(check all that apply)*

1. Fear of revenge 2. Financial dependence 3. Religious beliefs 4. Children‟s needs

5. Love for one‟s partner 6. Isolation

5. Which of the following are the most appropriate ways to ask about women exposed to IPV? *(check all that apply)*

[ ] "Are you a victim of intimate partner violence?"

[ ] "Has your partner ever hurt or threatened you?"

[ ] "Have you ever been afraid of your partner?"

[ ] "Has your partner ever hit or hurt you?"

*6.* Which of the following is/are generally true how to identify women exposed to IPV? *(check all that apply)*

[ ] There are common, non-injury presentations of women exposed to IPV

[ ] There are behavioral patterns in couples that may indicate women exposed to IPV

[ ] Specific areas of the body are most often targeted in women exposed to IPV cases

[ ] There are common injury pattern associated with women exposed to IPV

[ ] Injuries in different stages of recovery may indicate women exposed to IPV

**Section Three: Attitude**

Mark if Strongly Disagree= 1 Disagree=2 Agree=3 and Agree Strongly=4

| Statements | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| **1.** My workplace encourages me to respond to IPV. | | | | |
| 2. I can make appropriate referrals to services within the community for Women exposed to IPV. | | | | |
| 3. I am capable of identifying IPV without asking my patient about it. | | | | |
| 4. Patients who abuse alcohol or other drugs are likely to have a history of IPV. | | | | |
| 5. Victims of abuse have the right to make their own decisions about whether hospital staff should intervene. | | | | |
| 6. I feel comfortable discussing IPV with my patients. | | | | |
| 7. I am aware of legal requirements in this state regarding reporting of suspected cases of Women exposed to IPV. | | | | |
| 8. I am able to gather the necessary information to identify IPV as the underlying cause of patient illnesses (e.g., depression, migraines). | | | | |
| 9. Victims of abuse could leave the relationship if they wanted. | | | | |
| 10. Health care providers have a responsibility to ask all patients about IPV. | | | | |
| 11. My practice setting allows me adequate time to respond to victims of IPV. | | | | |
| 12. I have contacted services within the community to establish referrals for Women exposed to IPV. | | | | |
| 13. Victims of abuse often have valid reasons for remaining in the abusive relationship. | | | | |
| 14. I am able to gather the necessary information to identify IPV as the underlying | | | | |

| | | | | |
|---|---|---|---|---|
| cause of patient injuries (e.g., bruises, fractures, etc.) | | | | |
| 15. Women who choose to step out of traditional roles are a major cause of IPV. | | | | |
| 16. I can match therapeutic interventions to an IPV patient‟s readiness to change. | | | | |
| 17. I can recognize victims of IPV by the way they behave. | | | | |

**Section Four: Practice Issues**

1. Did you give IPV care for women exposed to IPV? [ ] yes [ ] no
2. How many *new diagnoses* of intimate partner violence (IPV) would you care?

   [ ] None [ ] 1-5 [ ] 6-10 [ ] 11-20 [ ] 21 or more

*3.* From below list, how did you ask to screen women exposed to IPV?

[ ] I screen all new female patients

[ ] I screen all patients with abuse indicators on history or exam

[ ] I screen certain female patients‟ categories only

*4.* How often, have you asked about the possibility of *women exposed to IPV* when seeing patients the following? *Circle the number if your response is never=1, seldom=2, some-time=3 and Always=4*

**a.** Injuries 1 2 3 4

**b.** Chronic pelvic pain 1 2 3 4

**c.** Irritable bowel syndrome 1 2 3 4

**d.** Headaches 1 2 3 4

**e.** Depression 1 2 3 4

**f.** Hypertension 1 2 3 4

**g.** Eating disorders 1 2 3 4

5. In the past 6 months, **which of the following actions have you taken** when you identified IPV? (*check all that apply*)

[ ] Provided information (phone numbers, pamphlet, other information) to patient

[ ] Counseled patient about options she may have

[ ] Conducted a safety assessment for the victim

[ ] Helped patient develop a personal safety plan

[ ] Referred patient

6. **Do you practice in a state where it is legally mandate** to report IPV cases involving competent (no vulnerable) adults? [ ] Yes [ ] No [ ] Unsure

7. **For every Women exposed to IPV you have identified in the past 6 months**, how often have you did:

*Circle if your response is never =1, seldom =2, some-time =3, Always =4*

| | | | | |
|---|---|---|---|---|
| A. Documented patient‟s statements IPV in chart | 1 | 2 | 3 | 4 |
| B. Used a body-map to document patient injuries | 1 | 2 | 3 | 4 |
| C. Photographed victim‟s injuries to include in chart | 1 | 2 | 3 | 4 |
| D. Notified appropriate authorities when mandate | 1 | 2 | 3 | 4 |
| E. Conducted a safety assessment for victim | 1 | 2 | 3 | 4 |
| G. Helped an Women exposed to IPV develop a safety plan | 1 | 2 | 3 | 4 |
| H. Contacted an IPV service provider | 1 | 2 | 3 | 4 |
| K. Provided referral and/or resource information | 1 | 2 | 3 | 4 |

8. Do you provide abused patients with IPV patient education or resource materials? *(Check one)* [ ] Yes [ ] no

Annex Two: Qualitative Part: Barriers **Focus Group Discussion**

Addis Ababa University College of health sciences allied health sciences Department of nursing and midwifery

Consent Form

My name is. ---------- (Interviewer)

I temporarily represent Addis Ababa University, college of health science, Department of Nursing and midwifery. This is a study to be conducted with the objective of identifying barriers to care Intimate partner violated women among women who are attending governmental health care. As the study is directly related to your profession, you are one of the nurses who have been selected randomly to participate in this study. Therefore, you are kindly requested to participate in this study and provide the information required from you. I would like to ask you a few questions if I may, but you can refuse to answer any question I ask. You can also refuse to participate in the study entirely. Your refusal will not restrict you from your job. The interview will last approximately 60 minutes. Your responses will be kept confidential and there will be no way of linking your individual responses to the results of the study findings. We would like to inform you that the responses that you provide to the questions are very essential, not only, for the successful accomplishment of the study, but also for producing relevant information which will be helpful in the planning and implementation of intervention activities for women exposed to intimate partner violence. Are you voluntary to respond to the questions?

Yes; ----proceed with the interview No; ---- thank her and End.

Name of interviewer who sought the consent: _____

Date Signature: _____

Name of supervisor: _____

Focus group discussion guideline

a. What are the socioeconomic barriers that affect the care given to *women exposed to IPV*? How it affect the care?
b. What are the Institutional barriers that affect the care given to *women exposed to IPV* that related to the victim? How it affect the care?
c. What are the barriers that affect the care given to *women exposed to IPV* that related to health staff? How it affect the care?
d. What are the barriers that affect the care given to *women exposed to IPV* that related to the victim? How it affect the care?

አዲስ አበባ ዩኒቨርስቲ ሜዲካል ፋኪሊቲ አጠጠቃላይ ነርስ ት/ቤት

Quantitative part የነርሶች የተሳታፊነት መረጃ ፎሞር

*በባላቻ/ በጎደኛ ተጽኖ የሚደርስባቸውን ሴቶች የሚሰጠው የጤና አገልግሎትን እቅፋት ሊሆኑ የሚችሉትን*

A. *ምን አይነት ማህበራዊ ኢኮኖማዊ ሁነታዎች በባላቻ/ በጎደኛ ተጽኖ የሚደርስባቸውን ሴቶች የጤና አገልግሎትን ተፅዕኖ ያደረሳሉ?*
B. *የጤና አገልግሎት ሰጪ ተቓማት ውስጥ ያሉ ተፅዕኖ ሊያመጡ የሚችሉ ተግዳሮች እንዴት ይገልፀዉታል?*
C. *ምን ዓይነት ተፅኖዎች የጤና ባለሙያውን ሴቶች ከባላቻ ተፅኖ ጋር ይለውን የጤና አገላግሎት ይስተጉላሉ?*
D. *የባላቻ/ጎደኛ ተጽኖ የሚደርስባቸው ሴቶች የጤና እንክብካቤ ላይ በሴቶች በኩል ሊሆኑ የሚችሉ እንቅፋቶች እንዴት ይገልፆቸዋል?*

አዲስ አበባ ዩኒቨርስቲ  ሜዲካል ፋኪሊቲ  አጠጠቃላይ ነርስ ት/ቤት

Quantitative part የነርሶች የተሳታፊነት መረጃ ፎሞር

የተከበሩ ተሳታፊ

1. የጥናቱ ርዕስ፡- ሴቶች በባላቸው/በጎደኛቸው የሚደርሰውን በደል/ጠብ የሚሰጠውን የጤና አገልግሎት የነርሶችን ዝግጁነት እንደዚሁም እንቅፋቶችን ለማጥናት የሚደረግ ጥናት፡፡
2. የጥናቱ አላማ፡- ሴቶች በባላቸው/በጎደኛቸው የሚደርሰውን በደል/ጠብ የሚሰጠውን የጤና አገልግሎት የነርሶችን እውቀት፣ ችሎታ እና አመለቃቀት ዝግጁነት እንደዚሁም እንቅፋቶችን ለማወቅ የሚጠና ጥናት ነው፡፡ አንተ/አንች የምትሰጠው/ጪው መረጃ ሴቶች በባላቸው/በጎደኛቸው የሚደርሰውን በደል/ጠብ የሚሰጠውን የጤና አገልግሎት ለማወቅ ይረዳል፡፡
3. የተሣትፎ ስርአት እና መምሪያ

   ሀ. የሚሠጡት መረጃ ስምዎ ሣይጠቀስ በሚስጥር ይያዛል፡፡ይህም ማለት የእርስዎ ስም በማንኛውም ቅፅ ላይ አይኖርም

   ለ. መጠይቁን ለመሙላት 30 ደቂቃ አካባቢ ይወስዳል

   ሐ. ጥያቄዎቹ በአማርኛ የተዘጋጁ እና ነርሶች እራሳቸው የሚሞሉአቸው ናቸው
4. የተሳትፎ ጥቅም እና አደጋ

ሀ. በእርሶ በዚህ ጥናት መሳተፍ ሁልጊዜ በእለትተቀን ኑሮዎ ከሚያጋጥሞዎ አደጋ የበለጠ አደጋ አያጋጥሞዎትም፡፡ ምን አልባት መጠነኛ አለመመቸት መጠይቁ ላይ ያሉትን ጥያቄዎች ሲያነቡ ሊያጋጥሞት ይችላል ነገር ግን ያለመመቸት አደጋው እለትተቀን በስራ ቦታዎ ወይም በሁልጊዜ እንቅስቃሴዎ ከሚሰማዎት አለመመቸት አይበልጥም፡፡

ለ. በዚህ ጥናት ላይ በመሳተፎ ጥቅም ሊያገኙ ይችላሉ፡፡ይህም ጥቅም ጥናቱን በመርዳትዎ መልካም ስሜት ሊሆን ይችላል፡፡

ሐ. በዚህ ጥናት ላይ በመሳተፍዎ ምንም ማበረታቻ አይሰጥም፡፡

5. ያለመሳተፍ ወይም የመውጣት መብት፡- የእርሶ ተሳትፎ በመልካም ፈቃደኝነት ላይ ይመሰረታል፡፡ፈቃደኛ ባለመሆንዎ የሚደርስቦ ምንም አይነት ቅጣት የለም፡፡ ይህም ማለት በማንኛውም ጊዜ የማቆም ወይም ምንም አይነት መልስ ያለመስጠት ሙሉ መብት አሎት፡፡

6. እንደተሳታፊ መብትዎ፡-ስለዚህ ጥናት ያልዎትን ማንኛውም ጥያቄ ሃይማኖት ዘለቀን ይጠይቁ

ስልክ ቁ. 0910371389  Email  haymanot.zeleke@yahoo.com

7. ለመሳተፍ ተስማሙ  አዎ ተስማምቻለሁ_____

አልተስማማሁም _____  ፊርማና ቀን _____

ክፍል I፡ ስነ ህዝብና ማህበረዊ ጉዳዮች

1. ጾታ [ ] ዎንድ [ ] ሴት
2. እድሜ [ ] 20-29 [ ] 30-39 [ ] 40-49 [ ] 50-59 [ ] >60
3. ሐይማኖት፡ [ ] ኦርቶዶክስ [ ] ካቶሊክ [ ] ፕሮስቴስታንት [ ] ሙስሊም [ ] ሌላ ከሆነ ይጠቀሱ_____
4. አሁን ሚሰሩበት ቦታ [ ] ተመላሽ ህክምና [ ] ማህጠን ና ወሊድ ክፍል [ ] ድንገተኛ ክፍል [ ] ሰርጅካል ክፍል [ ]ሚዲካል ክፍል [ ] ሌላ ከሆነ ይጠቀሱ_____
5. በባላቸወ/በጎደኛቸወ የሚደርስባቸወ በደል/ጠብ የሴቶች ብዛት [ ] ምንም [ ] በዚ አመት ምንም [ ] ከ20 በታች በዚ አመት [ ] ከ20 በላይ በዚ አመት
6. አማካን ህሙማን በሳምንተ አንተ/ች የሚታከሙት ብዛት [ ] ምንም ታካሚ አላከምኩኝም [ ] ከ20 በታች [ ] ከ20-39 [ ] ከ40-59 [ ] ከ60 በላይ
7. በሴቶች በባላቸወ/በጎደኛቸወ የሚደርስባቸወ በደል/ጠብ የታወቀ ስልጠና ወስዳሃል/ወስደሻል? [ ] አዎ [ ] የለም
8. አንተን/ችን ጨምሮ ስንት ነርስ አንድላይ አብሮ ይሰራሉ? _____
9. እንደዚሁም ስንት ሐኪም ውይም ረዳት ሐኪም ከአንተ/ች ጋር አብሮ ይሰራሉ?_____

ክፍል II: እውቀት

ሀ. አንድ መልስ ይመልሱ

1. ሴቶች በባላቸዎ/በጎደኛቸዎ የሚደርስባቸዎ በደል/ጠብ ከሁሉም የበለተ ብቻዉን ሊአጋልጥ የሚችል የትኛው ነው?

[ ] እድሜ (<30yrs) [ ] ባላቸዎ/ጎደኛቸዎ በአልኮል/መዳኒት ሱስ መያዝ [ ]ጾታ ሴት መሆን

[ ] የቤተሰብ ተጽኖ ታሪክ ያላት [ ] አላዎቅም

2. ባለቤታቸዎ/ጎደኛቸዎ ሴቶችን የሚጎሳቆሉ ከሚከተሉት ዉስጥ የትኛዉ ነዉ ትክክል

[ ] ብስጭታቸዎን መቆጣጠር ችግር ስላለባቸዎ ነዉ

[ ]ባለቤታቸዎን/ጎደኛቸዎን ለመቆታጠር ሲሉ በደል/ተጽኖ ያደርሳሉ

[ ] ደል/ተጽኖ የሚያደርሡት ምክናያት መጠጥ/መዳኒት ሱስ ስላለባቸዎ ነዉ

[ ] ከማንኛዉም ጋር መታላተ ስለሚመርጡ ነዉ

3. ሴቶች በባላቸው/በጎደኛቸው የሚደርስባቸው በደል/ተጽኖ ከሚከተሉት ዉስጥ አመልካች ምልክት የሆኑት /መልስ የሆኑትን ምልክት ያድርጉ/ [ ]ሊብራራ የማየችል የቆየ ህመም [ ]ጭንቀት [ ]ሱስ መያዝ

   [ ] ተከታታየ ጉዳቶች [ ]ድብርት

4. ከሚከተሉት መካከል የትኞች ናቸው ሴቶች በባላቸው/በጎደኛቸው ጠብ/ጭቆና የደርሰባቸው ግንኙአቸውን እዳያቆርጡ እንደ ምክኒያት ሊሆኑ የሚቺሉ /መልስ የሆኑትን ምልክት ያድርጉ/?

[ ] በቀል ስለሚፈሩ [ ]ገንዘብ ጥገኝነት [ ]የሀይማኖት አስተሳሰብ [ ]የህጻናቶች ፍላጎት [ ]ፍቅር ስላለባቸው [ ] ብቸኝንት

5. ከሚከተሉት መካከል በታም አግባብ ባለው ሁኔታ በባላቸው/በጎደኛቸው ጠብ/ጭቆና የደርሰባቸውን ሴቶችን መተየቅ የሚመች የትኞች ናቸው /መልስ የሆኑትን ምልክት ያድርጉ/?

[ ] "አንቺ በባሊሽ/በጎደኛሽ ጠብ/ጭቆና ተጠቂ ነሽ?" [ ] "አንቺ በባሊሽ/በጎደኛሽ ጉዳት/ ጥቃት ደርሶብሽ ያውቃል?"

[ ] "ባሊሽን/በጎደኛሽን ትፈሪዋለሽ?" [ ] "ባሊሽን/በጎደኛሽን ደብድቦሽ/ጎድቶሽ ያውቃል?"

6. ከሚከተሉት ውስጥ የትኛው/ዎች እውነት ነው /መልስ የሆኑትን ምልክት ያድርጉ/?

   [ ]ምንም ሳይቆስሉ/ጉዳት ሳይደርስባቸው በባል/በጎደኛ ጠብ/ጭቆና የሚመጡ ሴቶች አሉ።

   [ ]በጎደማሞች የጸባይ ሁኔታዎች ጠብ/ጭቆና ምልክት ሊሆኑ ምልክት የሚችሉ አሉ።

   [ ] ባብዛኛው በጠብ/በጭቆና የተወሰኑ የሰውነት አካላት የሚጠቁ አሉ።

   [ ] በባል/በጎደኛ ጠብ/ጭቆና ተያይዞ የታወቁ ቁስለቶች/ጉዳቶች ሁኔታ አመጣጥ አሉ።

   [ ] በተለያዩ የውጥ/የመዳን ደረጃ ውስጥ ቁስለቶች/ጉዳቶች መከሰት ጠብ/ጭቆና ምልክት ሊሆኑ ይችላሉ።

**ክፍል III: አመለካከት**

በጣም አልስማማም ቁጥር 1ን፣ አልሰማማም ቁጥር 2ን፣ እስማማለሁኝ ቁጥር 3ን እና በጣም እስማማለሁኝ ቁጥር 4ን ምልክት ያድርጉ፡፡

| አረፍተ ነገር | | 1 | 2 | 3 | 4 |
|---|---|---|---|---|---|
| 1. | ቦታ ስለ ባል/ነደኛዋ ጠብ/ጭቆና እንድጠይቅ ይገፋፋኛል፡፡ | | | | |
| 2. | ባል/ነደኛዋ ጠብ/ጭቆና የደረሰባቸው አገልግሎት እዲአገኙ ሪፈር/ማስተላለፊያ እጽፋለሁነኝ፡፡ | | | | |
| 3. | ባል/ነደኛዋ ጠብ/ጭቆና የደረሰባት መሆኑን ምንም ሳልጠይቃት መለየት እችላለሁኝ፡፡ | | | | |
| 4. | በመጠጥ/ በመዳኒት ሱስ ያለባቸው ታካሚውች በባል/በነደኛዋ ጠብ/ጭቆና ታሪክ ይኖርባቸዋል፡፡ | | | | |
| 5. | በባል/በነደኛዋ ጠብ/ጭቆና የተጋለጹ ታካሚውች የሆስቢታል ባለሙያ እንዲከባከቦቸው በራሳቸው ውሳኔ የመወሰን መብት አላቸው | | | | |
| 6. | ከእኔ ታካሚውች ጋር ስለ በባል/በነደኛዋ ጠብ/ጭቆና መነጋገር ምቾት ይሰመኛል፡፡ | | | | |
| 7. | በባል/በነደኛ ጠብ/ጭቆና ስለ ተጠረጠሩ ሴቶች ለማመለከት/ለመጠቆም አስፈላጊ ህጎች የሆኑትን ግንዛቤው አለኝ፡፡ | | | | |
| 8. | የታካሚው ህመም መንሴው በባል/በነደኛ ጠብ/ጭቆና መሆኑን አስፈላጊ የሆኑ መረጃዎችን ማሰባሰብ እችላለሁ፡፡ | | | | |
| 9. | በባል/በነደኛ ጠብ/ጭቆና ተጠቂ የሆኑት ግንኙነታቸውን ከፈለጉ ማቆም የችላሉ፡፡ | | | | |
| 10. | የጤና ባለሙያዎች ስለ ባል/ነደኛ ጠብ/ጭቆና ሁሉንም ታካሚዎች መጠየቅ ግደታ አለባቸው፡፡ | | | | |
| 11. | በባል/በነደኛ ጠብ/ጭቆና ተጠቂ ለሆኑት መልስ እድሰጥ የምሰራበት ቦታ በቂ ጊዜ እዲኖረኝ የተመቻቸ ሁኖልኛል፡፡ | | | | |
| 12. | በባል/በነደኛ ጠብ/ጭቆና ተጠቂ ለሆኑት ማስተላለፍ/ referrals ለማድረግ በአካባቢ ውስጥ ያሉትን አግልግሎቶችን እጠቀማለሁኝ፡፡ | | | | |
| 13. | በባል/በነደኛ ጠብ/ጭቆና ተጠቂ የሆኑት በዚ ግንኙነት የሚቀጥሉበት አብዛኛውን ጊዜ አሳማኝ የሆነ ምክናያት አላቸው፡፡ | | | | |
| 14. | የታካሚዎች ቁስሎች/ጉዳቶች በባል/በነደኛ ጠብ/ጭቆና የሚመጡ መሆናቸውን አስፈላጊ የሆኑ መረጃዎችን አሰባስባለሁኝ፡፡ | | | | |

| | | | | | |
|---|---|---|---|---|---|
| 15. | ሴቶች ከባህላዊ ስራዎች መውጣት በባል/በጎደኛ ጠብ/ጭቆና መጋለጥ ዋነኛ ምክናቶች ናቸው፡፡ | | | | |
| 16. | በባል/በጎደኛ ጠብ/ጭቆና ታካሚዎች እዲቀየሩ አግባብ ያለው ህክምና እሰጣለሁኝ፡፡ | | | | |
| 17. | በባል/በጎደኛ ጠብ/ጭቆና ተጠቂ የሆኑትን በሚአደርጉት ባህሪ መለየት እችላለሁኝ፡፡ | | | | |

ክፍል IV: ችሎታ/ልምድ ጥያቄዎች

1. በባል/በጎደኛ ጠብ/ጭቆና/ተፅኖ የደረሰባቸውን የጤና እንክብካቤ ሰጠዋል

   [ ] አውን [ ] የለም

2. ምን ያክል አዲስ ሴቶች በባል/በጎደኛ ጠብ/ጭቆና መለመልክ/አገኘህ?

[ ] ምንም [ ] 1-5 [ ] 6-10 [ ] 11-20 [ ] 21 ውይም ከዛ በላይ

3. *ከታች ከተዘረዘሩት አንተ/ች ቅርብ ጊዜ* ሴቶች በባል/በጎደኛ ጠብ/ጭቆና ከመለመልካቸው/ሻቸው ምልክት አድርግ/ጊ/መልስ የሆኑትን ምልክት ያድርጉ/

[ ] ሁሉንም አዲስ ሴት ታካሚ ህሙማንን ለመልመል ሁሉንም ጤይቄቸዋለው

[ ] ሁሉንም ሴት ታካሚ ህሙማንን በባል/በጎደኛ ጠብ/ጭቆና የደረሰባቸው መሆኑን የሚያመለክት ታሪክ/ ምርምር ያለባቸው ለመልመል ሁሉንም ጤይቄቸዋለው ::

[ ] የተወሰኑ የሴቶች ምድብ/ጎራ ያሉትን ለመልመል ሁሉንም ጤይቄቸዋለው፡፡

4. *በ 6 ወራት ውስጥ* ከሚከተሉት ህመሞች በባል/በጎደኛ ጠብ/ጭቆና ይሆናል ብለህ/ሽ የጠየካቸው/የጠየክሻቸው *ምን ያክል ናቸው፡፡ በፍጹም ከሆነ 1፣ በጣም ጥቂት ከሆነ 2፣ አልፎአልፎ ከሆነ 3፣ ሁለጊዜ ከሆነ 4 ከሆነ* ይክበቡ፡፡

ሀ. ጉዳቶች/ቁስሎች 1 2 3 4

ለ. የቆየ ዳሌ ህመም 1 2 3 4

ሐ. የሆድ ቁረጠጥ 1 2 3 4

መ. ራስ ምታት/ህመም 1 2 3 4

ሠ. ጭንቀት 1 2 3 4

ረ. ደም ግፊት 1 2 3 4

ሰ. የአመጋገብ ችግር 1 2 3 4

5. *በ 6 ወራት ውስጥ* በባል/በጎደኛ ጠብ/ጭቆና በደረሰባቸው አጉተ/ች የወሰድካቸው/ሻቸው ድርጊቶች ከሚከተሉት ውስጥ ይምረጡ/መልስ የሆኑትን በሙሉ ይምረጡ/

[ ] *በ 6 ወራት ውስጥ* ምንም በባል/በጎደኛ ጠብ/ጭቆና በደረሰባቸው አላገኘሁም መረጃ ሰጥቻለሁ /ስለክ ቁጥር፣ የተዘጋጁ ጽፎች፣ ሌሎች መረጃዎች/

[ ] ሊኖራት የሚችሉ አማራጮችን መክራለሁኝ

[ ] የደህንነት ምርመራ ተጠቂ ለሆኑት አድርጋለሁኝ

[ ] የግል ደህንነት እቅድ እዲሰሩ እረድቻለሁኝ

[ ] መሸኛ ሰጥቻለሁኝ

6. በባል/በጎደኛ ጠብ/ጭቆና የደረሰባቸውን ማስተላለፍ/reporting ህግ በሚያዝዘው ሁኔታ ነው የምትሰራ/ሪ?

[ ] አዎን [ ]አይደለም

7. በ 6 ወር ውስጥ በባል/በጎደኛ ጠብ/ጭቆና ተጠቂዎች የለየሐቸው/የለየሻቸው *ለእያንዳንዱ ምን ያህሉን ነወ አጉተ/ች;*

*መልስህ/ሽ በፍጹም ከሆነ 1፣ በጣም ጥቂት ከሆነ 2፣ አልፎአልፎ ከሆነ 3፣ ሁሌጊዜ ከሆነ 4* ይክበቡ፡፡

ሀ. የታካሚውውን የተናገራቸውን ንግግሮች ዶሲ/ chart ውስጥ መዝግቤአለሁኝ 1 2 3 4

ለ. የታካሚውን ቁስል/ጉዳቶች ለመዝገብ ተጠቅሚአለሁኝ 1 2 3 4

ሐ. የታካሚውን ቁስል/ጉዳቶች ዶሲ/ chart ውስጥ ለመመዝገብ ፎቶ ተጠቅሚአለሁኝ 1 2 3 4

መ. አስፈላጊ ሲሆን የሚመለከተው አካል አሳዊቃለሁኝ 1 2 3 4

ሰ. የደህንነት ምርመራ አደርጋለሁኝ 1 2 3 4

ረ. ተጠቂ ለሆኑት ጥቃት ለመከላከል እቅድ እዲአወጡ እረዳቸዋለሁኝ 1 2 3 4

ሸ. በባል/በጎደኛ ጠብ/ጭቆና ብቁ ባለሙያ ለሆነ አገናኛለሁኝ 1 2 3 4

ቀ.መሸኛ/ መረጃ/ ቁሳቁስ እሰጣለሁኝ 1 2 3 4

8. በባል/በጎደኛ ጠብ/ጭቆና የደረሰባቸውን ስለባል/ጎደኛ ጠብ/ጭቆና ትምህርት ወይም ቁሳቁስ ትሰጣለህ/ትሰጫለሽ? /አንድ ይምረጡ/ [ ]አዎን [ ]አልሰዉም

**DECLARATION**

I, the undersigned, declare that this thesis is my original work, has not been presented for a degree in this or another university and that all sources of materials used for this proposal have been fully acknowledged.

Name: Haymanot Zeleke Signature: _____.

Place: Addis Ababa.

Date of Submission: _____.

This proposal work has been submitted for examination with my approval a university advisor.

Ato Daniel Mengistu (BSC, MSC) Advisor's name Signature_____